Agenda Item: 1.4

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE

DATE OF MEETING	**Thursday 14th March 2024 9.30-12.30**
VENUE	**Microsoft Teams**

PRESENT	Richard Clark - Independent Member (Chair)
	Dafydd Vaughan - Independent Member Digital
	Iwan Jones - Independent Member
IN ATTENDANCE	Robert Holcombe - Director of Finance and Procurement
	Nicola Prygodzicz - Chief Executive
	Hannah Evans – Director of Strategy, Planning and Partnerships
	Rani Dash – Director of Corporate Governance
	Michelle Jones – Head of Board Business
	Jamie Marchant – Divisional Director of Estates and Facilities
	Mark Ross - Assistant Finance Director
	Gregg Bowen – Assistant Finance Director
	Alex Curley - NWSSP Procurement Sourcing
	Stephen Chaney - NWSSP
	Emma Guscott– Governance Support Officer
	Thomas Jaynes – Governance Support Officer
APOLOGIES	Leanne Watkins – Director of Operations

	Preliminary Matters
FPC 1403/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
FPC 1403/02	**Apologies for Absence** Apologies for absence were noted.
FPC 1403/03	**Declarations of Interest** There were no declarations of interest to record.
FPC 1403/04	**Draft Minutes of the meeting held on Thursday 21st December 2023**

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	The minutes of the meeting held on Thursday 21st December were ***AGREED*** as a true and accurate record.
FPC 1403/05	**Committee Action Log** Robert Holcombe (RH), Director of Finance and Procurement, updated that there was a challenge in receiving the specialist enhanced nursing data from other Health Boards for unknown reasons. RH advised that he would seek the information one more time and report this data to the next Committee meeting *The Committee **NOTED** the action log.*
	Items for Approval/Ratification/Decision
FPC 1403/06	**Review of Committee Programme of Business – Committee Self-Assessment** Michelle Jones (MJ), Head of Board Business, presented the Committee Self-Assessment Report for information. MJ thanked members for contributing to the self-assessment process and noted that five responses were received to the questionnaire which were then analysed to provide a summary of responses and recommendations for the improvement of Committee business. MJ advised that the outcome of the assessment confirmed that the Committee was effective and that the Committee was meeting standards of performance Shelley Bosson (SB) Independent Member, commented five responses was disappointing. SB queried a specific action regarding the delivery of training on report writing and whether this would be delivered within the current financial year. Rani Dash (RD), Director of Corporate Governance, responded this would be implemented in the new financial year across the breadth of the Board's business. RD added that the feedback would inform the development of the Committee's forward work plan. *The Committee **NOTED** the performance information contained within the report and **NOTED** that the improvement actions would be included within the*

	Committee Forward Plan 2024/2025 and wider Board Business Improvement Plan.
FPC 1403/07	**Committee Strategic Risk Report** Rani Dash (RD), Director of Corporate Governance, presented the report for decision and noted that the report provided a summary of the strategic risks that had been delegated to the Committee for monitoring on behalf of the Board. RD noted the report also informed the Committee of any significant operational risks identified by the Executive Committee on the Corporate Risk Register that have the potential to impact service delivery. The Committee noted that no new risks had been added since the Board received its last report at the end of January 2024 and the fwp for this committee when developed would provide sufficient assurance on Risks managed by the Committee. Iwan Jones (IJ), Independent Member, queried the risk on financial sustainability and whether this is still a risk as it is now financial reality. RD noted this would be considered by the Executive Committee Meeting on Thursday 14th March when the Strategic Risk Register would be reviewed. *The Committee **NOTED** the report.*
FPC 1403/07	**Committee Annual Report** Michelle Jones (MJ), Head of Board Business, presented the report which summarised the Committee's business during 2023/24. MJ noted that the report specifically included enhanced information in respect of the financial challenges ABUHB had faced over the past year and demonstrated assurance of the work the Committee. Shelley Bosson (SB) Independent Member, commented that it would be useful if the Committee focused on a deep dive approach to provide further assurance. ***Action:***

	• ***Director of Corporate Governance, to add deep dive approaches within the Committee's forward work plan*** *The Committee **NOTED** the report.*
	ITEMS FOR DISCUSSION
	Assurance In Respect of Organisational Performance Management
FPC 1403/08	**Estates Compliance Report, including Internal Audit Review of Estates and Facilities** *Jamie Marchant joined the meeting.* Jamie Marchant (JM), Divisional Director of Estates and Facilities, presented the Estates Condition report for discussion focused on the Health Board's: • Processes for reporting • Conditions of estates JM noted that the Internal Audit report provided limited assurance. The Committee was advised that this was due to the availability of all Wales capital and the availability of the Health Board's capital to fund and manage the estate that in turn had resulted in a backlog of estate work. JM reassured the Committee that the report noted significant matters that required management attention and advised that the Planning Department and Estates Team were addressing these actions along with developing a consistent approach across Wales as to how conditions were to be reported to aid better comparisons. Hannah Evans (HE), Director of Strategy, Planning and Partnerships, assured the Committee that the Planning and Estates Teams were cognisant of the report's findings when the Capital Programme was signed off by the Board in January2024. Richard Clark (RC), Independent Member, asked whether the Estates Strategy needed to be refreshed in respect of the findings of the report and was advised that the Estates Strategy and Capital Prioritisation influence each other. The Committee **NOTED** the report. **Internal Audit Review of Estates and Facilities**

	JM presented the Facilities Internal Audit Report for discussion which advised that reasonable assurance was provided in relation to bank process and rostering. JM stated the report provided unsatisfactory assurance was provided regarding Stock Management with a large number of key matters arising and high priority recommendations. JM assured the Committee that an action plan would be developed to resolve the issues by the end of April 2024. Stephen Chaney (SC), Deputy Head of Internal Audit, reflected the Health Board had good policies and procedures but noted that the issue to address was in relation to staff following procedures. *The Committee **NOTED** the report.*
FPC1403/09	**Performance Overview Report with Exception Reporting** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the Integrated Medium-Term Plan 2023/26 Quarter 3 Progress Report for discussion. HE updated the Committee on the progress made on Outcomes and Performance Framework and noted that: • 22 of the 31 measures had either improved or were statistically similar with 9 indicators deteriorated • Outcome measures for 'Every child has the best start in life' demonstrates good progress, with all indicators either reporting an improvement or sustaining performance levels. • There was mixed progress across the adult life course outcomes. • 5 out of the 7 outcome indicators for Older People had improved or were similar. The two deteriorating indicators were in relation to an increase in older people being free from limiting long term illness and an increase in accepted referrals to Rapid Response Services. • Across the Dying well as part of life priority area good progress was evidence in sustaining all indicator measures.

The Committee also noted the progress in relation to the Ministerial Priorities and Clinical Futures Programmes that included:

- Variable progress continued to be made across the Ministerial priorities and priority programmes with some notable achievements that deliver system change as well as some service areas with persistent challenges. The Committee noted that the current financial context had limited progression of service developments in some areas.
- High demand continues for services that included Primary Care (NHS Dental)and NHS Optometry. Both areas within quarter 3 were exceeding forecasted levels.
- Cancer demand continues to increase, and despite prioritisation of capacity, performance against the reduction in backlog of cancer patients waiting over 62 days and percentage of patients starting definitive cancer treatment within 62 days from point of suspicion had not been achieved.
- The Health Board was ahead of trajectory in eliminating waits of over 156 weeks for treatment. Improvements had also been made to wait times for treatments with a reduction in patient wait times although the Health Board remains off track to achieve Quarter 3 target.
- The growth in total waiting list remains an area of concern largely driven by the outpatient (stage 1) component. Mixed progress was noted across specialities with ENT, Orthopaedics and Ophthalmology currently behind trajectory.
- Challenges remain in the timely provision of mental health assessment and interventions and the Committee was reminded that performance was monitored by Executive Committee.
- The performance of Urgent & Emergency Care system remains a priority due to its fragility. During the period ambulance handovers over one hour increased during the winter period and peaked in January 2024, although this position had improved in February. Good progress continued to be made against milestones including the implementation of a new Falls Pathway, eTriage and Stroke reconfiguration.

HE also updated the Committee on IMTP planning scenario and the following progress was noted:

	• The planning scenarios had largely followed as predicted and was in line with the pressures on the availability of capacity due to delayed discharges and length of stay. • Outpatient and inpatient treatments were ahead of projections as of Quarter 3, reflecting the priority placed in addressing the longest waiting patients and managing demand. Progress had been made in reducing the number of the longest waiting patients for planned care treatments. • The Quarter 3 forecasts were in line with the actual activity for ED attendances with a total of 46,065 attendances during the quarter across all sites. The bed plan had continued to follow the overall expected occupancy levels and demand patterns with Medicine Division running at 99% occupancy against their bed plan and the Community Division at 107%. Iwan Jones (IJ), Independent Member, commented on neuro-developmental progress and how ADHD was diagnosed. HE responded there had had been a significant increase in demands on this service with waiting list substantially being increased when compared to pre-Covid levels. *Action:* • ***Director of Strategic Planning and Partnerships to confirm the ratio of demand and conversion to ADHD diagnosis*** Nicola Prygodciz (NP), Chief Executive, commented this was a significant area of concern and was a priority area and any opportunities to reduce waiting times further in this service would be considered by the Board. *The Committee **NOTED** the position against IMTP 2023/24 commitments as at Quarter 3 and the mitigating and improvement actions in place.*
FPC1403/10	**Quarterly Update on Implementation of the Performance Management Framework**

	Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided an update on changes and the following was noted: • The Performance Management Framework was agreed by Board in September 2024 and was introduced as part of the Escalation Status • 2 Divisions in accordance with the Escalation Framework had been placed into escalation. These were the Mental Health & Learning Disabilities Division and Urgent Care Division. • In February 2024, Welsh Government escalated the Health Board's escalation level from enhanced monitoring to targeted intervention. The committee noted that once the rescheduled inception meeting takes place the Committee would be formally updated. • Corporate teams have completed corporate reviews and findings would be brought back to the Committee. *The Committee **NOTED** the oral update.*
FPC 1403/11	**Monthly Finance Report & Monitoring** Robert Holcombe (RH), Director of Finance and Procurement, presented the report to assure the Committee of the financial performance of the Health Board as of 31st January 2024 month 10. The Committee noted • The financial performance as at the end of January 2024 and forecast position against the statutory revenue and capital resource limits that reported performance of £48.259m and noted that the adverse variance was impacted by energy costs • The savings position for 2023/24 with an overall forecast achievement was £43.3m • The Health Board's underlying financial position was a brought forward value of £89.6m • The capital position as at the end of January was breakeven RH updated the committee that: • The revised Health Board forecast was £52.9m which assumed Welsh Government funding of £88.4m;

	• A forecast deficit range of best-case scenario of £50m to worse case of £58m subject to delivery risk • Reported capital position was break even with a balanced forecast on the assumption that payment policy was not exceeded • Income includes anticipated funding of £33m including the remaining outstanding elements of the pay award • Pay Spend was at a similar level compared with month 9. Month 10 included £0.8m for industrial action cover. • Substantive Pay costs of £58.9m and variable pay costs of £6.7M with Non–Pay Spend (excluding capital adjustments) – was £91.6m in m10 that was an increase of c.£5.1m. This increase was due to regional ophthalmology costs, funding and spend for RIF, WHSSC, and 6 goals. • £43.3 m of savings was forecast with £42.3m identified as green (achievable) RH concluded that the report demonstrated the step progress made in addressing the deficit. *The Committee **NOTED** the report for assurance.*
FPC1403/12	**Draft Annual Plan 2024, including Financial Plan 2025** Robert Holcombe (RH) Director of Finance and Procurement, provided an overview of the Health Board's draft Financial Plan 2024/25. RH advised that the financial plan was predicated on an income assumption of £1,716m. RH noted that the plan aims to improve the revenue outturn; improve the underlying deficit identifies savings in excess of 2% noting that this was the minimum set by Welsh Government and also identifies medium and long-term opportunities to achieve a 3- year financial balance. The Committee noted that the draft 2024/25 forecast identified the following: • £81.4m deficit at the start of 2024/25, that was an improvement of £89m in 2024 • New discretionary funding of £51.8m was included • 2024/2025 target for savings was included of £29.1m • Therefore, a worst-case position for 2024/25 position was £61.9m.

RH noted that the opportunities existed to secure further savings and these included amber opportunities valued at £6.9m and red savings opportunities of £5.4m. RH concluded that if these opportunities and savings were realised, the best-case financial plan 2024/25 was £ 49.5m

Iwan Jones (IJ), Independent Member, commented that the Board was under a statutory duty to balance the budget over three years and sought assurance as to whether there was an opportunity to balance the budget next financial year and what steps need to be taken to bring the finances into balance.

RH advised that work needs to be undertaken in the early part of 2024/25 to progress these medium-term plans.

The Committee ***SUPPORTED*** the draft financial plan being submitted to the Board for approval.

Draft Annual Plan 2024/2025

Hannah Evans (HE) Director of Strategy, Planning and Partnerships, presented the Draft Annual Plan 2024/25. In particular the Committee noted:

- Three-year intent to achieve sustainable services by 2027
- System change areas and priorities that included embedding prevention and population health into work; progressing place-based models of care and suitability in primary and community services; improving urgent and emergency care systems focusing on experience, access and discharge pathways; continuing to prioritise cancer, urgent and the longest waiting patients for planned care and improving.
- To ensure that no patient waited over 156 weeks for treatment for all specialities and noted that a significant challenge was to secure waiting lists of less than 104 weeks.
- Three surgical specialities were not currently forecasted to deliver. The Committee noted that this would impact upon performance in achieving 52 weeks,
- Quantified efficiencies within the Plan as well as other opportunities that had not been quantified and reflected in the plan

	• Increasing productivity through service models was quantified in the plan with other opportunities not yet quantified and reflected in plan. The Committee ***SUPPORTED*** the draft financial plan being submitted to the Board for approval.
FPC1403/12	**Operational Control Checklist** *Gregg Bowen joined the meeting* Greg Bowen (GB), Assistant Director of Finance, presented the Governance and Control Escalation – Operational Control Checklist 2024 report. The report detailed progress made in assessment scores of each division, their compliance and RAG rating. GB provided the Committee with an overall summary of the current reported situation as at the end of January 2024. The Committee noted that: • Divisional budget holders had been completing a Governance Operational Control Checklist for their respective areas since October 2023 and since its inception progress at Divisional level was noted GB advised that the Finance Team had developed an internal assessment checklist to improve financial control and governance that in turn would improve financial sustainability. The Committee noted the assessment scores for each department and the associated movements since October 2023. *The Committee **NOTED** the report*
FPC 1403/13	**An Approach to Reporting Benefits Realisation** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the approach to the realisation of Benefits form Business Case and Investment Reports for information. HE noted that: • The Health Board's approach to benefits realisation process was completed through the multi- divisional Pre-Investment Panel (PIP) which scrutinises business cases prior to Executive Committee. • The PIP process scrutinises Business Cases against a set criterion to ensure projects were suitable for

	investment and noted that benefits realisation was a key element of this process. In terms of benefits realisation processes the following was noted: • Digital, Data and Technology Directorate operates a benefits and business change process as part of its programmes • Value in Health Projects and Investments; reporting and evaluation was required nationally • The Regional Partnership Board evaluates Regional Investment Fund schemes • Post Project evaluations were part of the HM Treasury approach • Ad hoc requests from Welsh Government in respect of reporting against ringfenced monies were also received. Richard Clarke (RC) Independent Member, queried whether savings plans go through the PIP process and was advised that the PIP process was used for investments at present. The Committee ***NOTED*** the report and next steps.
	OTHER MATTERS
FPC1403/14	**Items to be brought to the Attention of the Board and Other Committees** No items were brought to the attention of the Board.
FPC1403/15	**Any Other Urgent Business** No urgent business was raised.
FPC14/0316	**Date of Next Meeting:** 17th June 2024 09:30 – 12:30

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CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING- FINANCE & PERFORMANCE COMMITTEE
ACTION LOG

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Agenda Item - 1.5

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
07/09/2023	**FPC 0709/01.5**	**Committee Action Log ref 2106/02.3** Additional information was requested on Enhanced Care levels and costings in comparison to other Health Boards. Information to be shared with members outside of the meeting.	**Deputy Director of Nursing/ Assistant Director of Finance**	**March 2024**	**Outstanding** Director of Nursing has confirmed that presently this data is not available.
21/12/2023	**FPC 2112/02.1**	**Review of Committee Programme of Business- Draft Forward Workplan 2023/2024** During the review of the planning cycle for 2024-25 it would be determined if there would be further meetings required to cover the profile of work.	**Committee Secretariat/Head of Board Business**	**March 2024**	**Completed** The development of the FWP has been informed by discussions with Executive Directors and discussed at the Executive Committee. The proposed FWP is

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					included on the agenda for the 17th June 2024 meeting at 2.1
21/12/2023	**FPC 2112/03.2**	**An update on the Discharge Programme and Delays** To provide enhanced assurance, the Committee requested that a detailed report come back on discharge plans, actions, and the reconfiguration of the eLGHs.	**Chief Operating Officer and Deputy Director of Nursing**	**June 2024**	**In Progress** This item has been deferred to 9th September 2024 meeting
31/01/2024	**Transferred action; PPHPC/3101/ 03.7**	**Clinical Futures Programme Update** The Chair discussed planned care and the Outpatient Transformation Programme, stating that on visits, some outpatient areas looked underutilised. An update on	**Director of Strategy, Planning and Partnerships**	**June 2024**	**Completed** Included on the agenda for 17th June 2024 meeting item 3.3

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		the Outpatient Transformation Programme would be presented at the Finance and Performance Committee.			
14/03/2024	**FPC1403/02.3**	**Committee Annual Report** Director of Corporate Governance to add deep dive approaches to the Committee's forward work plan.	**Director of Corporate Governance/Secretariat**	April 2024	**Completed** The Forward Work Programme 2024/25 has been discussed at Executive Committee Meeting and is included at agenda item 2.1 of the June meeting.
14/03/2024	**FPC1403/03.1**	**Performance Overview Report with Exception Reporting** Independent Member requested further information on how neuro-developmental referrals are	**Director of Strategy, Planning and Partnerships**	**June 2024**	**In progress** Verbal Update to be given by the Director of Strategy, Planning and Partnerships at the June Committee meeting.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		progressed and how ADHD was diagnosed. Director of Planning and Performance to confirm the ratio of demand and conversion to ADHD diagnosis			

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.
Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

Agenda Item: 2.1

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2024
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance and Performance Committee - Committee Forward Work Plan 2024/25
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Board Business

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Finance and Performance Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2023/24 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

The purpose of the Finance and Performance Committee is to support the Board by providing assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, in accordance with the standards of good governance determined for the NHS in Wales. In doing so, the Committee will seek assurance that there is:

- ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework;
- that arrangements for financial management and financial performance are sufficient, effective and robust;
- that services are improving efficiency and productivity and financial plans are being delivered;
- there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and
- risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

In line with good governance practice, a committee forward work plan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The work plan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

Asesiad / Assessment

The Committee is requested to approve the Committee forward work plan as outlined in **Appendix 1** noting that the work plan will be presented at each Committee meeting for oversight and noting.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee work plan and **NOTE** that it will be brought forward to each future Committee meeting for oversight.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

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Agenda Item: 2.1

Annual Programme of Business for 2024-25

Finance and Performance Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

The purpose of the Finance & Performance Committee is to provide assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, the Committee will seek assurance that there is:

- ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework;
- that arrangements for financial management and financial performance are sufficient, effective and robust;
- that services are improving efficiency and productivity and financial plans are being delivered;

- there is timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services; and
- risks are suitably identified, mitigated, residual risks controlled, and corrective actions are taken as required to sustain or improve performance.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED (Report Title)	Lead	Frequency of Report	Schedule of Meetings			
			QTR 1 Apr to June *17th June 2024*	**QTR 2 July to Sept** *9th September 2024*	**QTR 3 Oct to Dec** *16th December 2024*	**QTR 4 Jan to Mar** 17th February 2025
Preliminary Matters						
Attendance and Apologies	Chair	SI	✓	✓	✓	✓
Declarations of Interest	All	SI	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓
Action Log and Matters Arising	Chair	SI	✓	✓	✓	✓
Reflections of the meeting held	Chair	SI	✓	✓	✓	✓
Committee Governance						
Development of Committee Annual Programme of Business 2024/25	Chai DoCG	AN	✓			
Review of Committee Programme of Business 2024/25	Chair	SI	✓	✓	✓	✓
Committee Risk Report	Chair DoCG	SI	✓	✓	✓	✓
Annual Review of Committee Terms of Reference	Chair DoCG	AN				✓
Annual Review of Committee Effectiveness 2024/25	Chair DoCG	AN			✓	

Outcome of annual Review of Committee Effectiveness 2024/25	Chair DoCG	AN				✓
Committee Annual Report 2024/25	Chair DoCG	AN				✓
Performance Management						
Annual Review of Performance Management Framework	DoSP&P	AN				✓
IMTP/Performance Ambitions for Future Years	DoF&P/DoSP&P	AN				✓
Exception Report on Performance Management Framework	DoSP&P	SI	✓	✓	✓	✓
Performance Report	DoSP&P	SI	✓	✓	✓	✓
Reporting on Benefits Realisation Projects	DoF&P/DoSP&P	SI	✓	✓	✓	✓
Benefits Realisation • Robotic Process Automation- cost and benefit realisation	DoD	AN			✓	
Financial Performance						
Monthly Finance Report and Monitoring Returns	DoF&P	SI	✓	✓	✓	✓
Financial Outlook for Future Financial Year, including Revenue Budget Allocation letter	DoF&P	AN				✓
Value and Sustainability Assurance Reporting	DoF&P	SI	✓	✓	✓	✓

Efficiency Opportunities and Update Report	DoF&P	SI	✓	✓	✓	✓
Commissioning Update Report to include: • Primary Care • CHC • Intra NHS Agreements • SLAs	DoF&P	AN				✓
Service Activity and Performance						
Targeted Intervention Update Report	DoSP&P	SI	✓	✓	✓	✓
Enhanced Monitoring Report – Urgent and Emergency Care	COO	SI	✓	✓	✓	✓
Outpatient Transformation Programme Update	COO	AN	✓			
Stroke Improvement Plan Update Report	DoT&HS	Bi- AN		✓		✓
Focussed Performance Report – Cancer Delivery	MD	AN	✓			
Focussed Performance Report – Theatres	MD	AN		✓		
Focussed Performance Report - CHC	DoF&P	AN			✓	
Focussed Performance Report - Medicines Management	MD	AN				✓
Focussed Performance Report - Workforce	DoW&OD	AN				✓
Focussed Performance Report – Non-Pay	DoF&P	AN				✓

Focussed Performance Report – Discharge Programme	DoN	Bi -AN	✓		✓	
Focussed Performance Report – Primary and Community Care	COO	AN	✓	✓		
Focussed Performance Report – Clinical Support Services	COO	AN		✓		
Focussed Performance Report – Mental Health & LD	COO	AN			✓	
Focussed Performance Report - Surgery	MD	AN				✓
Focussed Performance Report – Corporate	DOCG	AN			✓	
Information Management						
Information Governance Report, including SIRO	DoD	SI	✓	✓	✓	✓
Freedom of Information Act Report	DoCG	BI-AN		✓		✓
Digital and IM&T						
Delivery of Digital Strategy • *Assurance reports from the Digital, Data and Technology Group*	DoD	SI	✓	✓	✓	✓
Update on the Delivery of Specific Digital Programmes to include:- • *Digital and information management and*	DoD	Bi- AN		✓		✓

technology (IM&T) systems • Radiology Informatics System Procurement (RISP) Programme Update						
Capital, Estates and Facilities						
Delivery of Estates Strategy • Capital and estates related objectives and priorities as set out in the Board's IMTP	DoSP&P	AN				✓
Delivery of Specific Business Cases • Capital Business Cases and programmes of work	DoSP&P	SI	✓	✓	✓	✓
• Estates Compliance including compliance with Health Technical Memorandums	COO	Bi-AN		✓		✓

Lead Officer	

Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	!/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Agenda Item: 3.1

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2024
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update on Health Board's Performance and Accountability Framework & Welsh Government Oversight and Escalation Framework
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Trish Chalk, Assistant Director of Planning & Performance Hannah Evans, Director of Strategy, Planning and Partnerships

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

The purpose of this report is to update the Finance and Performance Committee on:

- Progress with implementation of the Health Board's Performance Management & Accountability Framework (PMF), including Divisions in higher escalation, and
- The Escalation levels of the Health Board under all Wales Oversight and Escalation Framework.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

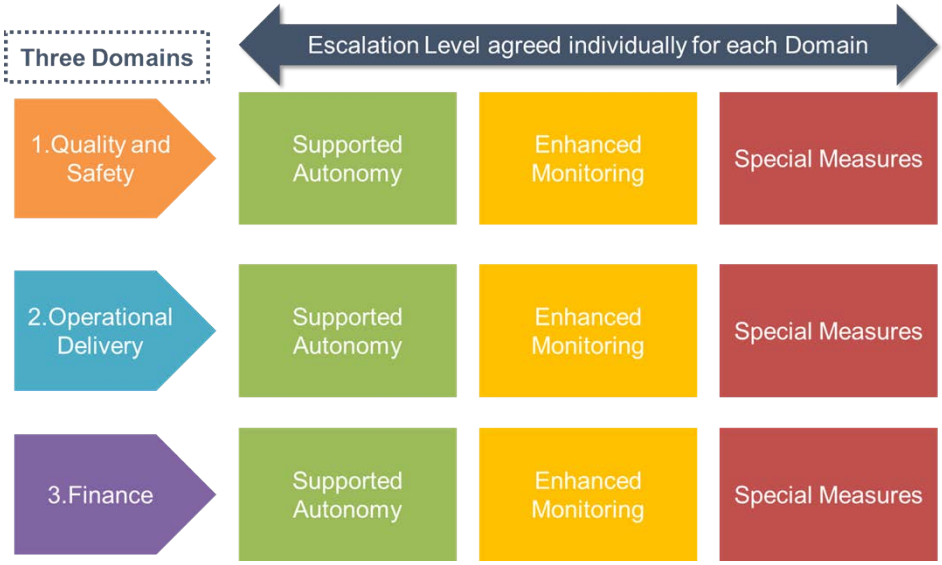
The Health Board's Performance Management and Accountability Framework (PMF) has been in operation since September 2023. The Finance and Performance Committee has previously been updated on the application of the PMF and specifically on the decisions and response to placing Divisions in higher levels of escalation in line with the Framework's triggers. This paper updates the committee on the ongoing application of the framework, noting that the twelve-monthly reviews have not yet concluded.

The Welsh Government re-issued the Oversight and Escalation Framework – NHS Wales Organisations in January 2024. In February 2024, the Health Board's escalation levels were increased from Enhanced Monitoring (level 3) to Targeted intervention (level 4) for planning and finance and from Routine Arrangements (level 1) to Enhanced monitoring (level 3) for performance and outcomes related to urgent and emergency care at The Grange hospital. This paper updates on the Health Board's bespoke escalation framework in response to this, the arrangements for oversight and the key actions.

Cefndir / Background

Health Board arrangements

In September 2023, the Board approved the Performance and Accountability Framework. Section 6 of the PMF sets out the arrangements for escalation using the 3 x 3 model set out below.



The PMF allows for consideration of escalation levels to occur at any time in line with triggers in the same section. However, as a minimum, a formal review of status should occur every 6 months.

After the 6 months review the following status were introduced:

Table 1: Summary of current escalation levels

	ESCALATION DOMAIN		
OPERATIONAL DIVISION	**Quality and Safety**	**Operational Delivery**	**Finance**
Facilities and Estate	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Scheduled Care	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Complex Care	Normal Arrangements	Normal Arrangements	Normal Arrangements
Urgent Care	Enhanced Monitoring	Enhanced Monitoring	Enhanced Monitoring
Medicine	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Primary Care	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Mental Health and LD	Special Measures	Special Measures	Enhanced Monitoring
Family and Therapies	Normal Arrangements	Normal Arrangements	Enhanced Monitoring
Clinical Support Services	Normal Arrangements	Normal Arrangements	Normal Arrangements

Mental Health – status Special Measures Quality and Safety and Operational Delivery

The escalation of the Mental Health Division was initiated by the Health Board following some quality and safety issues and events which emerged during 2023 regarding issues of quality, safety, culture, and leadership. A number of interventions and support have been put in place:

- Development of a 30/60/90-day improvement plan
- Additional support and expertise into Division to support development, delivery and assessment of progress against plan,
- Establishment of fortnightly oversight arrangements including Mental Health and Quality leads from NHS Executive Wales,
- Strengthened and increased oversight by the Executive Committee
- Update and reporting through to the Patient, Quality, Safety and Outcomes Committee (PQSOC)

Urgent Care - status Enhanced Monitoring all domains

The escalation of the Urgent Care Division was initiated by the Health Board in January 2024. This was across the two mains of quality and safety and operational delivery was due to the following reasons:

- Concerns at the sustained implementation of the Safety Flow Model which commenced in May 2023. Whilst there is recognition of improvements there remains concern at the variability and disciple of application of the Safety Flow model.
- Significant waits to be seen remain an ongoing issue for the Division and future assurance required that there be leadership focus on improving this in advance of improvements to waiting areas (via the ED extension BJC) given the significant risk to patients.
- Further improvements are required regarding the system level leadership of the division and oversight including a review of the flow centre model.

An improvement plan was developed and monitored through fortnightly Divsional and wider system escalation meetings, chaired by the COO.

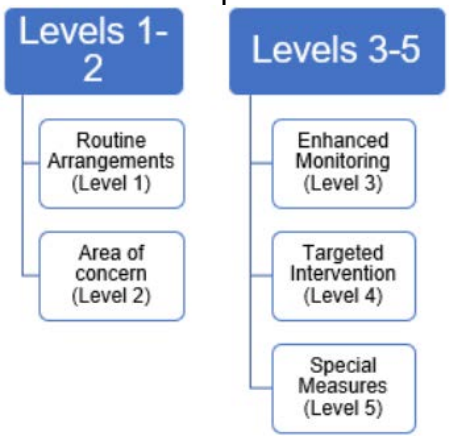
The end of year reviews complete mid-June and the Executive Committee will consider current escalation levels in its meeting of 20th June 2024. The assessment will be informed by:

- Outcomes of 12-month reviews
- In year delivery and management of risks
- In year delivery of financial plan

National Oversight and Escalation arrangements
The Welsh Government Oversight and Escalation Framework – NHS Wales Organisations (Jan 2024) sets out the process by which escalation levels are considered, triggered, and responded to. The escalation levels are considered by tripartite meetings twice yearly between Welsh Government officials, Audit Wales, and Healthcare inspectorate Wales (HIW).

The 6 national escalation domains are defined as:

There are 5 national escalation levels as per below:



As can be seen from above, the domains and levels of the Health Board's local escalation framework and those of the national framework are different although there is some synergy. Opportunities to align further will be explored when a formal review of the Health Board's PMF takes place in quarter 3 to align with the first 12 months of its operation.

Assessment

Implementation of the Health Board's PMF

The end of year (2023/24) reviews complete in mid-June and the Executive Committee will consider Divisional and Corporate escalation levels in line with requirements of the PMF in its meeting of 20th June 2024. The assessment will be informed by:

- Outcomes of 12-month reviews (including quality approaches and KPIs, operational delivery, workforce indicators)
- In year delivery and management of risks
- In year delivery of financial plan

The Committee and Board will be kept appraised of any changes in escalation levels following the imminent review by the Executive Committee.

In addition to reviews and escalation measures, the application and strengthening of the PMF continues, including:

- Accountability letters to be issued by the end of June to include the Budget changes during month 2 and the delivery expectation revisions agreed in the Annual Plan submitted May 31st. This is for all Directors to cover the broader spectrum of deliverables over and above budget delivery and include individual objectives,
- Divisional Director accountability letters in line with the above,
- Revised Performance Report approach and quarterly Integrated Report to be in place for Q1, aligned to commitments in plan,
- Strengthening the role of performance oversight with a restructure of the Assistant Director role to Planning and Performance and revised accountability for the Head of System Planning and Performance.
- Assessment of readiness for and servicing of the additional oversight and monitoring being introduced by Welsh Government (Monthly Chairs meeting with cabinet secretary, Monthly Performance Board meetings with CEOs and Director General and fortnightly meetings of Deputy NHS Wales CEO and COOs).

National escalation arrangements

In September 2023, the Health Board was escalated to Enhanced Monitoring (EM Level 3) for Finance and Planning and in February 2024, the Health Board's escalation levels were increased to Targeted Intervention (TI - level 4) for planning and finance. In addition the Health Board was moved from Routine Arrangements (level) to Enhanced monitoring (level 3) for performance and outcomes related to urgent and emergency care at The Grange hospital.

The requirements associated with the national escalation are set out in the Health Board's bespoke Escalation Framework which is attached in Appendix 1. The framework sets out:

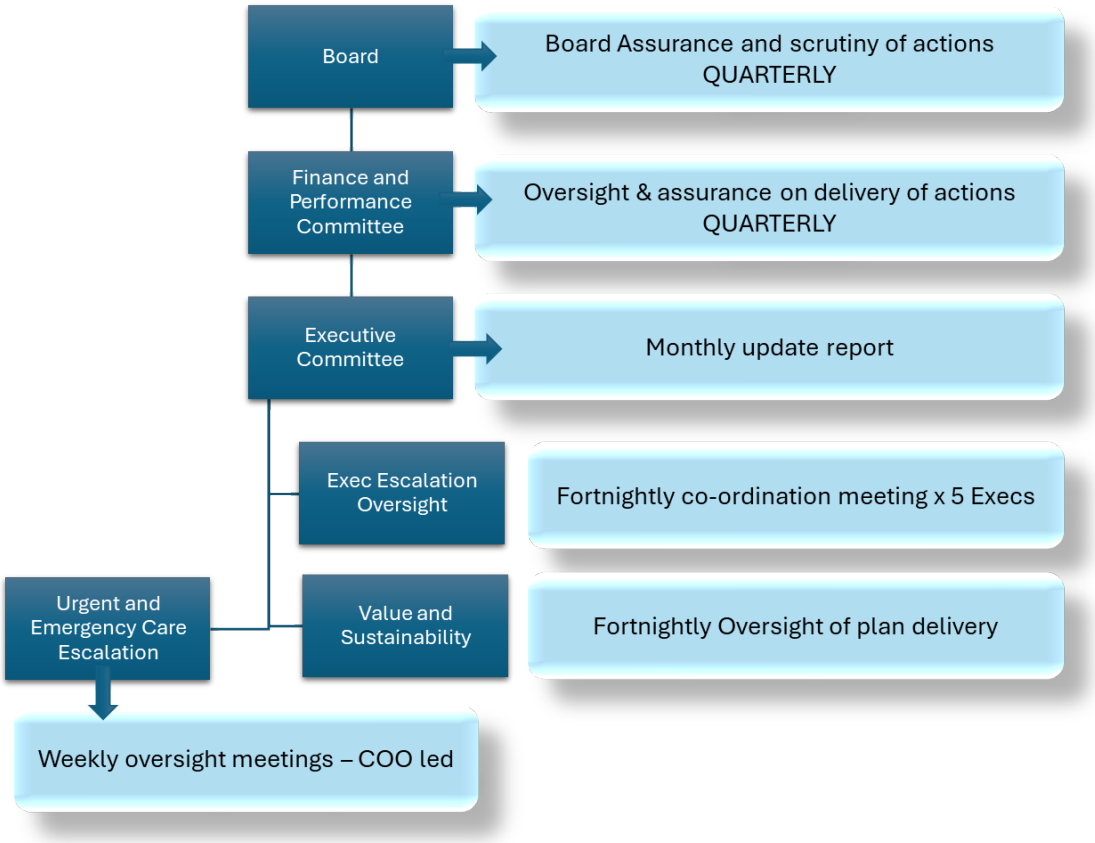
- The oversight and reporting arrangements
- Roles and responsibilities
- The expected outcomes from the escalation process
- The de-escalation criteria for both TI and EM domains

The internal and external reporting and assurance arrangements with the accountable officers are as follows:

Table 2 – Summary oversight arrangements

AREA OF ESCALATION	INTERNAL OVERSIGHT	EXTERNAL OVERSIGHT MTG
Enhanced monitoring – GUH ED	COO led oversight meeting with Operational & Clinical leads– Weekly Executive Team – Increased to weekly Finance and Performance Committee – Quarterly Board	IQPD - monthly
Targeted Intervention – Finance	Value and Sustainability Board – fortnightly cycle Performance management arrangements Finance and Performance Committee – Quarterly Board	Finance Touchpoints with FDU and WG – Monthly
Targeted Intervention – Strategy & Planning	Exec Oversight meting Executive Team Planning Committee Board	Planning Touchpoints - monthly
All escalation oversight	Executive Team Finance and Performance Committee – Quarterly Board	Quarterly escalation meeting with WG – Quarterly JET – 6 monthly Chair meeting with Cabsec*

Internally the following reporting arrangements have been established in line with requirements:



In response to the framework the Health Board have confirmed to following responsibilities:

ROLES	LEAD
AB lead	CEO – Nicola Prygodcziz
AB SRO	DOP – Hannah Evans
Finance lead	DOF – Rob Holcombe
Strategy - Planning Lead	DOP – Hannah Evans
GUD ED lead	COO – Leanne Watkins
Governance and Assurance lead	Director of Corporate Governance – Rani Dash

The national escalation framework sets out the expected outcomes which are expected to be achieved for de-escalation:

Finance	Strategy & Planning	Performance and Outcomes
• Demonstrate both a **robust financial & control environment** through undertaking a review of the financial management arrangements in place, • Clarity on **drivers of the current deficit** to inform a triangulated approach to identify and deliver actions that will improve efficiency and maximise the use of resources. • Clear policies and processes supporting the **identification, delivery and monitoring of all savings schemes** including a clear and robust Opportunities Framework (and Pipeline) • Demonstrate a **clear strategy to deliver a (recurrent) breakeven position** over the medium-term, with a clear roadmap and key milestones for delivery; • Evidence **clear improvement in the planned financial trajectory for 2024/25** including significant progress towards delivery of the Target Control Total	• Improved integrated planning evident across the organisation to develop an approvable IMTP for 2024-26, providing a route map towards the UHB's longer-term ambition. • Refresh the health board's clinical services strategy, underpinned by clinical and public engagement.	• Improved access across urgent and emergency care including: • a **sustained reduction in ambulance handovers**, • a reduction in **the time to be seen by a clinician**, • reduction in the number of **pathways of care delays** and • delivery of **effective flow** through the Grange University Hospital.

The framework also sets out the de-escalation criteria:

For Targeted Intervention these are:

Finance

1. The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
2. Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.

Strategy and Planning

1. Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework.
2. Evidence of a clear roadmap and implementation of the health board's clinical services plan.
3. Welsh Government's confidence in delivery based on an assessment against the planning maturity matrix.
4. Delivery of commitments set out within the annual plan, particularly in relation to the ministerial priorities.

For Enhanced monitoring these are:

- Three-month continuous reduction of at least 15% in each month (from the November 2023 baseline of 859) for ambulance handovers over an hour.
- Continuous improvement towards no more than 5% of patients waiting over 12 hours – to be maintained for three months.
- Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.

The following updates have been provided on the Health Board's response and Progress.

Finance - Targeted Intervention
Further de-risking of the plan and the savings opportunities identified, in the original submission of the financial element of the plan, which was approved by the Board in March 2024, which included **£9.7m** of full year effect of 2023/24 savings plus new 2024/25 opportunities of **£40.5m** presented as **£29.1m** savings and **£11.4m** opportunities. A revised savings assessment consisting of: • **£29.1m** original plan • **£5.4m** new confirmed opportunities converted to saving plans • **£6m work** progressing on opportunities Work has commenced on the options for the 'route map' to service and financial sustainability,' the following areas have been scoped as key pipeline routes, which need to be informed by future service plans, including: • Prevention • Service reconfiguration • Estate reconfiguration • Workforce models (& Variable Pay) • Productivity, Efficiency, and effectiveness of service provision including sustainability • ABUHB Operating Model(s)
Planning – Targeted Intervention
De-escalation will be assessed against an established Maturity Matrix The matrix has been reviewed with learning and support received from Hywel Dda and Betsi Health Board. This has resulted in an updated version for the Health Board with one additional category modelling and forecasting. Sessions have been held with Planning Senior Leadership and wider team reviewing the content and testing application. Session and assessment to be held with Board Planning, Partnerships and Population Health Committee and a stakeholder session with internal and external Partners. Following these sessions an Action Plan agreed for de- escalation will be drafted and applied for next planning cycle commencing August 2024 Work to restate and reframe the organisation's clinical strategy had begun drawing together: - Clinical Futures service models - The reconfiguration of the eLGH services - The emerging work on a regional clinical services plan - National work on key clinical services, eg the Maternity/Neonates work under the Joint Commissioning Committee
Performance and Outcomes – Enhanced Monitoring
An action plan targeted at the de-escalation criteria for emergency care in the Grange Hospital has been developed with some key elements summarised at a high level in Appendix 2. It consolidates and focuses the work previously taken forward under Safety Flow.

The corresponding metrics are attached in Appendix 3. These will be tracked through the COO led weekly oversight meetings as well as externally through the IQPD monthly meetings with Welsh Government.

Argymhelliad / Recommendation

The Finance and Performance Committee are asked to note:

- Progress with implementation of the Health Board's Performance Management & Accountability Framework (PMF), including Divisions in higher escalation,
- Note that a formal review of Divisional and Corporate escalation levels will take place before the end of June in line with completion of reviews,
- The Escalation levels of the Health Board under all Wales Oversight and Escalation Framework.
- Note the wider actions conducted and planned to continue to strength the approach to performance management and accountability.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	007
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply All Health & Care Standards Apply Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

APPENDIX 2 – Summary of actions for Enhanced Monitoring

Ambulance Handover >1hr focus	WTBS push to 1hr focus incl. triage	Time in ED department <12hr focus	Misc./Wider support
• **Escalation process of actions incl. 2 & 4 hours -** Steve	• **E Triage** – maximisation and evaluation – Chris	• **Short – stay / CDU** – Alistair	• **E-referrals process –** James C
• **WAST Flow centre compliance tracking re eLGH options** – Carl L	• **Business Case for Consultants** – Owain	• **24hrs in ED refresh focus** – Steve	• ***GIRFT* – GP Expected – Protocol for GP expected that come to ED into assessment areas –** Charlotte
• **Ambulance timely assessment – As per WAST request for portering in December**	• **Assessment space hold/SOPs/ring fenced** - Paul	• ***GIRFT* – Direct to specialty referral when under pressure** – Owain or nominated ED consultant	• **System to track on the day / next day staffing issues –** Paul / Tracy / Julie
• **PRU case development and decision**	• **Triage Working Group Outputs and changes -** Chris	• **Acute Frailty Response & CAATT feedback and developments to 7 days**	• **Community/Hospital/CHC capacity mapping –** Linda •
	• **Service model for phase 2 of ED extension to support department**	• **'Mapping workshop' outputs and next steps?**	• **UC Dashboard visibility and development -** Lloyd
			• **Review the roles & responsibilities of the Ops/Flow team (inc. daily beat/meetings etc.).** Carl & Steve

APPENDIX 3 – ENHANCED MONITORING BASELINE METRICS

The Grange University Hospital Emergency Department, Aneurin Bevan UHB													
GUH Emergency Department	**Baseline Nov-23**	**De-escalation Requirement**	**Dec-23**	**Jan-24**		**Feb-24**		**Mar-24**		**Apr-24**		**May-24**	
				Actual	**Difference from previous month**	**Actual**	**Difference from previous month**	**Actual**	**Difference from previous month**	**Actual**	**Difference from previous month**	**Actual**	**Difference from previous month**
Ambulance handovers over 1 hour	859	528	821	903	10.0% increase	728	19.4% reduction	691	5.1% reduction	831	20.3% increase	830	0.1% reduction
% of patients waiting 12 hours or more in ED	15.8%	5%	19.0%	19.6%	0.7 percentage point increase	19.2%	0.5 percentage point reduction	18.6%	0.6 percentage point reduction	21.2%	2.6 percentage point increase		
Median time from arrival at ED to assessment by a clinical decision maker (mins)	142	60	178	179	2 mins slower	169	10 mins quicker	171	2 mins slower	185	14 mins slower		
GUH Emergency Department only - Enabling measures													
Number of people admitted as an emergency who remain in an acute or community hospital over 21 days since admission for Aneurin Bevan[3]	750	643	737	792	7.5% increase	735	7.2% reduction	713	3.0% reduction				
Number of pathways of care delays due to awaiting completion of nursing / AHP / Medical / Pharmacy assessment	18	15	13	19	46.2% increase	23	21.1% increase	27	17.4% increase	7	74.1% reduction		
Proportion of all Wales responses to ED Patient Experience Survey received by Aneurin Bevan	<1%	19%[1]				1.2%							
Average Experience Rating to ED Patient Experience Survey		7.47 [2]				5.99							
Number of National Reportable Incidents[5]	0		2	1	50.0% reduction	0	100.0% reduction	2					
Number of never events	0		0	0	no change	0	no change	0	no change				
Number of Business Continuity Incidents	0												

Measure	**Baseline Q3 23/24**	**De-escalation Requirement**	**Q3 23/24**	**Q4 23/24**	
				Actual	**Difference from previous quarter**
Number of new complaints received during the quarter where the complaint setting was the emergency department	48		48	57	18.8% increase

Health, Social Care and Early Years Group
Welsh Government

Aneurin Bevan University Health Board

Escalation Framework

May 2024

Llywodraeth Cymru
Welsh Government

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Section A Introduction

The NHS Wales oversight and escalation framework sets out the process by which the Welsh Government maintains oversight of NHS bodies and gains assurance across the system. It describes the escalation, de-escalation and intervention process, the five levels of escalation and the domains against which each health board will be assessed.

A NHS body can be escalated for any or all of the domains highlighted below:

<u>Finance, strategy and planning</u>
In September 2023, Aneurin Bevan University Health Board was escalated to enhanced monitoring for finance and planning.

In January 2024, the health board was escalated from enhanced monitoring to targeted intervention/level 4 for finance, strategy and planning.

<u>Performance and outcomes</u>
In January 2024, Aneurin Bevan University Health Board was escalated to enhanced monitoring for performance and outcomes related to urgent and emergency care at the Grange University Hospital Emergency Department.

This document sets out the key areas to be addressed as part of the escalation and the expectations for improvement.

Section A1 Welsh Government approach to oversight and escalation

Information on the escalation and intervention approach can be found in the NHS oversight and escalation framework.

To optimise the capacity, efficiency and effectiveness across health care settings, prudent health care principles and value-based healthcare will be the basis on which services are planned and delivered. Value in health care is realised when the best possible health care outcomes is achieved for our population with the resources that we have.

Interventions will be:

- Collaborative – we will seek to minimise duplication by working collaboratively with other national committees, groups and programmes.
- Collective – we will maximise shared knowledge by sharing common approaches, tools, guidance.
- Impact focussed - we will examine and seek assurance and evidence how organisations are obtaining assurance over delivery and impact of actions.
- Be undertaken with openness; transparency; and mutual trust and respect between the health board, Welsh Government, and the NHS Executive.

Assessment and monitoring

Escalation will result in additional scrutiny being applied to those areas of concern.

Whilst in escalation:

- Normal performance management arrangements will continue through the Integrated Quality, Planning and Delivery Board (IQPD) and Joint Executive Team (JET) meetings.
- There will be quarterly escalation meetings chaired by the Director General of the Health and Social Services Group / Chief Executive NHS Wales.
- Welsh Government will agree with the health board whether a monthly progress report on the key areas in escalation will be required. For areas such as finance, this will include extant reporting arrangements such as the monthly monitoring return to Welsh Government.

Inception meeting

The inception meeting will review and agree the escalation plan (including targeted intervention and enhanced monitoring). The plan will set out the key objectives and key products; the composition of the project team; the ongoing monitoring and scrutiny approach.

Escalation Touchpoints

- Frequency of the finance and planning touchpoint meetings will be agreed with the NHS Executive - these will examine progress made against the action log, review

evidence and agree outputs for inclusion at the Welsh Government led escalation meetings.

- An oversight meeting, chaired by Welsh Government will be established to oversee the enhanced monitoring performance recovery at the Grange University hospital. It will bring together Welsh Government, NHS Executive and Aneurin Bevan University Health Board leads to co-ordinate and deliver the interventions as required within the enhanced monitoring improvement framework to support sustained service improvements.
- A quarterly escalation meeting chaired by the Director General of the Health and Social Services Group / Chief Executive NHS Wales.

A2 Aneurin Bevan University Health Board - Escalation

The health board is escalated to enhanced monitoring and targeted intervention for different domains of the escalation framework.

Expected outcomes

The escalation and related interventions are designed to help support the health board to:

Finance

- Demonstrate both a robust financial governance and a robust financial control environment through undertaking a review of the financial management arrangements in place, against an appropriate best practice framework(s) and developing and implementing an action plan to address any gaps in approach.
- Clearly articulate the drivers of the current deficit to inform a triangulated approach to identify and deliver actions that will improve efficiency and maximise the use of resources.
- Demonstrate clear policies and processes supporting the identification, delivery and monitoring of all savings schemes. This should include having a clear and robust Opportunities Framework (and Pipeline) that contains realistic opportunities to support and manage the short-term challenges being faced, as well as driving the larger-scale transformational changes that will support long-term sustainability.
- Demonstrate a clear strategy to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery; this will need to be an integrated plan, with clear and realistic planning assumptions, which triangulates with the Organisation's longer-term strategic objectives around service delivery, workforce, infrastructure, etc.
- Evidence clear improvement in the planned financial trajectory for 2024/25 including significant progress towards delivery of the Target Control Total; improved grip and control of the existing financial and operational pressures; and further progress around identification and delivery of opportunities.

Strategy and Planning

- Improved integrated planning evident across the organisation to develop an approvable IMTP for 2024-26, providing a route map towards the UHB's longer-term ambition.

- Refresh the health board's clinical services strategy, underpinned by clinical and public engagement.

Performance and outcomes

- Improved access across urgent and emergency care including a sustained reduction in ambulance handovers, a reduction in the time to be seen by a clinician, reduction in the number of pathways of care delays and delivery of effective flow through the Grange University Hospital Emergency Department.

Roles and responsibilities

Welsh Government

1. Support a formal structure for reviewing and reporting progress.
2. Signpost relevant best practice guidance and frameworks.
3. Act as a critical friend and sounding board on existing practices and new developments.
4. Review and provide feedback on developed products.
5. Direct the NHS Executive to provide support when agreed in line with the enhanced monitoring plan.
6. Provide additional analytic capacity to the health board to develop, undertake and share relevant analysis and deep dives of local and national data.
7. Provide additional capacity to the health board to support the development of specifically identified reports or products.
8. Enable shared approaches to key national issues across Welsh organisations and promote shared learning.

Aneurin Bevan University Health Board

1. Appoint an SRO(s) for the areas in escalation.
2. Have board ownership and oversight with a clear governance structure, ensure that the Board is appraised of the escalation plan and evidence regular progress updates to the Board on progress against de-escalation criteria.
3. Agree the targeted intervention plan and enhanced monitoring plans and commit sufficient resources to ensure that the plan deliverables are achieved.
4. Provide monthly progress reports and evidence against the escalation plan to Welsh Government.
5. Strengthen the formal review mechanisms to support urgency in delivering confidence and improvement to the financial position.

Section B Targeted Intervention

Targeted intervention (Level 4) is the second highest level of escalation within the NHS oversight and escalation framework. The Welsh Government will take and co-ordinate action and direct intervention to support the NHS organisation to strengthen its capability and capacity to drive improvement. The interventions will normally be undertaken by the NHS Wales Executive directed by Welsh Government. If appropriate, external support will be agreed with the organisation.

It is applied when organisations have serious problems and where there are concerns that they cannot make the necessary improvements without external support. It consists of a set of interventions designed to remedy the problems within a reasonable timeframe. Support will always be designed and delivered within the relevant organisational context and specific support needs will be reviewed through regular oversight meetings and additional enhanced oversight arrangements.

B1 Finance, strategy and planning

In September 2023, Aneurin Bevan University Health Board was escalated to enhanced monitoring for finance, strategy and planning as the health board was unable to produce an approvable balanced three-year plan in accordance with the direction given by Welsh Ministers and the NHS Planning Framework, which could be considered for approval under section 175(2A) of the NHS (Wales) Act 2006 (“the 2006 Act.

In January 2024, the health board was escalated to targeted intervention for finance, strategy and planning.

The finance, strategy and planning domain within the oversight and escalation framework gives consideration to the following:

- Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?
- Is the organisation able to deliver against plan and accountability conditions?
- Is there a significant underlying deficit and/or significant gap to the financial plan?

At month 6, the health board submitted an Accountable Officer letter to revise the forecast outturn position to a deficit of £145.7m, £32.8m adverse to the original plan of £112.8m. Following receipt of the additional Welsh Government Funding (£88.4m) in month 7, the forecast deficit was revised to £57.6m which did not align to the Target Control Total (TCT) of £13.0m. At month 7, the health board did not have a plan to enable the TCT to be achieved.

The finance intervention and focus whilst in targeted intervention covers the following areas and the health board will be required to action and demonstrate:

Financial governance and control environment

- The financial governance framework at the health board is robust in both design and implementation, including a self-assessment against best practice frameworks.
- The financial committee structure is clearly articulated and addresses key risks;
- Financial reports and supplementary presentations include the analysis and narrative explanation required to enable management and board to discharge their duties.
- Financial controls at the health board are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews or other control reviews.
- The finance function has the necessary capacity and capability to support the needs of the wider organisation.
- Budget holders and managers are held to account for delivering their financial plans.
- That as a result of the above, it has developed and is delivering an action plan to improve the financial governance and financial control environment.

Understanding the existing deficit and key drivers

- There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- It has reviewed prior year investments to assess whether the planned benefits have been delivered.
- Has a robust process for challenging underlying deficits reported at local divisional levels.
- The impact of the Grange investment has been fully reviewed including an assessment of reasons for deviation from the business case and any mitigating actions to be taken.
- The cost drivers and investment decisions responsible for the growth in workforce and non-pay are well understood.
- That as a result of the above there are triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

Development and realisation of opportunities

- Has a clear process and approach across the organisation to support the identification, delivery and monitoring of all savings schemes.
- Has a clear and robust Opportunities Framework and Pipeline that contains realistic opportunities to support and manage the short-term challenges being faced.
- Is translating national opportunities identified through the Value and Sustainability Board into local savings.
- Has clear policies and processes in place to enable budget holders and managers to realise and deliver identified savings schemes.
- Value based health care principles have been embedded across the organisation.

Clear financial plan and strategy

- An integrated and triangulated plan, with clear and realistic planning assumptions to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery; and
- A clear engagement plan to communicate the necessity for financial improvement across the organisation.

Delivery of Plan

- It is delivering clear improvement in the planned financial trajectory for 2024/25 (i.e. significant progress towards delivery of the Target Control Total), including further progress around identification and delivery of recurring opportunities.

Strategy and Planning Intervention

The strategy and planning intervention and focus whilst in targeted intervention covers the following areas and the health board will be required to action and demonstrate:

1. Submission and delivery of an approvable plan

- Deliver a credible annual plan as a stepping stone towards a full and financially balanced IMTP.
- Make good progress in delivering the ministerial targets, accountability criteria and the enhanced monitoring requirements.

2. Clinical strategy

- Demonstrate how the clinical strategy and plan are driving decision making across the organisation.

De-escalation Criteria

Finance

1. The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
2. Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.

Strategy and Planning

1. Submission of a balanced and credible three-year medium-term plan or acceptable annual plan in line with the current planning framework.
2. Evidence of a clear roadmap and implementation of the health board's clinical services plan.
3. Welsh Government's confidence in delivery based on an assessment against the planning maturity matrix.
4. Delivery of commitments set out within the annual plan, particularly in relation to the ministerial priorities.

Section C Enhanced Monitoring

Enhanced monitoring (level 3) occurs when Welsh Government has identified serious concerns related to the NHS organisation - this may include ongoing performance challenges, a growing financial deficit, inability to produce an integrated medium-term plan.

Monitoring will be more frequent than that carried out under routine arrangements and may also take a wider variety of forms, including regular interactions and meetings in addition to written progress updates and submission of evidence, including updated action plans and qualitative and quantitative data.

The NHS organisation will need to demonstrate that it is taking a proactive response to the escalation and will need to put in place effective processes to address the issue(s) and drive improvement itself. Welsh Government will co-ordinate activity to closely monitor, challenge and review progress.

C1 Performance and outcomes related to the emergency care pathways at the Grange University Hospital Emergency Department

In January 2024, Aneurin Bevan University Health Board was escalated to enhanced monitoring for performance and outcomes related to urgent and emergency care pathways at the Grange University Hospital Emergency Department.

The performance and outcomes domain within the oversight and escalation framework gives consideration to:

- Is performance in line with agreed trajectories and national requirements?
- Are issues delivering against plan and accountability conditions identified and addressed appropriately in a timely manner?
- Are outcomes measured and monitored appropriately, with any changes identified, investigated, and actioned promptly?
- Are contracted services managed appropriately?

There are concerns regarding the urgent and emergency care pathway including quality of care, patient experience and handover performance at the Grange University Hospital Emergency Department.

The performance and outcomes intervention and focus whilst in enhanced monitoring covers the following areas and the health board will be required to action and demonstrate:

1. <u>Establish baseline and agree improvement plans</u>

- Undertake a current situation report to highlight the baseline and opportunities. This will be repeated at agreed milestones to provide assurance to Welsh Government and the Board that progress is being made or where further interventions are required.
- Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.

2. Implement improvement plans

- Improve unscheduled care performance to ensure that patients access safe, timely and clinically effective unscheduled care services, reducing waiting times, delays and improving quality.
- Deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.

3. Work with national programmes and respond to external reviews

- Work with and implement the recommendations from national programmes including but not limited to Strategic Programme of Primary Care and the Six Goals for Emergency Care.
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

De-escalation criteria

De-escalation criteria are set out below and should be maintained for at least 3 months before de-escalation will be considered. Performance data will be enhanced by a monthly progress report from the health board across a range of measures.

Urgent and emergency care de-escalation criteria at the Grange University Hospital Emergency Department

- A three-month continuous reduction of at least 15% in each month (from the November 2023 baseline of 859) for ambulance handovers over an hour.
- Continuous improvement towards no more than 5% of patients waiting over 12 hours – to be maintained for three months.
- Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes and maintained for three months.

The below metrics are enabling metrics to support the achievement of the above criteria, at the Grange University Hospital Emergency Department:

- A three-month continuous reduction of at least 5% in each month (from the November 2023 baseline) in the number of people admitted as an emergency who remain in hospital over 21 days since admission.
- A three-month continuous reduction of at least 5% in each month in pathways of care assessments issues (from the November 2023 baseline).
- Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to urgent and emergency care.
- Assessment of declared BCIs, including reasons why, actions taken, and lessons learnt.
- Evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

The above metrics, and monthly reports will form the basis of an assessment by the Welsh Government and NHS Executive as to the confidence levels of the health board's ability to maintain and sustain improvements.

Section D Document Rendition

Date Created	Updated	Review date
11 March 2024	Circulated to ABUHB for comment and discussion at their inception meeting. Meeting unable to proceed.	
21 March 2024	Revised version sent to ABUHB, and comments requested prior to the inception meeting.	
4 April 2024	Amended to include use of Datix and Civica in de-escalation criteria.	
8 April 2024	Amended strategy de-escalation criteria.	
16 April 2024	Amended in light of comments following inception meeting.	
13 May 2024	Amended strategy, planning and finance with removal of regional planning work.	
23 May 2024	De-escalation criteria for performance and outcomes amended, as agreed at quarterly escalation meeting on 17 May 2024.	

Agenda Item: 3.2

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2024
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Performance Report – April 2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Trish Chalk Assistant for Director Planning and Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide the Finance and Performance Committee with an overview of performance against the key Ministerial Priorities. It complements the Annual Plan Quarterly Outcomes Report that is produced each quarter and covers the broader spectrum of Annual Plan commitments.

This new format of the performance report has been developed to provide assurance on key performance deliverables on the intervening months between the fuller Quarterly Outcomes report. This report therefore focusses on specific performance against the organisation's key priorities in line with the national performance framework. Please refer to the monthly metrics report in Appendix 1 for the analysis and actions.

The Committee is asked to:

- **Note** the progress achieved at the end of April 2024,
- **Note** the planned Actions against each Measure.

Cefndir / Background

The Annual Plan for 2024/25 sets out the vision for the organisation, that is to improve population health and reduce health inequalities experienced by our communities.
This report provides an overview of activity and performance updates where available as at the end April 2024, with a focus on delivery against key national targets included within the performance dashboard.

Asesiad / Assessment

The report details performance and delivery across five priorities:

1. Embedding Prevention and Population Health in all that we do
2. Progressing place-based models of care and sustainability in Primary and Community Services
3. Improving our Urgent & Emergency Care system focusing on experience, access and discharge pathways
4. Continuing to prioritise cancer, urgent and the longest waiting patients for planned care
5. Improving our Mental Health services

Priority 1 - Embedding Prevention and Population Health in all that we do
The vaccination performance for those who are up to date with scheduled vaccinations has remained stable at 87% for the past 3 quarters. The compliance for those receiving the HPV vaccination remains below compliance at 67.8 %. This is the lowest it has been in 3.5 years and notably so in boys.
The quarterly information against the ambition to increase weight and measurement at 8 weeks rates (Healthy Child Wales) has remained highly variable. The highest quarter was 62.5% and lowest quarterly compliance was 16.8%. However, since this low point in Q1 of 2022/23 the compliance has increased each quarter and is displaying an upward trend.

Priority 2 - Progressing place-based models of care and sustainability in primary and community services

Activity across General Medical Services (GMS) has increased in April with 322,858 appointments seen against an average of 333, 223 appointments since April 23. The trend in urgent primary care has been consistent since July. Activity in General Optometry Services (GOS) for Eye Health Examinations Wales (EHEW) has returned to previous trend since January.

There continues to be an increasing trend in use of the common ailments scheme since August 2023, stabilised at circa 5,000 in February, March and April 2024. All community pharmacies are now signed up to the common ailments scheme (CAS). The current priority is to continue to prioritise and support the increase in capacity.

Referrals in Palliative Care Services assessed within 2 days has seen a recovery in performance to 98%. The Rapid Response performance has seen a gradual increase through the last year after a notable change in September 2023. In April – September 2023, proportions were circa 9%. Since January 2024, proportion have

been maintained at 11%. Community Resource Teams (CRT) are now accepting referrals up until 5pm with a new pilot to be launched hosting a CRT consultant within the Flow Centre, with assessment by end of June.

Priority 3 - Improving our Urgent & Emergency Care system focusing on experience, access and discharge pathways

Urgent Care services continue to be under significant pressure both nationally, regionally and locally, making delivering timely care challenging. This is in the context of high demand and acuity and high levels of delayed discharges linked with significant social care workforce challenges.

Over the reporting period there has been no notable change in performance or improvement for a number of the metrics. There is additional oversight and reporting of a subset of these key metrics via the weekly escalation meetings in response to Enhanced Monitoring escalation levels.

During April 24, there was an increase in Hospital 2 Home & Step Closer to Home rates showing a decreasing trend from September 2023 where the range was 10-15/month down to a current position of 5-10/month.

The priority to reduce the number of Ambulance Handovers has seen a return to previous performance levels, the improvement noted in February and March has not been maintained.

There are many actions and programmes in progress to improve performance in Urgent and Emergency Care. Notable programmes included the Discharge Board, learning from the patient safety events, estate configuration, and realignment of the discharge resources across the whole pathway. Whilst it is noted these are yet to yield sustained improvement in performance of these key metrics, more assessment of the timescale for change is needed.

The Stroke measures are under review but are an important addition to the suite of metrics in urgent and emergency care. One area that has seen a small improvement is the percentage patients assessed by therapies (one of OT, PT, SALT) within 24 hours. There has been a gradual increase in all areas since October 2023, settled to around 30% notably up from 20% in SALT.

Priority 4 - Continuing to prioritise cancer, urgent and the longest waiting patients for planned care

Planned Care

The Health Board has a small number of 156 week waits (52) at the end of April, compared to the March 2023 position of 553, these are exclusively in ENT and Orthopaedic spines with specific actions put in place to recover this position in May.

Up to the end of April 2024 the number of patients waiting (all stages) over 104-week are increasing. In outpatients at the end of April 2024, there were 2,210 patients waiting over 104 weeks for a first outpatient appointment compared to 999

at the end of April 23. Most of this increase is in the specialties of ENT & Ophthalmology.
For those waiting for treatment at the end of April 2024, there were 1,807 patients waiting over 104 weeks for a first outpatient appointment compared to 1,430 at the end of April 23. Most of this reduction was in the specialties of Urology & T&O.

Maximising an individual's time is a core element of planned care. Eliminating two and three year waits for treatment is a primary objective of planned care recovery and as such, performance against trajectory for 52 weeks has seen a decrease in performance which is expected to continue.

Updated trajectories and associated actions for planned care were submitted on 31 May 2024 against new Welsh Government targets. This is subject to a separate paper for the committee. The Ophthalmology Regional Programme capacity has been factored into these projections and improves the 104 week position significantly.

Cancer

At the end of April 2024, the compliance rate with the Single Cancer Pathway (SCP) was 54.6% compared to 55.8% at the end of April 2023. Throughout 2023/24 the compliance rate was fluctuating around 60%.

Head & Neck, Sarcoma, Colorectal, Gynaecological and Urological are the tumour sites where targeted improvement is required (40% or below for the last 13 months).

The backlog of patients waiting over 62 days at the end of April 2024 was 398, it was 338 in April 2023. Up to the end of February 2024 the overall trend was that the backlog was reducing but it has spiked significantly in March and April increasing 33% in these 2 months. (from 301 to 398). Significant increases in demand relating to suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500. The decrease in compliance for the reduction in backlog of patients waiting over 62 days (SCP) can be attributed to increasing demand and is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres. Additionally, the number of SCP treatments undertaken has increased by 21% compared to pre-covid levels. Despite the pressures of increased demand and capacity challenges, the number of SCP backlogs has remained consistent. However, when looked at over time the recent spike is within normal variation.

Priority 5 Improving our Mental health services

Mental Health
Access to mental health care services is of equal importance to physical healthcare services and there are a range of measures that provide further details on performance in this area and support the organisation's understanding of future delivery.

In relation to compliance against key performance metrics, delivery against the 80% standard (% within 28 days) remains significantly below the target of 80% for both assessment (Part 1a) and interventions (Part 1b) .
However, the most recent month of April has increased to 27% which is 4% higher than any other month in the previous 12 and approximately 10% above the median rate. May's data expecting 37% and a further 10% rise in June.

Performance assessment to maintain CAMHS Part 1a national target compliance (assessment completed within 28 days) shows the latest data point available is April 2024 and is 82.1%. It has reduced over recent months but in the context of the 18 datapoints available this is normal variation within the process. However, CAMHS Part 1b national target compliance (intervention completed within 28 days)
the compliance rate is consistently 8% or below, significantly off the standard of 80%. The service has a number of actions are in place to address this performance issue including access to capacity with other organisations and a workforce assessment.

Argymhelliad / Recommendation

Board is asked to:

- **Note** the progressed achieved at the end of July/August 2023,
- **Note** the planned changes following the internal end of year review and Audit report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The report highlights key risks for delivery against the IMTP
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 1.1 Health Promotion, Protection and Improvement 2. Safe Care 2.1 Managing Risk and Promoting Health and Safety
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. This is a Quarterly report against the Integrated Medium-Term Plan and the key organisational priorities informed by our detailed understanding of how our system operates.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Performance Report

May 2024

Embedding **Prevention** and **Population Health** in all that we do

Progressing place-based models of care and sustainability in **Primary and Community Services**

Improving our **Urgent & Emergency Care** system focusing on experience, access, and discharge pathways

Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care.**

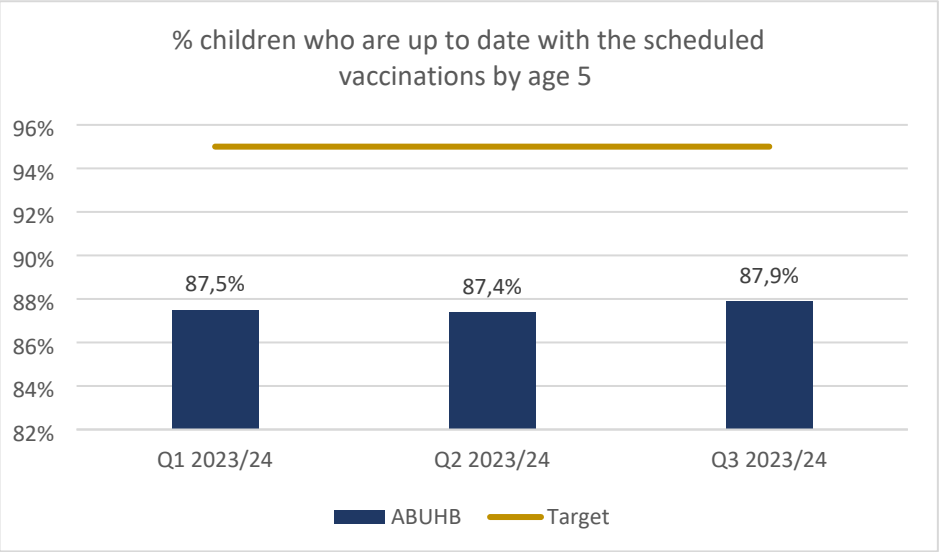
Improving our **Mental Health** services

This Performance report outlines delivery against the Welsh Government Ministerial Priorities. It complements the Annual Plan Quarterly Report that is produced each quarter and covers the broader spectrum of Annual Plan commitments

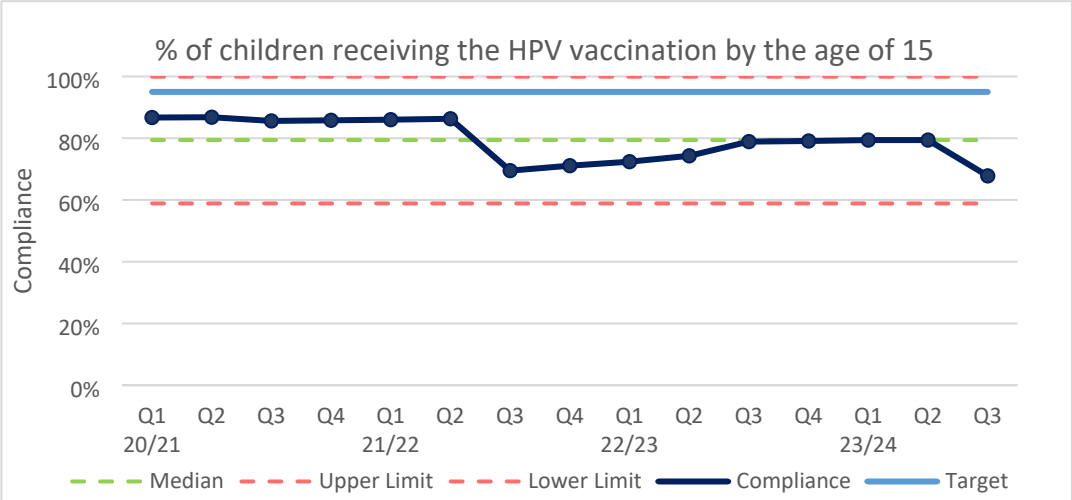
Embedding **Prevention** and Population Health in all that we do

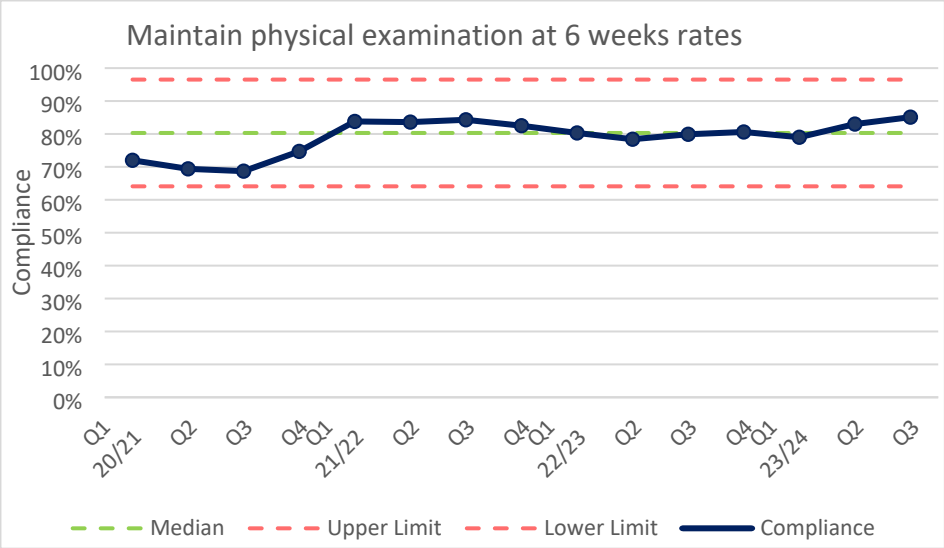
Performance

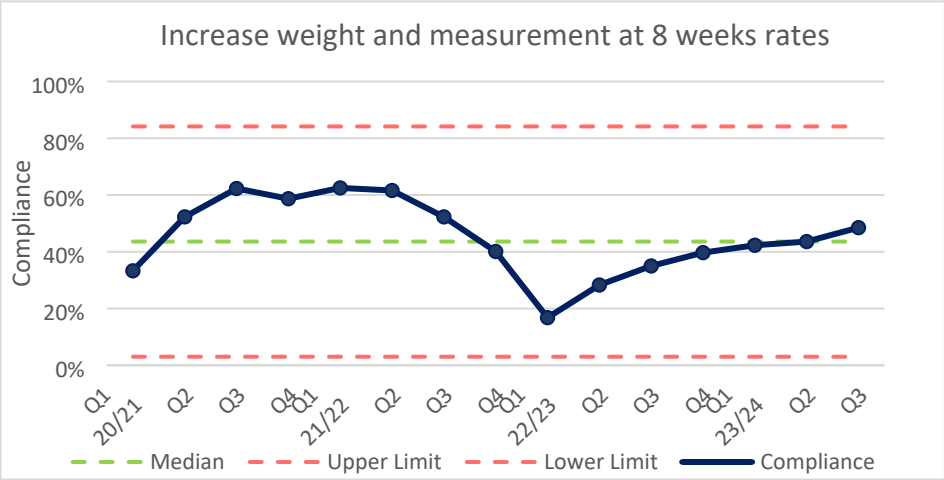
Increase percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)



Increase percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15
[COVER - National childhood immunisation uptake data - Public Health Wales (nhs.wales)]



Maintain national target compliance of the uptake of the influenza vaccination amongst adults aged 65 years and over	Not in Flu Season – Nothing to Report
Increase and maintain national target of percentage of adult smokers who make a quit attempt via smoking cessation services - at 4 weeks	Q1 to 3 2022/23 - 3.48% Q1 to 3 2023/24 – 3.31%
Maintain physical examination at 6 weeks rates (Healthy Child Wales) **[Percentage of eligible children with recorded Healthy Child Wales contacts, by quarter and health board (gov.wales)]**	

Increase weight and measurement at 8 weeks rates (Healthy Child Wales) **[Percentage of eligible children with recorded Healthy Child Wales contacts, by quarter and health board (gov.wales)]**	

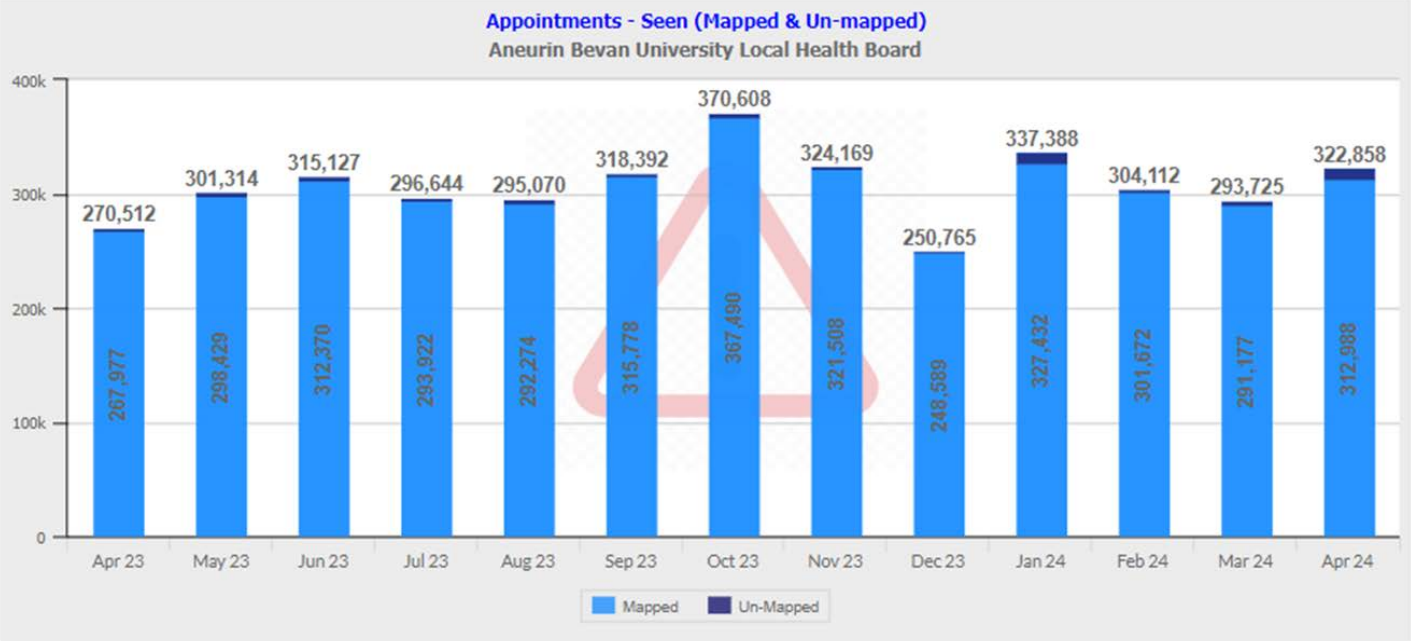
Analysis	
Increase percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	The rate has remained consistent at 87% over the last 3 quarters.
Increase percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	From September 2023 the HPV vaccination programme changed from a two dose to a one dose-only schedule following a Joint Committee on Vaccination and Immunisation (JCVI) recommendation. From September, immunocompetent adolescents who have received one dose of HPV vaccine will be considered fully vaccinated against HPV. The information displayed is only in relation to one dose. There was a significant dip between Q2 and Q3 in the FY21/22. Whilst there has been a recovery, compliance not yet in line with 6 quarters prior to this dip in performance. The most recent quarter is the lowest the compliance rate has been in the 3¾ years of data noted at 67.8%. The overall trend appears as though compliance is reducing. The uptake is also consistently lower in boys than girls.
Maintain national target compliance of the uptake of the influenza vaccination amongst adults aged 65 years and over	Not in Flu Season – Nothing to Report

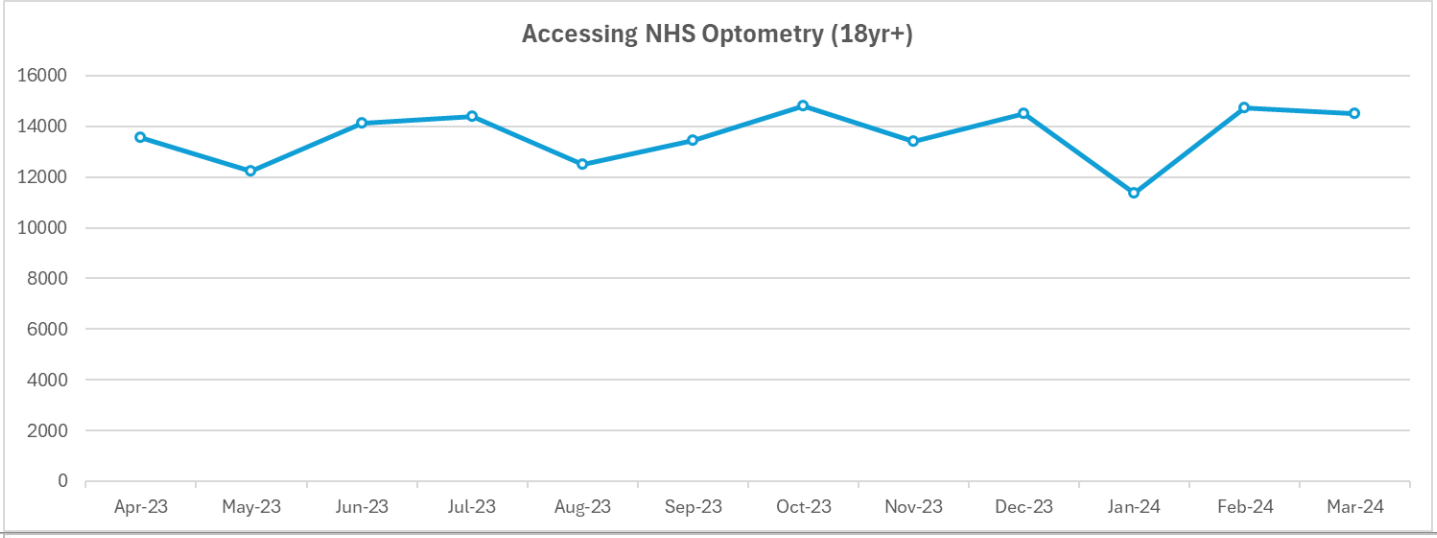
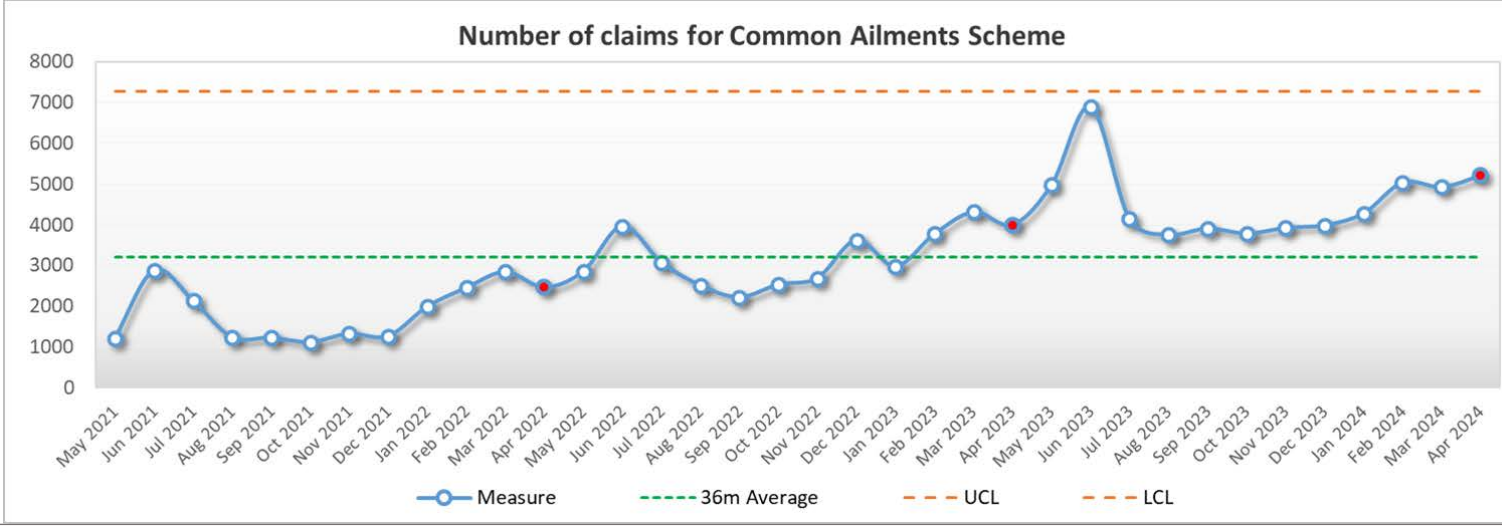
Increase and maintain national target of percentage of adult smokers who make a quit attempt via smoking cessation services - at 4 weeks	This is a previous measure that has been reintroduced as part of the National Performance Framework. Currently, there is no full dataset available to be able to report. When available this will be developed as the data is captured.
Maintain physical examination at 6 weeks rates (Healthy Child Wales)	The data is available quarterly. The last 15 quarters have been mapped. The latest quarter ending December 2023 was 85.1%. Over the last 11 quarters the compliance has been consistently around 80%.
Increase weight and measurement at 8 weeks rates (Healthy Child Wales)	The data is available quarterly. The latest quarter ending December 2023 was 48.5%. This metric has been highly variable. The highest quarter was 62.5% and lowest quarterly compliance was 16.8%. However, since this low point in Q1 of FY22/23 the compliance has increased each quarter and is displaying an upward trend.
Actions	
Increase percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose) **Increase percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15**	• School Health Nurses undertaking robust vaccination plan coupled with dedicated MMR catch up clinics are being delivered using a combination of Vaccination Centre appointments and pop- up clinics in areas of low uptake. • NCNs to collectively work with the Primary Care Immunisation Team in reviewing the childhood immunisation queues across the boroughs, identifying uptake in the lower preforming practices and support. • Plan to continue support and promote future Public Health with future health events to increase vaccinations and screening uptake. • Identify if there are any roles of community champions that could be created to assist in the education and increased uptake
Maintain national target compliance of the uptake of the influenza vaccination amongst adults aged 65 years and over	• N/A as not in flu season
Increase and maintain national target of percentage of adult smokers who make a quit attempt via smoking cessation services - at 4 weeks	• Promotion of the smoking cessation advice from optometry • Collaborative working between NCNs and ISPBs to support stop smoking, particularly within pregnancy. • Community Health Coaches to provide support and advice on healthy weight, alcohol, exercise, smoking cessation, and chronic condition education programmes
Maintain physical examination at 6 weeks rates (Healthy Child Wales)	• Date collection is through GP appointments. • Increased clinic provision across the Health Board with a realigned data collection process. The objective for the next phase is implement an improvement cycle to increase performance of HCWP. Improvement can already be attributed to HCWP 8,12,16 week contact from renewed clinic provision in September 23. • Primary Care Contracting Team carry out a regular audit every two months to reconcile the GP information against Child Health Systems in order to maximise uptake. Reports confirm that GPs average 92% compliance.

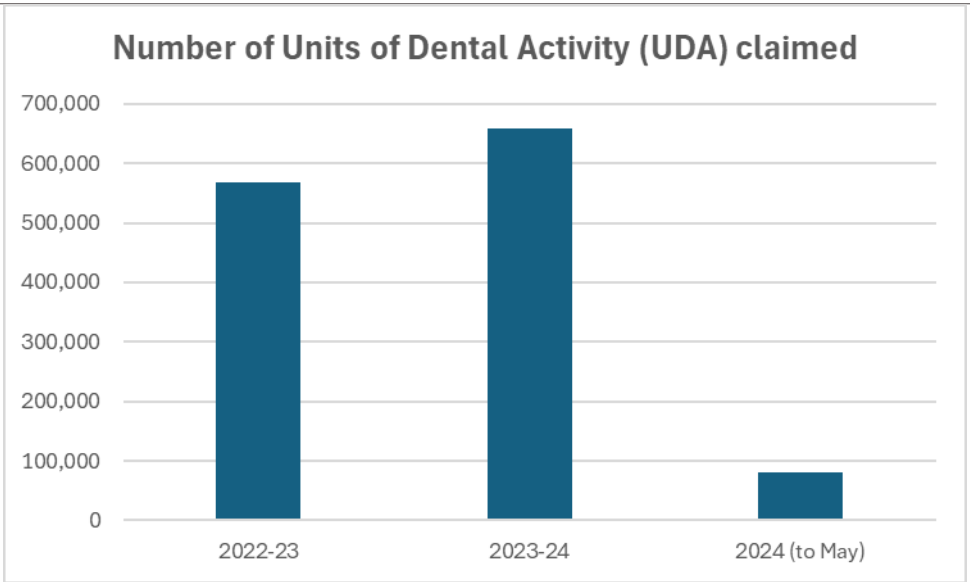
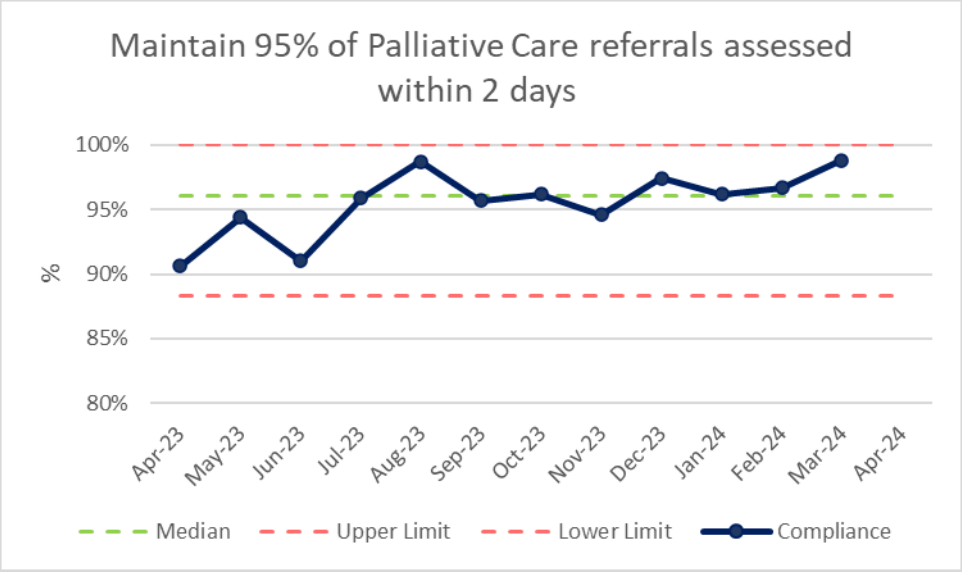
Progressing place-based models of care and sustainability in **primary and community services**

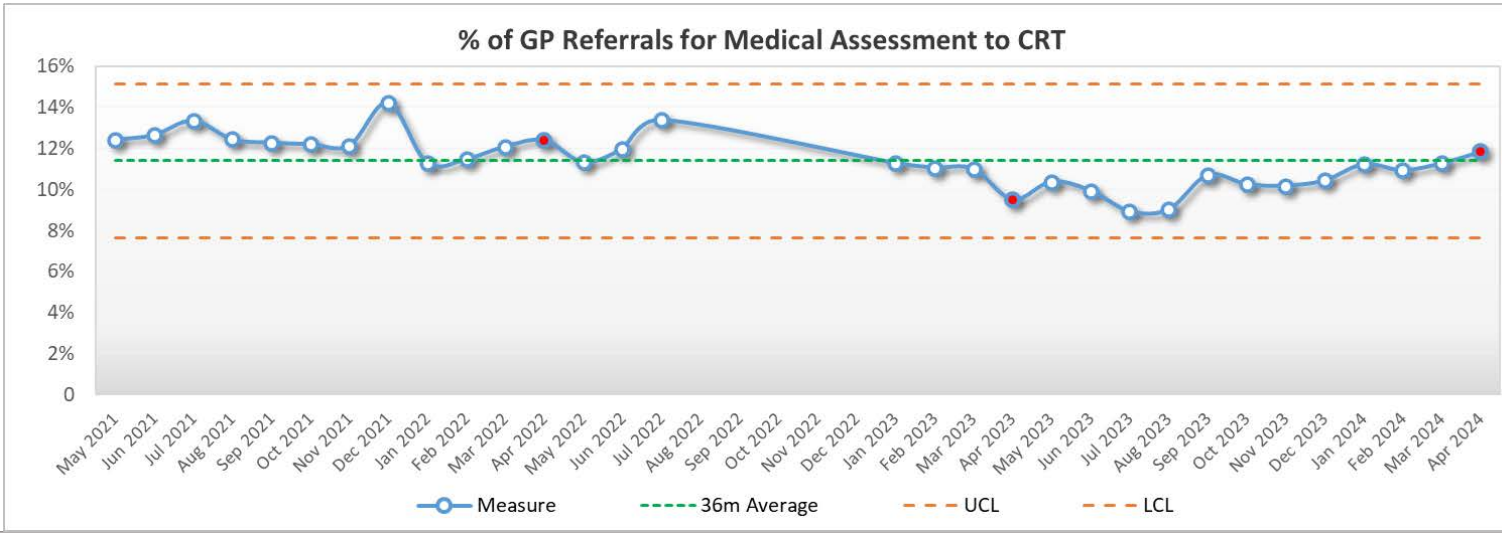
Performance

Maintain the number of appointments delivered in GMS



Maintain the number of patients accessing NHS Optometry Services	
Maintain the number of consultations undertaken by community pharmacy under the common aliments scheme	

Maintain the number of Units of Dental Activity (UDA) claimed		
Maintain 95% of Palliative Care referrals assessed within 2 days		

Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments (incl ED/MAU referrals)	

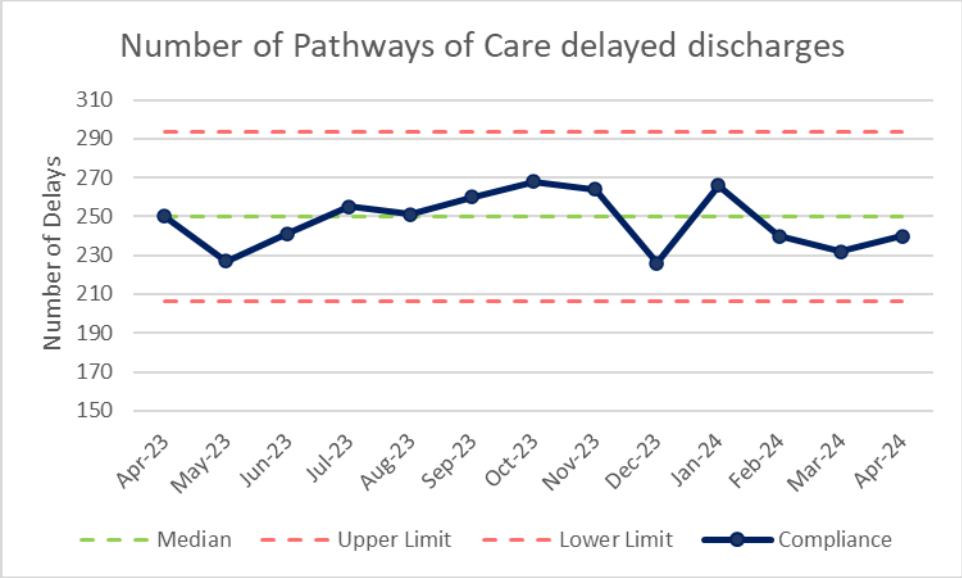
Analysis	
Maintain the number of appointments delivered in GMS	An increase in the number of appointments was noted for April 24 however this is not outside normal range
Maintain the number of patients accessing NHS Optometry Services	No significant change noted for this period
Maintain the number of consultations undertaken by community pharmacy under the common aliments scheme	Gradual increasing trend since August 2023, stabilised around 5,000 in February, March, and April 2024.
Maintain the number of Units of Dental Activity (UDA) claimed	Limited detail available to be able to comment on performance against the measure
Maintain 95% of Palliative Care referrals assessed within 2 days	The step change in July 2023, has been maintained ranging from 94.6% to 98.8% meeting the target.
Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments (incl ED/MAU referrals)	Gradual increase through the last year after a notable change in September 2023. In April – September 2023, proportions were circa 9%. Since January 2024, proportions been maintained at 11%.

Actions	
Maintain the number of appointments delivered in GMS	• Appointment activity is reported on a regular basis, and this is monitored through the Primary Care Contracts Team against the expected. • Regular contract discussions are held with GMS contractors that express challenges and escalation levels are monitored and responded to. • 100% achievements of Access Standards for 23/24 signed off. • Practices that apply through the sustainability assessment framework can apply for advice and resources as required. There are currently four practices in receipt of support. • All managed practices have moved to independent status and short-term support is being provided as part of the transition process.
Maintain the number of patients accessing NHS Optometry Services	• Following new legislation laid in October 2023, WGOS 1,2,3 & 5 have been implemented. • WGOS4, through the development of integrated pathways will be implemented in a phased approach over the coming months. • Occupational Health service implemented from the 1st of April 2024. • Regular contact through the Optometry contracting team with providers ensures any concerns about delivery of service can be addressed quickly.
Maintain the number of consultations undertaken by community pharmacy under the common aliments scheme	• All community pharmacies are now signed up to the common ailments scheme (CAS). The current priority is to support the increase in capacity. • Roll out of mandatory signage for pharmacies to display advertising the service. Signage now has links to the webpage outlining the services available to patients. • Feedback loop to the service managers providing a check of service availability. • Developing a system of access for all GMS practices to identify live service provision in their area. This will be for CAS, flu, and other services.
Maintain the number of Units of Dental Activity (UDA) claimed	• Two dental providers have recently provided notice and the division are reviewing provision. • From 1st April 24 there are 50 UDA practices and 25 practices have opted for contract reform. • Successful re-awarded GDS contracts following recent terminations (with affect from 1st July) • Two more terminations have been received and procurement process commenced with planned conclusion in September.
Maintain 95% of Palliative Care referrals assessed within 2 days	• Regular monitoring of referrals assessed to meet targets. • Performance is maintained within the current service provision.
Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments (incl ED/MAU referrals)	• The service is now accepting referrals up until 5pm within Community Resource Teams (CRT). • New pilot to be launched hosting a CRT consultant within the Flow Centre, with assessment by end of June. • The Redesign of Older Adults Programme has activities that will directly support the transfer of patients away from ED, e.g. AFR team at GUH. However, this does not directly influence GP referrals made.

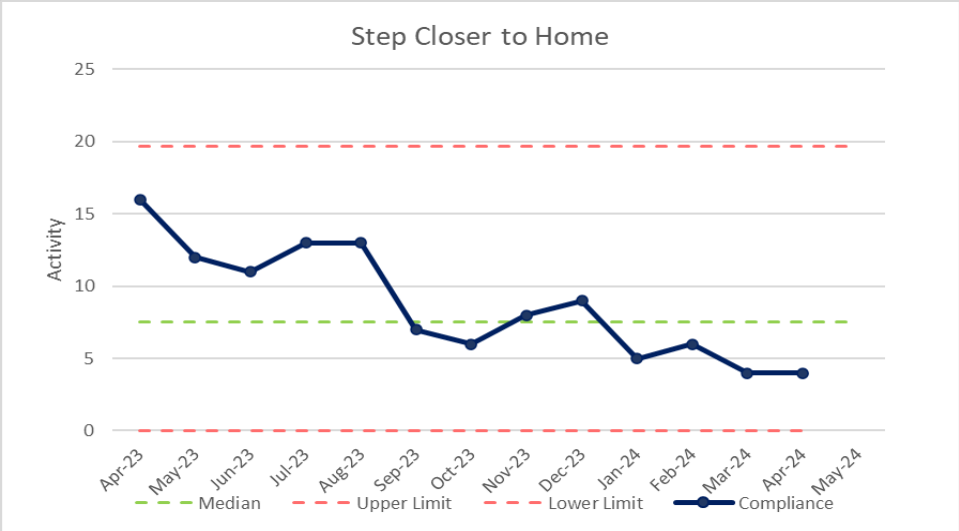
Improving our Urgent & Emergency Care system focusing on experience, access, and discharge pathways

Performance

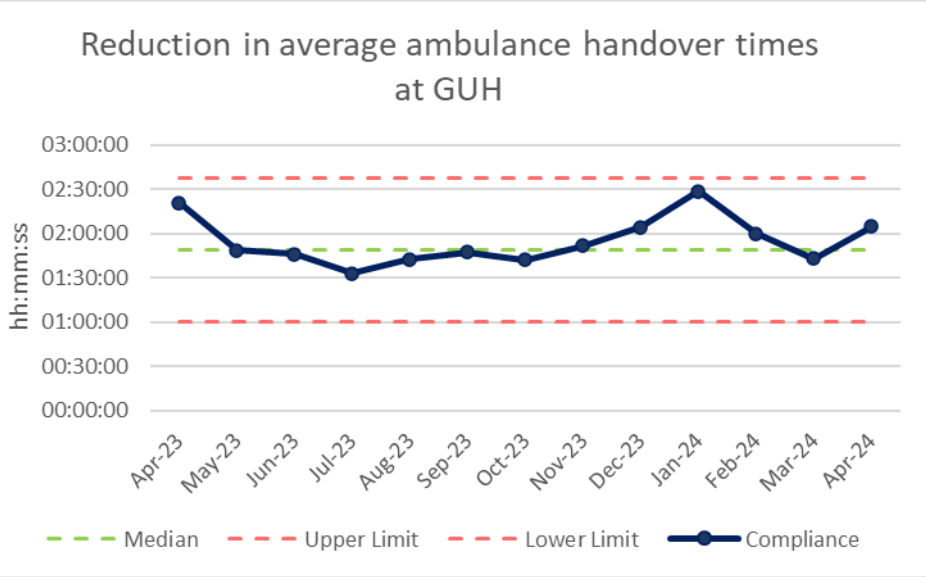
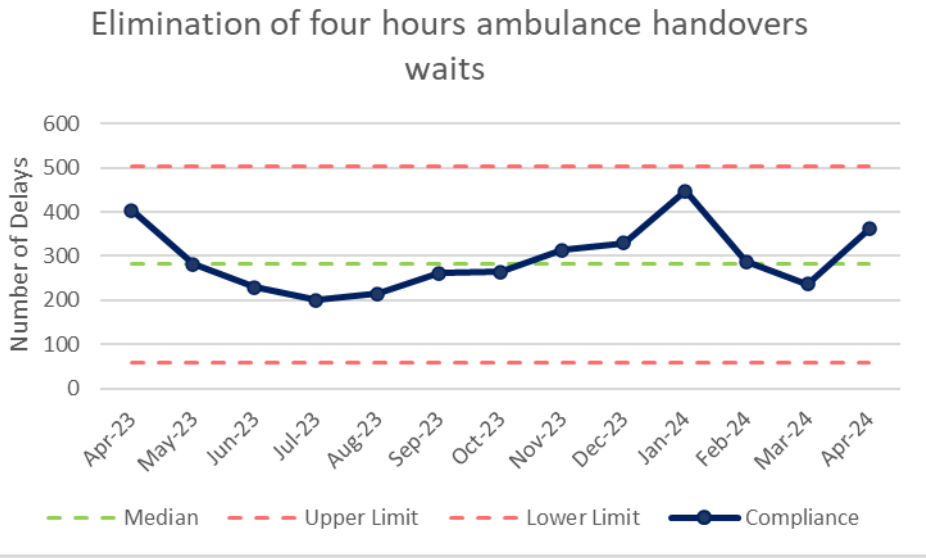
Reduction and maintain national target of number of Pathways of Care Delays

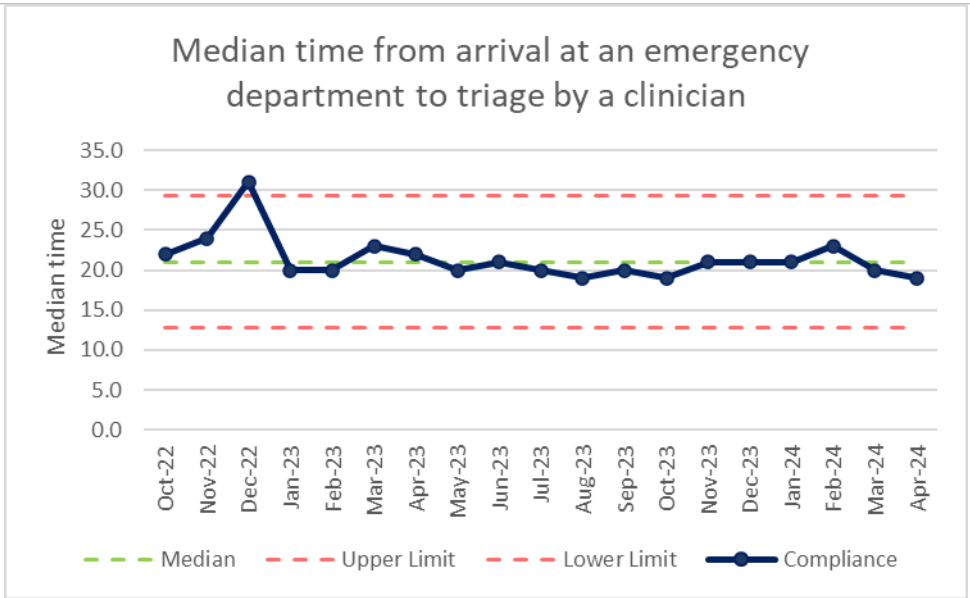
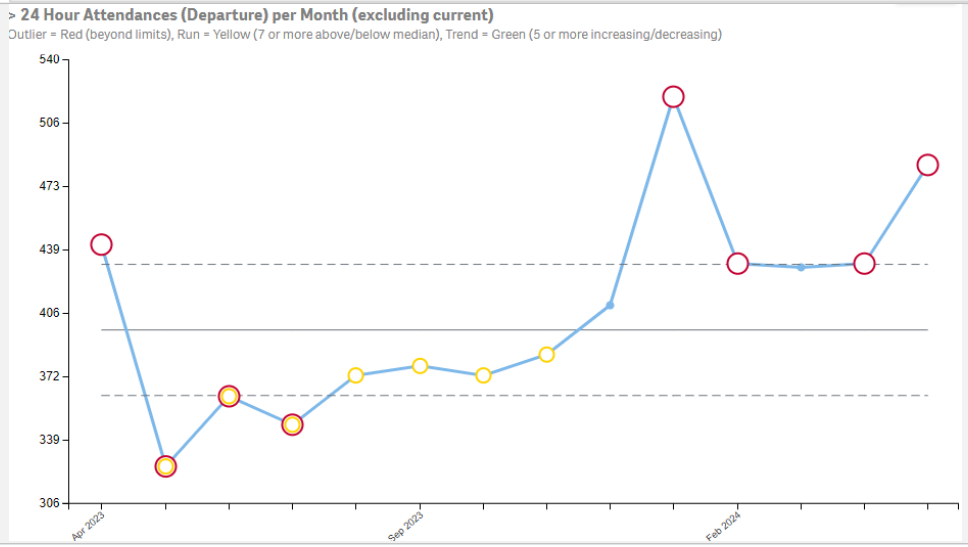


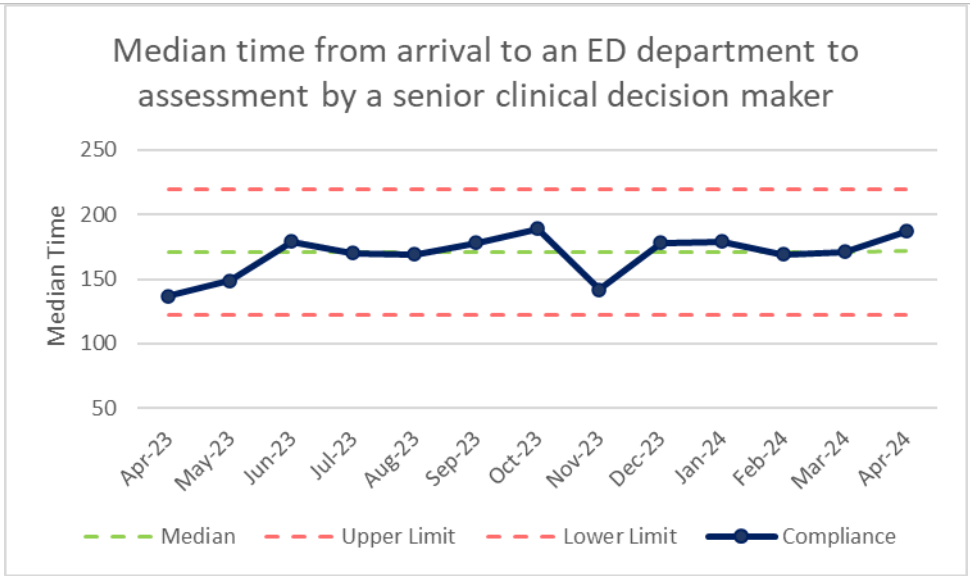
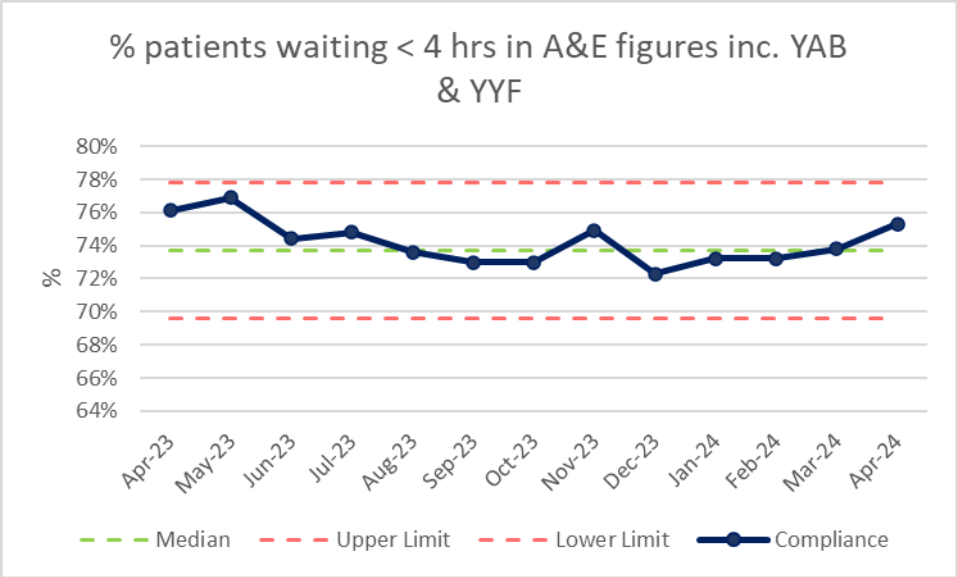
Increase in Hospital 2 Home & Step Closer to Home Rates

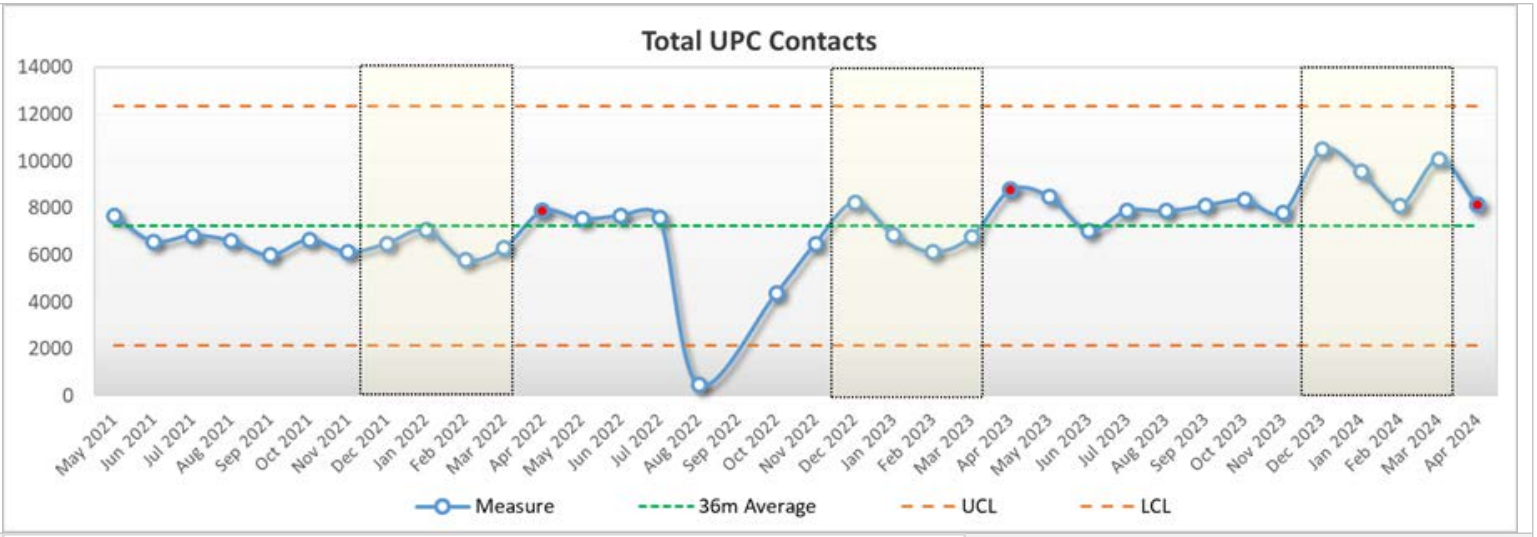
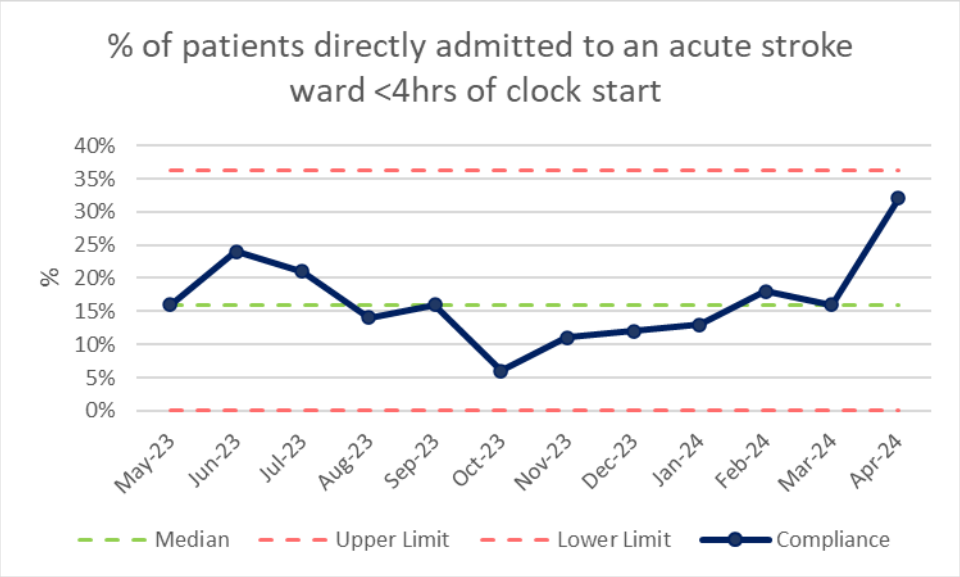


TOTAL NUMBER OF REFERRALS RECEIVED
181

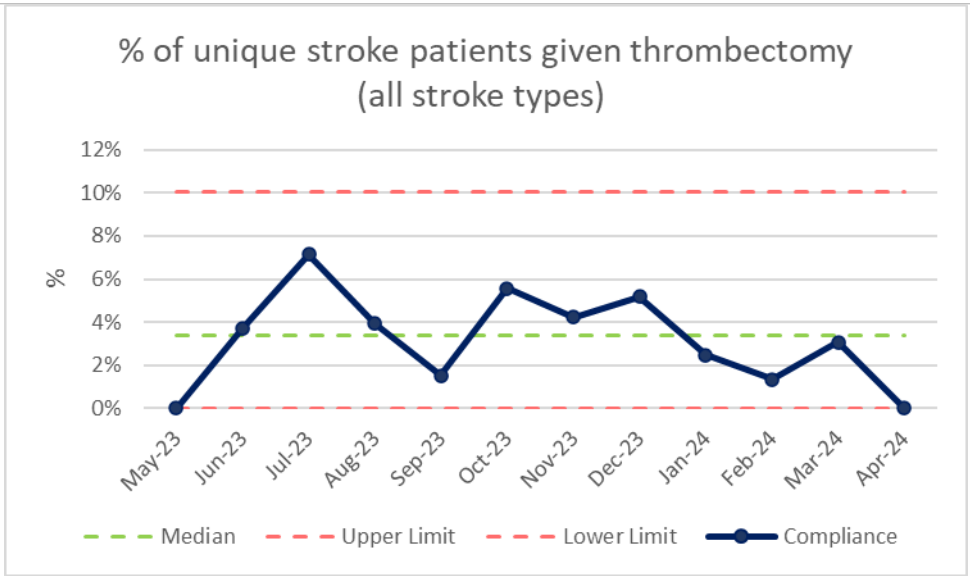
Reduction in average ambulance handover times at GUH		
Elimination of four hours ambulance handovers waits		

Reduction in time from arrival to ED triage - no waits over 30 minutes	
Decrease in ED attendances waiting over 24 hours	

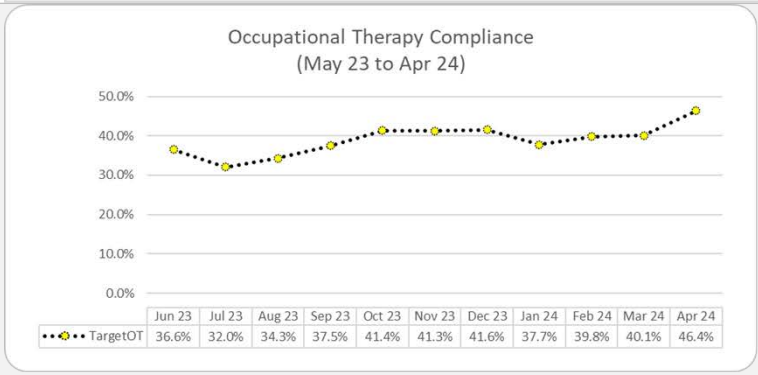
Reduction in time from arrival to ED to seen by clinician		
Increase and maintain national target of the percentage of patients waiting <4 hours in ED		

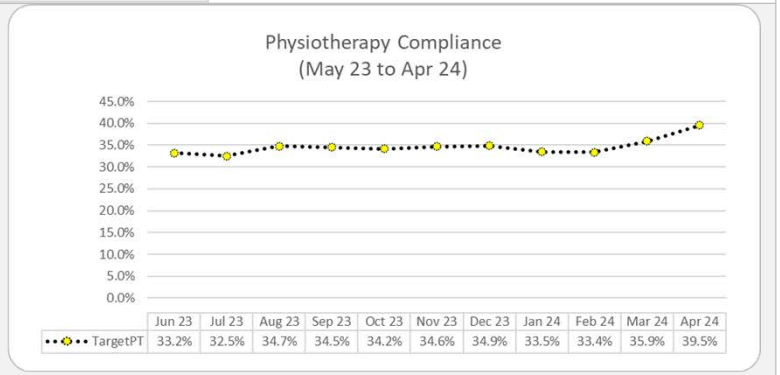
Maintain the number of Urgent Primary Care contacts (inc. virtual)	
% of patients directly admitted to an acute stroke ward <4hrs of clock start	

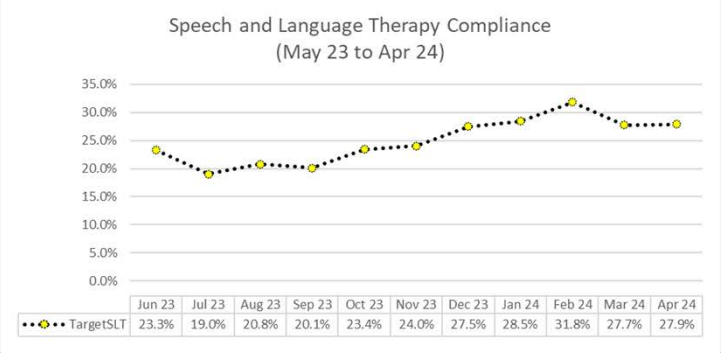
% of unique stroke patients given thrombectomy (all stroke types)

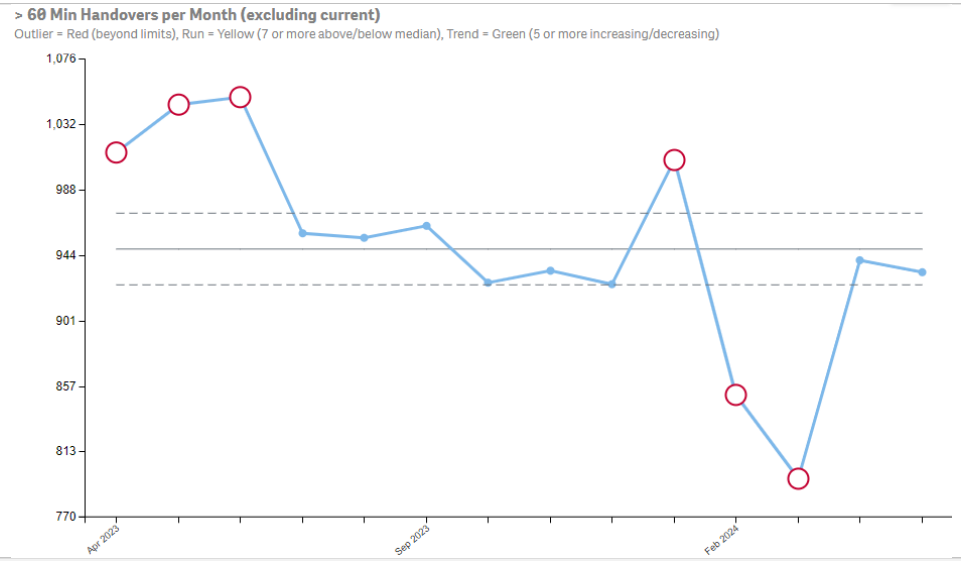


% Assessed by one of OT, PT, SALT within 24 hours





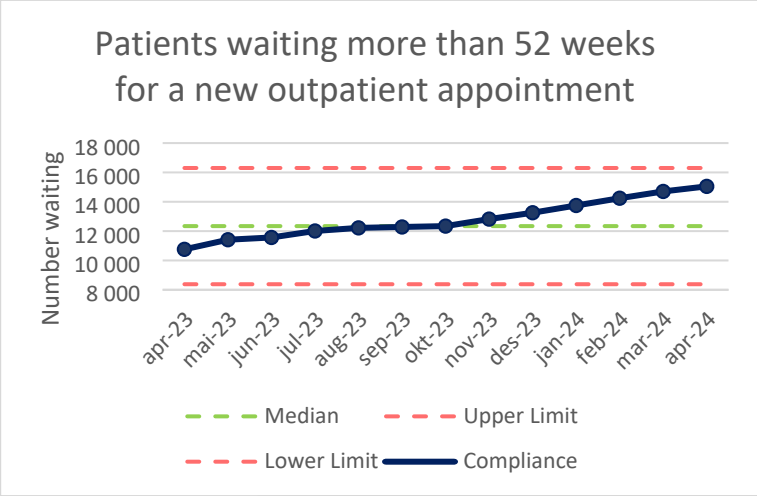
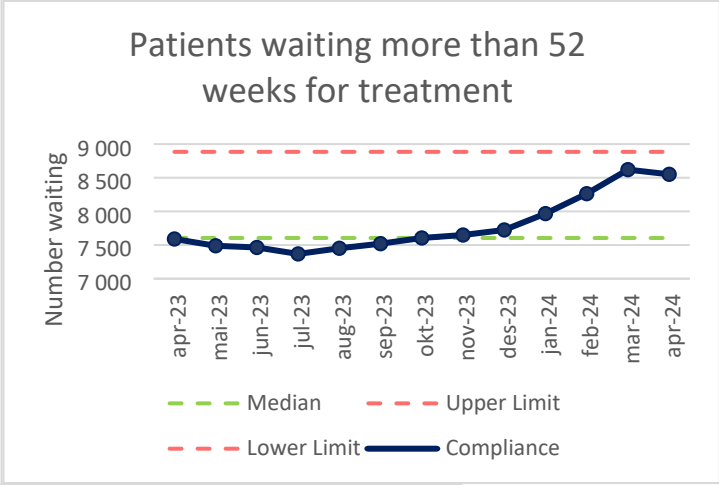
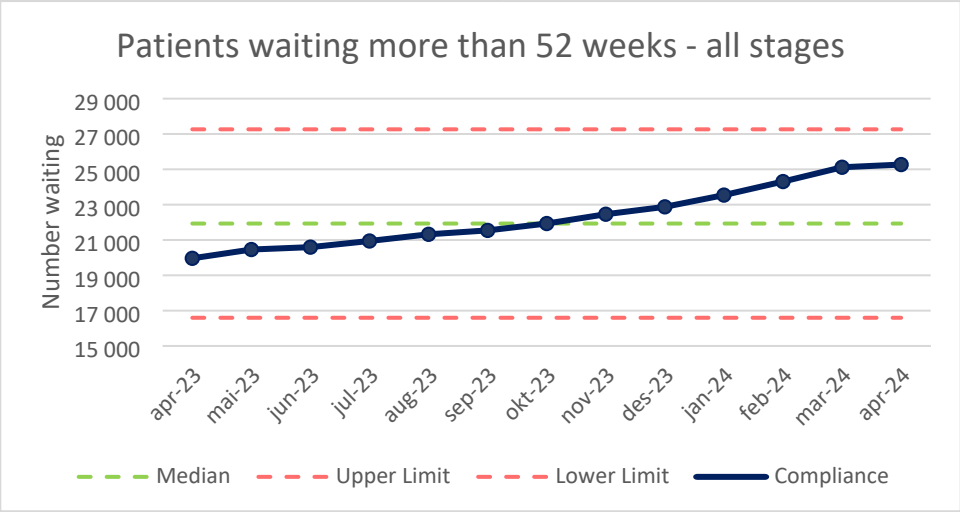


Ambulance waits >1 hour	

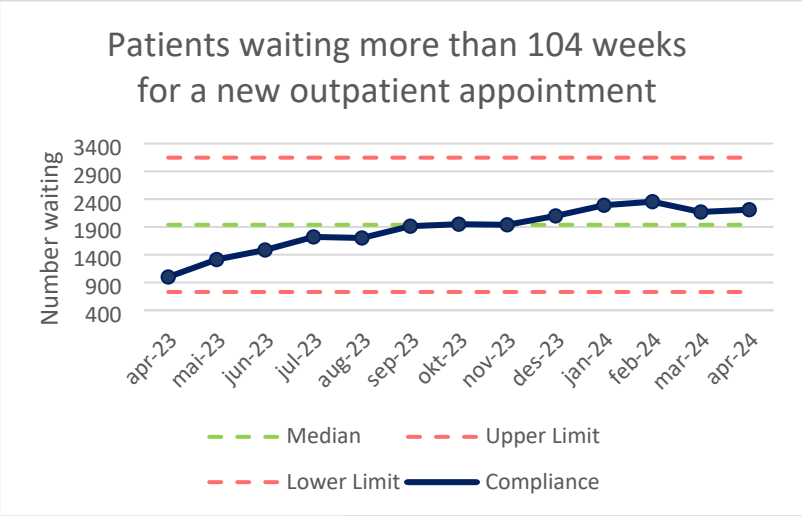
Analysis	
Reduction and maintain national target of number of Delayed Transfers of Care	No significant change to previous reporting period
Increase in Hospital 2 Home & Step Closer to Home Rates	Showing a decreasing trend from September 2023 where the range was10-15/month down to a current position of 5-10/month
Reduction in average ambulance handover times at GUH	No significant change to previous reporting period
Elimination of four hours ambulance handovers waits	No significant change to previous reporting period
Reduction in time from arrival to ED triage - no waits over 30 minutes	No significant change to previous reporting period
Decrease in ED attendances waiting over 24 hours	Increasing trend 325-410/month prior to January, increased to 430-520/month since January 2024
Reduction in time from arrival to ED to seen by clinician	No significant change to previous reporting period
Increase and maintain national target of the percentage of patients waiting <4 hours in ED	No significant change to previous reporting period
Maintain the number of Urgent Primary Care contacts (inc. virtual)	No significant change to previous reporting period

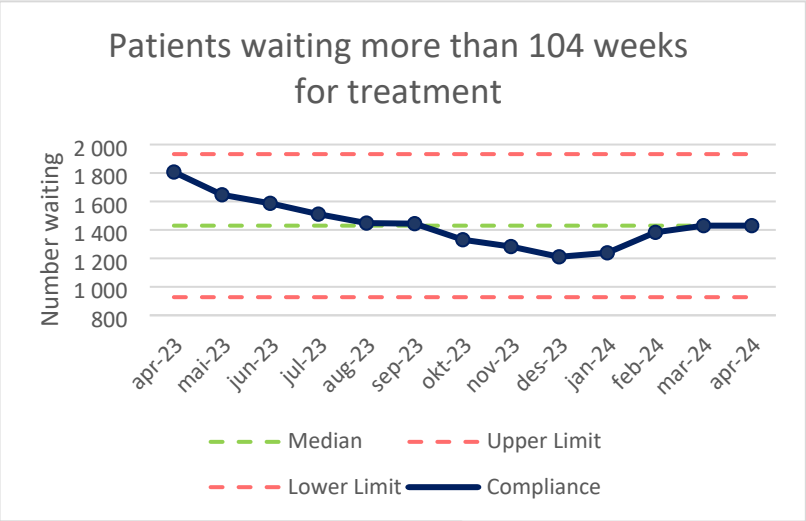
% of patients directly admitted to an acute stroke ward <4hrs of clock start	The performance is variable between 0-32%. There has been an increase to 32% from median level of 15% between March and April. *The data quality is currently being reviewed*
% of unique stroke patients given thrombectomy (all stroke types)	Early signs of a decrease in the numbers since January 2024
% Assessed by one of OT, PT, SALT within 24 hours	Gradual increase in all areas since October 2023, settled to around 30% up from 20% in SALT
Ambulance waits >1 hour	Reduction in February and March 2024 noted, however performance returned to previous levels in April 2024.
Actions	
Reduction and maintain national target of number of Pathways of Care delays	• Taking forward the learning from the Patient Safety Events, monitored via the Integrated Discharge Board • Robust validation process, monthly meeting with Local authorities chaired by PoCD Lead, consistent process identifying reason for delay. • Weekly PoCD meetings, chaired by PoCD Lead with Divisions • D2RA Digital Solutions roll out across Health Board in April/May 2024, enhanced data capturing including reason for delay, collation of meaningful data. • Single data repository, review of contemporary data and information • Education programme re. Red to Green, huddle to review day of value. • Themes identified i.e. awaiting Social Worker assessment, awaiting therapy assessment. • Community Hospitals, weekly 'Fishbowl' to review patients <28 days, • Community Hospitals, weekly flow meeting to review patients >28 days, senior decision maker, • Head of Patient Discharge, locality Head of Service • Acute Hospitals weekly flow meeting with Head of Patient Discharge • Discharge Resource, alignment of Discharge Hub, Ready to Go Unit and Discharge Lounge at RGH
Increase in Hospital 2 Home & Step Closer to Home Rates	• Continuing to work alongside Monmouthshire Local Authority and Chepstow Hospital • Raising awareness of H2H across the Health Board • Embed a robust referral/assessment process with a view to roll out across all Localities. • Continuing to proactively identify patients for H2H to support, to utilise all runs efficiently, relieve pressures within acute sites, and improve patient experience by reducing unnecessary length of stay and deconditioning. • Welcoming new staff members, providing effective leadership to establish the H2H team. • Advertising service through a formal comms campaign
Reduction in average ambulance handover times at GUH	• Focus attention through weekly escalation meetings chaired by COO and monthly oversight with Welsh Government • Development of a business case for additional ED consultants with plan for some resource to be allocated to senior rapid assessment (funding dependent) • Tracking WAST Flow Centre compliance across GUH and eLGH network • Supporting ambulance timely assessment, as per WAST request for portering in December • Developed PRU business case with full benefits evaluation of current service
Elimination of four hours ambulance handovers waits	

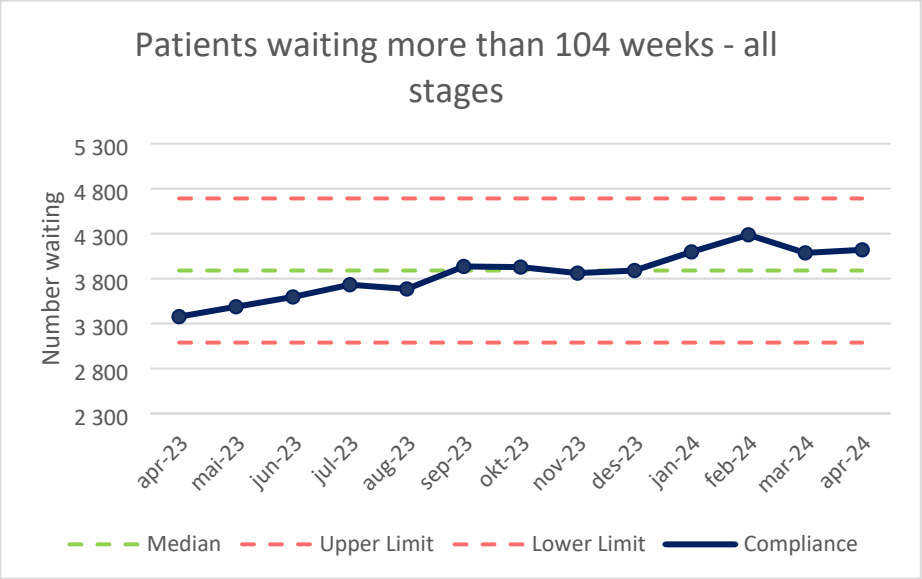
Reduction in time from arrival to ED triage - no waits over 30 minutes	• Implementing e-triage at end of Q1 with plan to evaluate maximation opportunities. • Reestablished Triage Faculty with ambition to improve time to triage across ED and MIUs • Developing service-level plans for ED Main Wait extension
Decrease in ED attendances waiting over 24 hours	• Exploring opportunities for Short Stay Unit to accommodate patient cohort currently experiencing the longest waits in ED. • Scoping opportunities to improve system flow through developing the discharge lounge model; undertaking mapping work with focus areas including the ED-Acute Medicine interface; undertaking community hospital and CHC capacity mapping; and establishing a comprehensive Operating Framework. • Planning to implement direct to specialty referrals and e-referrals to support timely communication between clinical specialties
Increase and maintain national target of the percentage of patients waiting <4 hours in ED.	
Reduction in time from arrival to ED to seen by clinician	• Developed business case for additional ED consultants with plan for some resource to be allocated to senior rapid assessment and commitment to timely time to first clinician (funding dependent) • Exploring opportunities to ring-fence assessment space, particularly during periods of peak demand. • Developing service model for Phase 2 of ED Main Wait Extension with focus on wait to be seen by a clinician
Maintain the number of Urgent Primary Care contacts (inc. virtual)	• Demand increasing and managed within current service capacity. • MDT sustainability - robust recruitment campaign ongoing for senior nurse and nurse practitioners. • Opening of the nurse led Urgent Primary Care Centre in YYF (Mon- Fri daytime) • Prioritised work on-going around consistency of practice which has supported management of demand and maintaining the status of the service, thus avoiding escalation.
% of patients directly admitted to an acute stroke ward <4hrs of clock start	• Proposal under development presented to Executive Committee to ring-fence all stroke beds with breaches permitted via COO or CEO approval only to ensure patient safety and capacity
% of unique stroke patients given thrombectomy (all stroke types)	• Brainomix AI implemented and in use. • Extension of South Mead's thrombectomy service from 6am to midnight • Covering 12-hours per day seven days per week with CNS team
% Assessed by one of OT, PT, SALT within 24 hours	• Executive Committee proposal submitted and intrinsically linked with this action area. • Discussion around business case to increase therapy staffing to recommended levels

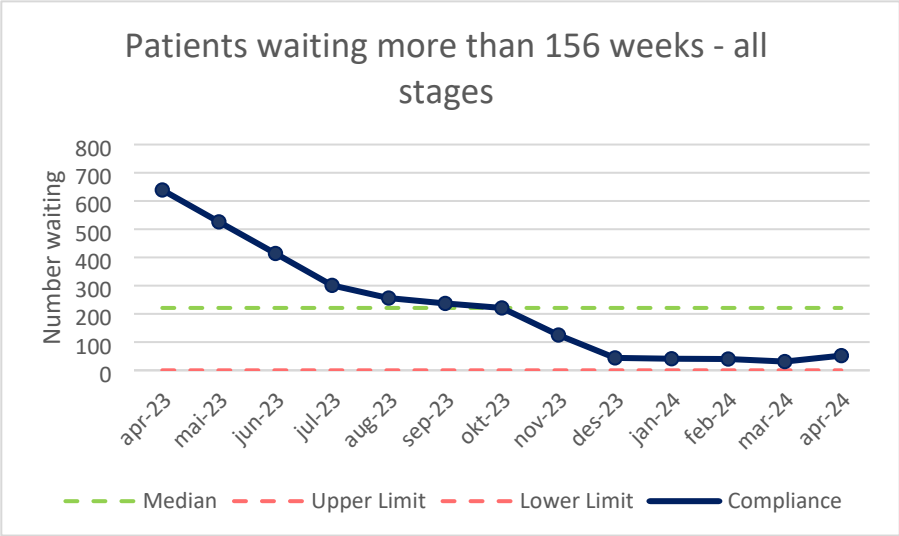
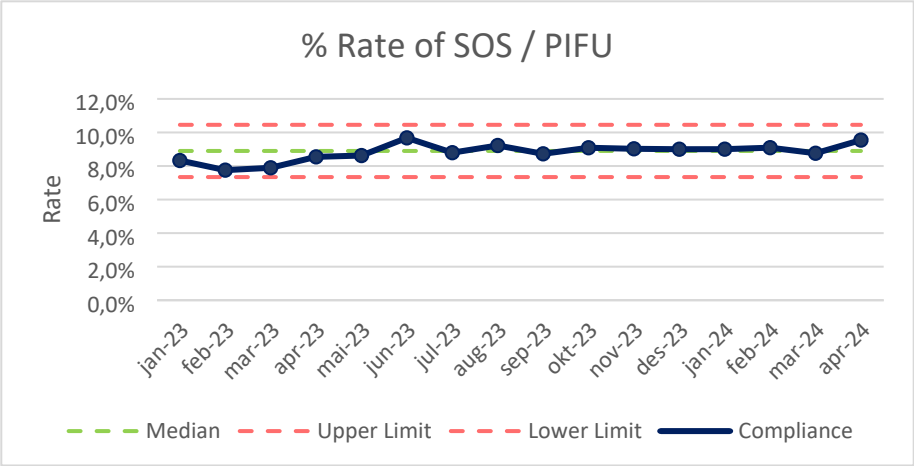
Continuing to prioritise **cancer, urgent and the longest waiting patients for planned care**	
Performance	
Numbers of patients waiting over 52 weeks (all stages)	  

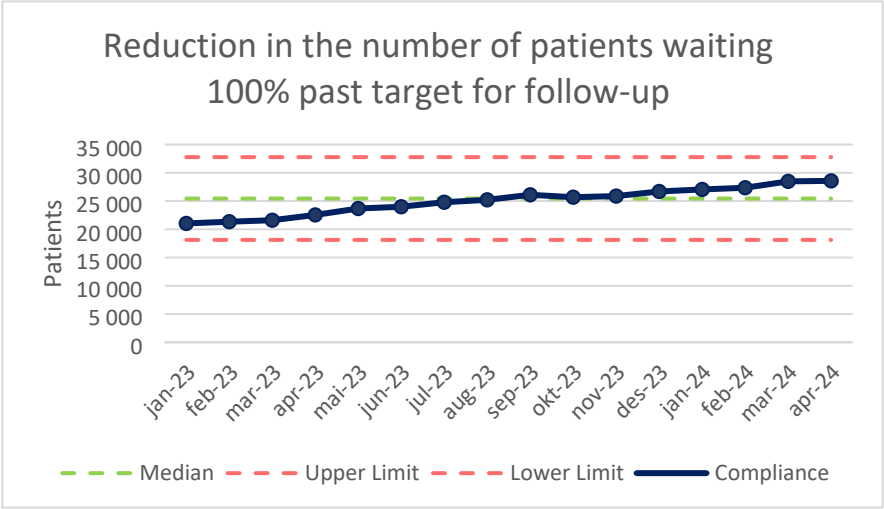
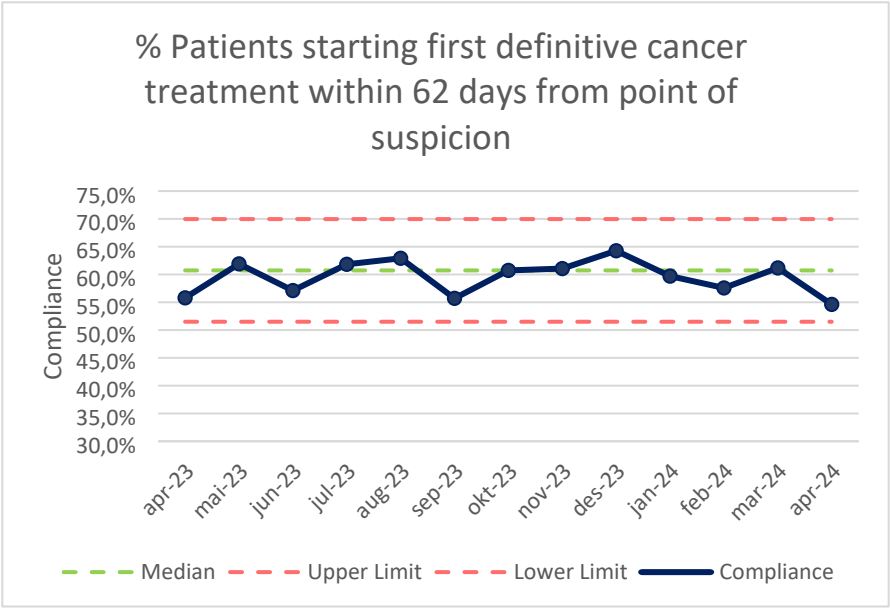
Numbers of patients waiting over 104 weeks (all stages)

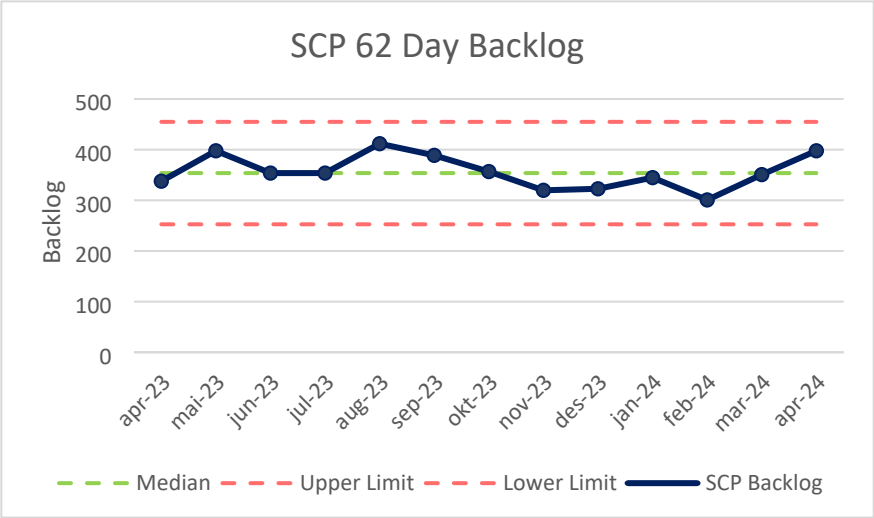
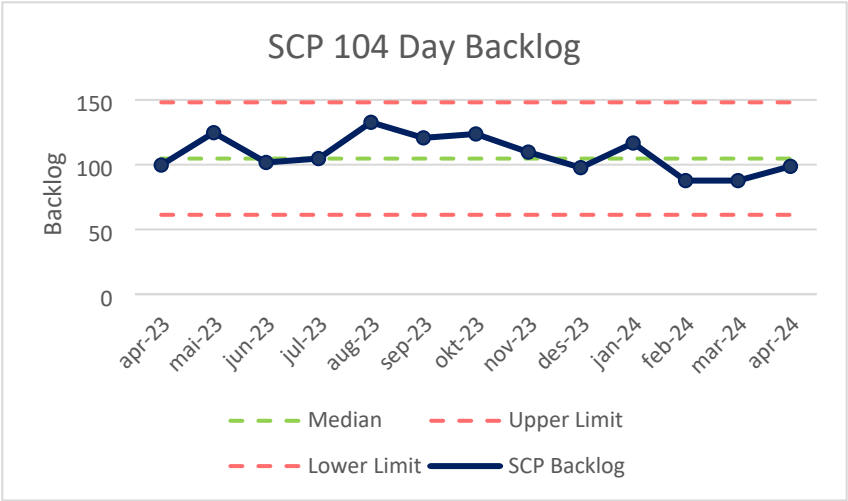




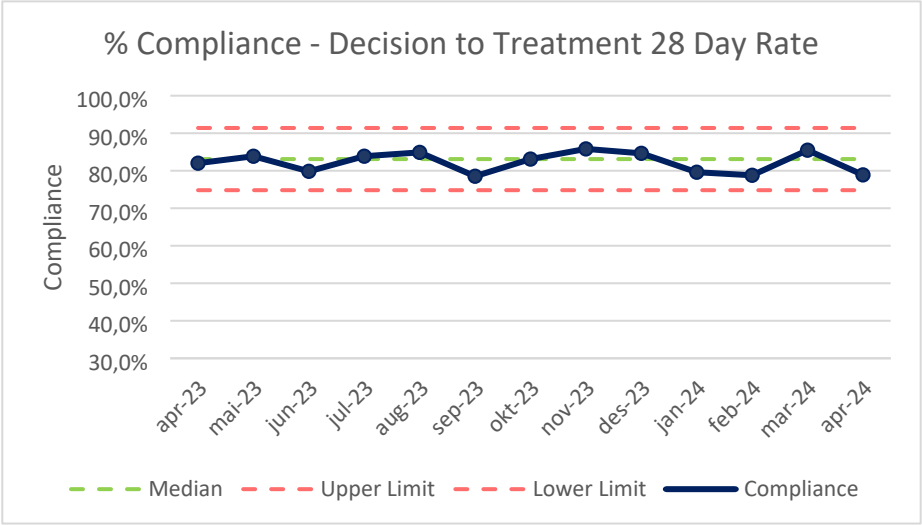


Elimination of total waits over 156 weeks (all stages)	
Increase in the rate of See on Symptom and Patient Initiated Follow-ups	

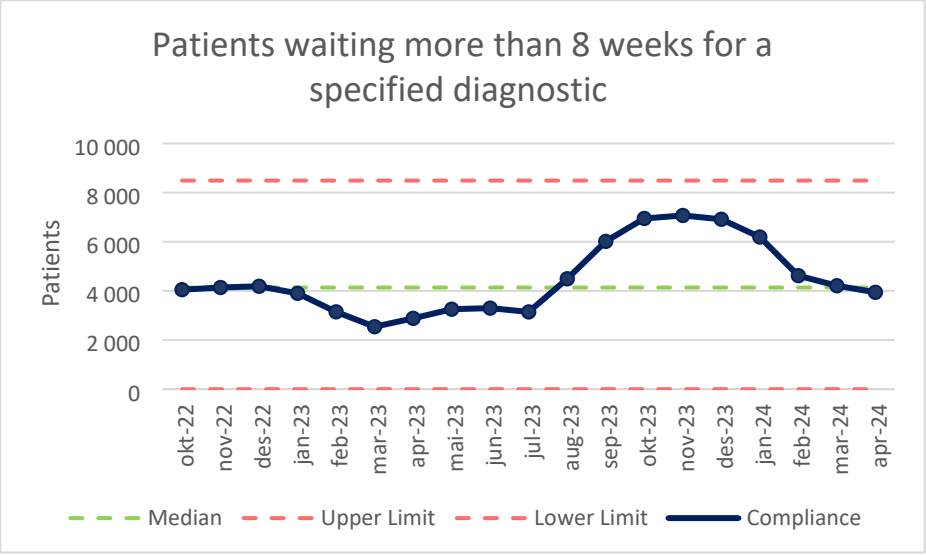
Reduction in the number of patients waiting 100% past Outpatient follow-up target date	
Increase in Single Cancer Pathway 62-day compliance	

Reduction in backlog of patients waiting over 62 days (SCP)	
Reduction in backlog of patients waiting over 104 days (SCP)	

Increase in rate of cancer diagnosis or discharges within 28 days



Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic



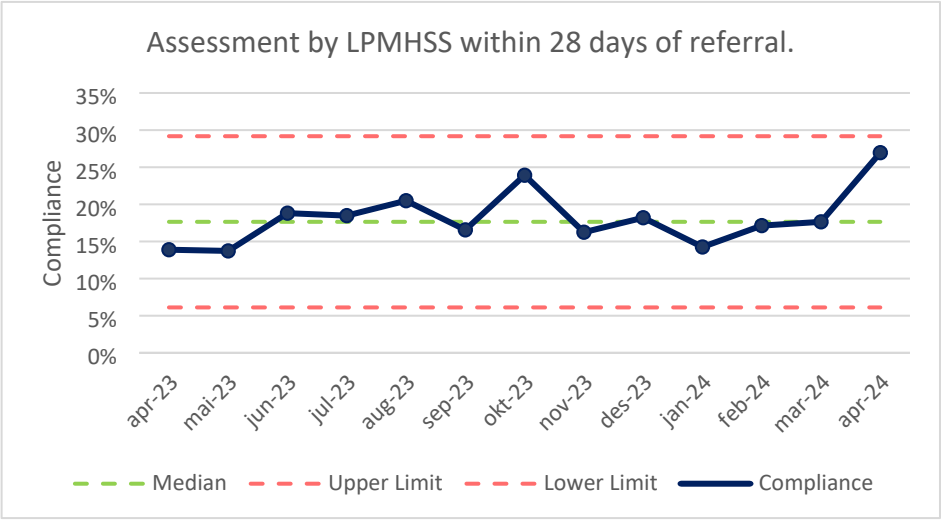
Analysis	
Numbers of patients waiting over 52 weeks (all stages)	***Outpatient*** • At the end of April 2024, there were 15,049 patients waiting over 52 weeks for a first outpatient appointment compared to 10,758 at the end of April 23. • Most of this increase is in the specialties of ENT & Ophthalmology. ***Treatment*** • At the end of April 2024, there were 15,049 patients waiting over 52 weeks for a first outpatient appointment compared to 10,758 at the end of April 23. • Most of this reduction was in the specialties of Ophthalmology & T&O. At all stages 52-week waiters are increasing.
Numbers of patients waiting over 104 weeks (all stages)	***Outpatient*** • At the end of April 2024, there were 2,210 patients waiting over 104 weeks for a first outpatient appointment compared to 999 at the end of April 23. • Most of this increase is in the specialties of ENT & Ophthalmology. ***Treatment*** • At the end of April 2024, there were 1,807 patients waiting over 104 weeks for a first outpatient appointment compared to 1,430 at the end of April 23. • Most of this reduction was in the specialties of Urology & T&O. At all stages, 104-week waiters are increasing.
Elimination of total waits over 156 weeks (all stages)	At the end of April 2024, there were 52 patients waiting over 156 weeks at all stages compared to 639 at the end of April 23. There is a definitive reducing trend. The remaining patients are in ENT and T&O only.
Increase in the rate of See on Symptom and Patient Initiated Follow-ups	The rate has remained consistent the last 11 months, it suggests a steady system. CSS has the highest rate over the last 15 months at 20.5%, Surgery is second with 10.5%, Family and Therapies 8.5% and Medicine 6.9%.
Reduction in the number of patients waiting 100% past Outpatient follow-up target date	At the end of April 2024, there were 28,569 patients waiting over 104 weeks for a first outpatient appointment compared to 22,544 at the end of April 23. Most of this increase is in Ophthalmology which during this period increased from 5,395 to 8,891.
Increase in Single Cancer Pathway 62-day compliance	At the end of April 2024, the rate was 54.6% compared to 55.8% at the end of April 2023. Throughout the FY23/24 the compliance rate was ~60%. H&N, Sarcoma, Colorectal, Gynaecological and Urological are the Tumour Sites where targeted improvement required. (40% or below for the last 13 months)

Reduction in backlog of patients waiting over 62 days (SCP)	The backlog at the end of April 2024 was 398, it was 338 in April 2023. Up to the end of February 2024 the overall trend was that the backlog was reducing but it has spiked significantly in March and April increasing 33% in these 2 months. (from 301 to 398). Significant increases in demand relating to suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500. Increased demand is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres. Additionally, the number of SCP treatments undertaken has increased by 21% compared to pre-covid levels. (FY23/24 = 4,493 Single Cancer Pathway treatments, FY22/23 =4,258 SCP treatments, FY21/22 = 3,849 SCP treatments, FY19/20 = 3,703 SCP treatments). Despite the pressures of increased demand and capacity challenges, the number of SCP backlogs has remained consistent. The recent spike is within normal variation.
Reduction in backlog of patients waiting over 104 days (SCP)	This has remained unchanged overtime. The April 2023 backlog figure was 100 and April 2024's position was 99. There has been variation in the interim. It was increasing in size up until October 2023 but has steadily declined since.
Increase in rate of cancer diagnosis or discharges within 28 days	This has remained consistent over the last 13 months. Reviewing the Tumour sites over this period they are also relatively consistent and displaying normal variation. Colorectal and Breast have had rates of 65.1% and 53.6% respectively over this period. Whilst Skin is at 88% over this period it is indicating a downward trend, Skin had a rate of 98.4% in April 2023 and 83.5% in April 2024.
Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	There was a significant increase between July 2023 and November 2023 where the patients wating more than 8 weeks increased from 3,144 to 7,070 having consistently been around 4,000 or less in the months previous. This has now recovered to 3,942 (April 2024) and has been displaying an improving trend for the last 5 months.
Actions	
Numbers of patients waiting over 52 weeks (all stages) **Numbers of patients waiting over 104 weeks (all stages)** **Elimination of total waits over 156 weeks (all stages)**	• Resubmitted planned care plans on 31st May. • Deep dives planned for June in ENT, Orthopaedics and Ophthalmology • Approval of plans in ENT, Max Fax, and T&O to reduce 104-week outpatient position. • 85% theatre utilisation in Max Fax and Ophthalmology drive for 24/25. • Treat in turn – speciality specific targets to deliver improvements necessary for stage 1 and 4 to achieve a significantly improved 104 positions. • Ophthalmology – progress with regional solution to increase capacity for cataract outpatient and inpatient stages to eliminate 104 weeks by December 2024. • Virtual spines clinic with SAS Doctor is resulting in a 70% discharge rate. • Increased volume lists (colorectal UGI) and increase productivity. • Bi-weekly RTT Directorate meetings focusing on elimination of 156 weeks.
Increase in the rate of See on Symptom (SOS) and Patient Initiated Follow-ups (PIFU)	• Previous years rate – 13.2%, current year 13.1%, last weeks – 14.6%. • Scoping exercise of pathways in place in other Health Boards in Wales to identify potential opportunities, information on potential gaps to be shared with relevant teams to identify current process/if SOS/PIFU would be appropriate (or if alternative pathways e.g. straight to discharge are in place)

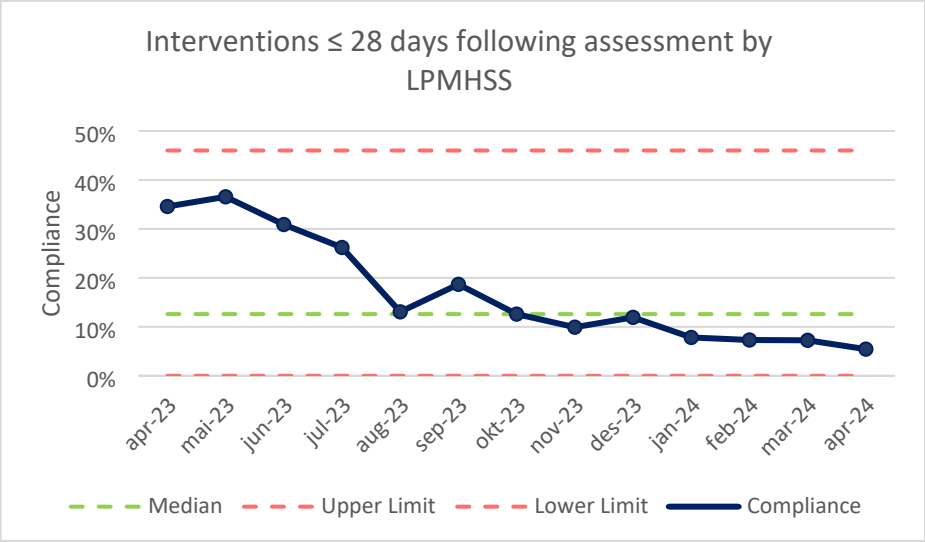
	• Sharing of Pathways from NHS England Website to identify potential opportunities, new pathways shared with relevant teams if no pathway in existence. • Working with specialties to support implementation of CIN recommendations for Discharge protocols/SOS/PIFU – General Surgery and Eye recommendations have been shared. • Meeting with COTE to discuss possibility of Benign tremor pathway. Meeting with individual specialties to discuss potential opportunities and support implementation. • National Development on WPAS to be confirmed – to increase options from 2-year review to have a selection of options to support clinically appropriate pathways for SOS and PIFU.
Reduction in the number of patients waiting 100% past Outpatient follow-up target date	• Promotion of Straight to Discharge, SOS and PIFU pathways • Validation of lists – limited resource available. Patient contact and validation team undertaken some clerical validation of lists whilst letter validation for new patients paused. From a sample of 309 patients validated, 143 removed. Validation lists produced by Performance Team looking at duplicates across RTT/Delayed follow ups/Treatments/SOS and PIFU to support targeted validation. • Scoping exercise to be undertaken of validation of follow ups in other Health Boards e.g. one Health Board identifies patients with potential for SOS and PIFU pathways based on clinical conditions, to support clinical review and moving over of pathway. • Individual specialty follows up plans to be developed as part of Outpatient Transformation plans. • Workstreams to maximise capacity e.g. focus on reduction of DNA's, clinic cancellations and maximising use of Outpatient space through clinic utilisation audits/development of Clinic Room Booking System and introduction of 6, 4, 2 process for Outpatients will impact both New and Follow up capacity
Increase in Single Cancer Pathway 62-day compliance. **Reduction in backlog of patients waiting over 62 days (SCP)** **Reduction in backlog of patients waiting over 104 days (SCP)** **Increase in rate of cancer diagnosis or discharges within 28 days**	• Task and Finish group established for x 3 tumour sites, gynae, urology and lower GI. • Demand and capacity exercise completed in Cellular Pathology and recruitment strategy developed in response to meet demand for USC tests, additional workforce will result in 75 average number of USC cases to pending per day by Q3 (currently 60) • Roche Ventana equipment to go live which will bring ICC tests inhouse for lung cancer and reduce wait for these patients starting on treatment. • Additional consultant staff in Pathology to support increase in reporting and reduction in urgent and USC reporting backlog. • Weekly Performance meetings with GM/AGM and service managers within Pathology to maintain focus on output. • Quarterly Directorate Assurance meetings instigated to focus on delivery, workforce, finance, risk, and governance including in pathology and Cancer Services
Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	• Mobile MRI scanner retained and supporting capacity. • Directing 60% of endoscopy capacity to USC backlog (partially caused by Industrial Action) • Options appraisal under development for Diagnostic Board around future of Neurophysiology service considering current fragility. • Workstreams and small cases of change identified from Toyota coaching groups implemented and actioned- further detail available once coaching groups commenced

Performance

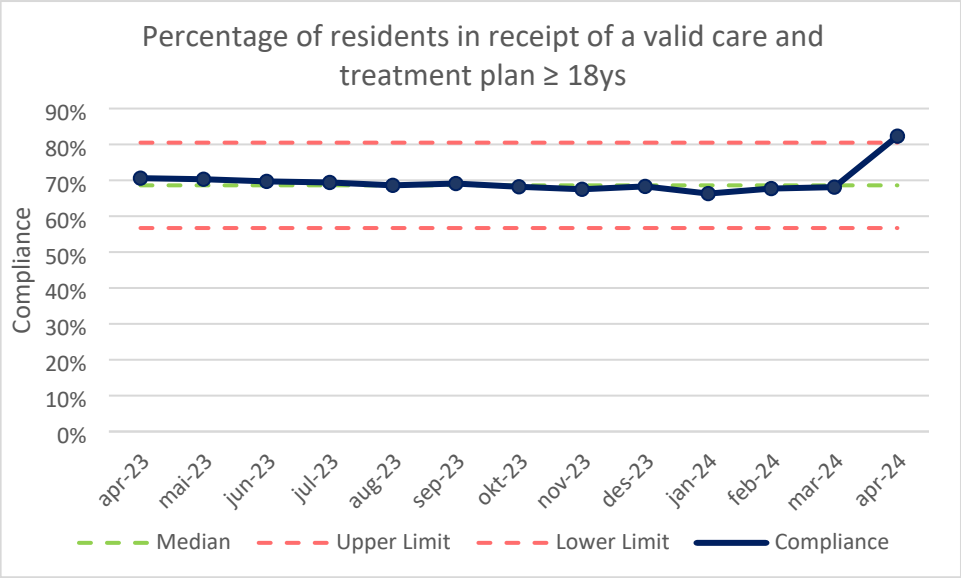
Adult Mental Health - Increase in Part 1a to national target (assessment completed within 28 days)



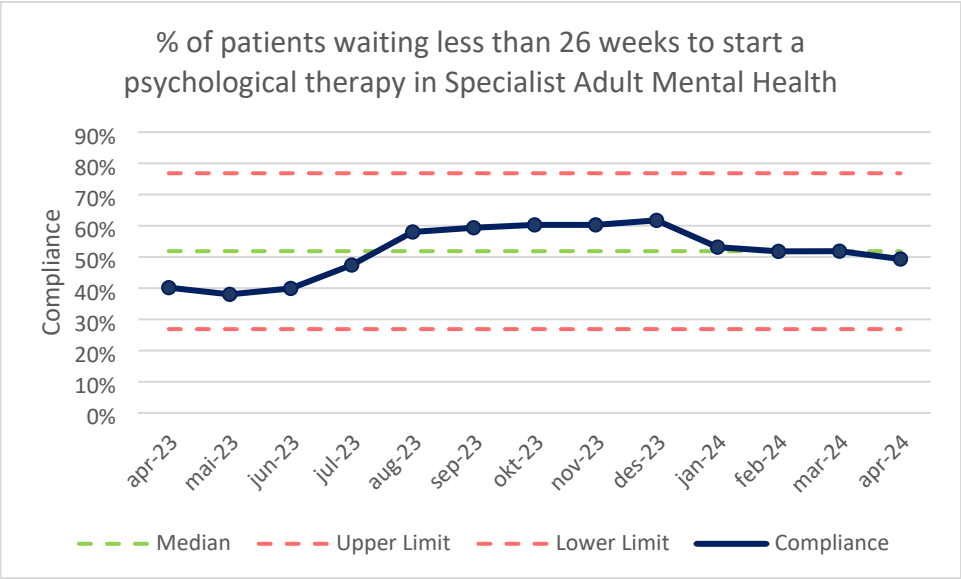
Adult Mental Health - Increase in Part 1b to national target (interventions completed within 28 days)



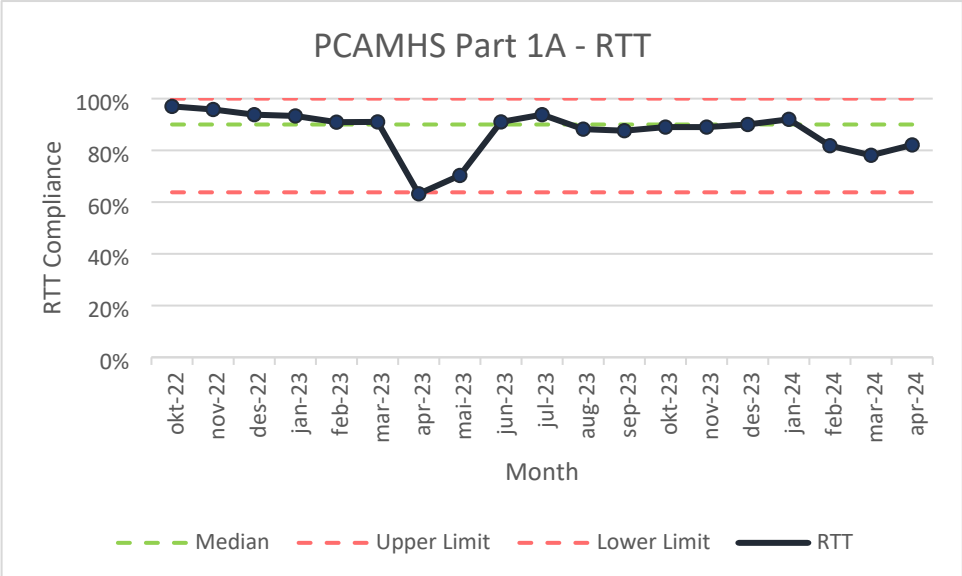
Adult Mental Health - Maintain Part 2 rates (number of individuals with a valid care and treatment plan)



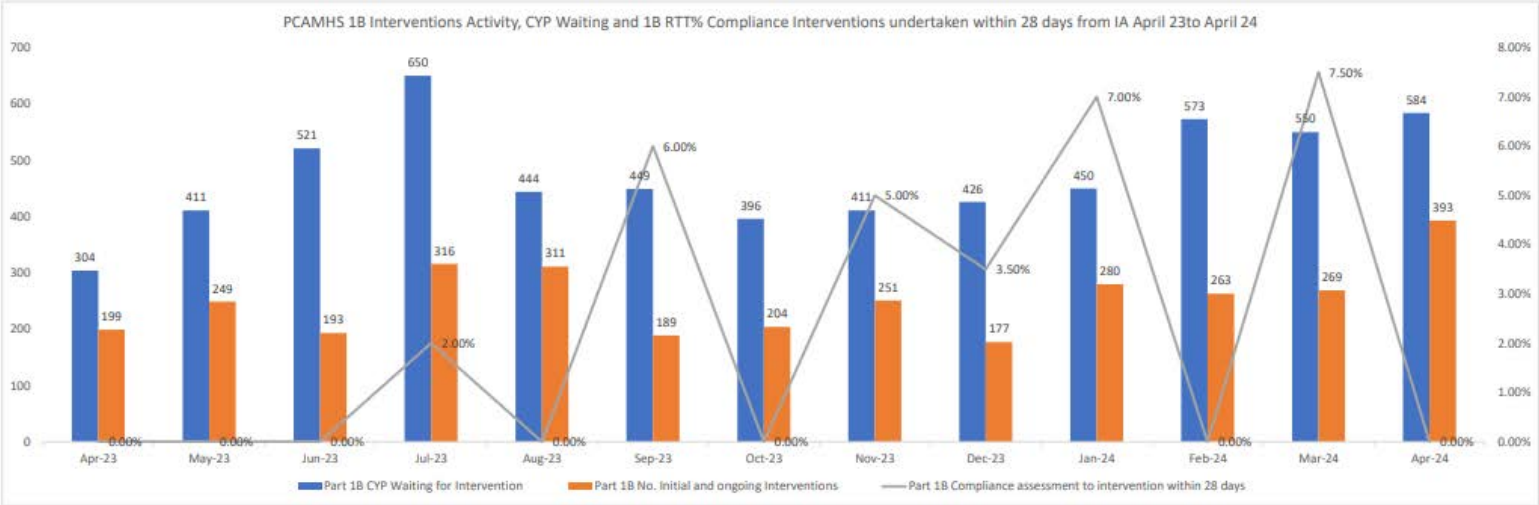
Maintain rate of psychological therapy received within 26 weeks



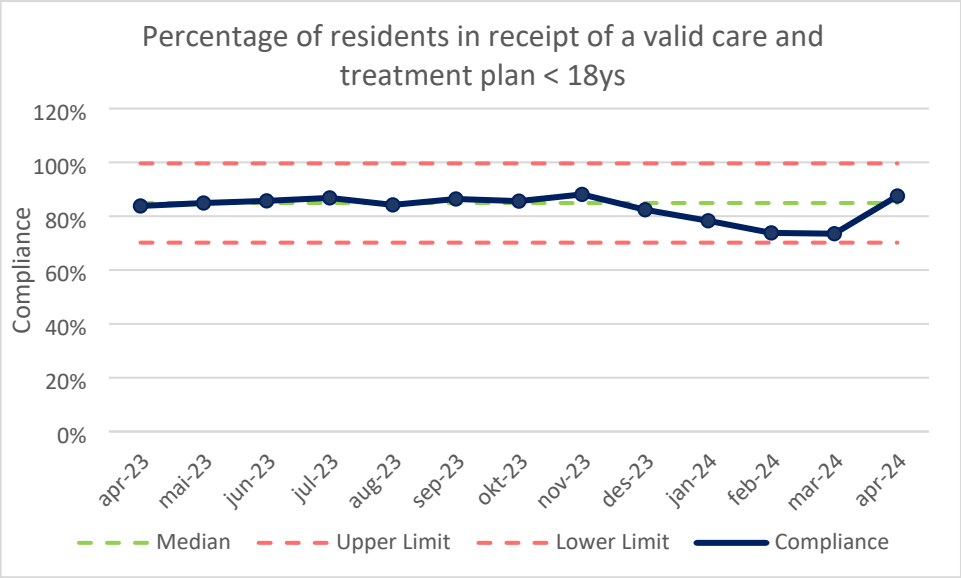
Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)



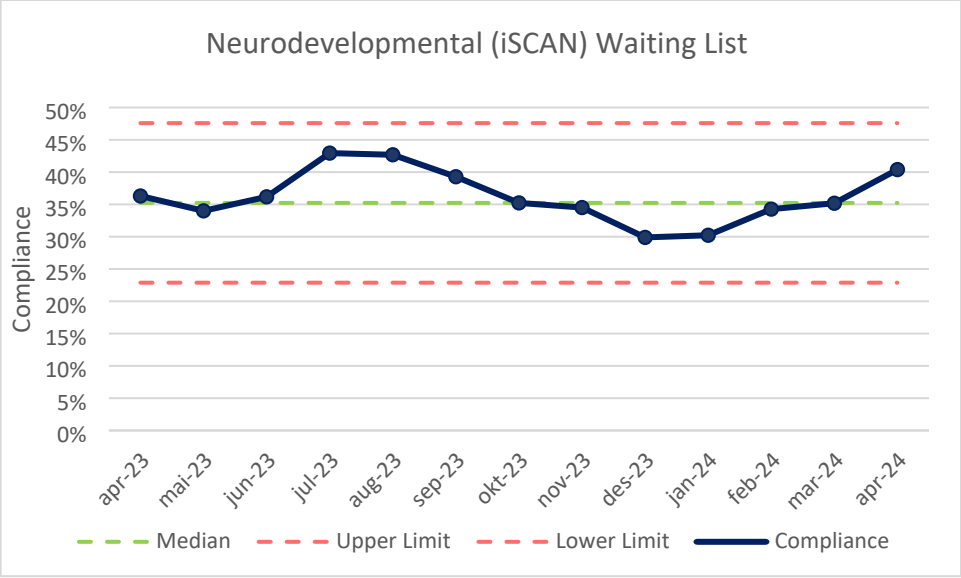
Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)



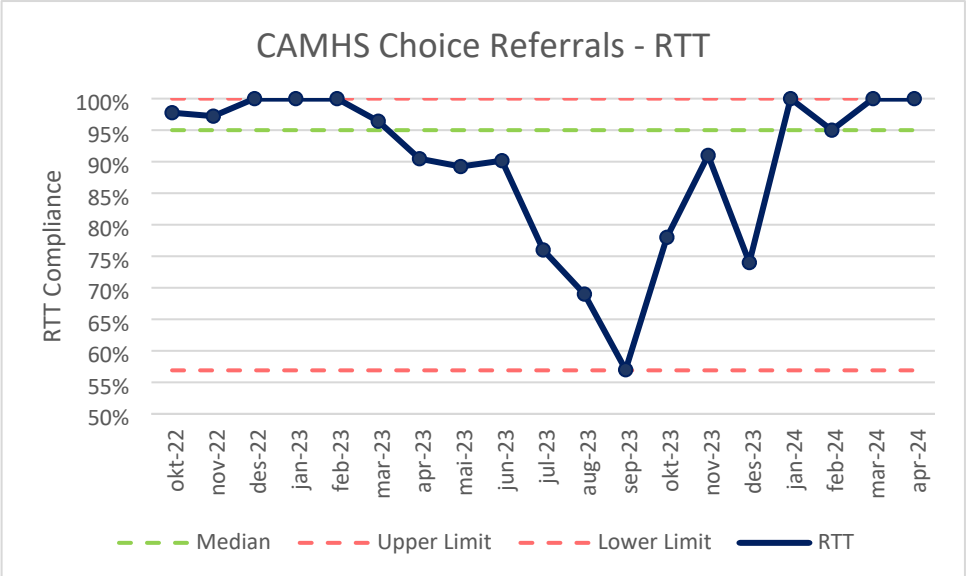
Maintain CAMHS Part 2 national target compliance



Improvement in Neurodevelopment (iSCAN) compliance



Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral



Analysis	
Increase in Part 1a to national target (assessment completed within 28 days)	Performance remains significantly below the target of 80% for both assessment and interventions. However, the most recent month of April has increased to 27% which is 4% higher than any other month in the previous 12 and approximately 10% above the median rate. May's data expecting 37% and a further 10% rise in June.
Increase in Part 1b to national target (interventions completed within 28 days)	Interventions less than 28 days following assessment at 5.4% during April 24. Over the last 13 months there is a downward trend being displayed. However, April has been reported at 10%, May expected around 17% with further increases expected in June.
Maintain Part 2 rates (number of individuals with a valid care and treatment plan)	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over) at the end of April is 82.3%. Over the previous 12 months the compliance has been around 70%. As with the assessment completed within 28 days measure April has seen a significant improvement in compliance.
Maintain rate of psychological therapy received within 26 weeks	Maintain rate of psychological therapy received within 26 weeks in April is 49.3%. Throughout the last 13 months the highest compliant month was December 2023 at 61.7%.
Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)	The latest data point available is April 2024 and is 82.1%. It has reduced over recent months but in the context of the 18 datapoints available this is normal variation within the process.

Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	The compliance rate is consistently 8% or below, significantly off the standard of 80%
Maintain CAMHS Part 2 national target compliance	Percentage of residents in receipt of a valid care and treatment plan < 18ys in April was 87.5%, very close to the 90% target. The median compliance rate over the past 13 months has been 84.9%.
Improvement in Neurodevelopment (iSCAN) compliance	Neurodevelopmental (iSCAN) Waiting List compliance in April was 40.4% against an 80% standard. Over the past 13 months the rate has been between 29% and 43%.
Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	The compliance rate reduced during Q2 2023/24 but has recovered and was above the 80% for the entirety of Q4 2023/24. As of April 2024 it was 100%.
Actions	
Increase in Part 1a to national target (assessment completed within 28 days)	• Action plan in place to improve service delivery. • Fortnightly performance meetings with Exec representative • Meetings with NCNs and GPs to discuss referral process. • Cleansing of waiting list achieved reduction of approximately 1500 clients in last six months. • Robotic Process Automation process for E-referrals being set up. All GPs referrals will now by through WCCG straight into WCCIS. Delivery date by end of July. This will significantly reduce the time to put referrals onto the system and allow more time for assessment within 28 days target. • Implementation of pilot of BRYN (brief review of your needs) this will allow prioritisation/triage of assessments and quicker access to intervention support.
Increase in Part 1b to national target (interventions completed within 28 days)	• Action plan in place to improve service delivery. • Development of on-line therapy service and enhanced group-based provision (CBT course) • Pilot of on-line therapy service completed and made live. • Next steps are to consider patient booking onto online courses. • Additional funding agreed to support 600 waiters for counselling. This will not impact compliance but will reduce waiting lists and ensure longest waiters are accessing appropriate interventions.
Maintain Part 2 rates (number of individuals with a valid care and treatment plan)	• Supporting the roll-out of the version 5 MHLD National Assessment Form which will support more accurate reporting of data around Part 2 compliance. • Working with directorate to ensure all Care Treatment Plans are accurate and up to date. • Caseload cleansing for data accuracy.
Maintain rate of psychological therapy received within 26 weeks	• Ongoing cleansing of caseload. • Recruitment challenges ongoing – continuous campaign to address vacancies. • MHLD performance Team has identified further work is needed in this area and an improvement plan required.

Maintain CAMHS Part 1a national target compliance (assessment completed within 28 days)	• Signposting to other sources of advice and support i.e. the Third Sector to support patients. • Advice and support to the referrer on future management • Referrals within Integrated CAMHS to continue to meet the needs of the child or young person
Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	• Extended waits for 1B interventions, workforce requirements identified to support a proposed recovery plan to reduce the extended waits for the large cohort of CYP who are waiting for PCAMHS intervention
Maintain CAMHS Part 2 national target compliance	• The Service are scoping the requirements for additional resource to recover the new core partnership interventions. The service has identified high complexity and acuity of CYP mental health needs waiting
Improvement in Neurodevelopment (iSCAN) compliance	• Reductions in Paediatrician capacity impacting performance, capacity gaps identified and further advertising for locum to cover other gaps to be actioned. • New SLTs for Under5 pathway have commenced for new patients, plus additional hours, with more focus on screening. • Recruitment to Over 5 pathways underway for lead OT. • Assessment underway to understand the need for a community embedded role to ensure linking across CAMHS portfolio. • Patients attending ISCAN in West from April 1st have been added to central waiting list, full West waiting list aim to be merged in June.
Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	• Neurodevelopment CHOICE documentation drawn up to mirror Portsmouth domains, all referrals being screened using these domains as trial. Soft launch planned for September 2024. • Continued weekly performance meetings and validation of CHOICE assessment and waiting lists demand and capacity. • Expressions of interest sought for Clinical CTP Lead for Care and Treatment planning to ensure the quality of CTPs and completion in a timely manner

Agenda Item: 3.4

Digidol, Data a Thechnoleg
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board
Digital, Data & Technology

Digital, Data & Technology Update

17th June 2024

Strategy Development

Data & Analytics Strategy

- Stakeholder engagement and workshops completed
- Draft strategy under review

Electronic Health & Care Record

- 16-week engagement with CGI
- Presentation on the Strategic Outline Case in July

Technical Strategy

- Workshops with vendors commenced
- Focus on cloud and cyber security

Will being component strategies together into a refreshed Digital Strategy for Board approval

Programme Update

Acute

Digital Ward

Digital Patient

ICT

Clinical Support

Community

Programme: Acute	**Programme Manager:** Carl Davies	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
Eye Care	Open Eyes – no progress, awaiting Welsh Government discussion on future of contract currently residing with C&V.	Decision on way forward (Open Eyes) Reviewing progress of pre-requisites (if required).
WICIS	Response to options appraisal submitted – not to proceed with implementation of WICIS.	National response to decision (expected early July).
Maternity	Working through transition into operational support.	Service acceptance & project closure
eTriage	Go live w/c 10th – 28th June	Service acceptance & project closure
Digital Dictation	Review of G2 solution, requirements gathering	Options appraisal (July 2024)
Dynamic Planning (LF)	Project mandate completed	Project initiation

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan
G2	Issue	Upgrade & contract extension required	6	Requirements & plan
G2	Issue	Uncertainty of suitability of G2 to replace medical secretary letters functionality	8	Requirements & clinical leadership

Programme: Digital Ward	**Programme Manager:** Gareth Jenkins	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
Careflow Connect	Reviewing requirements and scope to support bed management and patient flow	Steering groups Develop plan
Clinical Comms	Request for Information released Ongoing work to prepare Invitation to Tender Plan developed	Finalise tender for release 29th July, Scope extension of Stanley bleeps & Vocera post Sep 2025
WNCR	**Adults (85% complete):** St Woolos (RGH) completed Training at CCU (at GUH) commenced on 13th May Upgrade to v2.4 completed on 1st May **Paeds:** in response to funding cuts option to standardise without digitisation in 24/25 fed back to Programme	**Adults:** CCU due to be completed by 31st May YAB implementation due to commence early June User Acceptance Testing of v2.5 to commence 15th July **Paeds:** waiting for response from national programme

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan
DW	Risk	Services still sitting in programmes Capacity of clinical application support team	9	Service transition

Programme: Digital Patient	**Programme Manager:** Angela Jones	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
My Medical Record	Agreement to use local integration feeds / Go live on 11th Mar impacted by errors resolved by RPA workaround / staff and patient evaluation underway	MyMR test and acceptance of error fix / monitoring of stability in integration feeds
Digital Patient Comms	Phase one go live (issues around cancellation vs reminder SMS) / Letter checks for formatting / Testing of fixes to issues / T&O SMS templates reconfiguration	Resolution of issues around cancellation vs reminder SMS / Testing and implementation of fixes / T&O SMS templates
Video Consulting	Attend anywhere contract extended to Sept 2024 / O365 premium testing failed IG standards	Exploration of potential for MS TEAMS Options appraisal underway

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan
Digital Patient Comms	I437	Cancellation of 5day nudge message following clinical cancellation	12	Go-live without the 2-way confirmation reminder. Temporary 1-way solution for reminders
Digital Patient Comms	I432	Clear Zones miss-match on hybrid letters	12	Manual changes daily to letters to ensure formatting compatibility.

Programme: ICT	**Programme Manager:** Dominique Murray	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
Ty Gwent	All digital requirements captured Technical meetings held	Requirements for whole building required to develop plan Order remainder of ICT infrastructure
Server Refresh	26 servers remaining v 29 last reporting period	Slow progress due to complexity
Wi-Fi Remediation	Scoping work - focus on Radiology & mobile devices Technical assessments commenced	Complete scoping and technical assessments
Data Centr Move	New 10gb circuit into YAB completed New YAB WPAS database server live	10Gbps circuit in GUH planning WPAS integration servers go live
Netcall	Chatbot available but hidden	Support model, load balancer

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan
Ty Gwent	Risk	Requirements for building to confirm desk layout	9	Requirements requested
Server Refresh	Risk	Cyber risk – out of support OS	16	Cyber monitoring

Programme: ICT	**Programme Manager:** Dominique Murray	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
Windows 7 Replacement	Project closed	
BodyCam	Solution live	Service acceptance & closure
Patient Call	Go live planned across sites late June	Go live & service transition
Fuji Hardware	3D & Ortho-view moved to new hardware Removal of old equipment scheduled 10th-21st June	Closure by 5th July
Pharmacy Robot (New)	PID approved Floor plans for building submitted for approval	Technical requirements gathering
Ccube (New)	Project mandate completed	Project initiation

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan
Bodycam	Risk	Live service still with programmes (no support)	6	

Programme: ICT (Capital Estates)	**Programme Manager:** Dominique Murray	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
Satellite Radiotherapy	ICT changes agreed, site survey for PSBA route - go live early 2025	Ongoing planning activities
Tredegar	New site is open Kier delayed in phase 2 – old site	Demolishing old site – end date Nov 25
Newport East	OpenReach internal fibre delivered & schedule of works agreed – go live early 2025	Agreement on who will pick up revenue costs Ongoing planning & design activities
YYF Breast Unit	Vocera live Quotes received for additional cabling for missing AP's	Installation of missing AP's Project closure
GUH A&E	Building works progressing Core switch port secured	Ongoing planning activities - go live May 25

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan

Programme: CSS	**Programme Manager:** Mike Harber	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
LIMS 2.0	InterSystems are continuing to build the new LIMS UAT test plans have been agreed for all disciplines Resource plan developed (see below risk)	Ongoing risk / issue management Refine plans (request for additional resource) Micro benefits workshop
Winpath	Haemonetics upgrade completed (dependency)	Integration complete; testing & validation
RISP	Meeting held with Philips to develop local project plan (now being reviewed by stakeholders) Philips have requested a change to go live date (Nov / Dec 25)	Agree local project plan, approval of national plan – CCN to change deployment date Re-profile resource costs to 25/26
CANISC	Plan developed to move off CANISC by Oct 24 (Risk) Reporting – continued work on the dashboard Prep work – Palliative Care and Screening & Colposcopy	National Dependencies Oncology MDT's Finalise dashboards
Digi CellPath	Business case reviewed (waiting for feedback from PIP)	Feedback on business case

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan
LIMS 2.0	Risk	Resource to deliver the plan	20	Request for resource
Winpath	Risk	Timeline / Software Development delivery of integration	12	Under review
RISP	Risk	Delivery of project within required timeframes	15	Agree plans
CANISC	Risk	Delivery by October 2024	20	Request extension

Programme: Digital Community	**Portfolio Manager:** Simon Line	**RAG:**

Progress Update:

Project	Key Milestones	Activities for next Period
MH & LD	Escalation of RTT issues with request to bring a prioritised fix for June 2024 / Project closure	WCCIS project and programme closure / Transition to digital community programme / Requirements work and procurement start
Mobile Applications	Resolved issues in mobile charging from programme budgets / ongoing work on asset management process and control	Continued work to improve asset management
Integration	Testing of WCCG interface	On hold waiting for DHCW
Community Nursing	Delivery On Hold and rolled over to Digital Community programme	On Hold
Future of WCCIS	Requirements gathering workshops / Service engagement / procurement workstream started / Nonfunctional requirements	Transition to digital community programme / Requirements workshop and SoR / Tender approach and early market engagement

Escalated Risks & Issues:

Project	Risk / Issue	Description	RAG	Action Plan
MH&LD	R086	Advanced will not deliver the SoR	20	Prioritised CCN and defect list through exit strategy
MH&LD	R610	CareDirector V5 unsupported from January 2026	20	Implementation of alternative solution

Microsoft 365 Transformation

Programme: M365 Transformation	**Portfolio Manager:** Kelly Griffiths	**RAG:**

Progress Update:

Key Milestones	Activities for next Period
Digital Trainers trained to deploy SharePoint Training – Awareness sessions will start from 10/6/24 with Beginners guide to SharePoint Document Libraries.	Benefits monitoring for solutions recently implemented.
Ongoing solutions being developed, including: • Palliative Care Admissions Flows – improved information sharing • Veterans' treatment questionnaire – Will be rolled out in next quarter – Support decision making about the Veterans treatment plan • Infusion Device Training Booking System – Under development • Training Booking App being developed for WPAS Training	Further development of hot desk and room booking solution.
Continued trial of Microsoft Co-Pilot	Continued work on outpatient room booking solution

Escalated Risks & Issues:

Risk / Issue	Description	RAG	Action Plan
Issue	Configuration issues with Company Communicator preventing roll out	12	Further exploration with DHCW
Issue	Resource – Ability to address support calls and deliver transformation activities	12	Request for resource

Digidol, Data a Thechnoleg
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board
Digital, Data & Technology

Questions

Agenda Item: 3.5

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	17 June 2024
CYFARFOD O: **MEETING OF:**	Finance and Performance Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Internal and External Audit Recommendation Tracker
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As part of the annual review of Committee Forward Work Programmes, it has been agreed that each Committee will receive an update on any internal or external audit recommendations aligned with its Terms of Reference, in order to provide greater transparency and accountability of the improvements required to mitigate risks and gaps in assurance that may threaten the organisation's ability to deliver on its statutory responsibilities and defined strategic aims/objectives.

This paper provides an overview to the Finance and Performance Committee (the Committee) of all identified internal and external audit recommendations, as well as the current implementation resulting from planned audit reviews that fall under the purview of the Committee's agenda.

Cefndir / Background

As outlined in the Committee's Terms of Reference, the Committee will seek assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all

aspects of the health board's business, in line with the Board's Performance Management Framework. The Committee will seek assurance that arrangements for financial management and financial performance are sufficient, effective, and robust.

The Corporate Governance Directorate has a role in recording and tracking the findings, which are then reported as a standard item to the Audit, Risk and Assurance Committee (ARAC) for assurance, ensuring that the actions in place to implement the recommendations are carried out and completed within an appropriate time frame based on the assurance outcome and the priority rating of individual recommendations.

The Committee will receive an update on all recommendations owned by the Directors, as follows: -

- Director of Finance and Procurement;
- Director of Digital;
- Director of Strategy, Planning and Partnerships.

The audit reports and subsequent recommendations owned by the Director of Strategy, Planning, and Partnerships and reported to this Committee will cover performance, and delivery of capital programmes and strategic change programmes.

Asesiad / Assessment

Internal and External Audit Recommendation Tracking.

The Committee has been provided with data regarding the status of all overdue and completed recommendations as at the 31st March 2024 which were presented to the Audit, Risk and Assurance Committee and approved at its meeting in April.

'Overdue' represents recommendations that have passed their original or revised implementation date.

23 recommendations from the internal audit reviews, listed below, triggered as overdue in Q4 2023-24 (January–March), necessitating an update from the Director of Digital.

- Digital Benefits Realisation (2020)
- IM&T Control and Risk Assessment (2021)
- IT Strategy (2022)
- NIS Directive (Cyber Security) (2022)
- Records Management (2022)
- Robotic process Automation (2022)
- Stakeholder Engagement on IT projects (2023)

There were no overdue recommendations that required an update from the Director of finance or the Director of Strategy, Planning and Partnerships for the reporting period ending 31st March 2024.

Table 1 summarises the **23** 'overdue' recommendations by 'Year' and 'Priority Rating' that required a review and update.

Table 1

Overview of Recommendation Activity for Quarter 4 by 'Year' and 'Priority Rating'					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2020	-	-	-	4	**4**
2021	1	3	-	-	**4**
2022	1	12	-	-	**13**
2023	2	-	-	-	**2**
Total	**4**	**15**	-	**4**	**23**

The data in summary Tables 2 and 3 provide a breakdown of completed and overdue recommendations by the 'Year' and 'Priority Rating' of the audit.

Table 2 below summarises the position as at 31st March 2024 by the 'Year' and 'Priority Rating' in relation to the **five** completed internal audit recommendations. Further detail can be found at ***Appendix 1.***

Table 2

Completed Recommendations for Quarter 4 by 'Year' and 'Priority Rating'					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2020	-	-	-	1	**1**
2022	-	2	-	-	**2**
2023	2	-	-	-	**2**
Total	**2**	**2**	-	**1**	**5**

Table 3 below summarises the position as at 31st March 2024 by 'Year' and 'Priority Rating' in relation to the **18** (**17** of the **18** have revised deadlines) **<u>overdue</u>** audit recommendations.

Table 3

Overdue Audit Recommendations by 'Year' and 'Priority Rating'					
Year	**Priority Rating of Recommendation**				**Total**
	Low	**Medium**	**High**	**N/A**	
2020				**3**	**3**

2021	**1**	***3***	**1**		**4**
2022	**1**	**10** *(*1)*			**11** *(*1)*
Total	***2***	***13***	**1**		***18***

(*1) denotes the audit recommendation not approved for extension by ARAC.

Appendix 1 contains additional information on the 17 audit recommendations, as well as the approved revised implementation date. **Appendix 2** provides additional information about the one remaining overdue audit recommendation as at 31 March 2024.

Since this reporting period, recommendations with deadlines in quarter 1 of the financial year 2024/25 would have become overdue. These will be updated in preparation for the next reporting cycle.

Argymhelliad / Recommendation

- **NOTE** the closing position of the audit recommendations overseen by the Audit, Risk and Assurance Committee

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Risks associated with overdue recommendations will be captured locally and escalated to the strategic risk register if necessary.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	All terms are explained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

Appendix 5 Overdue Q4 Recommednations Post Update

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recom men-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Months passed Agreed Deadline	Proposed Revised Deadline	Months passed Revised Deadline	Date Deadline Approved by ARAC Committee	Due	Revised Deadline Due	If closed and not complete please provide justfication and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close down the reccomendation?	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital/Assistant Director of Programmes	N/A	R4	R4 The risk identification process should be formally linked to the issue / event / problem management process in order to ensure that underlying risks are identified.	A review of risk management processes has commenced. The Health Board has appointed a Chief Nursing Information Officer/Clinical Safety Officer who will lead the project to align risk management processes from Programmes, design, Service Delivery, Health Records and Information Governance and Cyber Security to inform the new governance structure.	31/12/2021	-26.92		-1487.93	08/02/2024	Completed/ Closed	Completed/ Closed		March 24 - The directorate is following the newly published HB Policy and framework for risk management. A seperate review of datix is underway with a view to move all directorate risks to this format. A further audit has also commenced regarding risk management across digital.January 2024: Work is underway to align the directorates existing risk management framework with the updated Health Board framework and will be complete by the end of February. Any digital issue, events and problems are managed using well defined best practice and roles are in place within Digital Service Delivery to support this. The new directorate framework will outline how operational risks identified through day-to-day support activities are managed using Datix as the single source of information. Strategic plan to incorporate cascade trainers into the training provision to increase compliance.				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R5	The Health Board should consider the purchase of additional robot capacity.	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-12.98		-1487.93	28.11.2023	Completed/ Closed	Completed/ Closed		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. Additional robot purchase not supported pending rebaselining of planned automations benefits			Mar 24 - additional robot capacity has been put in place on a case by case basis where digital workers have been required to solve issues e.g. PSA, Maternity & Medilogik. The service has secured 3 additional robots for 2024/25.	31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R6	Consideration should be given to increasing the level of ring fencing for specific robot time for time constrained processes as part of the ongoing development of the RPA service	The business case for submission in Q4 provides an option also to increase capacity of automation.	01/03/2023	-12.98		-1487.93	28.11.2023	Completed/ Closed	Completed/ Closed		Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Peak day time capacity consumes all current robot capacity. Additional robots have been procured from non RPA budgets to support critical functionality. The RPA architect continues to reprofile activity to ensure automations are deployed optimally to allow additional automations not dependent on in hours working to be undertaken.			Mar 24 - ring fencing is in place for robots where necessary e.g. finance however, robots can be utilised flexibly and it is best practice to sweat the asset where time is available within a robot's schedule of work to deliver activity	31/03/2024
Internal	2024.04	Stakeholder Engagement on IT Projects	Substantial	Director of Digital	Assistant Director of Digital Programmes.	Low	R1	A template should be developed in order to record all workshop attendance	Standardised templates for Steering Groups and Workshops will be developed b the Buisness change Team and will be incoorporated into the Project Management Framework.	31/03/2024	0.00		-1487.93		Completed/ Closed	Completed/ Closed		Mar 24 - Attendance sheet template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.			Completed - Attendance sheet template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.	31/03/2024
Internal	2024.04	Stakeholder Engagement on IT Projects	Substantial	Director of Digital	Assistant Director of Digital Programmes.	Low	R2	Consideration should be given for a single record to track attendance at project and programme boards.	A meeting attendance tracker will be created and will be implemented for use by all project boards.	31/03/2024	0.00		-1487.93		Completed/ Closed	Completed/ Closed		Mar 24 - Meeting attendance tracker template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.			Completed - Meeting attendance tracker template developed and guidance on its use issued to project teams. Links to documentation included in Project Management Framework.	31/03/2024

Appendix 4 Completed Q4 Recommendations Post Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Priority	Recom-men-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2022.12	Records Managment	Limited	Director of Digital	Medium	R5	R5 The need for records management storage places should be regularly reviewed to ensure that sufficient spaces are available for record keeping purposes.	This issue is to be raised with the All Wales Medical Directors Forum as Caldicott Guardians. The Data Protection Officer will raise this at quarterly meetings with the Medical Director and agree an action plan.	31/12/2023			Overdue	Overdue						31/03/2024

Appendix 3 Revised timescale requests Q4 Recommendations Post Updates

Audit Type	ABUHB Ref No:	Report Title	Assurance Rating	Director	Responsible Officer	Priority	Recommen-dation No.	Recommendation	Management Response	Deadline Agreed in Final Report	Proposed Revised Deadline	Date Revised Deadline was approved by ARAC Comittee	Final Report Deadline Status	Revised Deadline Status	Number of revised Timescales Requested including new request	If closed and not complete please provide justification and ensure evidence is avaliable	Progress of work underway	Barriers to implementation including any interdependencies	How is the risk identified being mitigated pending implementation?	What evidence is available to close/complete the recommendation?	Reporting Date
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital	N/A	R1	R1 The governance framework for IM&T / digital should be clarified and where control over aspects of IM&T has devolved to departments, there should be a process for these to feed into the relevant Committee to ensure oversight. Underneath the Committee the steering group remit and membership should be defined.	Agreed. The Health Board is establishing a new governance framework. Currently Informatics is reporting to the Audit Committee, the first report is scheduled for 8thApril. A Health Board governance framework is in development for informatics including exec oversight, investment and delivery. The management of the global pandemic has disrupted the planning work by 12 months but this is now re initiated. Recommendations arescheduled to be presented to Exec TeamQ1 , and Board in Q2;	30/06/2021	31/03/2023	16/04/2024	Overdue	Not Yet Due	3		March 2024: The Information Governance, Health Records and Cyber Security governance groups are now meeting and the first Information Governance Sub-Committee is being held on the 26/03/2024. The Digital, Data & Technology Sub-Committee terms of reference are completed and will be taken to the Executive Committee on the 11th April pending agenda setting.January 2024: The directorates new governance arrangements have been consulted and agreed internally. The Information Governance structure has been approved by the executive committee which will build on the well-established Governance & Assurance groups where there is strong engagement between the Information Governance team and Divisional leadership.				31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R5	R5 The Health Board should ensure greater links with divisions and the Informatics Directorate. The Informatics Directorate should be involved in the decision making process for all IM&T items.	Accepted. The CDO will present the recommended Target Operating Model to the HB which will include governance over Informatics as a Division and also departmental systems. Part of the framework will include decisions to procure and assurance processes not only for informatics division but informatics services owned outside. Part of adoption will help appraise strategic options in how the HB wishes to take this forward. Part of the SIRO objectives will set out the responsibilities for devolved asset owners and a performance management framework to identify risk and provide oversight. There is likely to be a resource impact in achieving this which will be subject to a business case.	31/03/2021	31/07/2024	16/04/2024	Overdue	Not Yet Due	3		"Mar 24 - Divisonal engagement meeting dates for meetings are being established for Families & Therapies and Unscheduled care division and will be in place in April 24 subject to Divisional staff availability.A communications an engagement plan that covers all the activities of the Health Board will be developed in Q1 2024/25. An annual operational plan has been developed to provide a detail account of the delivery plan for 2024/25 to sit alongside the IMTP Digital Enabler section.Divisional meetings are in place for Clinical & Support Services, Scheduled care, Primary & Community care & Urgent Care. New Digital Service Requests are in place to ensure all new requests are reviewed by the Senior Leadership team on a fortnightly basis. The digital enabler component of the IMTP has been completedA Microsoft Team Planner board is in place to track progress and outcome of requests to Projects or production. Internal Directorate communications are in place using Teams channels including a communications, learning & development and job vacancy segments.The Director of Digital has implemented regular online 'town hall' events for the Directorate. The Directorate has very regular lunch and learn sessions for internal and external speakers"Regular Divisional engagement meetings have been expanded to include Urgent Care leaving Mental Health & Learning Disabilities and Medicine to be implemented before the end of March 2024. Each Division will be provided with a 'Digital Buddy', a member of the Directorate Senior Leadership team who will chair the oversight meetings and will provide Divisions with a single point of contact for raising issues with the Directorate. As one of the key planning enablers the directorate participates actively in the annual planning process working with Planning to understand the needs of the service and align digital activities to those needs. The engagement and communication activities of the directorate will be summarised in a new Engagement & Communication Plan.				31/03/2024
Internal	2020.00	IM&T Control & Risk Assessment 2020/21 - Advisory	Not Rated	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	N/A	R8	R8 An assessment of the changes needed to implement the Digital Strategy should be undertaken, and the benefits of the changes articulated, along with the consequences of no change. The Health Board should develop a single roadmap to help deliver the Digital Strategy.	As part of the review Informatics has accepted the need for P3O Portfolio management. This work is ongoing and with an initial focus to core Informatics Division activity but provides a framework for Health Board oversight and transparency. The portfolio approach will extend subject to Board approval to all information assets in a planned programme of work. This forms part of the recommendations to Execs in Q1 2021.	30/06/2021	01/05/2024	16/04/2024	Overdue	Not Yet Due	3		Mar 24 - Divisonal engagement meeting dates for meetings are being established for Families & Therapies, Unscheduled car & MH&LD division and will be in place in April 24 subject to Divisional staff availability. January 2024: A new digital service request process will be implemented by February 2024 to funnel all requests for new services through the senior leadership team with additional appraisal undertaken of requests by the business analyst team with requestors to ensure requests are understood, are properly documented, and have sufficient detail to enable prioritisation. A key component of this will be strategic alignment with the core local and national digital strategies. The Digital, Data & Technology sub-committee of the Finance & Performance Committee will provide an additional governance space for assurance of the work of the directorate by its Health Board stakeholders as well as the Executive. Progress has been made on the portfolio register to surface all digital work including new service requests and ICT projects. Resource & capacity modelling being developed along with business change tools to support service readiness for change. Internal audit will shortly be undertaking an audit of our portfolio arrangements in line with best practice. Currently the new Data Strategy is currently under development and associated strategies for ICT and Cyber Security are planned for the first quarter this year. The Health Board has commissioned CGI to undertake consultancy of on the future of the Electronic Health & Care record across the organisation and we would expect a report for this in the summer. These strategies will be brought together as an overarching summary Digital Strategy following these developments.				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Low	R1	R1 For future iterations of the CAF there should be greater involvement of the system owners in the review of the responses.	ABUHB will ensure that in future iterations of the CAF there is greater involvement of System Owners	31/12/2022	31/05/2024	16/04/2024	Overdue	Not Yet Due	2		March 2024: Cyber continues to attend GAG (Governance and Assurance Groups) meetings when scheduled with divisions to highlight the need of Information Asset Owners (IAO) and Senior Information Asset Owners (SIAO). CSAG (Cyber Security Assurance Group) meeting has been postponed due to circumstances within the team, this will be rearranged when applicable. Attendees have been identified and agreed with the SIRO. Terms of Reference will be covered in the first scheduled meeting. January 2024: The Cyber Resilient Unit assessment is now scheduled for 22/01/2024. There was a pre assessment meeting arranged with the CRU before the new year to discuss scope and this included Information Asset Owners.There is strong engagement through our divisional assurance arrangements where regular meetings are held between the divisions and our cyber security team. This will be further strengthened with the Cyber Security Assurance Group which will be meeting for the first time this quarter. Nov 23: CRU assessment now scheduled for 22/01/2024. There will be a pre assessment meeting arranged by CRU in Nov/Dev to discuss scope and Digital will ensure this includes Information Asset Owners. Aug-23: CRU have provisionally provided a date for the next NIS CAF assessment process Oct 2023. As part of the engagement CRU have suggested a hybrid approach with onsite visits and interviews with systems owners. This is being piloted currently but is a process change from the previous assessment process undertaken in 2021				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R2	R2 Management should ensure that records of discussions and information provided to and from the CRU are captured for future annual self-assessments.	Management will ensure that during any future self-assessments records of discussions and informationsupplied to the CRU will be captured and available for internal or external review.	31/12/2022	31/05/2024	16/04/2024	Overdue	Not Yet Due	2		March 2024: As part of the NIS CAF, CRU have supplied Cyber with a "Findings Update" Excel documentation, which allows Cyber to provide monthly updates against the outcome recommendations for the Principle(s). Currently, Cyber's responsibility is to gather updates for CRU from Remedial Action Owners until CSAG (Cyber Security Assurance Group) meetings are held; however, CRU require monthly updates and CSAG will be on a quarterly basis. We are reviewing the project management arrangements to ensure the reporting requirements can be met. January 2024: In our assessment with the Cyber Resilience Unit in January we are discussing the documentation requirements and how we can ensure this audit recommendation can be satisfied going forward. Nov 23: CRU will outline what documentation/evidence they expect to be provided at the pre assessemnt scoping meeting prior to our January assessment. This is due to be held Nov/Dec 2023 Aug-23:CRU are piloting process changes to their approach from their initial NIS assessment undertaken in 2021, Future NIS CAF assessments will include evidence gathering ,recording and reporting as part of the new format.				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R4	R4 The costs associated with the improvement actions should be assessed and reported to a relevant committee to enable awareness of the full picture and prioritisation of actions and funding.	The NIS Improvement Plan will be submitted through the relevant governance committee for senior Management review and sign off. Prioritisation of remedial actions and related costs will be assessed through ABUHB formal risk governance structureand relevant committees. Note ABUHB are currently implementing the recommendations of the Templar consultancy report which will create the Office of the SIRO and create a new governance frameworkto support Risk Management within the Health Board.	30/09/2022	31/05/2024	16/04/2024	Overdue	Not Yet Due	2		March 2024: Due to unforeseen circumstances, Cyber has postponed the first meeting of the Cyber Security Assurance Group (CSAG) and is yet to set a rearranged date and time. Attendees have been agreed by the Cyber Security Manager and the SIRO and a Terms of Reference (TOR) paper has been created in readiness of this meeting. January 2024: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process and will form the basis of associated capital plans and potential bids to Welsh Government. Nov 23: New Cyber Security Assurance Group will be meeting in January and will provide assurance through the Information Governance Sub-Committee including progress against the NIS action plan which has now been developed. Any associated costs will be captured as part of the Digital IMTP planning process. AUG 2023: Awaiting next HBOTS meeting.				31/03/2024
Internal	2021.22	NIS Directive (Cyber Security)	Reasonable	Director of Digital	Director of Digital / Chief Technology Officer	Medium	R5	R5 A formal reporting route for cyber security should be established to ensure that senior staff are aware of the position relating to cyber security and the risk description should be reviewed, with inclusion of the potential financial penalties relating to noncompliancewith NIS.	ABUHB are adopting recommendations of the Templar Report that will establish a formal risk governance and committee structure within the Health Board which will support Cyber Security Risk Reporting.5.2As part of the improvements suggested by Templar a new Cyber Risk Register will be developed. As part of development process account will be taken to include the financial penalties associated with noncompliance to NIS regulatory requirements into the assessment methodology and reporting.	30/09/2022	31/05/2024	16/04/2024	Overdue	Not Yet Due	2		March 2024: The first Information Governance Sub-Committee meeting has been postponed until March 26th; however, the Cyber Security Assurance Group (CSAG) are yet to have their first initial meeting. January 2024: The new Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024.Regularly report of cyber incidents, risk, awareness and training will be provided to the Finance and Performance Committee through reporting from the Information Governance Sub-Committee. Nov 23: New Information Governance Sub-Committee will have its first meeting in February and will have a Cyber Security Assurance Group reporting too it which will have its first meeting in January 2024 Aug 2023: Awaiting next HBOTS meeting. May 23: work to commence shortly under SIRO Mar 23: Part of work programme that will be commencing from May under Rani Jan 23: Regular cyber reporting is in place, currently this runs through Digital Delivery Oversight Board and to execs. This will change to HBOTS/SIRO once fully established Sept 22. The reporting route is being established following the appointment of the new SIRO. Aug 22: Work is ongoing to implement the TOM and supporting Risk management framework, A governance and Assurance Committee has been established this will report IG and Cyber risks identified at the GAGS through to the HBOTS . This will be supported by a corporate risk management methodology. The assessment methodology and risk scoring will capture the costs of non compliance to NIS and subsequent financial penalties that could be imposed."				31/03/2024
Internal	2022.05	Digital Benefits Realisation	Substantial	Director of Digital	Director of Digital / Assistant Director for Strategy, Planning & Design	Medium	R1	R1 - The Health Board should finalise the "front of house" process and enable a process for a holistic prioritisation of programmes.	A draft New Digital Service Request (NDSR) process has been designed to provide transparent onboarding of new work for the informatics directorate. The process sets out how Informatics undertakes and supervises a workflow using agreed standard tools and documentation from triage, through evaluation, discovery & definition to transition to programmes or Service Delivery. This will provide internal assurance of the process and ensures that options are presented to Digital Delivery Oversight Board (DDOB) with a clear assessment of priority and recommendations. DDOB is the body that will make informed decisions on the prioritisation of Informatics programmes and projects. New national programmes will be tracked through the same process allowing the Health Board to locally prioritise and feedback these priorities back to national.	01/06/2023	31/05/2024	16/04/2024	Overdue	Not Yet Due	2		March 2024: The new digital service request has been drafted and will be completed by end of March 2024 for dissemination and implementation and will be presented to Exec Board in April 202. Jan 24: A new digital service request process will be implemented by March 2024 to funnel all new service requests using a request form in our Seren ICT portal through the DDaT senior leadership team with additional appraisal of requests undertaken by the business analysis team with requestors to ensure requests are understood, properly documented and managed and have sufficient detail to enable prioritisation and scaling to enable prioritisation and progression in alignment with Health Board priorities. Nov 23: The new digital service request process is nearing completion and will be launched shortly across the Health Board. The digital governance committee will provide assurance on the digital plan and the updated digital programmes framework ensures benefits management will be ingrained in all projects.				31/03/2024

Internal	2022.12	Records Managment	Limited	Director of Digital	DPO & Head of IG Interim ADI – Governance & Assurance	Medium	R13	R13 All records should be formally tracked to ensure that they are retrievable when they are needed.	a.) The Business case for DHR phase 3 is in development, this will include the scanning of paper records to be available to view in CWS/cCube Portal negating the need for tracking. b.) Future phases for community, District Nursing, children's services and therapies are being planned and expedited and tracking will be implemented.	31/12/2023	30/06/2024	16/04/2024	Overdue	Not Yet Due	1		Mar 24 - Phase 3 Mental Health, Community, District Nursing, Childrens Services Business case with Director of Digital for review.				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R2	Benefits realisation should be established as part of the go-live for automated processes, with the relevant department being required to monitor and confirm the benefits.	Benefits realisation is identified and confirmed by relevant departments and this will now be formally monitored and confirmed by the governance board. This is in part contingent on a successful business case.	28/06/2023	30/06/2024	16/04/2024	Overdue	Not Yet Due	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The interim product specialist is implementing a beneits register. This work will be ongoing during April and May 2024. Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R3	Consideration should be given to establishing a benefits sharing framework for cash releasing savings that would enable the RPA function to be self-sufficient.	This is not a unique issue to RPA but reflects the need for benefits realisation to include (when corroborated and confirmed) sharing of benefits including financial where this is the case. In order to mitigate the risk of priority based on ability to pay the process needs to be owned and curated at health board level rather than between departments. This recommendation will be considered in the case.	31/03/2023	30/06/2024	16/04/2024	Overdue	Not Yet Due	2		Mar 24 - a benefits management framework is being implemented in RPA. Benefits are captured duing the RPA opportunity assessment process (see above line 15). Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Service request forms and opportunity assessment form redesigned to provide better profiling of benefits. Process agreed by RPA Board for requesting service Finance BPA assurance of benefits before automations are agreed				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R4	The Health Board should seek to complete recruitment and staff the RPA team accordingly.	A revised business case is expected to be submitted to Executive colleagues in Q4.	01/03/2023	30/06/2024	16/04/2024	Overdue	Not Yet Due	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being interviewed in April 2024 Nov 23: Recruitment underway but experiencing delays in attracting the right level of candidates. Aug-23: RPA escalation SBAR presented to Exec Board in March 2023. 2 posts agreed.				31/03/2024
Internal	2022.14	Robotic process Automation	Reasonable	Director of Digital	Director of Digital	Medium	R7	The awareness of RPA and the change management process should be strengthened as RPA moves into an operational service. All services should be made aware of the requirement to notify Informatics of changes to any system that may interact with the robots.	Part of the transitional arrangements to operational services will be refined and robust service management arrangements. This is subject to a successful business case.	01/03/2023	30/06/2024	16/04/2024	Overdue	Not Yet Due	2		Mar 24 - an RPA architect has been recruited and will be in post in April 2024. The permanent RPA product specialist post is being intrviewed in April 2024. Handover needs to be completed from the RPA contractor and the product specilist recruited to enable the work to be undertaken to complete this recommendation Nov 23: Dependent on recruitment of of resources for RPA Aug-23: Transition to BASU will be undertaken when posts are appointed q3 2023				31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R2	The role of the CCIO and CNIO should be fully defined.	2.1a The CCIO currently has an AMD role profile. There has been discussions for some time in terms of role design and accountability with the CCIO MD CEO and CDO. A model role profile based on the Faculty of Clinical Informatics example has been agreed and is now being localised. The CNIO has a full role profile and agreed Job description	01/06/2023	30/09/2024	16/04/2024	Overdue	Not Yet Due	1		March '24 - no confimation of resourcing to support clinical engagement. Position not changed. CNIO position to be reviewed with Digital / Nursing directors with the retirement of current CNIO in July '25 Jan 24: Future arrangements and resourcing to support the clinical engagement across the Health Board will be presented to the Exeuctive Committee in early March. This will create a formal structure of CNIO and CCIO's and a relauch of the Clinical Council. Nov 23: CNIO role established. Work continuing on formalising the CCIO role. Aug-23: CNIO aspects of this have been met				31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R3	Leads within divisions should be established to work with the CCIO / CNIO	The principle of Divisional Leads is accepted by the health board. The proposition now needs to be explored and defined in a proposal by the CCIO and CNIO to the Digital Delivery Oversight Board.	01/06/2023	30/09/2024	16/04/2024	Overdue	Not Yet Due	1		March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed. HAR group review has identified a number of skateholders who would like to join the council Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again Aug-23: Clinical Informatics Council in place and meeting scheduled every 6 weeks, however service pressures have resulted in over half the meetings this year cancelled. More formal job planning needed to release resources to attend	Lack of job profiling to support time to release clinical staff to attend			31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	Director of Digital/Chief Technology Officer	Low	R5	The skills development work should be formalised into a skills development plan	Agreed. The skills development plan is under development and apprenticeships are actively being explored with the support of Organisational Development colleagues. Informatics are now engaging with other Health Boards who report having commenced apprenticeship schemes	01/12/2023	30/09/2024	16/04/2024	Overdue	Not Yet Due	1		March 2024: Application Process will close April 24 . We will receive applications for review and the standard interview process will start for an appointment September 24 "Jan-24: For Digital Specialist Procurement we have identified utilising Network 75, this combines a work placement and part time study as a route to a degree , the ethos of this scheme is for the directorate to grow their own talent for the future. •Analysis of current skills matched to Job Role has been largely completed and gap analysis is being undertaken. •Pre-requisite certification at Prince II foundation and ITIL v4 foundation desirable against all job roles. •Training Agreement has been implemented and is in use within the directorate but this needs consistency across all departments. •Budget restrictions have caused the removal of ring fenced training budget however many staff are taking advantage of non cost training (PLA etc) and being provided protected time for CPD. •Development of Learning & Develop Hub is making excellent progress •Need to agree on a skills management platform to implement "				31/03/2024
Internal	2022.15	IT Strategy	Reasonable	Director of Digital	CCIO / CNIO	Medium	R4	Work should be undertaken to embed the Clinical Informatics Council and encourage participation therein	Agreed. The CCIO and CNIO will revisit the membership and Terms of Reference for the Clinical Informatics Council which will be included as part of ??	01/06/2023	30/09/2024	16/04/2024	Overdue	Not Yet Due	1		March'24 - Dependency on agreement of clinial enagement model. This can not be undertaken until that is agreed Nov 23: Council not met for several meetings due to capacity issues and will need to be considered due to winter pressures so ToR will be looked at when we meet again				31/03/2024

Strategic Risk Dashboard

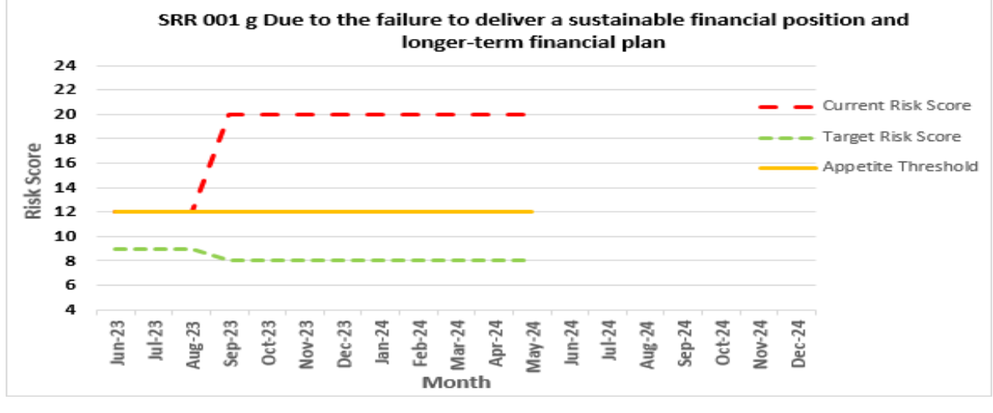
Reference				Risk Score Matrix											
				2	4	5	6	8	9	10	12	15	16	20	25
SRR 001	Director of Finance and Procurement	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan					×			◊			●	
	Director of Public Health & Strategic Partnerships		l) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.					◊×					●		
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems					×				●	◊		
			b) Due to an adverse impact on service delivery in the implementation of new digital systems				×				●		◊		
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future					×			●		◊		

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

Key		
	Current Score	●
	Target Score	×
	Appetite Threshold	◊
	Current to target	◄ –

RISK THEME	FINANCIAL SUSTAINABILITY			
Strategic Risk- SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**g)** Due to the failure to deliver a sustainable financial position and longer-term financial plan	**Publication Status**	Public	**Risk Appetite Level - Cautious.** Preference for safe, through accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 12 and below.** Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies. **SUMMARY** The current risk level is **OUTSIDE** of the target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	5 *(Almost certain)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	01 May 2024	**Risk rating**	**= 20** *(Extreme)*	**= 8** *(Moderate)*
Next Review Monthly review based on current risk score	01 June 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Budget holder training • Cost intervention procedures • 23/24 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings	Control mechanisms evaluated favourably by Audit. Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 - 24**	**Gaps in Assurance** • Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of 3 year recovery plan. **Action to Address Gaps in Assurance** • 2024/25 IMTP plans focussed on 'living within budget levels. • 2024/25 savings plans to be delivered. • Initial budget delegation approved - revised Budget delegations to be issued Q1. • Work underway to develop a 3 year recovery plan.	**Reasonable Assurance**

• Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance.		1. Savings Programmes Q3 - Not yet undertaken. Report expected Q1 2024/25 2. Financial Controls Q2 – Not yet reported. Report expected Q4 2023/24 3. Asset Management Q3 – Reasonable Assurance reported to ARAC April 2024 **External Audit Reports 2023 -24** 1. Efficiency Review Q3/Q4 – Not yet reported. 2. Structured Assessment - Received at ARAC November 2023. 3. Audit of Financial Statements Q4 2023/24 – Not yet reported. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring meetings with Welsh Government – monthly		

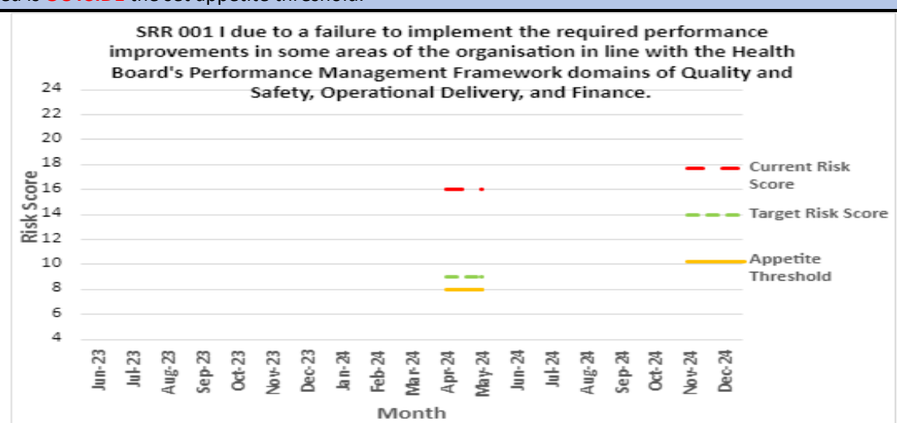
RISK THEME	COMPLIANCE AND SAFETY
Strategic Risk - SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population
Strategic Threat	I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance. — Public
Impact	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work ➢ Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications

Risk Appetite Level
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – Score 8 and Below
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of target and **OUTSIDE** of the appetite threshold. The target level to be achieved is **OUTSIDE** the set appetite threshold.

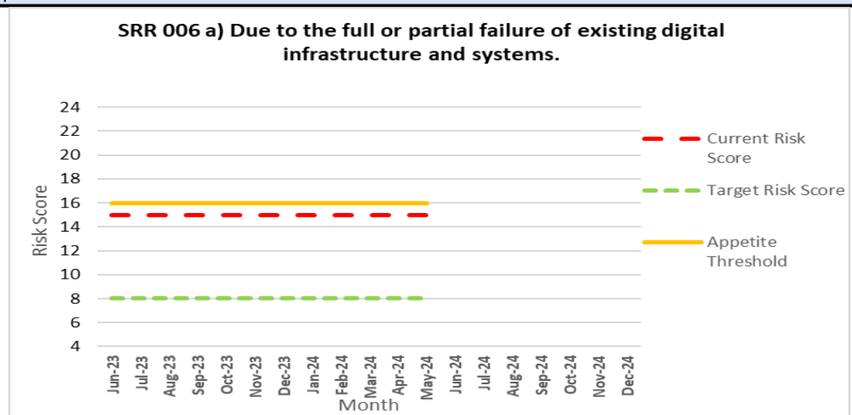
		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning & Partnerships			
Monitoring Committee	Finance and Performance Committee	**Likelihood**	*4 (Likely)* x	3 *(Possible)* x
Initial Date of Assessment	19 April 2024	**Impact**	***4** (Major)*	3 *(Moderate)*
Last Reviewed	09 May 2024	**Risk rating**	***= 16 (Extreme)***	***= 9 (High)***
Next Review (Monthly based on current score)	09 June 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Performance Management and Accountability Framework • Executive Accountability letters – to be issued by end of May 24 • Divisional Directors Accountability letters – to be issued by end of May 24 • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. • Reporting through to Finance and Performance Committee via Executive Committee • Specific areas of focus are discussed at Value & Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc.	• 6-month review of Performance Management and Accountability Framework • Alignment of internal mechanisms to national escalation framework • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Implement the performance framework. • Appropriate Business Partnering Support and analytical support. • Review of JD to explicitly include in Assistant Director of Planning and Performance role. • Will realign capacity and/or redefine roles to provide explicit support	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety Committee • Established reporting to the Board. • Routine reporting through the IQPD process **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • HIW Inspections • Llais for feedback	**Gaps in Assurance** • How effective the Performance and Accountability Framework is delivering improvements. **Action to Address Gaps in Assurance** • Internal Audit 2024/25 Plan - Review of the Performance Management and Accountability Framework24/25 plan.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	**a)** Due to the full or partial failure of existing digital infrastructure and systems.	**Publication Status**	Public.	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Data breaches; ➢ Litigation & Financial Penalties; ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 17 and below.** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	4 *(Major)*
Last Reviewed	01 May 2024	**Risk rating**	**= 15** *(Extreme)*	**= 8** *(Moderate)*
Next Review Due Monthly based on the current score	01 June 2024			



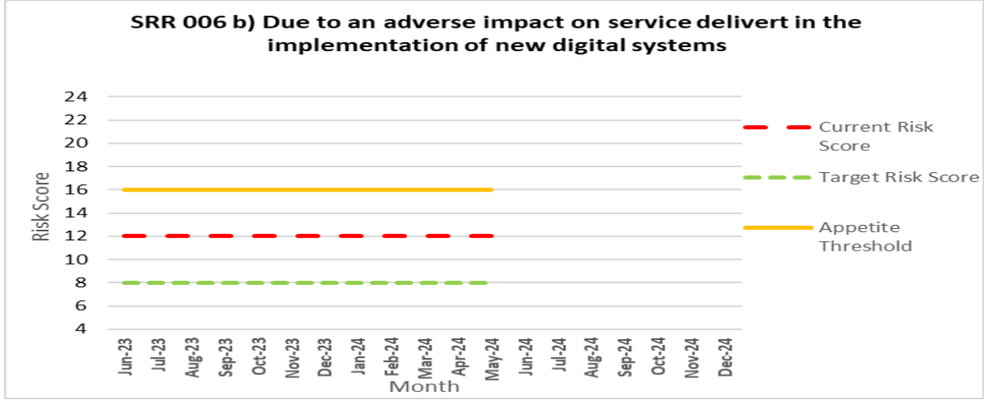
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Fo0llowing the CRU Assessment in Jan 24, the action plan has been revised and updated to capture further recommendations against NIS CAF. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber	Implement the recommendations from Templar report: Develop detailed action plan to address recommendations highlighted in CRU assessment report. Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting on progress to the Finance & Performance Committee on our cyber security action plan. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal audit • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance** An assessment against CAF was undertaken by CRU in January '24 and the report along with its recommendations has been circulated to key stakeholders.	**Reasonable assurance**

and the Teams to review compliance levels against policy. Results are captured within the monthly Cyber Report. • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk management process. • Cyber has maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. • Cyber has begun the roll out simulated phishing campaigns. The initial phish has been tested on ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023				

RISK THEME	SERVICE DELIVERY
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**

Strategic Threat	**b)** Due to an adverse impact on service delivery in the implementation of the new digital systems.	**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 17 and below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold

Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due Quarterly based on the current risk score	01 July 2024			

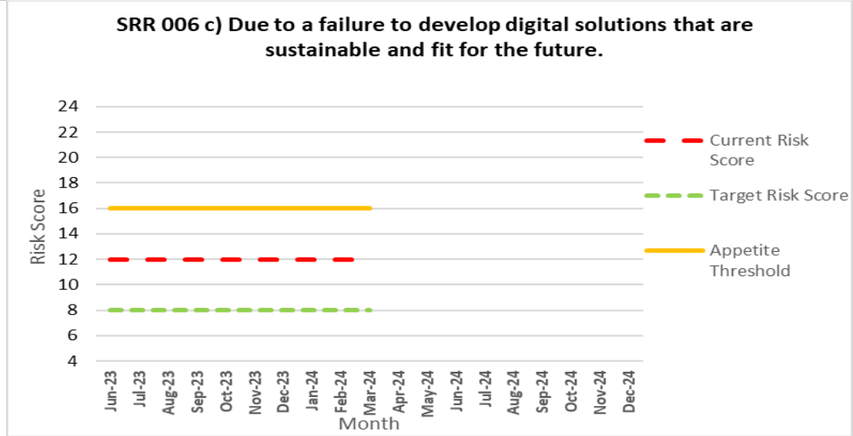


Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Project Boards meet monthly and report into the quarterly Digital Portfolio Progress Group • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit **Action to Address Gaps in Assurance** •	**Reasonable assurance**

• Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success. • Information Governance Sub Committee and Cyber Security Subgroup established		• Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit** • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance		

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	**c)** Due to failure to develop digital solutions that are sustainable and fit for the future.	**Publication Status**	Public	**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Data breaches; ➢ Litigation & Financial Penalties; ➢ Reputational damage and loss of public confidence.			**Risk Appetite Threshold - Score 17 and below.** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital			
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	07 April 2024	**Risk rating**	**= 12** (High)	**= 8** *(Moderate)*
Next Review Due Quarterly based on current risk score	01 July 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• New Digital Service Request process in place which provides governance in several key areas: 1. Information Governance – ensuring new services have appropriate controls to keep patient information safe. 2. Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. 3. Patient Safety – ensuring services do not introduce any patient safety risks. 4. Records – ensuring new systems comply with the requirements of records management. • Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. • Business change function which ensures implemented systems are effective and deliver the benefits required. • Formal framework in place for the adoption of new digital services and best practice guidance followed. • Operational delivery aligned to ITIL standards	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities. • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process. • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee. • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit • LINC Programme 23/24 – Not yet undertaken. • Network Infrastructure (VPN) 23/24 Q3 - Outcome reasonable assurance	**Gaps in Assurance** **Action to Address Gaps in Assurance** Annual operational plan completed and aligned with IMTP. NDSR process redrafted pending ratification. Prioritisation & Optimisation Framework redrafted pending ratification.	**Reasonable assurance**

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 001	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement	There is a risk that the Health Board will be uanble to deliver and maintain high-quality, safe and sustainable services that meet the needs of the population.	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	•Breach of statutory duty to breakeven over 3 years •Instigation of NHS Wales Escalation & Intervention Arrangements •Non – delivery of health board priorities, required improvements and achieve longer-term sustainability •Prioritisation and possible disinvestment in service delivery •Reputational damage and loss of public confidence	5	4	20	Extreme	Above Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	Medium	2	4	8	Moderate	01/05/2024	01/06/2024
		Compliance and Safety			I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications	4	4	16	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Performance Management and Assurance Framework Executive Accountability letters – to be issued by the end of May 2024 Divisional Directors Accountability letters – to be issued by the end of May 2024 Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reporting through to the Finance and Performance Committee via Executives Specific areas of focus are discussed at the Value & Sustainability Board System-wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. Embed in the regional programmes of work i.e. ophthalmology, diagnostics, and orthopaedics.	Medium	2	4	8	Moderate	01/05/2024	01/06/2024
SRR 006					a) Due to the full or partial failure of existing digital infrastructure and systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Implement the recommendations from Templar report: • Outline a step by step process of how the proposed risk treatments need to be implemented. This should include the activities to be performed, who is responsible and deadlines for completion. • Complete any outstanding policy and process development, ensuring there is engagement with non ICT teams including the SIRO and board • Ensure ICT disaster recovery policies are complete and refer to any system specific recovery processes. • Ensure non ICT teams are aware of disaster recovery policies and processes and engaged in developing system breach/failure response definition. • Complete a policy and process review after each incident to identify if anything could be improved in detection, resolution or prevention of a cyber security incident. Also, ensure the same is done whenever there are significant system changes. • Develop the policy and processes for identity and access management to ensure that privileged and critical system accounts are reviewed periodically e.g. 6 to 12 months, with other accounts reviewed through joiners/starters, movers and leavers processes. • Investigate circumstances where dedicated devices can be used for critical system access • Consider plans for certification of users and devices and how those certifications can be used. • Consider how to monitor privileged accounts e.g. with additional logs managing not just by exception but random and planned audits • Assess whether MFA can be implemented for privileged user accounts • Review any critical system logs that are created • Update systems or request updates to create additional logs where possible and include creation of logs on user devices in any investigation • Investigate a means of alerting for specific log conditions • Consider collective identification of appropriate tools and working with other OES within NHS Wales to identify appropriate tools.	Medium	2	4	8	Moderate	01/05/2024	01/06/2024

SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	B)Due to an adverse impact on service delivery in the implementation of new digital systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success	Medium	2	3	6	Low	07/04/2024	01/07/2024
					c)Due to a failure to develop digital solutions that are sustainable and fit for the future	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities	Medium	2	4	8	Moderate	07/04/2024	01/07/2024

Strategic Risk Dashboard

Reference				Risk Score Matrix											
				2	4	5	6	8	9	10	12	15	16	20	25
SRR 001	Director of Finance and Procurement	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	g) Due to the failure to deliver a sustainable financial position and longer-term financial plan					×←	- - - - -	- - -	◊-	- - - - -	- - -	●	
	Director of Public Health & Strategic Partnerships		l) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.					◊×	← - - -	- - -	- - -	- - -	●		
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems					×←	- - -	- - -	- - -	●	◊		
			b) Due to an adverse impact on service delivery in the implementation of new digital systems				×←	- - -	- - -	- - -	●		◊		
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future					×←	- - -	- - -	●		◊		

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

Key		
	Current Score	●
	Target Score	×
	Appetite Threshold	◊
	Current to target	◄ -

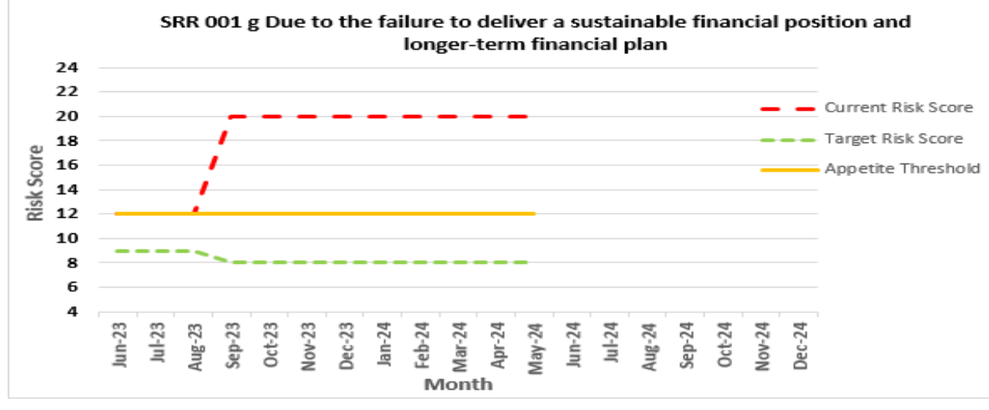
RISK THEME	FINANCIAL SUSTAINABILITY		
Strategic Risk- SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**		
Strategic Threat	**g)** Due to the failure to deliver a sustainable financial position and longer-term financial plan	**Publication Status**	Public
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence		

Risk Appetite Level - Cautious.
Preference for safe, through accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold - Score 12 and below.
Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies.

SUMMARY
The current risk level is **OUTSIDE** of the target and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	5 *(Almost certain)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	01 May 2024	**Risk rating**	**= 20** *(Extreme)*	**= 8** *(Moderate)*
Next Review Monthly review based on current risk score	01 June 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Budget holder training • Cost intervention procedures • 23/24 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings	Control mechanisms evaluated favourably by Audit. Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 - 24**	**Gaps in Assurance** • Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of 3 year recovery plan. **Action to Address Gaps in Assurance** • 2024/25 IMTP plans focussed on 'living within budget levels. • 2024/25 savings plans to be delivered. • Initial budget delegation approved - revised Budget delegations to be issued Q1. • Work underway to develop a 3 year recovery plan.	**Reasonable Assurance**

• Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance.		1. Savings Programmes Q3 - Not yet undertaken. Report expected Q1 2024/25 2. Financial Controls Q2 – Not yet reported. Report expected Q4 2023/24 3. Asset Management Q3 – Reasonable Assurance reported to ARAC April 2024 **External Audit Reports 2023 -24** 1. Efficiency Review Q3/Q4 – Not yet reported. 2. Structured Assessment - Received at ARAC November 2023. 3. Audit of Financial Statements Q4 2023/24 – Not yet reported. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring meetings with Welsh Government – monthly		

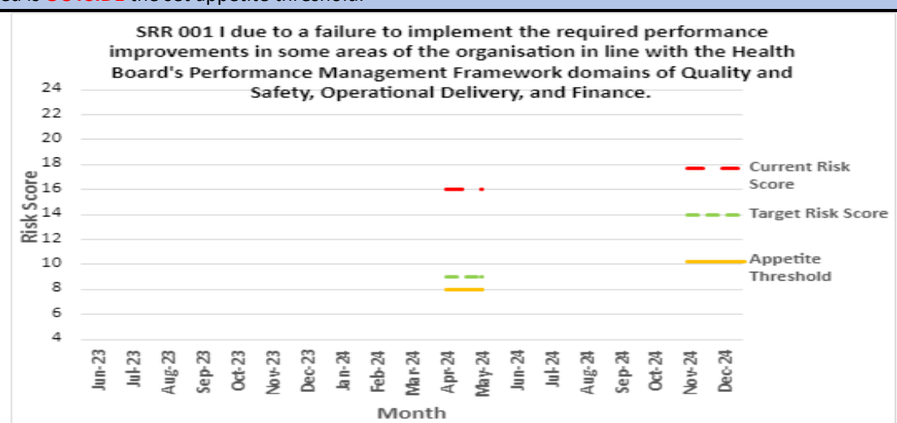
RISK THEME	COMPLIANCE AND SAFETY
Strategic Risk - SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population
Strategic Threat	I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance. — Public
Impact	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work ➢ Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications

Risk Appetite Level
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.

Risk Appetite Threshold – Score 8 and Below
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

SUMMARY
The current risk level is **OUTSIDE** of target and **OUTSIDE** of the appetite threshold. The target level to be achieved is **OUTSIDE** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Strategy, Planning & Partnerships			
Monitoring Committee	Finance and Performance Committee	**Likelihood**	*4 (Likely)* x	3 *(Possible)* x
Initial Date of Assessment	19 April 2024	**Impact**	***4** (Major)*	3 *(Moderate)*
Last Reviewed	09 May 2024	**Risk rating**	***= 16 (Extreme)***	***= 9 (High)***
Next Review (Monthly based on current score)	09 June 2024			



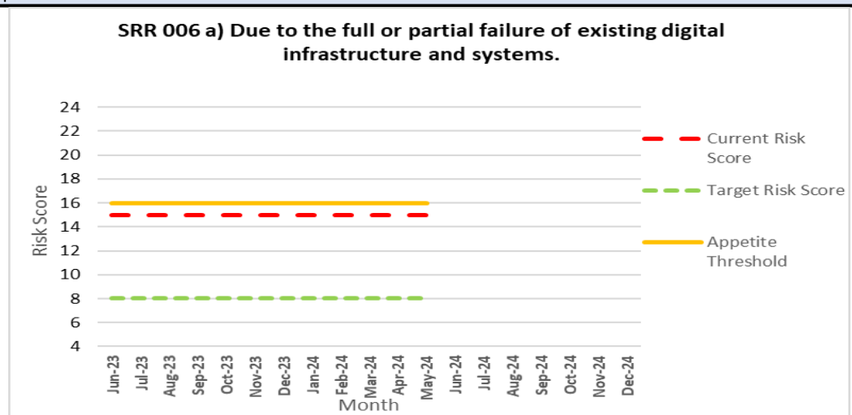
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Performance Management and Accountability Framework • Executive Accountability letters – to be issued by end of May 24 • Divisional Directors Accountability letters – to be issued by end of May 24 • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. • Reporting through to Finance and Performance Committee via Executive Committee • Specific areas of focus are discussed at Value & Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc.	• 6-month review of Performance Management and Accountability Framework • Alignment of internal mechanisms to national escalation framework • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Implement the performance framework. • Appropriate Business Partnering Support and analytical support. • Review of JD to explicitly include in Assistant Director of Planning and Performance role. • Will realign capacity and/or redefine roles to provide explicit support	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety Committee • Established reporting to the Board. • Routine reporting through the IQPD process **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • HIW Inspections • Llais for feedback	**Gaps in Assurance** • How effective the Performance and Accountability Framework is delivering improvements. **Action to Address Gaps in Assurance** • Internal Audit 2024/25 Plan - Review of the Performance Management and Accountability Framework24/25 plan.	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	**a)** Due to the full or partial failure of existing digital infrastructure and systems.	**Publication Status**	Public.	
Impact	➢ Harm or injury to patients and/or staff; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Data breaches; ➢ Litigation & Financial Penalties; ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	4 *(Major)*
Last Reviewed	01 May 2024	**Risk rating**	**= 15** *(Extreme)*	**= 8** *(Moderate)*
Next Review Due Monthly based on the current score	01 June 2024			

Risk Appetite Level - OPEN
Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.

Risk Appetite Threshold - Score 17 and below.
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

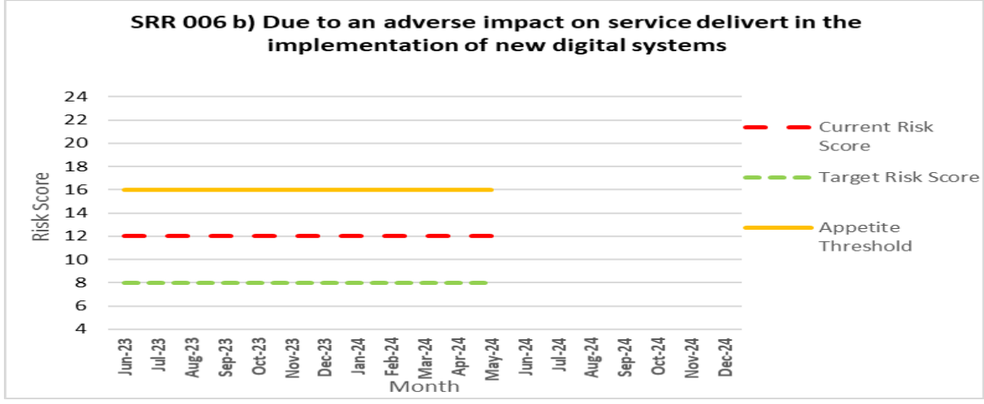


Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Fo0llowing the CRU Assessment in Jan 24, the action plan has been revised and updated to capture further recommendations against NIS CAF. • Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. • New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. • Governance group terms of reference agreed. Meetings started in November 2023. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber	Implement the recommendations from Templar report: Develop detailed action plan to address recommendations highlighted in CRU assessment report. Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting on progress to the Finance & Performance Committee on our cyber security action plan. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal audit • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance** An assessment against CAF was undertaken by CRU in January '24 and the report along with its recommendations has been circulated to key stakeholders.	**Reasonable assurance**

and the Teams to review compliance levels against policy. Results are captured within the monthly Cyber Report. • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk management process. • Cyber has maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. • Cyber has begun the roll out simulated phishing campaigns. The initial phish has been tested on ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023				

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	**b)** Due to an adverse impact on service delivery in the implementation of the new digital systems.	**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 17 and below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold

Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due Quarterly based on the current risk score	01 July 2024			

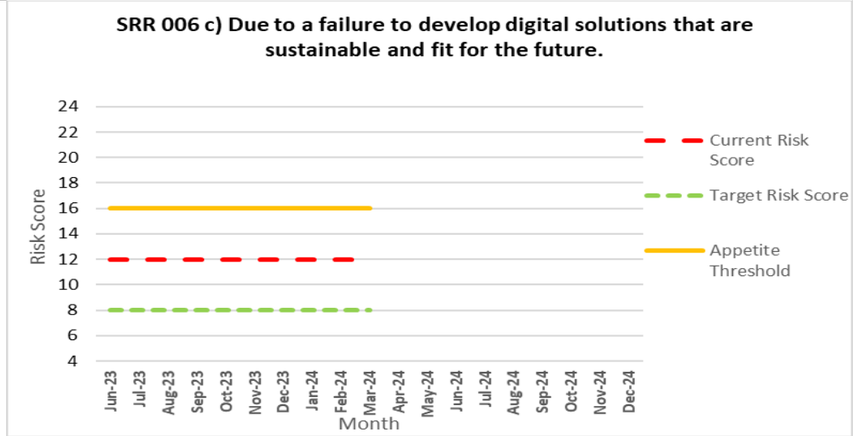


Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Project Boards meet monthly and report into the quarterly Digital Portfolio Progress Group • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit **Action to Address Gaps in Assurance** •	**Reasonable assurance**

• Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success. • Information Governance Sub Committee and Cyber Security Subgroup established		• Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. **Internal Audit** • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance		

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	**c)** Due to failure to develop digital solutions that are sustainable and fit for the future.	**Publication Status**	Public	**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Data breaches; ➢ Litigation & Financial Penalties; ➢ Reputational damage and loss of public confidence.			**Risk Appetite Threshold - Score 17 and below.** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Digital			
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	07 April 2024	**Risk rating**	**= 12** (High)	**= 8** *(Moderate)*
Next Review Due Quarterly based on current risk score	01 July 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• New Digital Service Request process in place which provides governance in several key areas: 1. Information Governance – ensuring new services have appropriate controls to keep patient information safe. 2. Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. 3. Patient Safety – ensuring services do not introduce any patient safety risks. 4. Records – ensuring new systems comply with the requirements of records management. • Strong business analysis function in operation which ensures the "as-is" and "to-be" process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. • Business change function which ensures implemented systems are effective and deliver the benefits required. • Formal framework in place for the adoption of new digital services and best practice guidance followed. • Operational delivery aligned to ITIL standards	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities. • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process. • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee. • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit • LINC Programme 23/24 – Not yet undertaken. • Network Infrastructure (VPN) 23/24 Q3 - Outcome reasonable assurance	**Gaps in Assurance** **Action to Address Gaps in Assurance** Annual operational plan completed and aligned with IMTP. NDSR process redrafted pending ratification. Prioritisation & Optimisation Framework redrafted pending ratification.	**Reasonable assurance**