

Oral *Chair of the Corporate Trustees*

4. Key Updates

4.1. Update from the Chair

Oral *Chair*

4.2. Update from the Chief Executive

Oral *Chair*

5. Patient Experience and Public Engagement

5.1. Patient Experience Story

Presentation *Executive Lead*

5.2. Report from Llais, Gwent Region

Attachment *Regional Director, Llais*

 Agenda_Item_5.2_.Llais Gwent Region_January 2025.pdf (15 pages)

6. Items for Discussion and Decision

6.1. Report on the GP Partnership, Dr J Ahmed and Dr J Allinson

Attachment *Chief Executive*

6.2. Statutory and Mandatory Training Report

Attachment *Director of Workforce and OD*

 Agenda_Item_6.2_Statutory and Mandatory Paper.pdf (11 pages)

 Agenda_Item_6.2a_Appendix 1_All StaM Core Learning Modules.pdf (2 pages)

6.3. Health and Safety Annual Report and Update

Attachment *Director of AHPs and Health Science*

 Agenda_Item_6.3_Health Safety Fire Annual Report 2023-24.pdf (7 pages)

 Agenda_Item_6.3a_Appendix 1 ABUHB Health Safety and Fire Annual Report 2023-24.pdf (40 pages)

 Agenda_Item_6.3b_Appendix 2 Strategic Risk Assessment (SRR 010 A).pdf (2 pages)

6.4. Electronic Prescribing & Medicines Administration Programme Update

Attachment *Director of Digital*

 Agenda_Item_6.4_REP_ePMA Update.pdf (10 pages)

6.5. Winter Resilience Plan 2024/25 - Progress Report

Attachment *Director of Strategy, Planning and Partnerships*

 Agenda_Item_6.5_Winter Resilience 2024 2025 Update.pdf (13 pages)

 Agenda_Item_6.5a_Appendices A and B_Winter Plan.pdf (11 pages)

6.6. 2024/25 Performance Reporting

Attachment *Executive Leads*

a. Interim Performance Report

b. Quality Outcomes Report

c. Financial Performance at Month 8

-  Agenda_Item_6.6a_Interim Performance Report.pdf (5 pages)
-  Agenda_Item_6.6ai_Appendix A_Interim Integrated Performance Report.pdf (44 pages)
-  Agenda_Item_6.6b_Quality Outcomes Framework - Q3 2024 Board.pdf (6 pages)
-  Agenda_Item_6.6bi_Appendix A_Quality Outcomes Framework.pdf (46 pages)
-  Agenda_Item_6.6c_Finance Report 24-25 M8.pdf (40 pages)
-  Agenda_Item_6.6ci_Appendix A_Finance Report appendices 24-25 M8.pdf (36 pages)

6.7. 2025/26 Financial Allocation Letter

Attachment *Director of Finance and Procurement*

-  Agenda_Item_6.7_Allocation Letter 2025_26.pdf (16 pages)

6.8. Strategic Risk Report, January 2025

Attachment *Chief Executive*

-  Agenda_Item_6.8_Strategic Risk Report_Jan 2025.pdf (8 pages)
-  Agenda_Item_6.8a_Appendix A_Strategic Risk Dashboard and Assessments.pdf (42 pages)
-  Agenda_Item_6.8b_Appendix B_Proposed Strategic Risk Assessment Decarb_Jan25.pdf (2 pages)

6.9. Nurse Staffing Levels (Wales) Act Annual Report

Attachment *Director of Nursing*

-  Agenda_Item_6.9_Annual Report NSLWA_January 2025.pdf (7 pages)
-  Agenda_Item_6.9a_Appendix 1_Annual Presentation of Nurse Staffing Levels.pdf (17 pages)

7. Consent Agenda

7.1. For Approval

7.1.1. Draft Minutes of the Health Board Meeting, held on 26th November 2024

Attachment *Chair*

-  Agenda_Item_7.1.1_Draft Minutes of Public Meeting Held On 26 November 2024.pdf (15 pages)

7.1.2. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

-  Agenda_Item_7.1.2_Report on Sealed Documents and Chairs Actions.pdf (5 pages)

7.1.3. Joint Commissioning Committee Governance Framework

Attachment *Director of Corporate Governance*

-  Agenda_Item_7.1.3_JCC Governance Framework V2.pdf (7 pages)
-  Agenda_Item_7.1.3a_Appendix 1 - ToR Planning Performance Finance.pdf (11 pages)
-  Agenda_Item_7.1.3b_Appendix 2 - ToR Quality Safety and Outcomes.pdf (14 pages)

7.2. For Noting

7.2.1. Board Action Log with Updates

Attachment *Chair*

-  Agenda_Item_7.2.1_Board Action Log_29January25.pdf (2 pages)

7.2.2. Strategic Partnership Updates:

Attachment *Director of Strategy, Planning & Partnerships and Director of Public Health*

a. Regional Partnership Board

b. Public Service Board

 Agenda_Item_7.2.2a_RPB Update January 2025.pdf (9 pages)

 Agenda_Item_7.2.2b_PSB update .pdf (5 pages)

7.2.3. Executive Committee Chair's Report

Attachment *Chief Executive*

 Agenda_Item_7.2.3_Executive Committee Chair's Report January 2025.pdf (7 pages)

7.2.4. Key Matters from Committees of the Board

Attachment *Committee Chairs*

 Agenda_Item_7.2.4_Key Matters from Committees of the Board.pdf (15 pages)

7.2.5. An overview of Joint and Partnership Committee Activity

Attachment *Chief Executive*

a. Joint Commissioning Committee

b. NHS Wales Shared Services Partnership Committee

 Agenda_Item_7.2.5a JCC Update Report.pdf (4 pages)

 Agenda_Item_7.2.5ai_Appendix A_JCC Assurance Report 12 November 2024.pdf (8 pages)

 Agenda_Item_7.2.5b_Shared Services Partnership Committee Update Report.pdf (3 pages)

 Agenda_Item_7.2.5bi_Appendix A_SSPC Assurance Report 21 November 2024.pdf (6 pages)

8. Other Matters

8.1. Any Other Business

8.2. Date of the Next Meeting

26th March 2025

AGENDA

Date and Time

Wednesday 29th January 2025 at 11.30 am

Venue

Conference Centre, Headquarters, St Cadoc's Hospital

Item

Title

Format

Presenter

1 PRELIMINARY MATTERS

1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence for Noting	Oral	Chair
1.3	Declarations of Interest for Noting	Oral	Chair

2 CONSENT AGENDA BUSINESS

2.1	The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion		Chair

3 CORPORATE TRUSTEE BUSINESS

3.1	Annual Report and Accounts 2023/24 for the Aneurin Bevan University Health Board Charitable Fund: a. Annual Accounts 2023/24 b. Annual Report 2023/24 c. Letter of Representation 2023/24	Attached	Director of Finance and Procurement
3.2	Charitable Funds ISA 260 Report	Attached	Audit Wales
3.3	Approval of the Annual Report and Accounts 2023/24	Oral	Chair of the Corporate Trustee

4 KEY UPDATES

4.1	Update from the Chair	Oral	Chair
4.2	Update from the Chief Executive	Oral	Chief Executive

5 PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT

5.1	Patient Experience Story	Presentation	Executive Lead
5.2	Report from Llais, Gwent Region	Attachment	Regional Director, Llais

6 ITEMS FOR DISCUSSION & DECISION

6.1	Report on the GP Partnership, Dr J Ahmed and Dr J Allinson	Attachment	Chief Executive
6.2	Statutory and Mandatory Training Report	Attachment	Director of Workforce & OD

6.3	Health & Safety Annual Report and Update	Attachment	Director of AHPs & Health Science
6.4	Electronic Prescribing & Medicines Administration Programme Update	Attachment	Director of Digital
6.5	Winter Resilience Plan 2024/25 - Progress Report	Attachment	Director of Strategy, Planning and Partnerships
6.6	2024/25 Performance Reporting: a. Interim Performance Report b. Quality Outcomes Report c. Financial Performance at Month 8	Attachment	Executive Leads
6.7	2025/26 Financial Allocation Letter	Attachment	Director of Finance and Procurement
6.8	Strategic Risk Report, January 2025	Attachment	Chief Executive
6.9	Nurse Staffing Levels (Wales) Act Annual Report	Attachment	Director of Nursing
7	CONSENT AGENDA		
7.1	FOR APPROVAL		
7.1.1	Draft Minutes of the Health Board Meeting, held on 26 th November 2024	Attachment	Chair
7.1.2	Report on Sealed Documents and Chair's Actions	Attachment	Chair
7.1.3	Joint Commissioning Committee Governance Framework	Attachment	Director of Corporate Governance
7.2	FOR NOTING		
7.2.1	Board Action Log with Updates	Attachment	Chair
7.2.2	Strategic Partnership Updates: - a. Regional Partnership Board b. Public Service Board	Attachment Attachment	Director of Strategy, Planning & Partnerships and Director of Public Health
7.2.3	Executive Committee Chair's report	Attachment	Chief Executive
7.2.4	Key Matters from Committees of the Board	Attachment	Committee Chairs
7.2.5	An overview of Joint and Partnership Committee Activity a. Joint Commissioning Committee b. NHS Wales Shared Services Partnership Committee	Attachment	Chief Executive

8	OTHER MATTERS
8.1	Any Other Business
8.2	Date of the Next Meetings: • 26th March 2025
9.	PRIVATE/IN COMMITTEE SESSION
	Motion to Exclude Members of the Public and the Press There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting: “Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.” <i>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</i>

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Charitable Funds Annual Accounts & Annual Report 2023-24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Robert Holcombe, Director of Finance and Procurement
SWYDDOG ADRODD: REPORTING OFFICER:	Mark Ross, Assistant Finance Director

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

Ar Gyfer Penderfyniad/For Decision

This report gives an overview of the Annual Accounts and Annual Report for the year ending 31 March 2024 for Aneurin Bevan University Health Board Charitable Fund and highlights the key issues that are contained in the accounts.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The final Accounts and Annual Report for 2023/24 and Audit Wales report will be presented to the Charitable Funds Committee on 13th January 2025. It is anticipated that the Committee will recommend them to the Board for approval.

Audit Wales have confirmed that they intend to give an unqualified audit opinion.

The Charitable Funds Committee met on 13th January 2024 and recommends to the Board, acting as Corporate Trustee, approval of the annual accounts, letter of representation and annual report and note that they will be filed with the Charity Commission by 31 January 2025.

Cefndir / Background

1. Annual Accounts

Aneurin Bevan University Health Board, as corporate trustee of its charitable funds, must file accounts for the year ended 31 March 2024 with the Charities Commission before 31 January 2025. The Accounts and Annual Report are attached and have been subject to external audit by Audit Wales. The audit process is completed, and Audit Wales is expected to issue an unqualified audit opinion on the accounts following approval of the accounts by the Board as corporate trustee.

The final Accounts and Annual Report for 2023/24 will be presented to the Charitable Funds Committee on 13th January 2025 it is anticipated that they will recommend approval.

Following completion of the draft accounts, a small number of amendments were identified which are reflected in these final accounts. They are identified in bold italics below.

The detailed accounts are shown in the supporting papers. The following are key points to note from the accounts for 2023/24:

Statement of Financial Activities for year ended 31 March 2024 (Page 2 of Accounts)

Income from Donations, Legacies and Grants (Note 4, Page 10 of Accounts)

Income from donations, legacies and grants has decreased by £107k from the previous year to £507k. There were 4 legacies received in the year.

During the audit process, it was identified that income in relation to 4 grants should not have been deferred and the income should have been recognised in the 2023/24 accounts. Within these final accounts we have adjusted for this error, which had a total value of £70k. One of these grants, totalling £10k has now been recognised as a donation due to a lack of conditions associated with the income received.

Income from Charitable Activities (Note 5, Page 10 of Accounts)

Income from courses has decreased by £70k from the previous year due to a reduction in the number of courses held. Other income has decreased by £102k, mainly due to monies received in respect of filming at St Cadocs Hospital in 2022/23.

Investment Income (Note 7, Page 10 of Accounts)

Investment income has increased by £11k from the previous year to £211k due to an increase in income on investments.

Expenditure (Page 2 of Accounts and Notes 8 & 9, Page 11 of Accounts)

Expenditure has increased by £209k. The main increase in spend relates to patient education & welfare and building and refurbishment.

The net impact of income and expenditure is a decrease in funds of £381k before investment gains, compared with an increase of £96k in the previous year. (Page 2 of Accounts)

Gain on Investment Assets (Page 2 of Accounts)

During the year there has been a net gain of £375k on investments which is mainly with CCLA reflecting stock market increases on underlying investments.

The stock market increases since the previous year resulted in an increase in our CCLA investments from £5,102k on 1 April 2023 to £5,477k on 31 March 2024 (Note 16, Page 13 of Accounts).

As part of the audit, it was identified that the investment valuation as at 31 March 2024, received from CCLA, and reported in the draft accounts was incorrect. This valuation was corrected in the quarterly report received at the end of April, but this error was not brought to our attention. The accounts have been amended and the correct valuation is presented in these final accounts. The difference in the valuation was £28k.

The overall net movement in funds for the year is therefore a decrease of £6k. (Page 2 of Accounts)

Balance Sheet as at 31 March 2024 (Page 3 of Accounts)

Net assets / liabilities have decreased by £6k reflecting the small decrease in funds during the year. The main movements in the balance sheet consist of an increase in the value of the CCLA investments offset by an increase in creditors. The balance sheet movements are as follows:

	£000
Investments	350
Increase in Cash Balances	114
Decrease in Debtor Balances	-26
Increase in Creditor Balances	-444
Total	-6

The balance movements for investments and creditors have been amended in the table above to reflect the audit adjustments in relation to the CCLA investment valuation and grant deferred income.

The following table gives a more detailed breakdown of fixed assets (Note 16, Page 13 of Accounts):

	Balance 1 Apr 2023 £000	Disposals £000	Realised Gains / (Losses) £000	Unrealised Gains / (Losses) £000	Balance 31 Mar 2024 £000
Fixed Asset Investments					
Investments					
CCLA	5,102	-	-	375	5,477
	5,102	-	-	375	5,477
Property					
13 Clytha Square	250	-	-	-	250
TP Price - Newport / Six Bells	25	- 25	-	-	-
TP Price - Strip of land Oakdale	55	-	-	-	55
	330	- 25	-	-	305
Other					
Painting	25	-	-	-	25
Total per Note 16 of the Accounts	5,457	- 25	-	375	5,807

Cash Balances (Note 18, Page 14 of Accounts)

Cash at 31 March 2024 totalled £641k as follows:

	£000
Nat West Current Account	618
Santander Bonus Account	22
Petty Cash	1
Total	641

2. Annual Report

The Trustees Annual Report is shown in the supporting papers and has been subject to audit, by Audit Wales, in conjunction with the Annual Accounts.

3. Letter of representation

As part of their annual audit process, Audit Wales have requested the Health Board submit a Letter of Representation, as evidence that trustees of the charity acknowledge and accept responsibility for the financial statements.

The letter, which is attached, details the responsibilities of the trustees of the charity and confirms that all information shared with the auditors relevant to the financial statements has been presented faithfully and represents a true and fair view of the financial statements.

The letter is being presented to the Board alongside the Final Accounts and Annual Report for final approval, before being submitted to Audit Wales.

4. Audit of Financial Statements Report

The audit of the financial statements has been undertaken by Audit Wales and they have indicated that they intend to give an unqualified audit opinion on the accounts.

5. Next Steps and Actions

Once the accounts and annual report are approved by the Board, signed accounts will be given to Audit Wales for the Auditor General for Wales to sign. They will then be filed with the Charity Commission before the deadline of 31st January 2025. The accounts and annual report will then be available on the Charity Commission website.

The Charity Annual Accounts and Annual Report will also be publicised internally via the intranet.

Asesiad / Assessment

This report presents the Annual Accounts and Annual Report of the charity for 2023/24.

Argymhelliad / Recommendation

The Board, acting as Corporate Trustee, is asked to approve the Annual Accounts, letter of representation and Annual Report of the charity for 2023/24 and note that they will be filed with the Charity Commission by 31 January 2025.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
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	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

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	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 Choose an item.

Aneurin Bevan University Local Health Board Charitable Fund and Other
Related Charities

The accounts for Funds Held on Trust.

FOREWORD

The Charity’s accounts and annual report for the year ended 31st March 2024 have been prepared by the Corporate Trustee in accordance with the Charities Act 2011 and the Charities (Accounts and Reports) Regulations 2008.

STATUTORY BACKGROUND

Aneurin Bevan University Local Health Board is the Corporate Trustee of the Funds Held on Trust under the National Health Service (Wales) Act 2006.

The Aneurin Bevan University Local Health Board and Other Related Charities registered with the Charity Commission on 7th January 2011, registration number 1098728.

Statement of Financial Activities for the year ended 31 March 2024

	Note	Unrestricted funds £000	Restricted Income funds £000	Total Funds 2023-24 £000
Incoming resources from generated funds:				
Donations, legacies and grants	4	237	270	507
Charitable activities	5	158	0	158
Investments	7	211	0	211
Total incoming resources		606	270	876
Expenditure on:				
Raising Funds	8	10	0	10
Charitable activities	9	887	360	1,247
Total expenditure		897	360	1,257
Net gains / (losses) on investments	16	375	0	375
Net income / (expenditure)		84	(90)	(6)
Transfers between funds	22	3	(3)	0
Net Movement in funds		87	(93)	(6)
Reconciliation of Funds				
Total Funds brought forward	23	4,531	1,239	5,770
Total Funds carried forward		4,618	1,146	5,764

Statement of Financial Activities for the year ended 31 March 2023

	Note	Unrestricted funds £000	Restricted Restricted Income funds £000	Total Total Funds 2022-23 £000
Incoming resources from generated funds:				
Donations, legacies and grants	4	418	196	614
Charitable activities	5	330	0	330
Investments	7	161	39	200
Total incoming resources		909	235	1,144
Expenditure on:				
Raising Funds	8	10	0	10
Charitable activities	9	811	227	1,038
Total expenditure		821	227	1,048
Net gains / (losses) on investments	16	(286)	(84)	(370)
Net income / (expenditure)		(198)	(76)	(274)
Transfers between funds	22	(73)	73	0
Net Movement in funds		(271)	(3)	(274)
Reconciliation of Funds				
Total Funds brought forward	23	4,802	1,242	6,044
Total Funds carried forward		4,531	1,239	5,770

Balance Sheet as at 31 March 2024					
	Note	Unrestricted funds £000	Restricted Income funds £000	Total 31 March 2024 £000	Total 31 March 2023 £000
Fixed assets:					
Investments	16	4,390	1,417	5,807	5,457
Total fixed assets		4,390	1,417	5,807	5,457
Current assets:					
Debtors	17	188	14	202	228
Cash and cash equivalents	18	475	166	641	527
Total current assets		663	180	843	755
Liabilities:					
Creditors: Amounts falling due within one year	19	435	451	886	442
Net current assets / (liabilities)		228	(271)	(43)	313
Total net assets / (liabilities)		4,618	1,146	5,764	5,770
The funds of the charity:					
Restricted income funds	23	0	1,146	1,146	1,239
Unrestricted income funds	23	4,618	0	4,618	4,531
Total funds		4,618	1,146	5,764	5,770

The notes on pages 5 to 17 form part of these accounts

Approved by the Trustees on 22 January 2025 and signed on its behalf by:

Signed :

Name : (Chair of Trustees)

Statement of Cash Flows for the year ending 31 March 2024			
	Note	Total Funds 2023-24 £000	Total Funds 2022-23 £000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	21	(122)	(46)
Cash flows from investing activities:			
Dividend, interest and rents from investments	7	211	200
Proceeds from the sale of investments	16	25	0
Net cash provided by (used in) investing activities		236	200
Change in cash and cash equivalents in the reporting period		114	154
Cash and cash equivalents at the beginning of the reporting period	18	527	373
Cash and cash equivalents at the end of the reporting period	18	641	527

Note on the accounts

1 Accounting Policies

(a) Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in October 2019 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2019.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in October 2019 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the risks to the Charity are a fall in income from donations or investment income but the trustees have arrangements in place to mitigate those risks (see the risk management and reserves sections of the annual report for more information).

The Charity meets the definition of a public benefit entity under FRS 102.

(b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified as a restricted fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The Charity's restricted funds tend to result from appeals, grants and legacies for specified purposes.

Those funds which are not restricted income funds, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the Trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Trustees' discretion, including the general fund which represents the Charity's reserves. The major funds held in each of these categories are disclosed in note 23.

(c) Incoming resources

Income consists of donations, legacies, grants, income from charitable activities and investment income.

Donations are accounted for when received by the charity. All other income is recognised once the Charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 12.

(g) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objects. The costs of generating funds consists of expenses for fundraising activities.

(h) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

(i) Fixed Asset Investments

Ethical Fund Investments are stated at mid-market value as at the balance sheet date, and Property Fund investments are stated at net asset value. Investment properties are included at their open market valuation. The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year.

Quoted stocks and shares are included in the balance sheet at mid-market price, excluding dividend.

Other assets are valued on an open market basis by a professional valuer.

(j) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

(k) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due.

(l) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

(m) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

2. Key Judgements and Assumptions

Average fund balances are used to apportion certain balances between restricted and unrestricted funds, which is deemed to be the most appropriate methodology to use.

There are no material assumptions judged to affect the 2023/24 accounts.

As at 31st March 2024, there is no other information to show that assets/liabilities would need to be materially adjusted during 2024/25.

3. Related party transactions

The Aneurin Bevan University Local Health Board is the sole beneficiary of the charity.

The charity had significant material transactions with Aneurin Bevan University Local Health Board as follows:

	2023-24		As at 31st March 2024	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Aneurin Bevan University Local Health Board	1,257	39	378	8

The Corporate Trustee has interests in related parties as follows:

Member	Related Organisation	Relationship with Related Party	2023-24		As at 31st March 2024	
			Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Nicola Prygodzicz	Velindre NHS Trust	Sister is a Senior Nurse in the Corporate Nursing Team	4	0	1	0
Penny Jones	Monmouthshire County Council	Councillor	1	0	0	0
Martin Blakebrough	Kaleidoscope Project	Chief Executive	0	0	0	0

The Corporate Trustee has interests in a number of related parties. All transactions with those related parties have been reviewed and there are nil transactions except for those listed above.
The value of income from Kaleidoscope Project was less than £500 and therefore rounds to £0 in the above table.

3. Related party transactions (continued)

In 2022-23 the charity had significant material transactions with Aneurin Bevan University Local Health Board as follows:

	2022-23		As at 31st March 2023	
	Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
	£000	£000	£000	£000
Aneurin Bevan University Local Health Board	1,048	24	144	31

The Corporate Trustee had interests in related parties as follows:

Member	Related Organisation	Relationship with Related Party	2022-23		As at 31st March 2023	
			Expenditure to related party	Income from related party	Amounts owed to related party	Amounts due from related party
			£000	£000	£000	£000
Glyn Jones	Welsh Ambulance Trust	Sister is Project Manager	0	21	0	0
Katija Dew	Newport Live	Trustee	1	0	0	0
Richard Clark	Torfaen County Borough Council	Elected Member, Executive Portfolio holder (Education) and Deputy Leader	0	0	0	0
Iwan Jones	Swansea Bay Health Board	Sister is Assistant Finance Director	4	2	0	2

The Corporate Trustee has interests in a number of related parties. All transactions with those related parties have been reviewed and there are nil transactions except for those listed above.

The value of transactions with Torfaen County Borough Council were less than £500 and therefore round to £0 in the above table.

4. Income from donations, legacies and grants

	Unrestricted funds £000	Restricted Income funds £000	Total 2023-24 £000	Total 2022-23 £000
Donations	237	0	237	418
Legacies	0	44	44	146
Grants	0	226	226	50
	237	270	507	614

5. Income from charitable activities

	Unrestricted funds £000	Restricted Income funds £000	Total 2023-24 £000	Total 2022-23 £000
Course income	149	0	149	219
Other income	9	0	9	111
	158	0	158	330

6. Role of volunteers

Volunteers have the trust and understanding of the community and are invaluable in engaging with our patients and providing support to paid professionals . The services they provide include:

- welcome services at our hospitals, directing patients and visitors
- befriending service for patients in our hospitals and nursing homes
- end of life companion support for patients in our hospitals
- operating buffet /coffee bars through volunteer organisations such as the League of Friends
- raising funds to purchase equipment across our hospitals.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

7. Gross investment income

	Unrestricted funds £000	Restricted Income funds £000	Total 2023-24 £000	Total 2022-23 £000
Fixed asset equity and similar investments	189	0	189	190
Short term investments, deposits and cash	22	0	22	10
	211	0	211	200

8. Analysis of expenditure on raising funds

	Unrestricted funds £000	Restricted Income funds £000	Total 2023-24 £000	Total 2022-23 £000
Fundraising office	0	0	0	0
Fundraising events	0	0	0	0
Investment management	0	0	0	0
Support costs	10	0	10	10
	10	0	10	10

The investment management fee is shown as nil as this is deducted from capital held by the investment management company.

9. Analysis of charitable activity

	Grant funded activity £000	Support costs £000	Total 2023-24 £000	Total 2022-23 £000
Purchase of equipment	263	36	299	467
Building and refurbishment	166	23	189	18
Staff education and welfare	288	39	327	434
Patient education and welfare	380	52	432	119
	1,097	150	1,247	1,038

10. Analysis of grants

The majority of grants are made to the Health Board to provide for the care of NHS patients in furtherance of our charitable aims. The charity makes grants to individuals from one specific fund which is used to support nominated medical students from deprived areas. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity is disclosed in note 9.

The trustees operate a scheme under which Fund Account Managers control how the Charity's designated funds should be spent. The day to day disbursements are in accordance with the directions set out by the trustees in the Charity's Standing Orders and Financial Instructions.

Where undesigned funds exist, the trustees do make grant awards based on applications from across the Health Board.

11. Movements in funding commitments

	Current liabilities	Non-current liabilities	Total 31 March 2024	Total 31 March 2023
	£000	£000	£000	£000
Opening balance at 1 April	563	0	563	274
Movement in funding commitments	(188)	0	(188)	289
Closing balance at 31 March 2024	375	0	375	563

As described in notes 9 and 10, the charity awards a number of grants in the year. Many grants are awarded and paid out in the same financial year. However, some grants are paid over a longer period.

12. Apportionment of support costs

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of a charity.

	Raising funds £000	Charitable activities £000	Total 2023-24 £000	Total 2022-23 £000	Basis
Governance					
External audit	1	18	19	19	Average fund balance
Finance and administration	6	76	82	73	Average fund balance
Total governance	7	94	101	92	
Finance and administration	3	56	59	55	Average fund balance
Total Finance and Administration	3	56	59	55	
	10	150	160	147	

	Unrestricted funds £000	Restricted Income funds £000	Total Funds 2023-24 £000	Total Funds 2022-23 £000
Raising funds	10	0	10	10
Charitable activities	122	28	150	137
	132	28	160	147

13. Trustees' remuneration, benefits and expenses

The charity does not make any payments for remuneration nor to reimburse expenses to the charity trustees for their work undertaken as trustee.

14. Analysis of staff costs

The charity has no employees. Staff services are provided to the charity by Aneurin Bevan University Local Health Board, the Corporate Trustee of the charity, which has received reimbursement of £414,818 (2022-23: £167,563) for these services.

15. Auditors remuneration

The auditors remuneration of £19,764 (2022-23: £18,761) related solely to the audit of the statutory annual report and accounts.

16. Fixed asset investments**Movement in fixed assets investments**

	Investment Properties £000	Investments Listed on Stock Exchange £000	Cash Held in Investment Portfolio £000	Other Assets £000	Total 2023-24 £000	Total 2022-23 £000
Market value brought forward	330	5,102	0	25	5,457	5,827
Add: additions to investments at cost	0	0	0	0	0	0
Less disposals at carrying value	(25)	0	0	0	(25)	0
Add any gain / (loss) on revaluation	0	375	0	0	375	(370)
Movement of cash held as part of the investment portfolio	0	0	0	0	0	0
Market value as at 31st March 2024	305	5,477	0	25	5,807	5,457

All investments are carried at their market value.

The investment valuation has been performed by CCLA Investment Management Limited.

The valuation of investment properties, consisting of a property and a small parcel of land, is based on a professional assessment of market value, by independent RICS (Royal Institute of Chartered Surveyors) qualified valuers at least every five years.

The significance of financial instruments to the ongoing financial sustainability of Aneurin Bevan University Health Board Charitable Fund is considered in the risk management section of the trustees' annual report.

The Charity receive the majority of their income in the form of donations. However, significant investments are made and are the source of the main financial risk.

Interest rate risk - the Charity is exposed to fluctuations in interest rates on the monies invested in deposits and the stock market.

Liquidity risk is the risk that the charity does not have sufficient available resources to enable it to meet its obligations as they fall due. The vast majority of expenditure is funded from donations and legacies and therefore the Charity is not exposed to significant liquidity risk. The Charity also holds around 6 months of expenditure in its cash balance to cover any short term fluctuations and holds a reserve to protect against any fluctuations in the value of investments. Investments can be converted into liquid cash easily and with short notice.

17. Analysis of current debtors

Debtors under 1 year	Total 31 March 2024 £000	Total 31 March 2023 £000
Accrued income	95	144
Trade Debtors	84	62
Prepayments	23	22
	202	228

18. Analysis of cash and cash equivalents

	Total 31 March 2024 £000	Total 31 March 2023 £000
Current Accounts	640	526
Petty Cash	1	1
	641	527

No cash or cash equivalents or current asset investments are held in non-cash investments or outside of the UK.

All of the amounts held on interest bearing deposit are available to spend on charitable activities.

19. Analysis of liabilities

Creditors under 1 year	Total 31 March 2024 £000	Total 31 March 2023 £000
Trade creditors	560	246
Deferred Income	305	181
Accruals	12	15
Other Creditors	9	0
Total creditors	886	442

20. Analysis of Deferred Income

	Total 1 April 2023 £000	Deferred £000	Released £000	Total 31 March 2024 £000
Grant Income	164	290	(162)	292
Other Income	17	13	(17)	13
	181	303	(179)	305

21. Reconciliation of net income / expenditure to net cash flow from operating activities

	Total 2023-24 £000	Total 2022-23 £000
Net income / (expenditure) (per Statement of Financial Activities)	(6)	(274)
Adjustment for:		
(Gains) / losses on investments	(375)	370
Dividends, interest and rents from investments	(211)	(200)
(Increase) / decrease in debtors	26	3
Increase / (decrease) in creditors	444	55
Net cash provided by (used in) operating activities	<u>(122)</u>	<u>(46)</u>

22. Transfer between funds

Transfers have been actioned between Unrestricted funds during 2023/24 to streamline the number of funds in line with the Charitable Funds Committee plans to merge and reduce the number of Charitable Funds.

In previous years a grant received for clinical trials was allocated to an existing fund and reclassified / transferred as a Restricted fund. Now that the grant has been spent, the balance of that fund has been reclassified / transferred back as an Unrestricted fund.

23. Analysis of funds**a. Analysis of restricted fund movements**

	Balance 1 April 2023	Income	Expenditure	Transfers	Gains and losses	Balance 31 March 2024
	£000	£000	£000	£000	£000	£000
Gastroenterology Fellowship Legacy	110	0	(4)	0	0	106
Royal Gwent Childrens Ward Legacy	106	0	(9)	0	0	97
Nevill Hall Rheumatology Legacy	86	0	(3)	0	0	83
Renal Unit Legacy	74	0	(4)	0	0	70
Nevill Hall Coronary Care Legacy	70	0	(3)	0	0	67
Royal Gwent Coronary Care Legacy	141	0	(81)	0	0	60
Royal Gwent Haematology Legacy	61	0	(2)	0	0	59
Royal Gwent Breast Care Legacy	61	0	(2)	0	0	59
NHS Charities Together Covid 19 Grant	0	62	(10)	0	0	52
Other - 58 restricted designated funds	530	208	(242)	(3)	0	493
	<u>1,239</u>	<u>270</u>	<u>(360)</u>	<u>(3)</u>	<u>0</u>	<u>1,146</u>

The material funds specified in the above note will vary from year to year dependent on the closing year end balance.

We consider that a closing fund balance of £50,000 or greater are material for disclosure in these accounts.

23. Analysis of funds (continued)

The objects of each of the restricted funds are as follows:

The Gastroenterology Legacy fund was bequeathed to the charity to assist in colonoscopy practices within the Health Board.

The Royal Gwent Hospital Children's Ward Legacy Fund was bequeathed to the charity for the benefit of the Children's Ward. A proposal for the purchase of various equipment to improve patient care and access was approved by the Charitable Funds Committee.

The Nevill Hall Rheumatology Legacy Fund was bequeathed to the charity for the use of the Rheumatology department at the hospital.

The Renal Unit Legacy Fund was bequeathed to the charity for the purpose connected with the research and treatment of patients under haemodialysis treatment (kidney unit).

The Nevill Hall Coronary Care Legacy Fund was bequeathed to the charity for the use of the heart unit at the hospital.

The Royal Gwent Hospital Coronary Care Unit Legacy Fund was bequeathed to the charity for the provision of medical facilities, towards the cost of providing equipment for the heart unit at the hospital.

The Royal Gwent Haematology Fund was bequeathed to the charity for the Haematology Unit at the Royal Gwent Hospital.

The Royal Gwent Breast Care Legacy Fund was bequeathed to the charity for the Breast Care Unit at the Royal Gwent Hospital.

The NHS Charities Together Covid 19 Grant was given to us from monies raised by Captain Sir Tom Moore and others for use across the whole of Aneurin Bevan University Local Health Board.

The other 58 restricted funds also related to monies bequeathed to the charity for various wards and departments.

23. Analysis of funds (continued)**b. Analysis of unrestricted and material designated fund movements**

	Balance 1 April 2023	Income	Expenditure	Transfers	Gains and losses	Balance 31 March 2024
	£000	£000	£000	£000	£000	£000
ABUHB Charitable Funds Reserves	0	196		25	376	597
ABUHB Breast Centre	261	13	(14)			260
Royal Gwent Property, 13 Clytha Square	250					250
Royal Gwent Casting Techniques Course	104	24	(18)			110
St Woolos Springfield Community Ward Project	111	1	(4)			108
The Care Project	119	45	(59)			105
Nevill Hall Voluntary Body	94	15	(23)			86
ABUHB Covid-19	92	(1)	(5)			86
ABUHB Outpatients	76		(3)	8		81
ABUHB Charitable Funds Committee	106	13	(42)	(8)	(1)	68
Royal Gwent Breast Care Unit	70		(2)			68
ABUHB Media Fund	62					62
ABUHB Employee Well Being Service	84	1	(24)			61
Monmouth Chippenham Community Nurses	66		(6)			60
Royal Gwent Prostate Cancer Fund	63		(7)			56
ABUHB Post Graduate Fund	62	4	(10)			56
ABUHB Rheumatology	58		(3)			55
ABUHB Dinky Dragons	46	24	(15)			55
Royal Gwent Property, TP Price	81			(26)		55
Nevill Hall Windsor Suite	54	1	(3)			52
Royal Gwent Post Graduate Fund	47	6	(3)			50
Other - 325 unrestricted designated funds	2,625	264	(656)	4		2,237
	4,531	606	(897)	3	375	4,618

The trustees have delegated all unrestricted funds as designated funds to the ward or department the donations were intended for.

The material funds specified in the above note will vary from year to year dependent on the closing year end balance.

We consider that a closing fund balance of £50,000 or greater are material for disclosure in these accounts.

24. Events after the reporting period

Our CCLA investments have increased in value to pre-pandemic levels but growth in the year ahead is expected to be challenging as a result of the war in Ukraine and a slow down in the global economy.

Statement of Trustee's Responsibilities

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the charity's financial activities during the year and its financial position at the end of the year. In preparing financial statements giving a true and fair view, the Trustee should follow best practice and :

- select suitable accounting policies and apply them consistently;
- observe the methods and principles of the Charities SORP;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards and statements of recommended practice have been followed, subject to any departures disclosed and explained in the financial statements; and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The Trustee is responsible for keeping accounting records which disclose with reasonable accuracy the financial position of the charity and which enable them to ascertain the financial position of the charity and which enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed. The Trustee is responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee confirms that they have complied with the above requirements.

By order of the trustee

Ann Lloyd
Trustee

Rob Holcombe
Financial Trustee

Dated:

The independent auditor's report of the Auditor General for Wales to the trustee of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities

Opinion on financial statements

I have audited the financial statements of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities for the year ended 31 March 2024 under the Charities Act 2011.

The financial statements comprise the Statement of Financial activities, Balance Sheet, Statement of Cash Flows and related notes, including the material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2024 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report.

My staff and I are independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee is responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit;
- sufficient accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements are not in agreement with the accounting records and returns; or
- the information given in the financial statements is inconsistent in any material respect with the trustees' report.

Responsibilities of the trustee for the financial statements

As explained more fully in the statement of trustee's responsibilities, the trustee is responsible for:

- maintaining sufficient accounting records;
- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the trustee determine is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless the trustee anticipate that the services provided by the charity will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities' policies and procedures concerned with:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances on non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.

- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals.
- Obtaining an understanding of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities' framework of authority as well as other legal and regulatory frameworks that the Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities operated in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the charity.
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, those charged with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the trustee;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- I also communicated relevant identified laws and regulations and potential fraud risks to all audit team and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities' controls, and the nature, timing and extent of audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Adrian Crompton
Auditor General for Wales
January 2025

24 Cathedral Road
Cardiff
CF11 9LJ

2023-2024



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Annual Report & Accounts

**Aneurin Bevan University Local Health Board
Charitable Fund and Other Related Charities**

**Trustee's Annual Report and Accounts
2023-2024**

Registered Charity No: 1098728



Aneurin Bevan Health Charity

About Us

We are a registered charity, receiving monies given to Aneurin Bevan University Local Health Board from grateful patients, their loved ones and the wider community; thanking us for the NHS care and treatment they receive.

Our Partner NHS Health Board

Aneurin Bevan University Local Health Board was established in October 2009 and achieved 'University' status in December 2013.

It is a multi-award-winning NHS organisation with a passion for caring and provides integrated acute, primary and community healthcare serving a population of 600,000 in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and some services to the people of South Powys with a budget of just over £1.6 billion.

The Health Board is the largest employer in Gwent, employing 13,082 whole time equivalent (WTE) staff at the end of March 2024 and providing an exceptional workplace to start, grow and build a career. It offers flexible working and promotes a healthy work life balance with occupational health support and an ambitious plan for a Wellbeing Centre of Excellence for staff.

Our Clinical Futures strategy continues to enhance and promote care closer to home as well as high quality hospital care when needed. This includes the Grange University Hospital which provides specialist and critical care and is the newest addition to the clinical futures strategy.

**Without the Health Board,
the Charity would not exist**



Message from our Chair

Thank you for taking the time to read this Annual Report and Annual Accounts for 2023-24. The final report provides information on our income received as well as our expenditure for the period mentioned above.

As a registered charity we welcome the support from the public, families, individuals and groups and others regarding donations for this important charitable work and we are most grateful for such contributions.

This annual report provides information which also explains how we have spent the money. Charitable funds were made available to help to improve the quality of life for the patients and individuals in Gwent, as well as supporting staff who deliver such wonderful care. There is such great work evidenced and to be helpful we have included some really useful and interesting case studies.



Finally, can I take this opportunity to say a huge thanks to the Charitable Funds Team of staff who do an incredible job in relation to producing this report. Also to recognise their excellent work throughout the year in supporting this charity - Much appreciated.

Paul Deneen, Chair of the Charitable Funds Committee

Message from our Chief Executive

Firstly, I would like to say a heartfelt thanks to everyone who made a donation, legacy or generated income for our Health Board charity. This funding made a real difference to many of our staff and services.

The Health Board continues to face financial challenges and I want to ensure we consider all the great ideas staff have on how we can better use our resources and avoid waste no matter how big or small the opportunity.

We continue to look to charitable funds to assist us in this, piloting projects, testing proof of concept and steering funds to where they are needed most.

Charitable funds provide opportunities to support staff wellbeing initiatives and events.

You will see from the highlights of our previous year, shown below, the types of projects we have been able to support which have made a real difference to staff and patients.



Thank You

Nicola Prygodzicz
Chief Executive

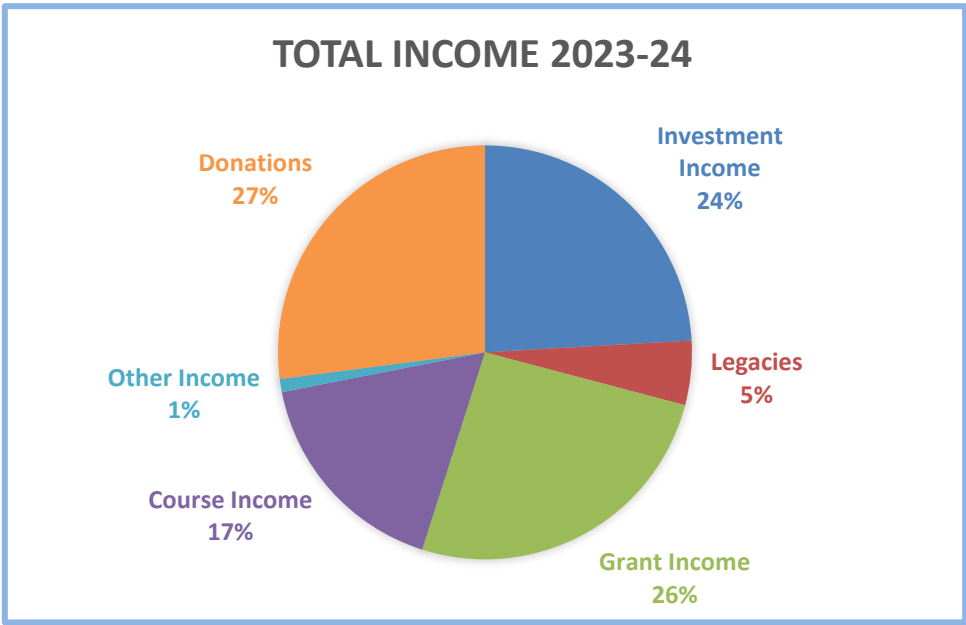
Introduction

On behalf of the corporate trustee, we present the Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities Annual Report together with the audited financial accounts for the year ending 31st March 2024.

2023-2024 At a Glance

INCOME

This year we received £876,000



DONATIONS £237,000

The donations we received is thanks to the generosity of patients, their relatives and friends in recognition of the care and treatment received from Aneurin Bevan University Local Health Board.

LEGACIES £44,000

We are extremely grateful to those individuals who have had the generosity to leave a gift to us in their will.

GRANT INCOME £226,000

This money is received from external organisations to fund specific schemes / projects. Some of this funding was received from NHS Charities Together – monies raised by Captain Sir Tom Moore and others.

COURSE AND OTHER INCOME £158,000

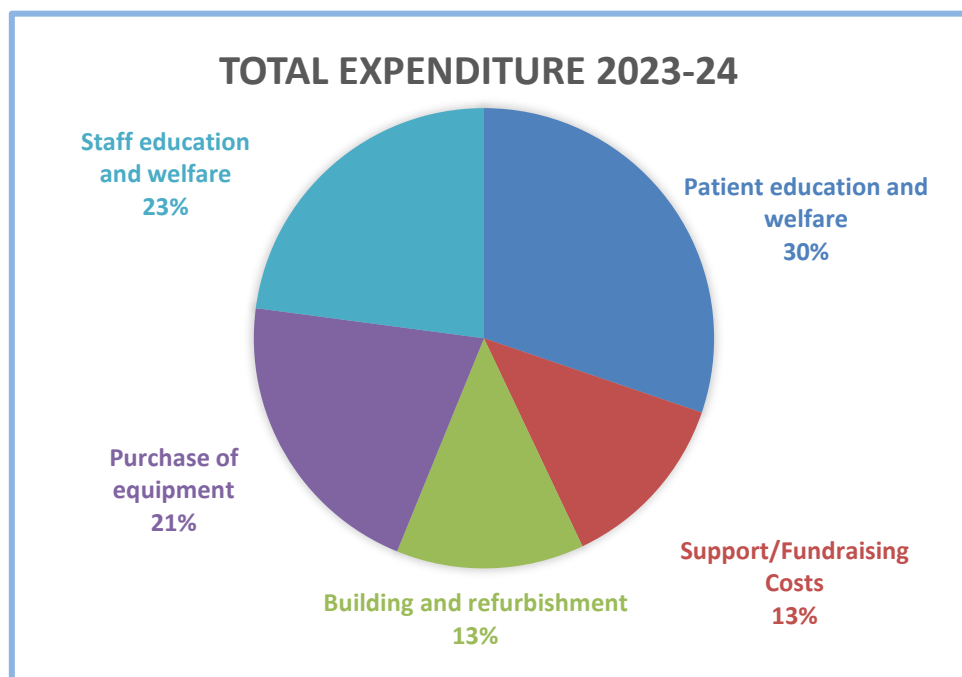
Fees and sponsorship for courses which are run mainly through our Postgraduate department.

**INVESTMENT
INCOME
£211,000**

We received this from our investment portfolio. This was up £11,000 on last financial year.

This year we spent £1,257,000

EXPENDITURE



This year, we have continued to use this money towards a project providing psychological support for patients introducing Cancer Café's; purchasing Christmas gifts for those patients in hospital during the festive season.

**PATIENT
EDUCATION &
WELFARE
£380,000**

This was spent on a range of varied equipment across the Health Board with around £40k of this used to purchase defibrillators and cabinets in the community from our Jack's Appeal Fund.

**PURCHASE OF
EQUIPMENT
£263,000**

The main items consist of conferences and seminars, training course fees and related travelling expenses, subsistence and accommodation and support for employee well-being. Around £50k of this relates to medical student bursaries.

**STAFF
EDUCATION &
WELFARE
£288,000**

We spent this mainly on various grounds and garden projects, improving the environment, making it better for our patients, staff and visitors.

**BUILDING &
REFURBISHMENT
£166,000**

This covers the cost of the Charitable Funds Team, Corporate support and auditor fee in administering the funds.

**SUPPORT COSTS
£160,000**

Charitable Funds are spent in line with the Charity's objects and are intended to provide those additional amenities that will improve the conditions under which patients are cared for and treated or staff work

**KEY
PURCHASE**

**Bladder scanner, CasGwent Ward,
Chepstow Community Hospital**

Bladder scanners are portable, handheld ultrasound devices which can perform quick, easy and non-invasive scans of the bladder and is painless for the patient. It can be used to help identify bladder distension, causes of urinary frequency and bladder irritability and is useful in assisting with accurate assessments of hydration status. The purchase of an additional bladder scanner enables the nursing staff to use them at the patient's bedside which is beneficial to both patients and staff.



KEY PURCHASE

Ocular Response Analysers x2 and Slit Lamp for Ophthalmology, Royal Gwent Hospital



Patients seen by their local optometrist, suspected of having glaucoma are referred to the hospital ophthalmologists for diagnosis and treatment.

Glaucoma is an eye condition, more common in adults in their 70s and 80s, where the optic nerve that connects the eye to the brain becomes damaged. It is caused by a fluid build-up at the front of the eye which increases the pressure inside the eye. This equipment is used in assessing the condition.

KEY PURCHASE

TULA Laser System for Urology, Royal Gwent Hospital

The Transurethral Laser Ablation (TULA) laser allows removal of small bladder tumours in an outpatient setting as opposed to theatre. The equipment is a space saving, economical and versatile device and presents several benefits to patients including reduced infection and readmission rates, as well as optimised use of theatre and bed capacity.



Patients with bladder tumours currently require inpatient stay in hospital for resection, increasing risk of infection. Using the TULA laser, small, non-complex bladder tumours can be removed under local anaesthesia on an outpatient basis and minimises the turnaround time allowing more patients to be treated on a list. The TULA offers the potential to free up a significant number of theatre slots and overnight beds to be used for higher risk patients and will reduce the waiting times for both low and high-risk patients. It particularly benefits elderly patients with co-morbidities who may need multiple resections under anaesthesia.

Key Purchase

Benevision Central Monitoring System, Coronary Care Unit, Grange University Hospital

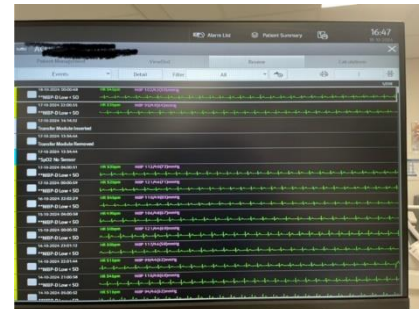
The Central monitoring system is used within the Acute Coronary Care Unit (ACU) which is a 17 bedded specialised cardiac unit located on Ward B2. We also have 11 telemetry boxes that enable the staff to monitor the patients that are within the hospital and not on our unit.



We provide continuous monitoring and a high dependency care area for cardiac conditions including heart attack, unstable angina, rhythm disturbance, cardiogenic shock and for those patients who have had catheter laboratory procedures such as insertion of devices like pacemaker and defibrillators and interventions such as angiograms/ angioplasties.



The Benevision Central Monitoring system allows us to continuously view the patients on the monitors and on the telemetry. It will display the cardiac rhythms and inform us of any changes. We can set the monitor to see all the area or if we want to review one specific patient, we can use the monitor to get exact information for example if there have been any events, and graphic trends.



All this information is vital for patient safety whilst they are in hospital and to ensure the patient gets the correct treatment.

KEY PURCHASE

Other Medical Equipment

- Simulate Realiti Go Simulation System, Critical Care Unit, Grange University Hospital.
- ECG Arrhythmia Detection Equipment, Ward A, Grange University Hospital.

The NHS was 75 on 5th July 2023. As a Health Board we are privileged to be named after its founder. To commemorate the 75th anniversary of the NHS, staff across our services held celebrations, events and parties to mark this special birthday.



A few photos from the wards at Ysbyty Aneurin Bevan. All the wards put on tea parties for staff and patients to celebrate NHS 75 - fun party activities included musical bingo and watching old films. Nurses also dressed up in 1940s uniform and decorated the wards for the occasion!



Whatever the occasion, our patients and our staff love to get involved. Donations to the wards help pay for these celebrations. Whether it is for balloons and bunting, easter eggs, themed afternoon teas for the patients or a mince pie in July (mince pies are not just for Christmas); these small things make a big difference.

Raffles

Staff raising funds

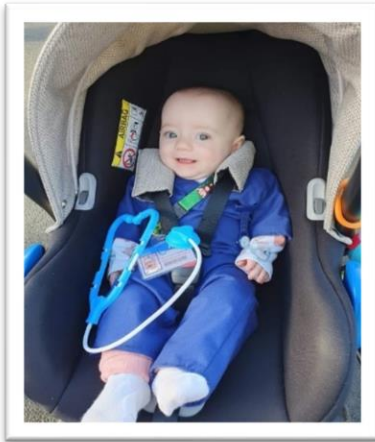


Staff on Ward C6 West in Royal Gwent Hospital raising funds for their ward so that they can make a difference.



Aww.....

Little Francesca raising funds



Little Francesca-Rae dressed up as her favourite superhero, a NICU nurse, to take part in a sponsored walk-in aid of Dinky Dragons, and so far, has raised over £425!

Dinky Dragons is part of our registered charity and provides support to families during and after their NICU journey and raise funds for specialist equipment.

Francesca-Rae was born in the Grange University Hospital in January 2023, 13 weeks early, weighing just 1lbs 6oz (643g).

She thinks NICU nurses are true superheroes, and Francesca-Rae and her family are extremely grateful for the care and support they received during their stay!

"Dinky Dragons" is the name of the fundraising group for our Neonatal Intensive Care Unit.



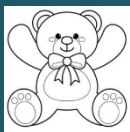
And.....

Don't forget the Mums

The Mothers' Union in Caldicot, led by Jean Hackett, held an afternoon tea recently and raised over £400 to help purchase items for the two upgraded houses on GUH site that are for parents of babies in NICU.

We are so grateful for their ongoing support and the array of items donated - from Halogen Ovens and travel cots to linens and home decor items - as well as essential items for the babies onsite.

Some of the ladies were able to visit the family area of NICU and staff joined them to express their gratitude for such generous support.



Make their Day!

Just when you're having a quiet day, 72 teddy bears turn up!

A huge thank you to the lovely people from TLC Monmouthshire who made everyone's day on the unit by bringing the teddies.

It definitely brought a smile to Chester's face and to everyone in the photo!

It's fantastic when people make donations for the children in hospital. We are incredibly grateful and really hope TLC Monmouthshire have the time to visit the children again very soon!





In partnership with the Shaw Foundation, our Care Fund Project is used to identify individuals from less privileged backgrounds, with a potential to become qualified doctors by supporting them with a programme of mentoring and financial support. The project looks at innovative ways to encourage and train these individuals with the necessary skills and knowledge to obtain a place in medical school and support them through the training process to hopefully lead to them becoming active doctors within the Health Board locality.

We are delighted to announce that we have a second student who has qualified this year and is staying in South Wales completing their foundation training.

'I am pleased to share that I graduated as a doctor in July and have now begun my medical career at the University Hospital of Wales, where I will be working for the next two years. I hope to continue living and working in Wales throughout my training and beyond. None of this would have been possible without the invaluable support and funding from the Care Fund bursary. I am forever grateful for the opportunity it has provided me, and I look forward to contributing to the health and wellbeing of my community here in Wales.'

The following comments have been received from other recipients of our Care Project Bursary Fund:

Student A

The bursary I received in 2023 was instrumental in supporting my academic journey and overall well-being. As a student with limited financial resources, the bursary alleviated a significant portion of the financial burden associated with commuting. This support allowed me to allocate more time and energy to my studies, without the constant worry of balancing financial constraints.

The bursary also provided me with the means to afford essential study materials and resources, which would have otherwise been challenging to obtain. The ability to attend all lectures and optional sessions consistently

was so important in gaining a deeper understanding of the lecture content and in forming meaningful connections with my peers.

I am very grateful for the opportunities this bursary afforded me. Without it, my capacity to participate fully in my academic and extracurricular activities would have been significantly hindered. The bursary not only supported my educational aspirations but also allowed me to engage more fully in the university community, for which I am truly thankful.

I have grown both personally and academically. I am now one of the Presidents of the Med Prep Society, a role that allows me to lead and organise teaching sessions for incoming first-year students. This position feels incredibly rewarding, as it enables me to actively contribute to the academic development of my peers while developing my own leadership skills.

Student B

The bursary that I received last year allowed for me to receive an iPad and MacBook which heightened my studies, allowing me to work, revise and research much more effectively for my course. The grant also gave me more financial peace of mind and allowed me to continue my sports membership, which I found essential to disconnect from university in stressful times. It also allowed me to dedicate more time to studies instead of working extra shifts.



Jacks Appeal



Jack was a very fit and healthy 15-year-old. Being a grade A* student he had been successful in gaining a scholarship at Cardiff Sixth Form College, representing Wales in Taekwondo across Europe.

On 12th February 2012 Jack became one of the 12 young people who die suddenly each year from an un-diagnosed heart condition. He had no signs or symptoms before his heart suddenly stopped. Jack had never been ill, so his cardiac arrest and death came as a complete shock.

Jack's family still have no answers as to why their precious boy became unconscious and never woke up.

Jack's family have channelled their grief setting up several charities and work streams in Jack's memory. At the time of Jack's death, all local leisure centres had been provided with Automated External Defibrillators (AEDs) but not the schools.

Because of what happened to Jack, a fund called "Jack's Appeal" was set up with Aneurin Bevan Health Charity to be used to prevent such heart-related tragedies. Working together, all schools in Gwent have been provided with an AED. We have also supplied AEDs to sports clubs and other community groups.

Our focus now is to provide communities with 24/7 public access Defibrillators, externally housed in secure cabinets.



All donations no matter how small will help keep Jack's memory going. You can donate to help support the purchases of defibrillators, wall cabinets and consumables such as defibrillator pads and batteries.

NHS CT Grant

Enhanced Psychological Programme in cancer Supporting the emotional needs of our patients

NHS Charities Together (NHS CT) allocated money for supporting Covid-19 projects across the NHS in the UK to be accessed through individual bodies' charitable funds; we successfully obtained a grant of £308,000 for psychological support for people accessing cancer services.

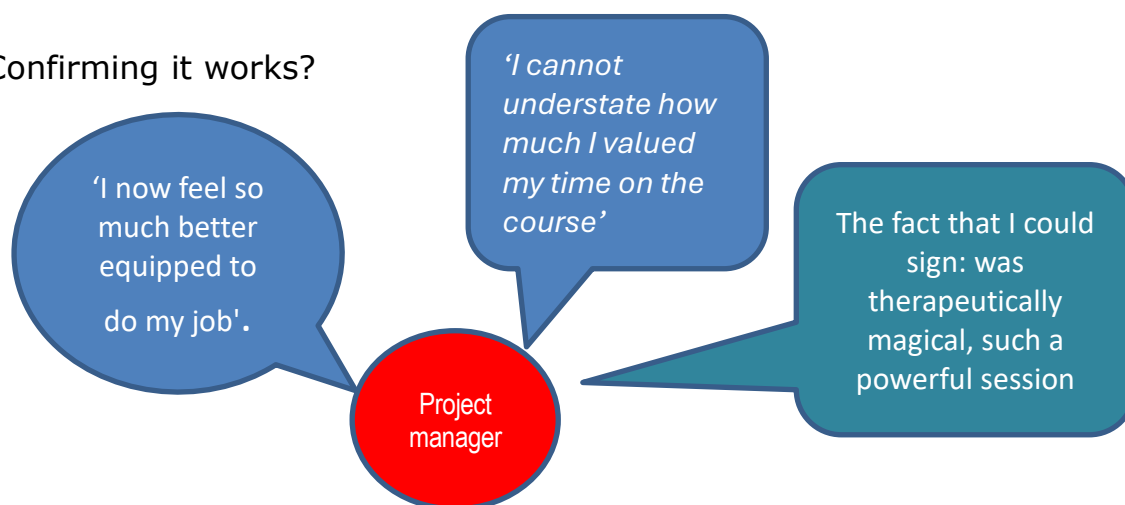
The enhanced psychological programme includes:

- Staff training: recognising and responding to psychological distress
- Clinical supervision
- Psychological support for patients that require it, across all cancer pathways
- Peer and volunteer support
- Increased support for vulnerable groups
 - LGBTQI plus
 - Deaf/Sensory loss
 - Diverse populations
 - Inequities
 - Digital inclusion

What makes it work?

Skills	Training & Education
Ability	Expertise, Time, Guidance, Mentorship
Opportunity	Resources, Co-ordination, Navigation
Motivation & Engagement	Awareness, Purpose, Patient Feedback

Confirming it works?



The cancer café workstream is a core area of activity of the 'Enhanced Psychological Support' project. The cafes encompass offering peer support, and a friendly and relaxed opportunity for anyone with a cancer experience (patient, carer/ family, to meet and share experiences with others who truly understand. The cafés are supported by ABUHB trained volunteers and take place in a variety of community venues in all boroughs of ABUHB. Each session is 2 hours in duration and refreshments are provided.



Following the success of our first Cancer Cafe at Caerphilly Library in October, the Cancer Cafe continued to take place for the remainder of 2023 and is hosted twice a month at locations across the Gwent borough from January 2024.

Hosted by the Enhanced Psychological Care team and supported by a group of Volunteers, the cafe offers a friendly and relaxed opportunity for anyone with a cancer experience (patient, family or carer) to meet and share experiences with others who truly understand.



Gemma Wham

Project Manager - Enhanced Psychological Support

Verbal Quotes/ Feedback from attendees:

- 'I felt so positive after leaving'.
- 'I am so pleased I have made it today and will come again'.
- 'A huge well-done for organising this -it is exactly what we need, and I need - a great support and has impacted me greatly - thank you'.
- 'These cafes really are a great resource for those of us trying to move on. It really does help such a lot to speak to other people & realise we are all dealing with the same things.'

What's new Breast Unit at Ysbyty Ystrad Fawr opens

On Monday 5th February 2024, the brand-new Breast Care Unit at Ysbyty Ystrad Fawr welcomed Gwent patients for the very first time!

The Unit brings together diagnostic, treatment and surgical services that were spread across three hospitals.



Contact Us

Charitable Funds Team

Alison Griffiths – Charitable Funds Manager



Linda Proudman – Charitable Funds Officer
(until September 2023)

Wendy Keyte – Charitable Funds Officer



Sue Turley – Charitable Funds Officer

Logan Pewtner – Finance Trainee
(from October 23 to April 24)



By E-mail

Charitable.funds.ABB@wales.nhs.uk

By Phone

01495 765431

Charity Governance, Audit and Finance

1. Reference and Administrative Details

Charity Name: Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities

Charity Working Name: Aneurin Bevan Health Charity

Registered Charity No: 1098728

Address of Charity: Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
NP18 3XQ

Administration of the Charitable Funds:

The accounting records and the day-to-day administration of the funds are undertaken by:

Charitable Funds Section
Corporate Finance Department
Aneurin Bevan University Local Health Board
Block C, Mamhilad House
Mamhilad Park Estate
Pontypool, Torfaen
South Wales NP4 0YP

Tel No: 01495 765431

E-mail: Charitable.funds.ABB@wales.nhs.uk

Professional Advisors:

Bankers: National Westminster Bank PLC
Government Banking Parklands
De Havilland Way
Horwich
Boulton
BL6 4YU

Santander
Customer Services Centre
Bootle
Merseyside
L30 4GB

Investment Managers: CCLA Investment Management Limited
1 Angel Lane
London
EC4R 3AB

External Auditors: The Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Internal Auditors: NHS Wales Shared Services Partnership
Audit & Assurance Services
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

VAT Advisor: Ernst & Young LLP
The Paragon
Counterslip
Bristol
BS1 6BX

**Legal advice
For T P Price Estate** Douglas-Jones Mercer Solicitors
Axis Court
16 Mallard Way
Swansea Vale
Llansamlet
Swansea
SA7 0AJ

**Estate Management
For TP Price Estate:** NHS Wales Shared Services Partnership
Specialist Estate Services
3rd Floor, Companies House
Crown Way
Cardiff
CF14 3UB

Savills
2 Kingsway
Cardiff
CF10 3FD

**Valuations for
13 Clytha Square:**

The District Valuer
District Valuer Services
Ty Rhodfa
Ty Glas Road
Llanishen
Cardiff
CF14 5GR

Valuations for Painting: Bonhams
7-8 Park Place
Cardiff
CF10 3DP

2. Structure, Governance and Management of Charitable Funds

Objects of the Charity

The objects of the charity are as follows:

The main purpose of the charity is to apply income for any charitable purpose relating to the National Health Service delivered by Aneurin Bevan University Local Health Board.

The corporate trustee is Aneurin Bevan University Local Health Board. The executive directors and independent members of the Board share the responsibility for ensuring that the health board fulfils its duties as a corporate trustee in managing charitable funds.

The chair and independent members of the Board are appointed by the Welsh Government and the executive directors are appointed by the Health Board.

Trustee Arrangements

Aneurin Bevan University Local Health Board is the corporate trustee of the Charity. The directors who served the Aneurin Bevan University Local Health Board during the year to 31st March 2024 were as follows:

Name	Designation	Dates (if less than full year)
Executive Directors		
Nicola Prygodzicz *	Chief Executive	Full Year
Hannah Evans	Director of Strategy, Planning and Partnerships	From 01/04/2023
Christopher Dawson-Morris	Interim Director of Planning and Performance	Until 02/04/2023

Rob Holcombe *	Director of Finance and Procurement	Full Year
Dr James Calvert	Medical Director / Deputy Chief Executive	Full Year
Sarah Simmonds	Director of Workforce and OD	Full Year
Jennifer Winslade	Director of Nursing	Full Year
Peter Carr	Director of Therapies and Health Sciences	Full Year
Tracy Daszkiewicz	Director of Public Health	From 01/04/2023
Dr Chris O'Connor	Interim Director of Primary, Community and Mental Health Services	Until 30/04/2023
Leanne Watkins	Director of Operations	Until 30/04/2023
Leanne Watkins	Chief Operating Officer	From 1/05/2023
Independent Members		
Ann Lloyd	Chair	Full Year
Pippa Britton	Vice Chair	Interim until 02/5/2023
Shelley Bosson	Independent Member (Community)	Full Year
Louise Wright *	Independent Member (Trade Union)	Full Year
Richard Clarke	Independent Member (Local Authority)	Full Year
Professor Helen Sweetland	Independent Member (University)	Full Year
Paul Deneen *	Independent Member (Community)	Full Year
Iwan Jones *	Independent Member (Finance)	Full Year
Dafydd Vaughan	Independent Member (Digital)	Full Year
Martin Blakebrough	Independent Member (Third Sector)	From 03/05/2023
Penny Jones	Independent Member (Community)	From 15/01/2024
Directors in Attendance		
Paul Solloway	Director of Digital	From 28/06/2023
Special Advisors to the Board		
Phil Robson	Special Advisor to the Board	Full Year
Associate Members		
Vacant	Chair, Stakeholder Reference Group	Full Year
Vacant	Chair, Health Professionals Forum	Full Year

Vacant	Director of Social Services	Full Year
Director of Corporate Governance		
Rani Dash	Director of Corporate Governance	Full Year

* Members of the Charitable Funds Committee.

Charitable Funds Committee

The Board of Aneurin Bevan University Local Health Board, as the corporate trustee, delegates its governance work to the Charitable Funds Committee which is a subcommittee of the Board. The Committee is required to:

- Control, manage and monitor the use of the fund's resources for the public benefit having regard for the guidance issued by the Charity Commission.
- Provide support, guidance and encouragement for all its activities whilst managing and monitoring the receipt of all income.
- Ensure that 'best practice' is followed in the conduct of all its affairs fulfilling all its legal responsibilities.
- Ensure that the Investment Policy approved by the Health Board is adhered to and that performance is continually reviewed whilst being aware of ethical considerations.
- Keep the Health Board fully informed on the activity, performance and risks of the charity.

Membership of the Charitable Funds Committee is as follows:

Name	Designation	Dates (if less than full year)
Charitable Funds Committee Members		
Paul Deneen	Independent Member (Community)	Full Year
Louise Wright	Independent Member (Trade Union)	Full Year
Iwan Jones	Independent Member (Finance)	Full Year
Nicola Prygodzicz	Chief Executive	Full Year
Rob Holcombe	Director of Finance and Procurement	Full Year

The following also attended the committee with other staff as appropriate for specific agenda items:

Name	Designation	Dates (if less than full year)
In Attendance		
Mark Ross	Assistant Director of Finance, Financial Systems & Services	Full Year
Estelle Evans	Head of Financial Services and Accounting	Full Year
Rani Dash	Director of Corporate Governance	Full Year
Michelle Jones	Head of Board Business - Corporate Services	Full Year

Independent Members are appointed to hold office for a period of up to four years in any one term. During this time, a member may resign or be removed by the Board. The Chair of the Health Board keeps under review the membership of Board Committees to ensure changes are made regularly to refresh the membership of each committee and respond to circumstances when new members join the Board.

Trustee Induction and Training

As part of their induction programme, new Executive and Independent Members of Aneurin Bevan University Local Health Board are made aware of their responsibilities as Board members and as a Corporate Trustee of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities.

At each Charitable Funds Committee meeting, members are advised of any changes in legislation or other requirements relating to charities.

The Board received a Development Session on the Charities Act 2022 in July 2024.

Public Benefit

The objects of the charity are such that all expenditure from the charity is for the benefit of the National Health Service and as such is therefore for 'public benefit'. The Charitable Funds Committee is aware of its duties in relation to public benefit and ensures that all expenditure fulfils public benefit criteria. This is demonstrated further in this report in the Expended Resources Section of Item 7.

Management of Funds

The Director of Finance is responsible for the day-to-day management and control of the administration of charitable funds and reports to the Charitable Funds Committee. The Director of Finance has responsibility for ensuring that:

- The spending is in accordance with the objects and priorities agreed by the Charitable Funds Committee.
- The criteria for spending charitable monies are fully met.
- All accounting records are maintained.
- Devolved decision making or delegated procedures are in accordance with the policies and procedures set out by the Board on behalf of the corporate trustee.

Within the charity there are 408 internal funds which are delegated to authorised fund holders to approve expenditure within predefined limits. All expenditure requests exceeding £25,000 are subject to Committee approval. A further 5 funds are controlled by the Charitable Funds Committee. The Health Board has a formal procedure that sets out guidance to delegated fund managers to aid them in the process of approving appropriate expenditure from funds.

3. Strategic Objectives & Activities

Charitable Funds received by the charity are accepted, held and administered as funds held on trust in accordance with the National Health Service (Wales) Act 2006.

The principal areas in which the funds are applied for the benefit of the public are:

- The purchase of medical equipment for use by Aneurin Bevan University Local Health Board.
- The provision of patient welfare activities and amenities.
- The education and welfare of staff.

The corporate trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund. The trustee respects the wishes of our generous donors to benefit patient care and advance good health and welfare of patients and staff.

The charity is constituted of 346 unrestricted and designated funds and 67 restricted funds as at 31st March 2024. Material fund details are shown in Note 23 to the accounts. The current structure of the individual funds reflects the fact that most of the income and expenditure is focused where patients receive services. Fund managers exercise control over the funds donated to their management area.

4. Risk Management

The main risks associated with the charity relate to:

- Financial controls risk.

- Investment risk.

Financial Control Risk

A financial control procedure has been developed for Charitable Funds and agreed with the Charitable Funds Committee and approved by the Audit Risk & Assurance Committee to ensure that there are sufficient management controls in place to ensure regulatory compliance and minimise risk of fraud and error. Specifically, to:

- Ensure the spending is in accordance with the objects of the charity and the priorities agreed by the Charitable Funds Committee.
- Ensure the criteria for spending charitable funds are fully met.
- Ensure all accounting records are maintained.
- Ensure devolved decision-making is within specified parameters.

All other Financial Control Procedures covering core financial systems within Aneurin Bevan University Local Health Board are also applied to the financial administration of the charity.

An internal audit is undertaken periodically, based on the assessment of risk, to evaluate the adequacy of procedures and controls in place and to test compliance against those procedures. Audit Reports are presented to both the Charitable Funds and Audit Risk & Assurance Committee of the Health Board and this is a key measure in mitigating control risk. The latest Internal Audit report carried out in November 2021 provided substantial assurance on controls covering charitable funds. This definition of assurance generally means there is substantial assurance that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively and that few matters require attention and are compliance or advisory in nature. Financial reports showing the income statement and balance sheet together with analysis of significant financial changes are reported to each Charitable Funds Committee meeting. In addition, the Charitable Funds Committee reviews the draft annual accounts while the Board approves the final annual accounts of the charity.

The external audit of the accounts is undertaken by the Auditor General for Wales. The accounts have historically received an unqualified audit opinion.

Investment Risk

This risk is mitigated by investing in a diversified portfolio of investments through the professional advice of investment managers. Our investment managers, CCLA, usually attend the

Charitable Funds Committee annually to present and discuss investment performance and strategy.

5. Reserves Policy

The Charitable Funds Committee reviews the Charity's reserve policy, observing both Charity Commission guidance on reserves and the current level of funds held.

If reserves are too high, the charity is retaining funds without justification and this could constitute a breach of trust. If reserves are too low, the fund's ability to meet future commitments or needs may be at risk.

The Charity operates on the basis that it only spends what it has received and does not rely on future donations to meet its commitments. Therefore, the reserves should be set at a level sufficient to cover the liabilities that face the charity, namely the cost of administering the funds and any unrealised losses and to hold some money in reserve to act as a buffer against stock market fluctuations.

The corporate trustee fully understands the need to regularly review the level of reserves and the charity's activities and operations so that future reserves can be maintained at a level which will mitigate the risk of significant fluctuations in the levels of donations and investments, and provide financial stability for the charity, to ensure that its aim of being able to apply charitable funds within a reasonable time is achieved.

Due to the unrealised loss on investments in 2022/23 the reserves held were utilised to mitigate the loss incurred. The Charitable Funds Committee approved the creation of a new reserve to offset any future loss on investments by retaining the interest and dividends for 2023/24 and 2024/25 together with any unrealised gain. The balance of the reserve held is £597,000.

The charitable funds reserve value is reviewed annually.

6. Grant Making Policy

The use of our funds is restricted by the governing document which established the charity for purposes connected with the NHS. Grants consist of:

General Funds

This consists of donations received by the charity where no preference as to its expenditure has been expressed by donors. The

Charitable Funds Committee decides on how these funds should be spent by receiving requests from across the Health Board. The value of general funds held is £665,000. There are also fixed asset valuations totalling £330,000 which includes 2 investment properties (£305,000) and 1 painting (£25,000).

Designated Unrestricted Funds

These consist of donations where a particular part of the hospital or activity was nominated by the donor at the time their donation was made. Whilst their nomination is not binding on the trustee, the designated funds reflect these nominations. The value of the designated unrestricted funds is £3,623,000.

Restricted Funds

These consist of legacies and grants where a legal document and signed agreement restricts the use to the terms of the bequest/agreement. The value of restricted funds held is £1,146,000.

During the year the charity made grants of £1,097,000 representing 87% of the total charitable expenditure. In making grants the trustee requires that the activity falls within the objectives of the charity and relate to the specific purpose of the individual funds from which it is being met.

7. Review of our Finances, Achievements and Performance

The financial statements for 2023-24 are presented at the end of this report.

The net assets of the Charity as at 31st March 2024 were £5,764,000 (2023 £5,770,000). Overall net assets decreased by £6,000.

Incoming Resources

Incoming resources when comparing against the 2022/23 position were £268,000 lower than the previous year. Donations decreased by £181,000, legacies decreased by £102,000, investment income increased by £11,000, grant income increased by £176,000 and income from charitable activities decreased by £172,000.

The charity received four legacies during the year, total value £44,000 (2022-2023 five legacies, value £146,000).

The charity received five new grants in 2023-2024 totalling £198,000 (2022-2023 four new grants, value £130,000) of which £169,000 has been carried forward to 2024-2025. Additional income of £156,000

has been received in respect of an existing grant. Income of £162,000 brought forward from prior years has been released to meet expenditure in the current year.

Expended Resources

Charity expenditure for the year totalled £1,257,000, an increase of £209,000 from the previous year. Expenditure for the year was across several categories as follows:

I. Purchase of Equipment

Total expenditure on equipment was £263,000. This was on a range of varied equipment across the Health Board.

II. Building and Refurbishment

Total expenditure on building and refurbishment was £166,000.

III. Patients Education and Welfare

Total expenditure on patients' welfare and amenities was £380,000. This consists of various therapies, seasonal activities, support groups and other items of expenditure to benefit patients.

IV. Staff Education and Welfare

Total expenditure on staff education and welfare was £288,000. The main items consist of seminars, training course fees, textbooks, professional journals and related travelling, subsistence and accommodation expenditure.

V. Fundraising Costs

There were no specific fundraising costs this financial year.

VI. Support Costs

Total expenditure on support costs was £160,000. This includes the audit fee of £20,000 and costs of the charitable funds office and corporate support.

Investment Properties

Investment properties owned by the charity are the T P Price Estate £55,000 and 13, Clytha Square, Newport £250,000. T P Price Estate consists of one small parcel of land.

13 Clytha Square, Newport is a large Victorian building in the centre of Newport which is rented to Aneurin Bevan University Local Health Board to use as offices.

Income from the investment properties was £14,000 (2022-2023 - £16,000).

Investments on the Stock Exchange

The charity’s investments are managed by CCLA Investment Management Limited, with the aim of managing the funds to achieve a balance of growth and income.

The charity’s investment policy does not allow managers to invest in those companies whose main business is related to the production or sale of tobacco or alcohol, or those companies involved in the arms trade.

Details of the investments (including cash held as part of the investment portfolio) and investment performance for 2023-2024 are shown in the table below:

Investment Performance 2023-24	
	CCLA
	£000
Balance 1 April 2023	5,102
Acquisitions	0
Disposals	0
Movement of Cash	0
Realised Gains/(Loss)	0
Unrealised Gains/(Loss)	375
Balance 31 March 2024	5,477
Income	174
Gains/(Loss) %	7.09%
Returns %	3.29%

Other Investments

“The Domestic Chaplain”, a painting donated to the charity many years ago is valued at £25,000 and is currently on loan to the National Museum of Wales, Cardiff.



8. Key Achievements

Funding

The charity supported many bids from across the organisation from its general funds and via the 413 delegated charitable fund accounts. This support significantly enhanced services for the patients and staff in the Aneurin Bevan University Local Health Board.

Charitable Funds Strategy

Progress on streamlining funds has continued throughout the year.

Fundraising

Our fundraising campaign to supplement a new Breast Care Centre which opened in February 2024 in Ysbyty Ystrad Fawr has ended but the fund remains open for general donations to the unit.

Investment Management

Following a competitive retendering exercise last year, CCLA were reappointed to provide investment management services to the charity from 1st April 2023 for a term of 3 years with an option to extend for an additional year. We continue to invest in their ethical investment fund.

Governance Arrangements

The accounts and trustees annual report have always been produced on time with unqualified audit opinions and filed on time with the Charities Commission.

9. Plans and Objectives for the Future

Income continues to be received by the charity due to the generosity of the public in recognition of the care and treatment received from the Health Board. The charity will continue to use its funds to improve patient experience.

Other objectives for the forthcoming year are to:

- Consider the effectiveness of support to staff in working with partners to obtain grants from companies, external organisations and charities for identified equipment and projects.

- Explore the objectives of the charity to ensure they remain relevant and appropriate for the Health Board.
- Ensure that all accounting or charity regulatory requirements are fully complied with.
- Continue to review funds for the redesign of service, in line with Clinical Futures Strategy.

10. Events since the Year End

- Information from our investment company in August 2024 suggests:
 - ❖ Another volatile month for equities, but most major markets end positively
 - ❖ Inflation will continue to fall, supporting expectations of lower interest rates
 - ❖ Economic indicators pointing to continuing growth, albeit at a modest pace

Continuing positive, if modest, economic growth should bode well for corporate earnings and hence for equity returns over the medium term. Markets will remain alert, though, to emerging macroeconomic data and commentary from central banks, responding to reflect any implications that new information may have for the path of monetary policy.

Meanwhile it is always possible for geopolitical developments, especially when they arise without warning, to destabilise markets. Volatility is therefore likely to remain a feature of equity markets but need not undermine positive outcomes in the medium term. For long-term investors who are able to focus on the fundamental economic drivers of companies' long-term returns, price movements which are influenced by more transient shifts in sentiment can in fact present opportunities to add value.

- In October 2023 we sold the last remaining ground lease held within the T P Price Estate at auction.
- The Charitable Funds Committee have received approval from the Health Board to sell the property 13 Clytha Square, Newport.

Approved on behalf of the Corporate Trustee

Ann Lloyd CBE

Chair

Aneurin Bevan University Local Health Board

Date: 22 January 2025



Our Ref MR/SG

Direct Line: 01495 765472

Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Date: 22 January 2025

Representations regarding the 2023-24 financial statements

This letter is provided in connection with your audit of the financial statements of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities for the year ending 31 March 2024 for the purpose of expressing an opinion on their truth and fairness and their proper preparation.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

We have fulfilled our responsibilities for:

- The preparation of the financial statements in accordance with legislative requirements and Charities Act 2011; in particular the financial statements give a true and fair view in accordance therewith;
- The design, implementation, maintenance and review of internal control to prevent and detect fraud and error.

Information provided

We have provided you with:

Bwrdd Iechyd Prifysgol Aneurin Bevan
Pencadlys,
Ysbyty Sant Cadog
Ffordd Y Lodj
Caerllion
Casnewydd
De Cymru NP18 3XQ
Ffôn: 01633 436700
E-bost: abh.enquiries@wales.nhs.uk

Aneurin Bevan University Health Board
Headquarters
St Cadoc's Hospital
Lodge Road
Caerleon
Newport
South Wales NP18 3XQ
Tel No: 01633 436700
Email: abh.enquiries@wales.nhs.uk

- Full access to:
 - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
 - additional information that you have requested from us for the purpose of the audit; and
 - unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities and involves:
 - management;
 - employees who have significant roles in internal control; or
 - others where the fraud could have a material effect on the financial statements;
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- The identity of all related parties and all the related party relationships and transactions of which we are aware.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by the Trustee of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Aneurin Bevan University Health Board on 22 January 2025.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:
Nicola Prygodzicz

**Chief Executive and
Accountable Officer**

Date: 22 January 2025

Signed by:
Ann Lloyd

Board Chair

Date: 22 January 2025

Audit of Accounts Report – Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities

Audit year: 2023-24

Date issued: December 2024

Document reference: 4616A2024



This document has been prepared as part of work performed in accordance with statutory functions. Further information can be found in our [Statement of Responsibilities](#).

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

About Audit Wales

Our aims and ambitions

Assure



the people of
Wales that public
money is well
managed

Explain



how public
money is being
used to meet
people's needs

Inspire



and empower
the Welsh
public sector to
improve



Fully exploit
our unique
perspective,
expertise and
depth of insight



Strengthen our
position as an
authoritative,
trusted and
independent
voice



Increase our
visibility,
influence and
relevance



Be a model
organisation for
the public sector
in Wales and
beyond

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Introduction

I have now largely completed my audit in line with my Audit Plan 2024 presented to committee on the 7 November 2024, subject to the following:

- final review of audit files and clearance of review points;
- completing final checks on the signed financial statements after the Board have agreed them; and
- a review of events after the reporting period up to the Auditor General's signing date.

This Audit of Accounts Report summarises the main findings from my audit of your 2023-24 annual report and accounts. My team have already discussed these issues with Assistant Director of Finance (Financial Systems & Services), the Head of Financial Services and Accounting and their team.

I am very grateful to your officers for their support in undertaking this audit.



Adrian Crompton
Auditor General for
Wales

Your audit at a glance



Audit opinions

We are proposing to give an unqualified opinion on the accounts.

We have nothing to report under the other sections of my report, ie those relating to going concern; other information; other matters; or matters I report by exception.



Significant issues

There are no uncorrected misstatements above our trivial levels but lower than materiality.

During our audit, we identified misstatements that have been corrected by management, but which we consider should be drawn to your attention. These are set out in **Appendix 3**.

Other than the corrected misstatements identified during the audit there are no other significant issues we wish to report to you.

Financial statements' materiality



Materiality £66,000

My aim is to identify and correct material misstatements, ie those that might otherwise cause the user of the accounts to be misled.

Materiality is calculated using:

- 2023-24 gross assets of £6.68 million
- Materiality percentage of 1%

I apply the materiality percentage to gross expenditure to calculate materiality.

I will report to you any misstatements above £3,000, calculated as 5% of materiality (called the 'trivial level').



Areas of specific interest

There is one area of the accounts, related party disclosures, that we judge may be of more importance to the user of the accounts. We have therefore set a lower materiality of £5,000 for these disclosures.

Ethical compliance



Compliance with ethical standards

We believe that:

- we have complied with the ethical standards we are required to follow in carrying out our work;
- we have remained independent of yourselves;
- our objectivity has not been comprised; and
- we have no relationships that could undermine our independence or objectivity.

In our Audit Plan, we explained that one of our trainees was undertaking a secondment with Aneurin Bevan University Health Board for the period, December 2022 to June 2023.

To guard against any potential threats to our independence or objectivity, we agreed the following safeguards:

- the secondee will not have any management responsibilities; and
- the secondment will be short-term (no more than 12-months).

Proposed audit opinion



Audit opinion

We intend to issue an unqualified audit opinion on this year’s accounts once you have provided us with a Letter of Representation (see below).

Our proposed audit report is set out in **Appendix 1**.



Letter of representation

A Letter of Representation is a formal letter in which you confirm to us the accuracy and completeness of information provided to us during the audit. Some of this information is specified as being necessary by auditing standards; other information may relate specifically to your audit.

The letter we are requesting you to sign is included in **Appendix 2**.



Issues arising during the audit



Misstatements

A misstatement arises where information in the accounts is not in accordance with accounting standards.

Uncorrected misstatements

There are no misstatements that we identified that remain uncorrected.

Corrected misstatements

During our audit, we identified misstatements that have been corrected by management, but which we consider should be drawn to your attention.

These are set out in **Appendix 3**.



Other significant issues

In the addition to misstatements identified during the audit we also report other significant issues to you.

Other than the corrected misstatements identified during the audit, there are no other significant issues we wish to report to you.

Recommendations

We have made a recommendation during the course of the audit, which is set out in **Appendix 4** along with management's response to the recommendation.

We will monitor progress against the recommendations during next year's audit. Where any recommendations are not fully implemented, we will report to you as part of next year's Audit of Accounts Report.

Appendix 1

Proposed audit report

The independent auditor's report of the Auditor General for Wales to the trustee of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities

Opinion on financial statements

I have audited the financial statements of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities for the year ended 31 March 2024 under the Charities Act 2011.

The financial statements comprise the Statement of Financial Activities, Balance Sheet, Statement of Cash Flows and related notes, including the material accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2024 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis for opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report.

My staff and I are independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the trustee with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee[s] [is/are] responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Matters on which I report by exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit;
- sufficient accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements are not in agreement with the accounting records and returns; or
- the information given in the financial statements is inconsistent in any material respect with the trustees' report.

Responsibilities of the trustee for the financial statements

As explained more fully in the statement of trustee's responsibilities the trustee is responsible for:

- maintaining sufficient accounting records;
- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the trustee determine is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustee anticipate that the services provided by the charity will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management and those charged with governance, including obtaining and reviewing supporting documentation relating to Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities' policies and procedures concerned with:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition, posting of unusual journals.
- Obtaining an understanding of Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities' framework of authority as well as other legal and regulatory frameworks that the Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the charity.
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, those charge with governance and legal advisors about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the trustee;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential

bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and

- I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Aneurin Bevan University Local Health Board Charitable Fund and Other Related Charities' controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Adrian Crompton
Auditor General for Wales
[Date]

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Appendix 2

Letter of representation

[Audited body's letterhead]

Auditor General for Wales
Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

[Date]

Representations regarding the 2023-24 financial statements

This letter is provided in connection with your audit of the financial statements of Aneurin Bevan University Health Board Charitable Fund and Other Related Charities for the year ended 31 March 2024 for the purpose of expressing an opinion on their truth and fairness and their proper preparation.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

We have fulfilled our responsibilities for:

- the preparation of the financial statements in accordance with legislative requirements and Charities Act 2011; in particular the financial statements give a true and fair view in accordance therewith;
- the design, implementation, maintenance, and review of internal control to prevent and detect fraud and error.

Information provided

We have provided you with:

- full access to:
 - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;

- additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to staff from whom you determined it necessary to obtain audit evidence;
- the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud;
- our knowledge of fraud or suspected fraud that we are aware of and that affects Aneurin Bevan University Health Board Charitable Fund and Other Related Charities and involves:
 - management;
 - employees who have significant roles in internal control; or
 - others where the fraud could have a material effect on the financial statements;
- our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others;
- our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements;
- the identity of all related parties and all the related party relationships and transactions of which we are aware.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by [insert name of those charged with governance]

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by Anuerin Bevan University Health Board on [insert date].

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:

Nicola Prygodzicz

Chief Executive and Accountable Officer

Date:

Signed by:

Ann Lloyd

Board Chair

Date:

Appendix 3

Summary of corrections made

During our audit, we identified the following misstatements that have been corrected by management, but which we consider should be drawn to your attention.

Value of correction	Accounts areas	Explanation
£70k	Analysis of Deferred Income	The SoRP requires specific performance or time related conditions to be attached to grants for the income to be deferred. A review of grants received in year identified 4 grants that did not meet this criterion. 3 grants should have been recognised as grant income (£60k) with the 4 th grant needing to be recognised as a donation (£10k) due to a lack of any conditions on the spend.
£28k	Fixed asset investments	The investments listed on the stock exchange were overstated by CCLA Investment Management LTD as at the 31 st March 2024. CCLA sent the Charity the incorrect certificate of balances. CCLA did not correct this until the quarterly report received at the end of April and they did not draw their error to the attention of the Health Board.
£9k	Analysis of Liabilities	A creditor had been misclassified as a Trade Creditor - transaction was not in relation to normal course of business as it was a payment in error. This has been amended and now classified as an Other Creditor.
Various	Annual Report	A small number of inconsistencies were identified between the annual report and the financial statements.

Appendix 4

Recommendations

We set out below recommendations from our audit along with your management’s response to them.

Matter arising 1 – Treatment of Grant Income	
Findings	A material amount of grant income was incorrectly deferred during 23-24 as they did not have the sufficient conditions to allow deferment per the SORP.
Recommendation	Review new grants to assess whether sufficient conditions have been met to allow income to be deferred. Several grant periods are due to expire in 2024-25, so consideration should be made around the treatment of that deferred income if it remains unspent.
Accepted in full by management	Accepted in full
Management response	We will review all new and expiring grants to ensure full compliance with the SORP
Implementation date	Immediate – backdated to 1 April 2024

Audit quality

Our commitment to audit quality in Audit Wales is absolute. We believe that audit quality is about getting things right first time.

We use a three lines of assurance model to demonstrate how we achieve this. We have established an Audit Quality Committee to co-ordinate and oversee those arrangements. We subject our work to independent scrutiny by QAD*, and our Chair acts as a link to our Board on audit quality. For more information see our [Audit Quality Report 2023](#).

Our People



The first line of assurance is formed by our staff and management who are individually and collectively responsible for achieving the standards of audit quality to which we aspire.

- Selection of right team
- Use of specialists
- Supervisions and review

Arrangements for achieving audit quality



The second line of assurance is formed by the policies, tools, learning & development, guidance, and leadership we provide to our staff to support them in achieving those standards of audit quality.

- Audit platform
- Ethics
- Guidance
- Culture
- Learning and development
- Leadership
- Technical support

Independent assurance



The third line of assurance is formed by those activities that provide independent assurance over the effectiveness of the first two lines of assurance.

- EQCRs
- Themed reviews
- Cold reviews
- Root cause analysis
- Peer review
- Audit Quality Committee
- External monitoring

* QAD is the quality monitoring arm of ICAEW.

Supporting you

Audit Wales has developed a range of resources to support the scrutiny of Welsh public bodies and to support those bodies in continuing to improve the services they provide to the people of Wales.

Visit our website to find:

	our Good Practice work where we share emerging practice and insights from our audit work in support of our objectives to assure, to explain and to inspire.
	our newsletter which provides you with regular updates on our public service audit work, good practice, and events.
	our publications which cover our audit work completed at public bodies.
	information on our forward performance audit work programme 2023-2026 which is shaped by stakeholder engagement activity and our picture of public services analysis.
	various data tools and infographics to help you better understand public spending trends including a range of other insights into the scrutiny of public service delivery.

You can find out more about Audit Wales in our [Annual Plan 2024-25](#) and [Our Strategy 2022-27](#).



Audit Wales
1 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and
telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

Llais Gwent Region – Report for Aneurin Bevan University Health Board, Public Board Meeting.

January 2025



To inform Aneurin Bevan University Health Board of current issues of concern, and positive observations, or public feedback being addressed by Llais Gwent Region in relation to the planning and delivery of health and social care services.

Accessible formats

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

01633 838516

gwentenquiries@llaiscymru.org

Llais Gwent Region,
Raglan House,
William Brown Close
Cwmbran
NP44 3AB

www.llaiswales.org

www.llaiscymru.org

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About Llais



We believe in a healthier Wales where people get the health and social care services, they need in a way that works best for them.

We are here to understand your views and experiences of health and social care, and to make sure decision-makers use your feedback to shape your services.

We seek out both good and bad stories so we understand what works well and how services may need to get better. And we look to particularly talk to those whose voices are not often heard.

We also talk to people about their views and experiences by holding events in your local communities or visiting you wherever you're receiving your health or social care service.

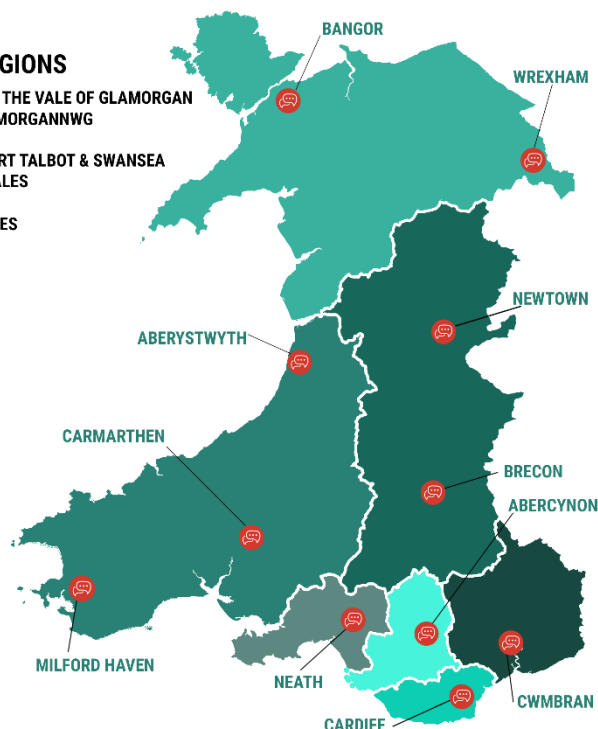
We also work with community and interested groups and in line with national initiatives to gather people's views.

And when things go wrong, we support you to make complaints.

There are 7 Llais Regions in Wales. Each one represents the "patient and public" voice in different parts of Wales.

LLAIS REGIONS

- CARDIFF & THE VALE OF GLAMORGAN
- CWM TAF MORGANNWG
- GWENT
- NEATH PORT TALBOT & SWANSEA
- NORTH WALES
- POWYS
- WEST WALES



Introduction



The purpose of this report is to inform Aneurin Bevan University Health Board of current issues of concern and positive observations, and public feedback being addressed by Llais Gwent Region in relation to the planning and delivery of health and social care services.

Llais continues to work in respect of engaging with the population, scrutinising, and offering independent challenge to the NHS and social care, to monitor and consider routine and urgent service changes. We also continue to provide independent Complaints Advocacy Service.

A National Conversation: Llais strategic plan 2024-2027



We now have our first national strategic plan. This plan has been created using what we have been told by the people of Wales, by our staff and volunteers and other bodies and groups we work with.

When this plan was being created, we thought about our legal duties and responsibilities such as the Quality and Engagement Act 2020, Equality Act 2010, The Well-being of Future Generations Act 2015, The Welsh Language Standards 2016, The Socio-Economic Duty, the Public Sector Duty, and national plans and commitments such as the LGBTQ+ and the Anti-racist Wales Action Plan, as well as our remit letter.

Building on what we have learned in our first year, we have grouped things into five main priorities:¹

- 1) Drive a national conversation about the future of health and social care services
- 2) Push for services that meet everyone's needs.
- 3) Work together better.
- 4) Help people and services to use technology in ways that work for them.
- 5) Grow and improve as an organisation.

¹ <https://www.llaiswales.org/about-us/national-conversation-llais-strategic-plan-2024-2027>



Local activities and feedback:

1. Gwent Advocacy Services

There were 74 contacts in November and December. 61 were formal concerns and 13 were enquiries that required early resolution.

Of the 74 contacts, 8 have now been resolved and 66 are still active.

Health & Social Care Services:

- **GP services** (32 contacts), Access to appointments, attitude, services provided being inadequate, prescription issues, off-listing.
- **Secondary Care services** (11 contacts), Waiting times, miss diagnosis, lack of care.
- **The Grange University Hospital** (9 contacts), Communication, waiting times, cancelled operation, lack of care, Maternity, wait on the back of an ambulance.
- **Mental Health Services** (7 contacts) - inadequate, lack of support, diagnosis
- **Dental Services** (3 contacts), treatment received, practice closure.
- **Covid Vaccine** (2 contacts), access and treatment
- **Serennu Centre** (1 contact), Poor communication
- **Welsh Ambulance Services NHS Trust** (1 contact), Waiting times
- **Pharmacy** (1 contact) access to treatment
- **Social Services** (7 Contacts) – (4 contacts) children services focussed on communication and support from Social Care and (3 contacts) Adults Social Care based around package of care, lack of person-centred care.

2. Local Representations that we have made or been involved in

We have a duty to make representations to health and social care services on behalf of our population when services may change or when we hear about health and social care performance matters that impact on people's experiences (positively or negatively). We might make these representations via formal letter, in emails or by attending planned service groups/meetings hosted by our health and social care partners.

Since November, we have been involved in or made **Local representations** about:

- Nursing Midwifery Council: Culture Report
 - Llais asked ABUHB what support they are providing to staff and patients whilst investigations were underway re the culture report. We were assured by the health board that their support framework includes:
 - Early Intervention and Communication
 - Comprehensive Support Mechanisms
 - Ongoing Monitoring and Escalation
 - Patient and Public Concern Management
 - ABUHB also told us that since the Independent Culture Review, they have strengthened their escalation process to the Nursing Midwifery Council regarding the well-being of staff under fitness to practice investigations. They have also implemented regular meetings between Divisional Nurses and Professional Regulation Leads to optimise communication.
- Ty Cyfannol Patient Safety Concern:
 - Concerns following information received from a patient which included:
 - Safety of patients “patients feeling safe” and
 - Access to medicine in an appropriate and timely manner.

The Ward Manager has provided assurances.

3. Children and Young People

In November, Llais attended the first Torfaen Youth Alliance meeting which was held at Crownbridge School. There were young representatives from:

- Crownbridge School
- Pontypool Youth Council
- Torfaen Opportunity Group
- St Giles

We had the opportunity to listen to young people's feedback about their wellbeing, care, and needs. Young people shared a common theme around their experience with access to CAMHS and counselling services at school.

We have arranged to visit Torfaen Opportunity Group in January 2025 to speak to Young People about their health and social care experiences in more depth.

As part of Llais Local in Blaenau Gwent, we attended Blaenau Gwent Learning Zone and spoke to 42 young people.

Feedback:

- Young People told us they find it difficult to get a GP appointment (no specific practices were named)
- Difficulty in getting help and support for mental health issues, this also included long waits to access mental health services.

4. Primary Care Services

Throughout November and December, peoples access to Primary Care Services, particularly GP Services has been a growing concern, in response Llais has raised a series of representations and developed a visiting schedule to hear people experiences across General Practices.'

Announced visits will take place at:

- Pontypool Medical Centre (New Inn Surgery) 13.01.25
- Pontypool Medical Centre (Main Surgery) 13.01.25
- Pontypool Medical Centre (Goytre Surgery) 13.01.25
- Bevan Health & Wellbeing Centre (Tredegar) 14.01.25
- Aberbeeg Medical Centre 15.01.25

- Blaenavon Medical Practice 16.01.25
- Lliswerry Medical Centre 16.01.25
- Rhymney Integrated Health & Social Care Centre (Meddygfa Cwm Rhymni Practice) 17.01.25
- Meddygfa Gelligaer Surgery 17.01.25

- **Ringland Health Centre (61 people)**

In November, we used people's feedback about their access to services, to make representations to the practice:

- We asked the practice, where appropriate, could they make people aware of the NHS App as most people we spoke to would like to use an online platform to book appointments, but did not use the App.
- People had concerns about the move, to the 19 Hills Health and Wellbeing Centre, including what services they thought were going to be offered. We asked the practice to clarify this for us. (There is an active Coms and engagement group)
- We asked the practice if people were allowed to frequently book appointments with the same clinician as many people were unsure if they could.
- People had difficulties making appointments via telephone. We asked the practice how this could be improved.

We have received early assurances from the practice that they have already implemented new processes and telephone systems ready for the move to the 19 Hills Health and Wellbeing Centre on 13th January 2025.

Report available upon request.

- **Brynmawr Medical Practice (12 people)**

In response to concerns raised, Llais made a series of representations to ABUHB around access and patient safety, this was reported to HIW. Llais also carried out an announced visit to the practice on the 18th of December.

We heard:

- People find it difficult to book an appointment at the practice. There is a telephone queuing system in use, and quite often

there are 30 people in the queue. When they eventually get through, they are told there are no appointments available. People felt worried this could lead to clinical risk.

- We were told there were occasions when the practice shuts at 4pm due to a lack of clinicians.
- The self-check-in machine has been out of order for some time, causing unnecessary queues at the reception desk.
- However, people told us when they get an appointment, the nurses, and doctors are “great,” although patients would like some continuity of clinicians as many are locums.

We Have been advised: As part of the Health Boards enhanced monitoring processes, they will discuss the content of the report in their next assurance meeting.

Report available upon request

- **Bevan Health & Wellbeing Centre (43 people)**

On the 6th of December, Llais attended the Bevan Health and Wellbeing Centre to engage with people about their access to services. In total, we spoke to 43 people.

Glan-Yr-Afon Surgery feedback:

Overall, people felt satisfied with the service they received from this practice.

“Rang at 08:15 asking for an appointment with a doctor and was offered 10:30 to which I was surprised and delighted with. I did self-check-in which was easy. My appointment was with a paramedic”

Tredeggar Medical Practice feedback:

People told us they find it difficult to get an appointment.

“Have to phone up at 8am and then all the appointments are gone, so have to call the next day. Parking is very difficult and not enough disabled spaces”

In November, Llais made a representation about the process of booking an appointment in advance. We were told practices are required to offer a level of pre-bookable appointments and should be moving away from stipulating set times that patients should telephone in.

5. Mental Health Services

In December, we launched our Mental Health survey, with the aim to find out people's experiences of accessing mental health services in Gwent. We will use this survey as a tool whilst engaging with people in the community to gather insights.

Our survey can be accessed online by using the following links or scanning the QR Codes:



Welsh



English

- **Community Mental Health Team, Duty Desk, Blaenau Gwent**

Since the transformation of Community Mental Health Team Duty Desk in Blaenau Gwent, we started working alongside Social Care Blaenau Gwent and ABUHB Mental Health and Learning Disabilities Qi-nnovation Hive. We want to hear from people who have recently used the service, ensuring we hear from those who have accessed the services, before and after the changes were made to understand the impact of service change for people and staff.

To do this, we have given people the option to tell us their feedback by completing a short survey, online, or in the post. We have also offered people to call us and speak to a member of our team, or by joining us for an online focus group during January 2025.

- **Inpatient Visits**

We are visiting several mental health inpatient wards across Gwent at the end of January 2025, to understand people's experiences of receiving care and treatment as an inpatient.

6. Engagement in Gwent (November - December)

We focussed our “Llais Local” engagement in Blaenau Gwent to strengthen community voice and experiences of health and social care services. We engaged with 165 individuals in community spaces, education settings, social care settings, and support groups. Our approach is to listen to people and use what they’ve told us to influence change (*we listen, you said, we did*).

We attended the following venues:

- Men’s Den
- Ladies Lounge
- Ebbw Vale Sports Centre
- Blaenau Gwent Learning Zone
- Bevan Health & Wellbeing Centre
- Rainbow Tots & Craft Group
- Cuppa & Company Group
- Tredegar Sports Centre
- Talking Shop

We are collating the experiences and stories people told us and will share this with NHS and Social Care providers by the end of January 2025.

Early insights:

“I went to the Grange with chest pain and was seen within minutes, I underwent tests and required urgent stents in my heart. Within 3 hours of admission, I had stents fitted and was recovering on a ward”

Mental Health and Learning Disabilities, people felt services were ‘Inadequate.’ Lack of support for; autistic adults, serious mental health conditions, people with disabilities. More support needed for people with dementia and their families.

“I am currently waiting 45 weeks for an “urgent” appointment to see a Gastroenterologist”

Smiles Dental Practice, Ebbw Vale ‘They strike you off,’ people are not sent check-up reminders and if they forget to book a check-up, they’re taken off the patient list and are no longer registered with a dentist.

7. Upcoming Activities

1) Llais Local: Monmouthshire

In February, we're planning focussed engagement in Monmouthshire. Our volunteers and staff will be in the community, speaking to people about Llais and gathering their insights on health and social care services. We will amplify the voices of Monmouthshire to inform the health board, and local authorities, highlighting where improvements are needed to enhance future services.

2) Presentations

In January and February, we are receiving presentations on the following hot topics:

- Southeast Wales Emergency Out of Hours Social Services Support

National Work:

1. Access to Dentistry in Wales

Llais has released its position statement on the Welsh Dentistry crisis after hearing from over 12,000 people across Wales about their health and social care issues, with dentistry consistently coming out near the top.

[Dental care crisis in Wales: Llais calls for urgent action to ensure fair access for all | Llais](#)

2. Access to GPs in Wales

Based on both the research report, our own engagement, and our national intelligence from sources such as the Older People's research and round tables on GP access among others, Llais will share their position statement in January 2025.

3. Same Day Urgent Care Project

In January 2025, utilising insights from the pan Wales same day urgent care project, and data from the NHS executive, Healthcare Inspectorate Wales reports and Welsh Ambulance Services Trust information we will demonstrate the challenges people face while accessing urgent care.

Thanks



We thank everyone who took the time to share their views and experiences with us about their health and social care services and also sharing their ideas with us.

Feedback

We'd love to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

Contact details

Llais Gwent Region,
Raglan House,
Llantarnam Business Park,
Cwmbran,
NP44 3AB.

Telephone: 01633 838516

Email:

gwentenquiries@llaiscymru.org

Website: www.llaiscymru.org

Facebook: @gwentllais

twitter: Llais_wales



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Statutory and Mandatory Training
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sarah Simmonds, Executive Director of Workforce & Organisational Development
SWYDDOG ADRODD: REPORTING OFFICER:	Peter Brown, Assistant Director of Workforce and Organisational Development; Matthew Bidgood, Senior Organisational Development Practitioner; Clare Cullis, Learning and Organisational Development Manager; Kratika Mathur, Organisational Development Co-ordinator

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

Statutory training learning modules are mandated by law and mandatory training mandated by Welsh Government, the Health Board and in some cases by professional bodies.

Two years ago, the Health Board, was facing a range of challenges in its approach to statutory and mandatory training (StaM). Compliance was 76.80% against a Welsh Government target of 85%. Furthermore, there was no mechanism in place to provide governance and assurance in relation to StaM.

At that time, compliance with StaM requirements varied significantly across departments. Furthermore, there was no mechanism in place to consider requests for additional mandated training, with requests speculatively sent to the Organisational Development (OD) team. Consequently, in September 2023, the Core Learning Committee (CLC) was formed to address these challenges. The CLC comprises of multidisciplinary subject matter expert representatives from each of the Executive Committee's professional portfolios, ensuring that each of the core learning subjects are represented. The CLC makes recommendations to the

Executive Committee and also reports progress and updates to the People and Culture Committee.

As of December 2024 organisational compliance is 81.60%. It is acknowledged that further improvement is required to meet and exceed the 85% national target.

The Board is asked to provide comments and endorse the associated actions to improve compliance as outlined within the paper.

Cefndir / Background

StaM provides a base level of knowledge across a series of topics for all employees and is essential for ensuring employers and employees meet their obligations and duties in the delivery of high-quality care. StaM comprises core learning which is provided through e-learning undertaken by all employees via the NHS Electronic Staff Record (ESR) staff information system platform and some additional classroom modules. The number of StaM modules vary dependent on staffing group (largely clinical or non-clinical, see **Appendix 1**).

Any requests for additions to mandatory training are submitted to our internal governance mechanism, the CLC, for scrutiny and recommendation via member vote. The Executive Committee is then asked to approve or reject the recommendation of the CLC. This governance has been in place since September 2023 and to date has received 5 submissions, all of which have been mandated following Executive Committee ratification. The benefits of the CLC include:

- Receiving requests for additional mandatory training.
- Monitoring of staff compliance.
- Identifying opportunities to improve compliance through a number of measures (including ease of access to training and clarity of requirements by professional/staff group).
- Provides a multi-disciplinary forum to provide discussion and focus on StaM.
- Working closely with subject matter experts to accurately determine StaM training requirements and proactively address any challenges that arise.

The collaborative approach of the CLC ensures the Health Board remains aligned with best practice and regulatory standards and makes pragmatic recommendations to support staff compliance. for example, revising the existing Manual Handling renewal dates from a two-yearly to a three-yearly requirement. This has been recognised and commended by the Health & Safety Committee.

Following consideration by the CLC, the Executive Committee has mandated the following competencies since September 2023:

- Counter Fraud – 60-minute duration (*E-learning, all staff*).
- Mental Capacity Act and Deprivation of Liberties (MCA/DoLS) – 30-minute duration (*E-learning & classroom, dependent on level required and role*).
- Consent – 30-minute duration (*E-learning, appropriate clinical staffing groups*).
- NHS Wales Blood Transfusion Training 01: Essential Transfusion Practice – 30-minute duration (*E-learning, clinical staff*).

- Supporting Smokers in Secondary Care – 30-minute duration (*E-learning, tbc*).

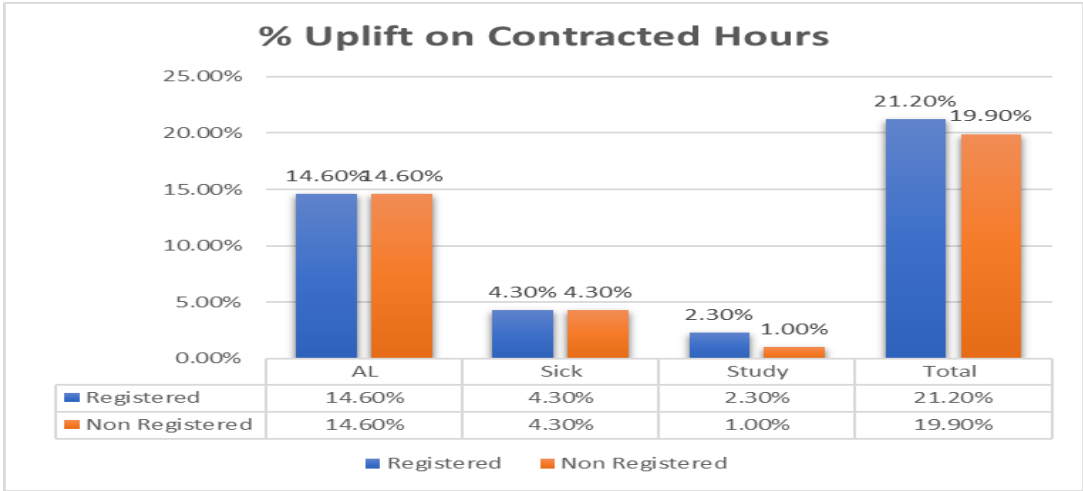
Table 1 below outlines the time commitment for clinical and non-clinical staff in order to be compliant. This will vary depending on the existing knowledge and learning speed of each staff member. Each StaM module has a different renewal time, some are one off, others require renewal after 2 or 3 years, as shown in **Appendix 1**.

Table 1: The average number of hours required to complete StaM in order to be 100% compliant based on suggested time for each module.

	Minutes	Hours
Non-Clinical Staff	750	12 hours 30 minutes
Clinical Staff	1,100	18 hours 20 minutes

Table 2 depicts study time built into rosters for nursing colleagues to complete training (not solely StaM).

Table 2: % Uplift on contracted hours by reason for registered and non-registered nurses



The table shows that additional hours are planned within rosters to cover a range of topics. Both registered and non-registered nursing staff have a planned uplift in contracted hours for study time of 2.3% and 1%, respectively. This is built into rosters to allow staff to undertake study, which could include StaM, notwithstanding that other training requirements outside of StaM will be required.

There is 2.3% study time built into nursing rosters which equates to 0.86 hours per RN per week (pro rata for part time staff). Therefore, in theory a new member of staff in a work area where training uplift is applied should be able to complete all StaM within 21 weeks. For most staff, this time commitment will be less as some modules are only required to be completed once and others have varying renewal schedules of 1, 2 or 3 years.

To provide some context, a 1% increase in study allocation for ward areas would cost approximately £300,000 per annum based on current roster information. Allocated study time is also contractual for doctors, dependent on grade.

Asesiad / Assessment

The 85% compliance target for StaM in NHS Wales is part of the broader framework for ensuring training compliance within the public sector.

Organisational compliance is currently 81.60% against the 85% target. The Health Board has 13,223.20wte employees (December 2024) importantly there are always a number of employees, who for a range of reasons, will not be in the workplace. Table 3 shows the number of staff that were not in work at any given time at November 2024 which is a typical representation.

Table 3: Percentage of total workforce not in work at any given time

Reason for absence	%
Sickness	7
Maternity Leave	3
Special Leave/Authorised Unpaid Leave/ Career Break	2
Study leave	2
Paternity Leave/Delays in classroom training or completion upload	1
Total	15% (~2400 staff)

Bank workers, who may work in several service areas and book shifts on an ad hoc basis, are expected to be 100% compliant with StaM training in order to book shifts. Training is monitored on a monthly basis via ESR. If someone is below 100%, they are contacted and advised they need to access ESR to bring their compliance to 100% as quickly as possible.

Support is offered to anyone who may need additional help or advice in relation to ESR or any other issues in relation to accessing and completing the required learning.

Industry Standards on Compliance in Statutory and Mandatory Training

StaM training is essential for ensuring healthcare organisations meet legal obligations and prioritise the well-being of patients, staff, and visitors. Regulatory bodies, such as Healthcare Inspectorate Wales (HIW), expect organisations to provide evidence of training in core areas such as basic life support, infection control, fire safety, safeguarding, and information governance.

While many StaM topics are introduced during education and training pre-registration, ongoing training ensures knowledge remains current and aligned with evolving standards. For the Health Board, year on year increase in compliance is shown in Figure 1 below.

Figure 1: StaM compliance 2022-2024

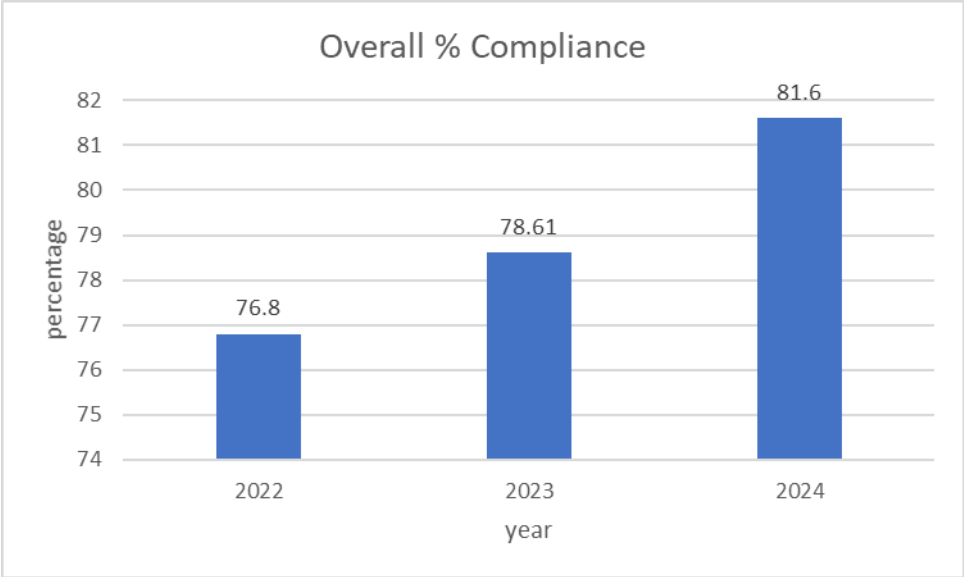


Figure 2 shows percentage compliance by area, with 3 out of 9 (from ESR) achieving compliance of over 85%

Figure 2: Overall % compliance by area

Org L4	Assignment Count	Required	Achieved	Compliance %
040 CLINICAL SUPPORT SERVICES	1722	37693	30657	81.33%
040 CORPORATE	1404	29131	25871	88.80%
040 ESTATES AND FACILITIES DIVISION	1551	31208	21194	67.91%
040 FAMILY & THERAPIES DIVISION	2828	63352	54051	85.32%
040 MEDICINE	1969	44514	34398	77.27%
040 MENTAL HEALTH & LEARNING DISABILITIES DIVISION	1575	35309	28775	81.49%
040 PRIMARY CARE & COMMUNITY SERVICES	2301	51575	44318	85.90%
040 SURGERY	1793	40193	29679	73.84%
040 URGENT CARE	554	12360	9448	76.44%

Particular Areas of Focus for StaM Learning

Whilst attention is provided to all training, the following key areas require particular focus:

Moving & Handling (mandatory training, 3-year renewal) – 70.14% compliance. The manual handling training strategy within the Health Board is currently being reviewed. Within the last few months, vacancies within the team have been successfully filled, which will revitalise the manual handling training plans. The plan will not only focus on the foundation training but also support the cascade trainers to deliver the update training.

Paul Ridd Disability Awareness (mandatory training, no renewal required)- 72.15% compliance.

To address this, a targeted action plan is being implemented aimed at increasing uptake and maintaining long-term compliance. Key initiatives include; raising awareness through internal communication methods, empowering line managers to monitor and encourage staff participation and offering dedicated support for those staff facing barriers to completion.

Information Governance (IG) (statutory training, 3-year renewal) – 73.71% compliance.

Compliance across NHS Wales is challenging and an all-Wales review of this learning is underway to ensure people receive training that is specifically relevant to them. The new learning will be split into three levels and the content refreshed to shorten this training package, condensing the content and time taken to complete, as follows:

1. **Level 1** – Basic IG Training for all staff regardless of role (10-15 minutes duration).
2. **Level 2** – Intermediate IG Training for staff who have some contact with personal data as part of their role (20-25 minutes duration).
3. **Level 3** – Higher IG Training for staff who are responsible for the management and handling of large volumes of personal data as part of their day-to-day role (30-40 minutes duration).

Barriers to Achievement in Statutory and Mandatory Training

Despite concentrated efforts to enhance compliance, staff feedback (along with well-publicised pressures on our system) has illuminated several significant barriers that hinder progress. Addressing these challenges is crucial for fostering a culture of learning and ensuring compliance with training requirements.

Complexity of the Electronic Staff Record (ESR) system.

Due to the requirement to use the ESR training platform only a few times a year many staff often need to refresh themselves on how to use the system. "How to" guides are readily available for staff. There can on times be technical issues experienced with e-learning on ESR, this may include translating modules into the Welsh language when they are UK set. Help guides are provided on the intranet to assist staff in these issues and a new ESR system is currently being procured nationally with an expected launch date of 2027.

Time constraints

Time and conflicting priorities can pose a substantial challenge, particularly for those in clinical roles. The urgent nature of their responsibilities balanced with other professional training requirements can make it difficult to prioritise StaM at times.

Lack of Digital Access and NHS email address

Some staff groups do not have an NHS email address (mostly within Estates and Facilities) or who may not have regular access to IT in the workplace due to the nature of the roles. Many staff need to use their own smartphones (if they have one) to access ESR and StaM.

Accessibility

This is an ongoing issue affecting some staff groups with protected characteristics. Due to most StaM requiring completion of a test to update compliance, some staff members are unable to complete StaM independently or find difficulties with access. Whilst local reasonable adjustments will be made available, this feedback has been shared with NWSSP in the development of the new ESR system.

Perceived value of completing the training

StaM as a measure of clinical expertise and general competence has been questioned. At times professional literature may be deemed to support the importance of clinical continuing professional development (CPD) as a priority. Articles in the British Medical Journal and the BEME (Best Evidence Medical Education) recognise that StaM training has been developed in good faith by organisations but research does not necessarily support that compliance with StaM is connected directly connected with safe clinical outcomes.

(Hitting the target and missing the point? A BEME systematic review of evidence regarding the efficacy of statutory and mandatory training in health and care: BEME Guide No. 87, Feb 2023. BMJ, April 2019)

Addressing these barriers will require a multifaceted approach, focusing on navigating the ESR system, enabling time and resources, and effectively communicating the value of statutory training within the broader context of professional development. By doing so, training compliance may be enhanced.

Whilst as an organisation we must demonstrate compliance with StaM, there are a range of other robust measures ensuring competency and safe care, including but not limited to:

- **Clinical Guidelines and Standard Operating Procedures** - Evidence-based clinical guidelines and Standard Operating Procedures serve as essential frameworks. These guidelines outline best practices for patient assessment, treatment, and management, ensuring consistency and quality across all care settings. By adhering to these established protocols, staff are equipped to make informed clinical decisions that prioritise patient safety.
- **Incident Reporting and Quality Assurance** - Regular quality assurance audits are conducted to evaluate compliance with safety standards and clinical protocols, ensuring that our practices remain aligned with best practices.
- **Continuing Professional Development (CPD)** - CPD is a requirement of all healthcare professionals and a number of professional corporate roles. Regular CPD opportunities for all staff, including workshops, seminars, and online courses help staff stay current with the latest advancements and regulatory requirements. This commitment was also included as a priority area for the Collective Agreement (Non-Pay Deal) 2022-2024.
- **Competency Assessments** - Regular competency assessments are conducted to evaluate staff skills and knowledge. These evaluations may include direct and indirect supervision, performance reviews, and peer assessments, ensuring that staff are equipped to deliver safe and effective care.
- **Professional Registration** - A range of professions are required to be registered with relevant regulatory bodies to practice. Maintaining up-to-date registration is crucial for compliance and patient safety. The exception to this is

Health Care Support Workers (HCSW). To ensure safe practice, there are a range of robust measures in place across NHS Wales, including the [HCSW Framework](#), [Code of Conduct](#) and [All Wales Delegation Standards](#).

- **Revalidation and Continuing Fitness to Practice** - Many professionals are subject to periodic revalidation processes mandated by regulatory bodies.
- **Appraisal** - All staff are required to undertake appropriate appraisal on an annual basis. For Agenda for Change staff this includes a review of overall performance, including compliance of StaM.

Future Plans to Improve Compliance of StaM

To continue to improve StaM compliance a series of additional approaches will be deployed throughout 2025 as follows:

Core Learning Committee (Quarterly)

CLC meetings are held quarterly, offering a structured forum to review progress, share updates, and address challenges. Bringing together key stakeholders ensures ongoing communication and engagement in training compliance efforts, while fostering an open dialogue about departmental challenges and opportunities for improvement.

Divisional Deep Dives (via CLC Meetings)

Divisional deep dives are a targeted approach to assessing and enhancing training compliance within specific areas of the Health Board. These sessions will involve comprehensive reviews of learning data, identifying gaps in compliance and addressing specific challenges. By engaging divisional leaders and frontline staff in discussions, tailored strategies can be deployed to improve training uptake. The next deep dive is planned for February 2025 and will focus on medical and dental colleagues.

Advise and Support with Priority Training

Given that the statutory element means there is a requirement by law, any statutory competencies that are below the required target of 85% will be prioritised for focus and discussion at CLC meetings. Currently, the lowest of these is Information Governance at 73.71%.

Roadshows (Summer 2025)

Roadshows will serve as an interactive method for providing information about StaM, along with opportunities for staff to complete it. These events are designed to engage staff across all levels, providing an opportunity for direct communication and feedback. During the roadshows, the importance of compliance, the importance of StaM, and the available training resources are explored. Additionally, staff can be supported with queries and questions in real time.

Masterclasses and Lunch and Learns (From March 2025)

A dedicated session will be designed where employees can understand the purpose of StaM and the importance of compliance whilst receiving support for navigating ESR. This would also be another mechanism to understand individual and departmental challenges whilst providing support and ensuring employees know how to access the Core Learning Hub on the intranet with User Guides and FAQ

documents for self-service. These sessions also provide an opportunity for staff to network and share experiences, fostering a collaborative learning environment.

External Training and Development & Pay Progression

Staff should be compliant with StaM learning as a prerequisite for accessing external training and development. Encouraging this practice staff will help to increase StaM compliance whilst valuing staff through additional opportunities to develop role and organisational related skills. This could also be fundamental in supporting other key People Plan objectives, such as Talent and Succession Planning and Retention Frameworks.

The Pay Progression policy came into effective on 01 October 2022. There are five standards that must be adhered to, once of which is completion of StaM. Staff no longer automatically receive pay impacting increments unless a ‘yes’ has been recorded for Pay Progression in ESR. This is monitored regularly by Workforce & OD teams.

Bespoke Opportunities for Estates and Facilities Colleagues

Plans are underway to provide e-mail addresses to all staff working within Estates and Facilities, this will allow all colleagues to receive e-mail notifications. These reminders will prompt staff to complete their modules on time. Furthermore, OD colleagues with work with leaders within Estates and Facilities to develop a bespoke training plan designed to grow compliance.

NHS Wales New Digital Solution to Replace ESR

The Digital Workforce Team within NHS Wales Shared Services Partnership (NWSSP) are currently exploring a new digital solution to replace the ESR for NHS Wales. It is hoped this innovative platform will streamline training management processes, making it easier for staff to access and track their StaM training requirements and make completion quicker and easier. This will launch in 2027 and will be rolled out across Wales and England over a 5-year period to 2032.

Argymhelliad / Recommendation

The Board is asked to provide comments and endorse the associated actions to improve compliance as outlined within the paper.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 2.7 Safeguarding Children and Safeguarding Adults at Risk 7.1 Workforce

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Within the body of the paper
Rhestr Termau: Glossary of Terms:	CLC - Core Learning Committee CPD – Continuing Professional Development CQC – Care Quality Commission ESR – Electronic Staff Record HCSW – Health Care Support Workers HIW – Health Inspectorate Wales IG – Information Governance MCA/DoLS – Mental Capacity Act and Deprivation of Liberties NWSSP – NHS Wales Shared Services Partnership OD – Organisational Development PADR – Performance Appraisal Development Review SOPs – Standard Operating Procedures StaM – Statutory and Mandatory Training
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Digital Learning Wales HEIW Internal departments

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/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Appendix 1: All StaM Core Learning Modules

Statutory Training			
Non-Clinical Staff	Renewal	Clinical Staff	Renewal
000 NHS Wales Equality, Diversity and Human Rights	3 Years	000 NHS Wales Equality, Diversity and Human Rights	3 Years
000 NHS Wales Fire Safety	2 Years	000 NHS Wales Fire Safety	2 Years
000 NHS Wales Health, Safety and Welfare	3 Years	000 NHS Wales Health, Safety and Welfare	3 Years
000 NHS Wales Infection Prevention and Control Level 1	3 Years	000 NHS Wales Infection Prevention and Control Level 1	3 Years
000 NHS Wales Information Governance, Records & Cyber Level 1 - Certification	2 Years	000 NHS Wales Information Governance, Records & Cyber Level 1 - Certification	2 Years
000 NHS Wales Moving and Handling Level 1	3 Years	000 NHS Wales Moving and Handling Level 1	3 Years
000 NHS Wales Resuscitation Level 1	3 Years	000 NHS Wales Resuscitation Level 1	3 Years
000 NHS Wales Safeguarding Adults Level 1	3 Years	000 NHS Wales Safeguarding Adults Level 1	3 Years
000 NHS Wales Safeguarding Children Level 1	3 Years	000 NHS Wales Safeguarding Children Level 1	3 Years
000 NHS Wales Safeguarding Adults Level 2 (Patient facing)	3 Years	000 NHS Wales Safeguarding Adults Level 2	3 Years
000 NHS Wales Safeguarding Children Level 2 (Patient facing)	3 Years	000 NHS Wales Safeguarding Children Level 2	3 Years
000 NHS Wales Violence and Aggression (Wales) Module A	No Specified Renewal	000 NHS Wales Safeguarding Adults Level 3 (Dependant on Role)	3 Years
000 NHS Wales Violence and Aggression (Wales) Module B	3 Years	000 NHS Wales Safeguarding Children Level 3 (Dependant on Role)	3 Years
		000 NHS Wales Violence and Aggression (Wales) Module A	No Specified Renewal
		000 NHS Wales Violence and Aggression (Wales) Module B	3 Years

Mandatory Training			
Non-Clinical Staff	Renewal	Clinical Staff	Renewal
000 NHS Wales Welsh Language Awareness Certification (more than just words).	3 Years	000 NHS Wales Welsh Language Awareness Certification (more than just words).	3 Years
000 NHS Wales Dementia Awareness	No Renewal	000 NHS Wales Dementia Awareness	No Renewal
000 NHS Wales Paul Ridd Learning Disability Awareness	No Specified Renewal	000 NHS Wales Paul Ridd Learning Disability Awareness	No Specified Renewal
000 NHS Wales Violence Against Women, Domestic Abuse and Sexual Abuse	3 Years	000 NHS Wales Violence Against Women, Domestic Abuse and Sexual Abuse	3 Years
000 NHS Wales Moving and Handling	3 Years	000 NHS Wales Moving and Handling	3 Years
000 NHS Wales Fraud Awareness	3 Years	000 NHS Wales Fraud Awareness	3 Years
		000 NHS Wales Healthy Start	3 Years
		000 NHS Wales Aseptic Non Touch Technique	
		000 NHS Wales Basic Life Support	
		000 NHS Wales Immediate Life Support (Dependant on Role)	
		000 NHS Wales Advanced Life Support (Dependant on Role)	
		000 NHS Wales Consent	3 Years

Language Training			
Non-Clinical Staff	Renewal	Clinical Staff	Renewal
000 NHS Wales Listening/Speaking Welsh	No Specified Renewal	000 NHS Wales Listening/Speaking Welsh	No Specified Renewal
000 NHS Wales Writing Welsh	No Specified Renewal	000 NHS Wales Writing Welsh	No Specified Renewal
000 NHS Wales Reading Welsh	No Specified Renewal	000 NHS Wales Reading Welsh	No Specified Renewal

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health, Safety & Fire Annual Report 2023/24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Carr, Executive Director of AHPs & Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Peter Carr, Executive Director of AHPs & Health Science

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 report is to present the Health, Safety & Fire Annual Report for the period 2023/24.

The report identifies both the opportunities and challenges for the Health Board in ensuring and sustaining compliance with Health and Safety legislation, including the specific compliance improvement action delivered in this period.

The Board is asked to formally receive the annual report and note the actions being taken to achieve and sustain compliance.

Cefndir / Background

The purpose of the annual report (Appendix 1) is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2023/24. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2024/25.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of Allied Health Professions & Health Science.

Asesiad / Assessment

The progress against the Health, Safety & Fire Improvement Plan, implemented in November 2023, has provided a focus on key risk areas of concern, resulting in an improvement across all areas, though there remains further work to reduce to a level of risk within tolerance.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 49.4% (2022/23) to 67.7% reported within the required timeframe (2023/24). The reporting compliance for the period April to December 2024 was 67.2%.
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2023/24 compared with 2022/23. This includes both the Health & Safety and Violence & Aggression training surpassing the Welsh Government standard of 85%. The table below illustrates the compliance against all health and safety training.

Training Course	Compliance at Mar 2023	Compliance at Mar 2024	Compliance at Dec 2024
Health and Safety	82%	86.7%	85.9%
Fire Safety	79%	82.9%	82.7%
Manual Handling	52%	55.3%	69.4%
Violence and Aggression	81%	85.1%	85.5%

- **Reduction in the following incident types:** Contact with needle of medical sharps; manual handling; slips, trips or falls
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for the inpatient areas across acute hospitals. These assessments yielded an average Health Board compliance score of 88.2%. The programme of health, safety and environment workplace inspections for 2024/25 is targeted towards inpatients areas within the Community Hospitals and Mental Health & Learning Disabilities areas.
- **Health and Safety Risk Assessments:** an additional 295 employees were trained in Health & Safety Risk Assessment. The Corporate Health and Safety

Department are supporting Divisions to review the high and extremely high health and safety risks.

- **Fire Risk Assessments:** 96% completed/reviewed against the planned areas in 2023/24. This is an increase of 30% compared with 2022/23. The Health Board is on target to complete 100% of the fire risk assessments planned for review in 2024/25.
- **Fire Alarm System Replacement:** work programmes have commenced on replacing the fire alarm systems at Royal Gwent Hospital and St Cadocs Hospital. Fire alarm systems across the Health Board have been analysed and a planned upgrade / replacement programme has been developed. End of year capital funding has also been approved to implement improvements to the fire alarm systems at Nevill Hall and County Hospital. It is important to note that all sites have working fire alarms.
- **Fire Barriers (Compartmentation):** relates to the condition of fire barriers analysed across Hospital sites, identifying improvements required at Nevill Hall Hospital and Royal Gwent Hospital. End of year capital funding has been approved to conduct a survey of the fire compartmentation at Royal Gwent Hospital. Fire compartmentation will remain a priority for the Corporate Health & Safety capital bids.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of ongoing risk areas for focus for 2024/25, as follows:

Health and safety leadership

The level of knowledge and understanding of health and safety responsibilities for managers and supervisors presents a risk to the Health Board.

A health and safety training programme for managers and supervisors is being prepared and a proposal will be presented to the Health and Safety Committee for approval in 2025.

Health and safety assistance

The capacity of the Corporate Health and Safety Department to deliver the corporate function, has presented a challenge to the Health Board in meeting the demands and requirements of compliance.

Approval has been obtained to recruit a Deputy Head of Health, Safety & Fire, in order to strengthen and expand the corporate team.

Health and safety policies & procedures

There remains a backlog of Health and Safety policies that are overdue review and update.

A plan has been developed and commenced to achieving full compliance with health and safety policies by the end of quarter 1 2025/26.

Manual handling training

Despite marked improvement over the past 12 months, the level of compliance with manual handling training continues to present a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

The Health Board has recruited Manual Handling Trainers to support the compliance at a corporate level for new starters. Divisional arrangements to provide manual handling training to existing employees continues to be scrutinised and challenged at routine divisional assurance reviews, which have already driven improvement. In addition, individual staff compliance with all statutory and mandatory training is reviewed in the routine Personal Appraisal and Development Reviews, with staff being reminded and supported to achieve compliance.

Fire safety training

Whilst very nearly achieving the target compliance for fire safety training (HTM 05-03 part A: Operational provisions – Training) any gaps in staff training presents a risk to the Health Board. The organisation is currently dependant on staff completing their training and gaining competence by attending eLearning training. The Health Board is reviewing the fire safety training framework.

Violence in the Workplace

The level of violence to which Health Board staff are exposed is a risk and needs to be reviewed with prevention and reduction strategies implemented.

The Health Board is developing a Violence Prevention & Reduction Strategy for implementation in 2025. The strategy will identify key actions for the Health Board in preventing and reducing incidents of violence in the workplace.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013

Failure to comply with RIDDOR reporting timelines leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

RIDDOR compliance is actively reported via the Health and Safety Committee, and Divisional performance monitored and reported at routine Divisional assurance reviews with challenge and support to achieve full compliance.

Health and safety monitoring

The Health Board is planning to implement health and safety monitoring as part of the established ward accreditation programme.

Health and safety risk assessments

The quality of risk assessments is critical to ensure identified actions adequately mitigate the likelihood of accidents and incidents occurring resulting in harm and the increased risk of enforcement action.

The Corporate Health and Safety Department will undertake an audit in 2024/25 on the quality of health and safety risk assessments. The findings and recommendations of the audit will support the improvement and compliance.

Adequacy of fire alarm systems

The ongoing adequacy of fire alarm systems in some of the hospitals within the Health Board present a risk. This is primarily a result of the systems being beyond life-cycle, albeit all sites currently have working alarms.

End of year capital investment has been approved to support improvements to the fire alarm systems at Nevill Hall and County Hospitals. Future upgrade and

replacement of fire alarms across the Health Board estate is prioritised according to risk and forms part of the capital investment programme for future planning.

Fire barriers (compartmentation)

Breaches in the fire barriers at Nevill Hall Hospital and the unknown condition of the fire barriers at the Royal Gwent Hospital presents a risk to the fire strategy and evacuation plan at those sites.

End of year capital investment has been approved for the completion of a survey of the fire compartmentation at Royal Gwent Hospital.

Recognising the Health Board compliance challenges summarised above, a health and safety strategic risk (SRR 010) was developed in 2023/24 – see Appendix 2. The risk is monitored monthly and reported via the Audit, Risk and Assurance Committee. The risk level has been reduced following the implementation of plans implemented to improve controls; however, the risk level remains outside of target level and outside appetite threshold (current risk score at 12 against a minimal risk appetite level which should be managed to a score of 8 or below). The risk areas of focus, listed above and set out in the annual report, will be the basis of the ongoing compliance improvement plan for Health & Safety, with routine progress reported to the Executive Committee.

Argymhelliad / Recommendation

The Board is asked to formally receive the annual report and note improvement in compliance during the reporting period, and the actions being taken to achieve ongoing compliance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Draft Health, Safety & Fire Annual Report 2023/24
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Health Board Health and Safety Committee Health Board Executive Committee

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	Choose an item.
• Service Activity & Performance	Choose an item.
• Financial	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. 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	Choose an item. Choose an item.

<https://futuregenerations.wales/about-us/future-generations-act/>



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Health, Safety and Fire Annual Report 2023 / 24



Our Values and Behaviours

People First

**Personal
Responsibility**

**Passion for
Improvement**

**Pride in What
We Do**

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1 EXECUTIVE SUMMARY

The purpose of the report is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2023/24. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2024/25.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of AHPs & Health Science.

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 49.4% (2022/23) to 67.7% (2023/24)
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2023/24 compared with 2022/23. This includes Health & Safety and Violence & Aggression surpassing the Welsh Government standard of 85%
- **Reduction in the following incident types:** Contact with needle of medical sharps; manual handling; slips, trips or falls
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for the Inpatient areas across Acute Hospitals. These assessments yielded an average Health Board compliance score of 88.2%.
- **Health and Safety Risk Assessments:** an additional 295 employees trained in Health & Safety Risk Assessment
- **Fire Risk Assessments:** 96% completed/reviewed against of the planned areas in 2023/24. This is an increase of 30% compared with 2022/23.
- **Fire Alarm Systems:** work programmes have commenced on replacing the fire alarm systems at Royal Gwent Hospital and St Cadocs Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** condition of fire barriers analysed across Hospital sites, identifying improvements required at Nevill Hall Hospital and Royal Gwent Hospital.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2024/25.

1.1 Risk Areas for Focus in 2024/25

Health and safety leadership

The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance

The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures

Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training

The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training

Compliance with requirements of fire safety training guidance (HTM 05-03 part A: Operational provisions – Training) presents a risk to the Health Board. The organisation is currently dependant of staff completing their training and gaining competence by attending eLearning training.

Violence in the Workplace

The level of violence Health Board staff are exposed to is a significant risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013

Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring

The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments

The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

Adequacy of fire alarm systems

The adequacy of fire alarm systems in some of the hospitals within the Health Board present a risk. This is primarily a result of the systems being well beyond life-cycle.

Fire barriers (compartmentation)

Breaches in the fire barriers at Nevill Hall Hospital and the unknown condition of the fire barriers at the Royal Gwent Hospital presents a risk to the fire strategy and evacuation plan.

2 INTRODUCTION

This report provides analysis of the level of health and safety performance throughout the Health Board for 2023/24.

The Health and Safety at Work (etc.) Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular, the Act requires an organisation to provide and maintain:

- A Health and Safety Policy;
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances;
- A safe and secure working environment, including provision and maintenance of access to and egress from premises;
- Safe and suitable plant, work equipment and systems of work that are without risks;
- Information, instruction, training and supervision as necessary;
- Adequate welfare facilities;

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

Health, Safety and Security is an identified quality pillar within the Health Board Quality Strategy. The 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

The Health Board operates a Health and Safety Management System, utilising the Health and Safety Executive (HSE) '*Managing for health and safety*' (HSG65) model.



The model is structured into the Plan, Do, Check, Act approach (see diagram 1).

Plan, Do, Check, Act helps achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

Diagram 1: PDCA Health and Safety Management Model

3 HEALTH, SAFETY AND FIRE GOVERNANCE STRUCTURE

3.1 Accountability

The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of AHPs & Health Science.

3.2 Health and Safety Leadership

Effective health and safety performance is led by the senior responsible officers of the Health Board. Members of the Board have both collective and individual responsibility for health and safety. Directors and boards need to examine their own behaviours, both individually and collectively, against the guidance given and, where they see that they fall short of the standards it sets them, to change what they do to become more effective leaders in health and safety.

Why directors and board members need to act:

- Protecting the health and safety of employees or members of the public who may be affected by your activities is an essential part of risk management and must be led by the board.
- Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership.
- Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety.

Business leaders have responsibility for determining and implementing effective health and safety management and monitoring its success, so it's essential that they understand how to implement a risk management strategy.

To support Board Members and Executive Directors to deploy their health and safety responsibilities, training for will be arranged in 2024/25. A Board Development session is planned for April 2024.

Regulation 7 of The Management of Health and Safety at Work Regulations 1999 states that *"Every employer shall, subject to paragraphs (6) and (7), appoint one or more Competent Persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions"*.

The legislation states that a person shall be regarded as 'competent' if they have sufficient training, experience, or knowledge and 'other qualities'.

The Corporate Health and Safety Department employs specialist safety professionals to advise and support the Health Board to deliver and maintain health and safety standards.

The department structure (as at end of March 2024) is illustrated in diagram 2.

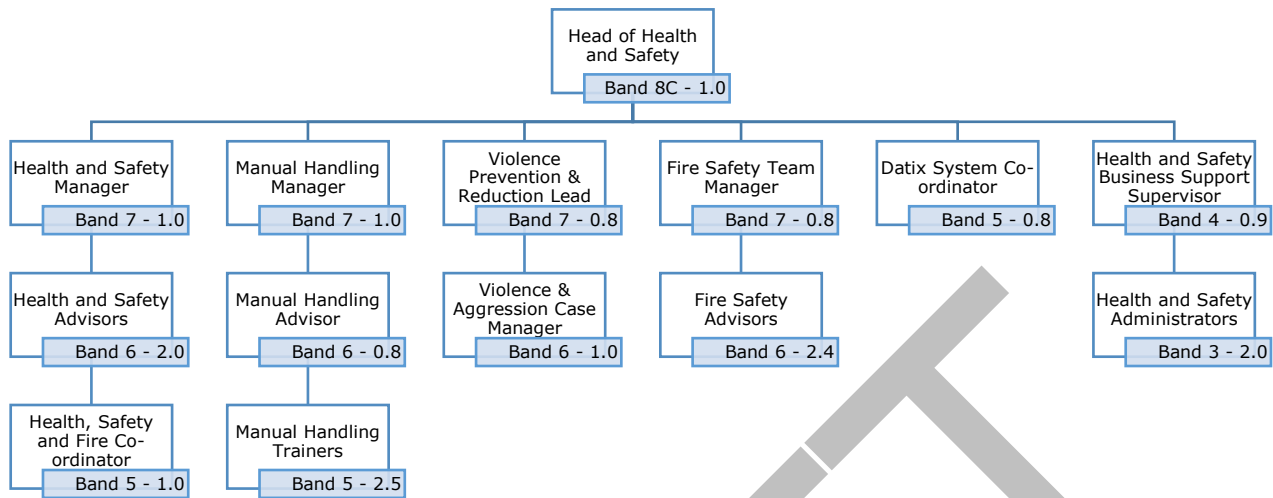


Diagram 2: Corporate Health and Safety Department Structure

The department is currently carrying vacancies in posts; Violence Prevention & Reduction Lead (Band 7) and Manual Handling Trainer (Band 5). Plans are in place to recruit to these posts in 2024/25.

The Corporate Health and Safety Department is structured within specific functions i.e. health & safety, fire safety, manual handling and violence & aggression.

The individuals within the functions are allocated areas of responsibility across the Health Board to support the development of effective relationships with key stakeholders. (See diagram 3)

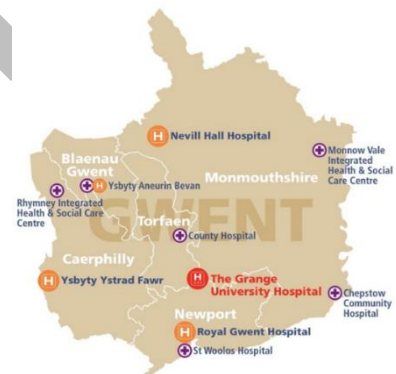


Diagram 3: Map of Gwent Hospitals

During 2023/24 the Corporate Health and Safety Department has effectively integrated into the Health Board leadership structures and regularly engage via specific Health Board meetings, including Quality and Patient Safety, Hospital Management Groups etc.

To ensure the Health Board can effectively meet its legal duties under Health and Safety legislation there is a need to consider the current resource available to the Corporate Health & Safety Department.

A review of the Corporate Health and Safety Department was completed in 2023/24. The review identified additional positions as key to enhancing the current establishment.

3.3 Health and Safety Reporting Arrangements

The Health and Safety Committee has been established to plan, manage and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties.

The Executive Director of AHPs & Health Science is the Chair of the Health and Safety Committee, being the Director with delegated responsibility for health and safety within Aneurin Bevan University Health Board. The Health and Safety Committee is accountable to the Quality and Patient Safety Operational Group, which is in turn, responsible to the Patient Quality and Safety Outcomes Committee.

The Health and Safety Committee receives reports from the subgroups and ratifies policies. The reporting arrangements are illustrated in diagram 4.

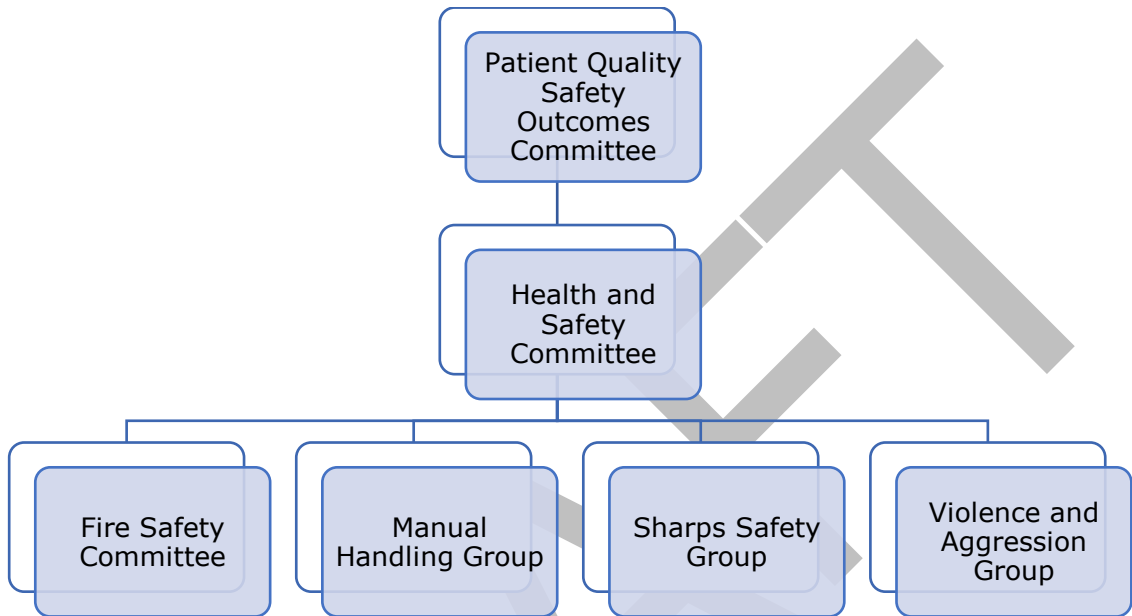


Diagram 4: Health and safety reporting arrangements

The Health and Safety Committee met three times in 2023/24. In May, July and November 2023.

The Committee Terms of Reference was reviewed early in 2024 with agreed membership comprising of Executive Team members.

3.4 Health and Safety Committee Subgroups

The review of the Health and Safety Committee terms of reference included an assessment of the current subgroups.

The revised subgroups reporting to the Health and Safety Committee are documented below.

Group	Chair	Frequency of Meetings
Fire Safety Management Group	Head of Health, Safety & Fire	Quarterly
Health and Safety Operational Group	Head of Health, Safety & Fire	Quarterly
Violence Prevention & Reduction Group	Head of Health, Safety & Fire	Quarterly

Each subgroup is responsible for the production and updating of their own policies and terms of reference. These documents are submitted to the Health and Safety Committee for ratification.

During 2023/24 only the Fire Safety Management Group (previously known a Fire Safety Committee) has routinely met. A plan of meeting dates for the subgroups will be implemented in 2024/25.

In addition to the corporate reporting arrangements, health and safety is a regular agenda item at the Divisional Quality and Patient Safety forums providing an opportunity to monitor health and safety performance.

3.5 Health and Safety Policies & Procedures

Health and safety policies and procedures have been developed within the Health Board to outline the organisations plans to achieve compliance with the relevant health and safety legislation and/or standards.

The table below illustrates the current health and safety policies and procedures within the Health Board and their status. An objective for 2024/25 is to ensure all policies are reviewed and updated as appropriate.

Policy Title	Issue Date	Review Date	Status
Handling Violence and/or Aggression (Internal Sanctions) Policy and Procedure	Oct 2014	Oct 2017	Overdue Review
Use of Restrictive Physical Intervention Policy	Sep 2016	Jun 2019	Overdue Review
Lone Working Policy	Apr 2017	Apr 2020	Overdue Review
Control of Substances Hazardous to Health (COSHH) Policy	Oct 2017	Oct 2020	Overdue Review
Safer Manual Handling Policy	Jan 2019	Jan 2022	Overdue Review
Occupational Health & Safety Policy	Mar 2019	Mar 2022	Overdue Review
Incident Reporting Policy	Dec 2019	Dec 2022	Overdue Review
Procurement and Use of Portable Items of Non-Clinical Electrical Equipment Policy	Jan 2020	Jan 2023	Overdue Review
Fire Safety Policy	Jan 2020	Jan 2023	Overdue Review
Management of Violence and Aggression by members of the Public Policy	Jul 2021	Jul 2024	Current
The Use of Bedrails and Bedrail Covers Policy	Feb 2022	Feb 2025	Current
Policy for Workstation Display Screen Equipment (DSE)	Mar 2022	Mar 2025	Current
First Aid at Work Policy	Nov 2022	Nov 2025	Current
New & Expectant Mothers Health and Safety Obligations at Work Policy	Feb 2024	Feb 2027	Current

The Health Boards policy for New & Expectant Mothers Health and Safety Obligations at Work was reviewed and updated in 2023/24.

All of the policies highlighted as 'Overdue Review' have been partly reviewed in 2023/24 by the Corporate Health and Safety Department, however, these need to be progressed further for approval.

Enforcement action taken by the Fire & Rescue Service against NHS Wales organisations relating to the control and management of ignition sources in healthcare has highlighted the requirement to develop a 'Search Policy'. This development is currently being led by the Corporate Health and Safety Department with engagement from key individuals across the Health Board.

3.6 Audit and Assurance

There has been no Internal Audits conducted during 2023/24 which relate to health and safety.

Recommendations from previous Internal Audits conducted in 2019/20, which elicited a 'limited assurance' response, are still being monitored. The recommendations relate to health and safety workplace inspections and quality of risk assessments.

The plan to revitalise the health and safety monitoring process was severely impacted by the demands placed on the Corporate Health and Safety Department by the Covid-19 Pandemic. A programme of health and safety monitoring in the form of health, safety and environment workplace inspections was completed in 2023/24. (See Health and Safety Monitoring under section 10.1 of this report for further information).

There has been engagement with the Divisions to actively review and update risks recorded on the risk module on the DatixWeb system. This will support the programme to improve the quality and management of risk assessments. The Corporate Health and Safety Department are leading the education programme for risk assessment within the Health Board. (See Risk Management and Risk Reporting under section 5 of this report for further information).

An audit conducted in 2022/23 to review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates, specifically the Health and Safety Executive (HSE) identified matters requiring management attention. These include:

- A standard operating procedure should be developed to set out how HSE actions are monitored, tracked, escalated and overall assurance provided.
- An inconsistent approach and a lack of evidence to the tracking of HSE actions by the respective committees

A draft standard operating procedure 'Management of Health and Safety Executive (HSE) Inspections and Reviews' has been developed and is currently awaiting approval.

The Health and Safety Legislative Assurance Framework identifies the compliance with health and safety statutory instruments. The document is subject to an assessment by the Corporate Health and Safety Department in 2024/25.

4 HEALTH, SAFETY AND FIRE ENFORCEMENT ACTIVITY

During 2023/24, no prosecutions or enforcement actions have been issued by the Health and Safety Executive (HSE), however, South Wales Fire & Rescue Service (SWFRS) issued the Health Board with an enforcement notice in February 2023. The notice related to concerns with the fire safety arrangements for the Gerylyn accommodation building at Nevill Hall Hospital.

The following matters highlight the non-compliance with the provisions of the Regulatory Reform (Fire Safety) Order 2005 for the building.

- Fire doors are being held open inappropriately
- Intumescent strip seals missing, damaged or defective
- The fire safety measures evaluated in the fire risk assessment have not been implemented
- The fire detection system is inadequate for the type and use of the premises
- The existing provision of manual firefighting equipment is inadequate
- Emergency routes and exits could not be used as quickly and as safely as possible
- The standard of fire separation is not adequate
- Fire resisting doors are not adequately maintained

The timescale for compliance with the notice is August 2024.

During 2023/24 there have been HSE intervention costs of approximately £17,000. These costs relate specifically to HSE investigations into a patient fall incident. (The Health and Safety (Fees) Regulations 2012 places a duty on HSE to recover its costs for carrying out its regulatory functions, from those found to be in material breach of health and safety law.)

In 2023/24, the Health Board received a workplace concern from the Health and Safety Executive (HSE) about Diesel Engine Exhaust Emissions (DEEE) exposure at the Grange University Hospital's Emergency Department, primarily from idling ambulances on the forecourt. DEEE exposure, while generally low, can pose health risks, particularly with prolonged exposure.

In response, the Health Board, in collaboration with WAST, conducted a comprehensive risk assessment and workplace air monitoring, which found DEEE levels to be significantly below legal limits. However, recognising the presence of emissions, the Health Board implemented additional control measures, including installation of industrial fans, provision of designated welfare areas for WAST employees, implementation of safe working practices, and increased staff communication in relation to DEEE exposure.

Plans are underway to install a High Low Extraction Ventilation System as part of the Emergency Department expansion to further mitigate DEEE risks. Ongoing job observations and safety talks have been conducted to improve compliance with safe working practices, and further air monitoring will be done post-installation to ensure the effectiveness of these measures.

5 RISK MANAGEMENT AND RISK REPORTING

A health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored monthly and reported via the Audit, Risk and Assurance Committee.

The risk level has been reduced following the implementation of plans to improve controls, however, the risk level is outside of target level and outside appetite threshold.

The completion of risks assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the risk assessment programme, the Corporate Health and Safety Department deliver risk assessment training, promoting best practice in the completion of a risk assessment and the principals of effective Risk Management within departments and in the wider organisation.

The Health and Safety Professionals within the Corporate Health and Safety Department continue to provide advice and guidance on the implementation of statutory risk assessments through the various subgroups. Specialist risk assessments being completed by the Health and Safety Professional upon request.

Most of the health and safety risks are reported via the risk module on the DatixWeb system. The Health Board also subscribe to CoSHH management software for the risk assessments relating to substances hazardous to health. All fire safety risk assessments are recorded via the NWSSP fire auditing and reporting system. New software for recording and monitoring fire risk assessments will be introduced in 2024/25.

To aid Divisions in Risk Management practices, a Risk Assessment Self-Assessment tool was developed and communicated to the Divisional Triumvirates with the request of the self-assessment tool being disseminated within their areas of responsibility. The self-assessment tool was developed in order support Divisions in evaluating their risk assessment practices against industry best practices as well as collecting necessary data to aid wider improvement in relation to risk assessment activities.

A total of 106 responses were received. The table below identifies the number of responses received by Division or Service.

Division / Service	Number of Responses
Primary Care & Community	42
Digital Data & Technology	24
Scheduled Care	23
Clinical Support Services	6
Urgent Care	6
Families & Therapies	5
Medicine	0

On the back of the Risk Assessment Self-Assessment results, a new guidance document on Health & Safety Risk has been developed and communicated to all persons who have undertaken Health & Safety Risk Assessment Training, formally Competent Person Training. The guidance documents aim to:

- **Provide comprehensive Risk Assessment Procedures:** Step-by-step instructions to identify, evaluate, and control risks.
- **Identify Best Practices:** Proven strategies and examples to ensure a safe working environment.
- **Improve Legal Compliance:** Guidelines to meet regulatory requirements and industry standards.
- **Provide Tools and Templates:** Ready-to-use resources to streamline the risk assessment process.

The Health and Safety Committee receives reports on health and safety risks from the Divisions for consideration, action and assurance.

As part of the monitoring arrangements, the Corporate Health and Safety Department continually engage with Risk Leads to review the risks recorded as Extreme High and High with the view to provide further advice and support and ensure that appropriate mitigation is applied as a means to manage the risks at a level that is so far is reasonably practicable.

6 HEALTH, SAFETY AND FIRE TRAINING

Suitable and sufficient training is a requirement of The Health and Safety at Work Act 1974 and The Management of Health and Safety at Work Regulations 1999.

The Management of Health and Safety at Work Regulations state "every employer shall ensure that his employees are provided with adequate health and safety training".

The health and safety statutory and mandatory training compliance as of 31 March 2024 was as follows:

Training Course	2023/24 Compliance %	2022/23 Compliance %
Health and Safety Awareness	87%	82%
Fire Safety	83%	79%
Manual Handling	55%	52%
Violence & Aggression	85%	81%

During 2023/24 there has been an increase in compliance against all of the health and safety statutory and mandatory training compared with 2022/23.

Except for manual handling training, the delivery of the health and safety statutory and mandatory training programme in 2023/24 continues to be delivered by eLearning with access via the electronic staff record (ESR) self-service portal for ease to individuals. Line managers can view their team's compliance and are also notified when staff are nearing non-compliance.

Compliance levels for manual handling training are well below the required standard. The manual handling training strategy is to be reviewed in 2023/24 to ensure the Health Board has a sustainable programme of manual handling education, particularly for high-risk areas.

Manual Handling training within NHS Wales is delivered to the scope of the All-Wales Manual Handling Passport. This ensures a consistent and standard approach to training.

During 2023/24, the Manual Handling Team have continued to deliver manual handling training to Health Board staff. The table below provides details of the manual handling training delivered and the attendance.

Manual Handling Course Title	No. of Sessions	No. of Attendees	No. of DNA's
People Handlers Foundation Training	43	444	164
People Handlers Update Training	10	62	39
Object Handlers Foundation Training	8	73	14
Object Handlers Update Training	8	48	5
People Handlers Trainers Foundation Training	2	19	0
People Handlers Trainers Update Training	7	46	5
Object Handlers Trainers Foundation Training	5	29	5
Object Handlers Trainers Update Training	4	29	4

Staff attendance on manual handling training and specifically those who do not attend remains a challenge.

Violence and aggression training is aligned to the All-Wales NHS Violence & Aggression Passport Scheme. The passport scheme is broken down into four areas:

Module A – Induction and Awareness Training: Introduction to the basic concepts of violence and aggression prevention, including organisational policies and employee responsibilities.

Module B – Theory of Personal Safety and De-escalation: In-depth theoretical training on personal safety techniques and strategies for de-escalating potentially violent situations.

Module C – Breakaway Techniques: Practical training on breakaway techniques to safely disengage from physical confrontations.

Module D – Restrictive Physical Intervention: Training on the appropriate and safe use of restrictive physical interventions when necessary.

All Health Board staff are mandated to complete modules A & B, whilst module C & D is based on risk assessment. Members of the Corporate Health and Safety Department have attended accredited training to enable them to teach module C.

During 2023/24, the Violence & Aggression Team undertook a targeted initiative to address specific risks associated with the violence and aggression from elderly patients within our Care of the Elderly Wards. Training sessions have been delivered across Acute and Community Hospital settings, with a total of 254 Health Board employees receiving this training.

Recognising the unique challenges faced by staff in these settings, a series of bespoke training sessions were developed and delivered, aimed at enhancing staff capability in managing violence and aggression, particularly where these risks intersect with conditions such as dementia, other mental health issues and environmental constraints.

Feedback from staff who attended the training has been positive. Colleagues have reported that the training provided them with a deeper understanding of the complexities associated with managing violence and aggression from these patients. They have particularly valued the practical techniques taught during the sessions, which they have found immediately applicable in their daily work. Staff have noted an increase in their confidence when dealing with challenging behaviours, as well as a reduction in the number of incidents requiring physical intervention.

6.1 Health and Safety Training for Managers

A Health and Safety for Managers Training package is currently being developed nationally. This work is being led by Cwm Taf Morgannwg University Health Board and will be agreed at the All-Wales Health and Safety Management Group.

Once the course is approved it will be implemented within the Health Board to provide Managers with an awareness of their role in health and safety management and implementation. The course will cover vital information such as the legal requirements, safety management systems, safety culture, risk assessment & hazard control and incident investigation.

6.2 Ward Talk Safety Talks

Ward Talk Safety Talks have been implemented as a method to provide further information, instruction & training to Health Board employees in relation to health and safety matters.

The Ward Talk Safety Talks are short training presentations that are conducted within the working environment and provide safety reminders, brief refreshers and quick lessons on safety topics. The Ward Talk Safety Talks are developed by the Corporate Health and Safety Department and can either be delivered by a member of the Corporate Health and Safety Department or local Ward / Department Manager.

The use of Ward Talk Safety Talks has provided greater opportunity to discuss recent incidents, near misses and everyday tasks. The following Ward Talk Safety Talks have been developed during 2023/24:

- Diesel engine exhaust emissions (DEEE)
- Management & prevention of slips, trips and falls
- Safe use of ladders
- Selecting the right ladder
- Workplace exposure to Entonox in maternity

6.3 Manual Handling Cascade Trainers Training

To support the delivery of the manual handling training strategy, cascade trainers are nominated in areas across the Health Board. The cascade trainers i.e. Transfer Specialists, Safer Handling Coaches etc. attend foundation training and are required to attend an update every two years to maintain their competency.

The COVID-19 pandemic contributed to a backlog of trainers becoming out of date with their two-yearly refresher. The register of cascade manual handling trainers was cleansed and a programme of updates was delivered in 2023/24. This included 10 update courses for Transfer Specialists with a total attendance of 62 learners.

6.4 Risk Assessment Training

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the Health Board to maintain its legislative requirement and ensuring the provision of competent risk assessors, the Risk Assessor Training course has been revitalised for 2023/2024, 37 courses have been delivered and 295 Health Board Employees trained in Health & Safety Risk Assessment.

The aim of the course is to ensure all participants have an understanding on the concept of risk assessment, when a risk assessment is required within the workplace and how to conduct a suitable and sufficient risk assessment. A training programme has been developed and communicated through the Health Boards structure, further to the delivery of Risk Assessment Training in 2023/2024. There has been positive feedback in relation to the updated course and participants who have attended the training have scored their confidence and ability to conduct a risk assessment highly.

6.6 Fire Safety Training

The compliance data for fire safety training appears acceptable, however, these results are derived from compliance with eLearning modules alone. Staff with the responsibility to evacuate immobile patients require additional, in-depth evacuation training, delivered face-to-face by a Fire Safety Advisor. This requirement is highlighted in the fire safety guidance contained in Welsh Health Technical Memorandum (WHTM) 05:01.

This additional level of training is delivered to all Theatres, Critical Care and similar departments caring for high dependency patients. Unfortunately, concerted efforts by the Fire Safety Team to expand face to face training to all inpatient wards in 2023/24 have been unsuccessful.

There is an aspiration to introduce a programme of face-to-face fire evacuation training for staff on inpatient wards in 2024/25. However, this will require a review of Health Board resources to deliver this effectively.

6.7 Fire Warden Training

Fire wardens at Health Board premises perform a vital function in maintaining safe environments. Their role during fire emergencies is as a *critical friend* to department and ward managers who are responsible for initiating and managing evacuations.

Key functions of fire wardens include the continual monitoring and completion of monthly safety checks of their areas to identify fire safety problems. They provide the valuable service of liaison with the Fire Safety Advisors to provide early warning and resolution of potential safety issues.

The Fire Safety Team continue to promote the role via the fire risk assessment process with the goal that every work area in the Health Board has at least one fire warden assigned.

An additional 73 fire wardens were identified and attended training in 2023/24.

6.8 Fire Response Team Training

Following liaison with the operations directorate and site management teams, training has been provided (in line with the training needs analysis) for fire response teams at County Hospital, Grange University Hospital, Nevill Hall Hospital, Royal Gwent Hospital and Ysbyty Ystrad Fawr Hospital.

The training included awareness of how the buildings are constructed to limit fire spread, site specific evacuation procedures and facilities on site to allow movement of patients between floors i.e. escape stairs, evacuation lifts and sprinkler isolation, where appropriate.

6.9 Fire Drills & Exercises

The Fire Safety Team conduct an annual programme of fire drills and exercises across the Health Board. The purpose of these is to confirm the fire evacuation strategies for the areas are robust.

In 2023/24, The Fire Safety Team carried out 12 fire exercises across the Health Board. The majority of the exercises were conducted on Acute Hospital sites and the areas were both clinical and non-clinical, including Inpatient areas and Theatres.

An evacuation exercise was conducted at Ysbyty Ystrad Fawr in 2023/24 which included engagement from South Wales Fire & Rescue Service.

7 RIDDOR REPORTING

Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), certain workplace accidents, incidents, ill health and certain near miss events must be recorded. Depending on the severity and nature of the injury, and indeed the party affected, the Health Board has a legal duty to report this data to the Health and Safety Executive (HSE).

The reporting process to the HSE is undertaken by the Corporate Health and Safety Department.

During the period of April 2022 to March 2023 the Health Board reported a total of 79 incidents to the Health & Safety Executive which met the criteria of being reportable under RIDDOR. 49% of these incidents were reported outside of the legal reporting timeframes.

This highlighted the significant need for improvement in ensuring that all areas are fully aware and compliant with their RIDDOR duties. Non-compliance with RIDDOR duties can have severe consequences, both in terms of Health & Safety and legal ramifications for the Health Board.

To address this, the Health Board has undertaken a comprehensive review and enhancement of its processes.

The Standard Operating Procedure (SOP) for RIDDOR has been updated to reflect the latest requirements and best practices.

A new RIDDOR Awareness Training Session has been developed. This training is designed to provide all managers with a clear understanding of their duties under RIDDOR, ensuring that they can fulfil their responsibilities effectively.

A RIDDOR Compliance Dashboard have been established within the Datix Cymru system to enable Divisions to proactively monitor their RIDDOR compliance and identify areas of good practice, but also areas of further improvement. Compliance with RIDDOR is a health and safety performance indicator and will be included in the Divisional Assurance Reviews in the future.

The total number of RIDDOR reportable incidents reported to the HSE in 2023/24 was 90 incidents. This is a 13.9% increase on the number reported in 2022/23. (See figure 1)

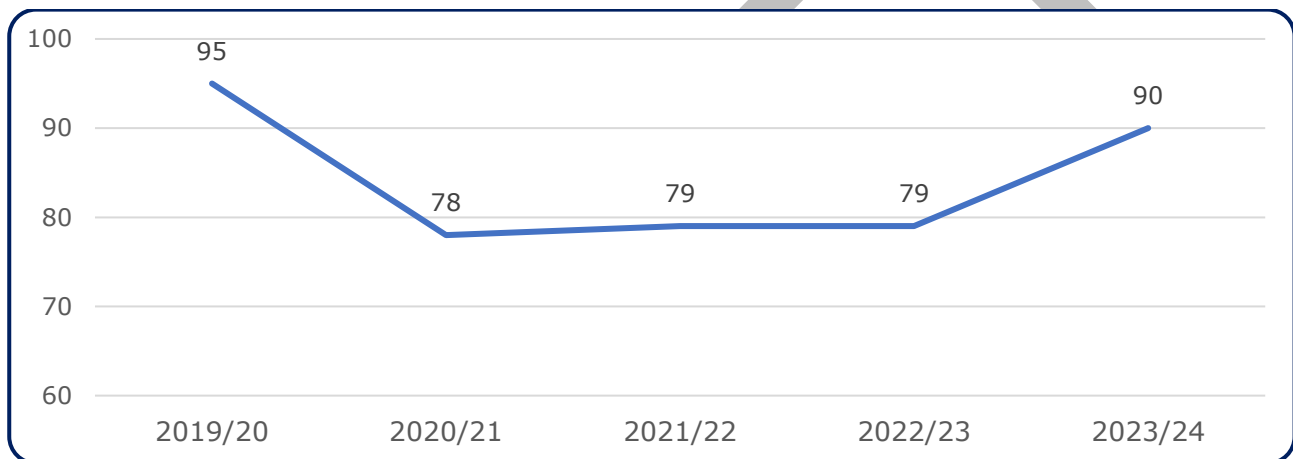


Figure 1: Total number of RIDDOR reportable incidents reported to the HSE for the past five financial years

In 2023/24 there has been one fatal incident reported, a patient fall. The same number of fatal incidents reported in 2022/23. Over-seven-day incapacitation of a worker are the highest reported classification in 2023/24 with 57 incidents reported, an increase of 4 incidents compared with 2022/23. The number of specified injuries has risen from 18 incidents reported in 2022/23 to 26 in 2023/24. (See figure 2)

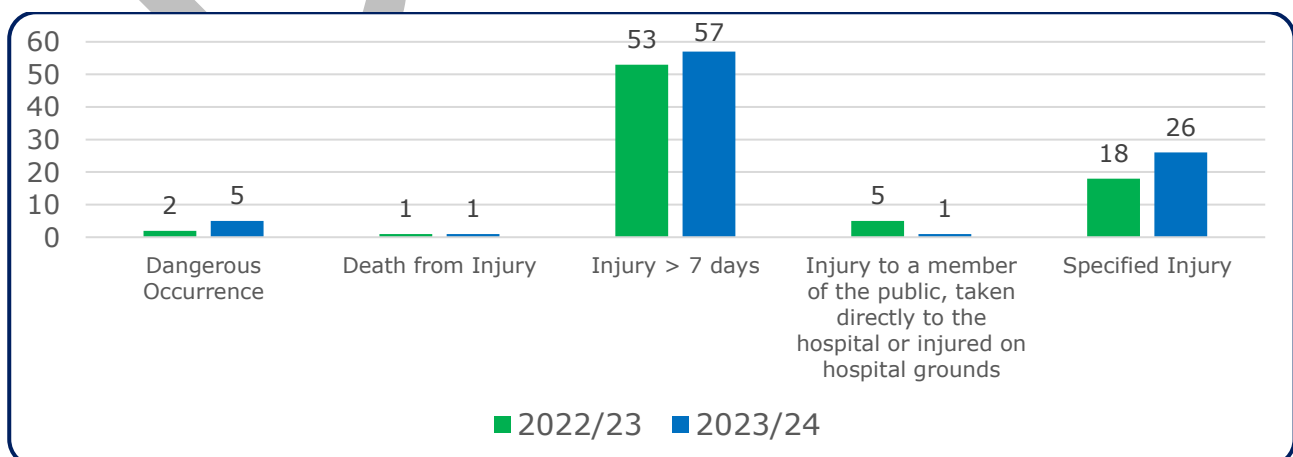


Figure 2: RIDDOR reportable incidents by classification reported to the HSE for 2023/24

Slips, trips and falls to staff continue to be the highest type of RIDDOR reportable incident reported to the HSE. The 38 slips, trips and falls reported in 2023/24 was a slight increase from the 35 reported in the previous financial year.

There was a 109% increase in the number of abuse to staff RIDDOR reportable incidents reported to the HSE in 2023/24 (23) compared with 2022/23 (11).

Manual handling RIDDOR reportable incidents have decreased by 67% from 20 in 2022/23 to 12 in 2023/24. (See figure 3)

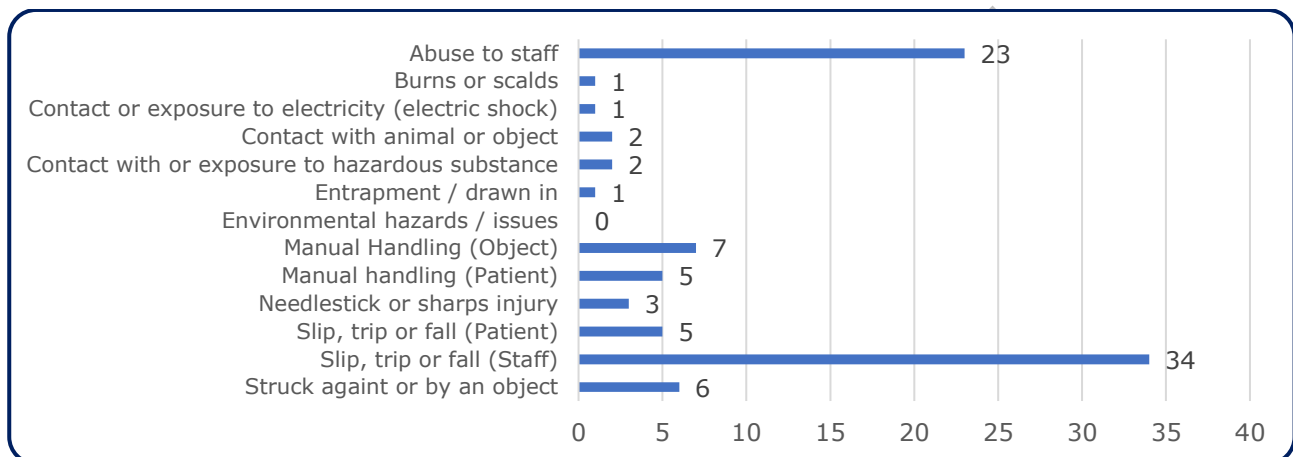


Figure 3: Type of RIDDOR Reportable incidents reported to the HSE for 2023/24

RIDDOR reporting compliance for 2023/24 was 67.7% an 18% improvement on the compliance reported in 2022/23 (49.4%).

8 LEARNING FROM EVENTS

The Corporate Health and Safety Department has implemented various communication methods to support learning from incidents across the Health Board.

As part of these methods, information is cascaded through Health and Safety performance reports, post investigation meeting de-briefs, amendment to relevant health and safety training packages and organisational alerts.

During 2023/24 there have been twelve information sheets issued which relate to the following:

- HSI-2023-001 – Fire Safety Arrangements – Royal Gwent Hospital
- HSI-2023-002 – Management of hoist batteries
- HSI-2023-003 – Hazard Identification – Mental Health Garden Inspections
- HSI-2023-004 – Labelling of High-Risk Samples
- HSI-2023-005 – Management of Banner Stand Displays
- HSI-2023-006 – Risk posed by items in the vehicle footwell
- HSI-2023-007 – Management of Hazardous Substances
- HSI-2023-009 – Hazard Identification (Slips, Trips and Falls)
- HSI-2023-010 – Safe Movement & Transportation of Beds
- HSI-2024-001 – Management of Bed and Air Pump Power Cords
- HSI-2024-002 – Survival Bracelets in Mental Health Units
- HSI-2024-003 – Unauthorised Access Tailgating

The Corporate Health & Safety Department has provided support to Legal Services in relation to Personal Injuries Claims by assisting in the investigation process, supplying necessary documentation, and facilitating the identification and communication of key learnings from events to prevent future occurrences.

An example of this collaboration occurred after an incident in which a Health Board employee sustained an injury due to a fall within a Mental Health Unit Garden. The employee was assisting a service user in the garden area and tripped over a protruding tree stump which caused obstruction on the garden pathway. In response, the Corporate Health & Safety Department conducted an investigation into the incident, which led to the development of a Mental Health Unit Garden Inspection Checklist. This checklist serves as a proactive tool to identify and mitigate potential hazards within mental health garden environments. This includes specific examples of common risks, such as uneven pathways, poor maintained greenery, inadequate lighting, security deficiencies, along with recommended corrective actions. The checklist is now an integral part of the safety measures implemented, ensuring that similar incidents are less likely to occur in the future by promoting regular inspections and prompt hazard management.

10 HEALTH AND SAFETY

10.1 Health and Safety Monitoring

The Corporate Health & Safety Department initiated a programme of workplace health, safety, and environment inspections spanning from December 2023 to March 2024.

These inspections align with the Workplace (Health, Safety and Welfare) Regulations 1992, which encompass fundamental health, safety, and welfare concerns applicable to the Health Board.

The inspection criteria have been developed based on the stipulations outlined in the Regulations, as well as consideration of other pertinent workplace hazards. The inspection criteria included:

- Lighting
- Noise
- Prevention of Slips, Trips, & Falls (including falls from height and falling objects)
- Temperature & Ventilation
- Workstations, Seating, Furniture, and Fittings
- Welfare Facilities
- Cleanliness, Waste Management, & Sharp Safety
- Access and Egress
- Electrical Equipment
- Handling of Chemicals & Hazardous Substances
- Prevention of Violence & Aggression
- Alert Systems & Communications
- Provision of First Aid

A goal was established to complete health, safety, and environment inspections for all inpatient areas across Acute Hospital sites by the end of March 2024. This objective has been successfully met, with a total of 51 inspections carried out.

These assessments yielded an average Health Board compliance score of 88.2%. The table below offers a detailed breakdown of the number of inspections completed per site and the corresponding site compliance score (average).

Site	Total Number of Inspections Completed	Site Compliance (Average)
Grange University Hospital	16	90.1%
Nevill Hall Hospital	8	89.6%
Royal Gwent Hospital	18	84.8%
Ysbyty Ystrad Fawr	9	91.2%

The inspections revealed both areas of compliance and areas requiring attention to ensure a safe working environment. While an average Health Board compliance score of 88.2% indicates overall adherence to regulations, specific areas of concern were identified of which further attention is required.

The main findings of the health, safety and environment workplace inspections are as follows:

Control of Substances Hazardous to Health (COSHH)

- Most areas lacked COSHH Inventories and Assessments.
- Employees lacked clarity on accessing COSHH Assessments and understanding precautionary measures for substance use.
- Cleaning substances, such as Actichlor solution, were frequently left unattended without proper storage and security measures.

Electrical Equipment Checks

- While user checks on electrical equipment were noted, there was insufficient evidence to confirm regular checks.

Tripping and Entrapment Hazards

- Cables supplying air mattresses and electric profiling beds were often positioned in ways that posed tripping and entrapment risks.

Unauthorised Access

- Various areas within ward environments were frequently left open, allowing unauthorised access.

Signage for Anti-Violence Measures

- Absence of signage regarding NHS Wales Anti-Violence Posters was noted.

Seating for DSE Use

- In some clinical areas, ergonomic office chairs were utilised but often had castors unsuitable for the flooring type.

General Condition of Premises

- Flooring was generally in good condition with no significant defects or obstructions affecting safety.
- Lighting levels were found to be adequate for activities within the areas.
- Window restrictors limiting window opening were robust and tamper-proof.
- No workplace noise issues were identified, and employees did not raise concerns.
- No defects such as exposed wiring or damaged casing were identified.
- Workplace temperature was considered reasonable, and concerns regarding thermal comfort were limited.

Provision and Access to Welfare Facilities

- Welfare facilities such as break rooms and W/Cs were routinely available.
- Facilities for heating food/drinks and storing personal items were provided.

Employee Awareness and Reporting

- Employees demonstrated substantial awareness of how to raise health and safety concerns and report accidents, incidents, and near misses.

Where actions in relation to non-compliance have been identified, these areas must be addressed in order to reduce the likelihood of accident and ill health and to close any gaps in compliance. The responsible person must ensure that sufficient progress notes are recorded within the assigned action point detailing the action(s) taken to address and remedy the identified non-compliance.

As part of the 2024/25 Corporate Health & Safety Department monitoring programme, further workplace health, safety and environment inspections have been scheduled. These will be conducted for all inpatient areas across Community Hospitals and Mental Health & Learning Disabilities sites. The programme will also include a review of outpatient settings across both Acute and Community Hospitals.

10.2 Health and Safety National Meetings

The All-Wales Health and Safety Management Steering Group represents Health & Safety professionals working in NHS Wales in all areas of health and safety management, providing a forum to network, share best practice and work collaboratively to develop improvements in health and safety.

The group represent all NHS organisations, recognising the importance of providing informative and stimulating meetings, workshops, and seminars for the continued professional development of all members.

The purpose of the All-Wales Health and Safety Management Steering Group is to:

- Discuss all areas of health and safety management to ensure compliance with the legislative and regulatory frameworks in place for managing health and safety effectively.
- Share lessons learned and best practice identified for effective health and safety management.
- Encourage strong leadership in health and safety and championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.
- Where appropriate, advise the Health Boards and Trusts on where and how, its health and safety management may be strengthened and developed further.

The aims of the group are to:

- Support members to develop the health and safety management arrangements within healthcare organisations.
- Provide a forum in which health and safety risk and issues can be debated, to ensure effective communication of ideas, sharing of experiences and areas of best practice.

Subgroups and workstreams have been established to review current health and safety practice in specific areas and develop minimum standards for implementation across NHS Wales.

During 2023/24 an All-Wales Health & Safety Workstream has been developed in relation to Health & Safety Incident Codes recorded within Datix Cymru. The purpose of this workstream is to standardise the Health & Safety Incident Codes for all NHS organisations in Wales in order to reduce barriers to incident reporting and to improve the quality of incident data which will further support in identifying learning from incident themes and trends.

10.3 Reinforced Autoclaved Aerated Concrete (RAAC)

The Corporate Health & Safety Department has conducted comprehensive Risk Assessments in areas of Nevill Hall Hospital (NHH) where Reinforced Autoclaved Aerated Concrete (RAAC) has been identified during structural surveys.

To ensure safety, Acrow props have been installed in these areas. The Risk Assessments focus specifically on evaluating the hazards and potential risks associated with the introduction of Acrow props into the working environment.

The assessment aims to mitigate any risks posed by the structural supports, ensuring that the hospital environment remains safe for both staff and patients. The Risk Assessments have been recorded within the Datix Risk Module and local Department risk leads have been assigned to enable ongoing management of the risk.

As part of the governance arrangements in relation to the management of RAAC, the Corporate Health & Safety Department attend the RAAC Fortnightly Governance Group of which the group focus is on the actions that have been taken and the ongoing management of the challenges enabling wider discussions of service implications and also remediation plans.

10.4 Falls Awareness Campaign

During Falls Awareness Week in September 2023, the Corporate Health & Safety Department actively supported the campaign by introducing a Slips, Trips, and Falls Hazard Spotting Checklist. This checklist was specifically designed to help departments and areas identify common hazards and assess potential risks related to slips, trips, and falls in the workplace. The checklist provides examples of hazards that can be found in and around workplaces, and suggests actions that can be taken to resolve them.

Additionally, a comprehensive presentation on the Management and Prevention of Slips, Trips, and Falls was delivered throughout the week. This presentation aimed to educate employees on best practices for minimising these risks and to reinforce the importance of maintaining a safe working environment.

10.3 Health and Safety Incident Reporting

The following data provides a detailed breakdown of the type of health and safety related incidents that have been reported in 2023/24. *This excludes violence and aggression and fire incidents as these are reported on in the relevant sections of this report.*

Figure 4 indicates an increase of 21.1% in the number of reported incidents affecting staff, contractors or visitors compared with last five financial year.

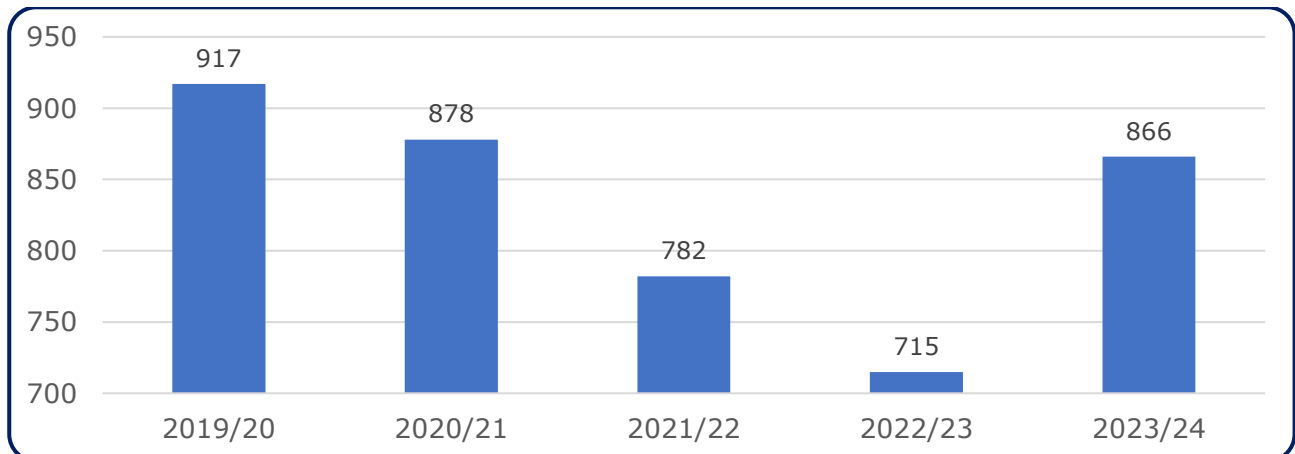


Figure 4: Number of reported incidents affecting staff, visitors and contractors for the past five financial years

Contact with needles or medical sharps is the most reported health and safety incident category affecting staff or contractors (189 incidents), however, this is a slight reduction on the number of incidents reported during 2022/23. (See figure 5)

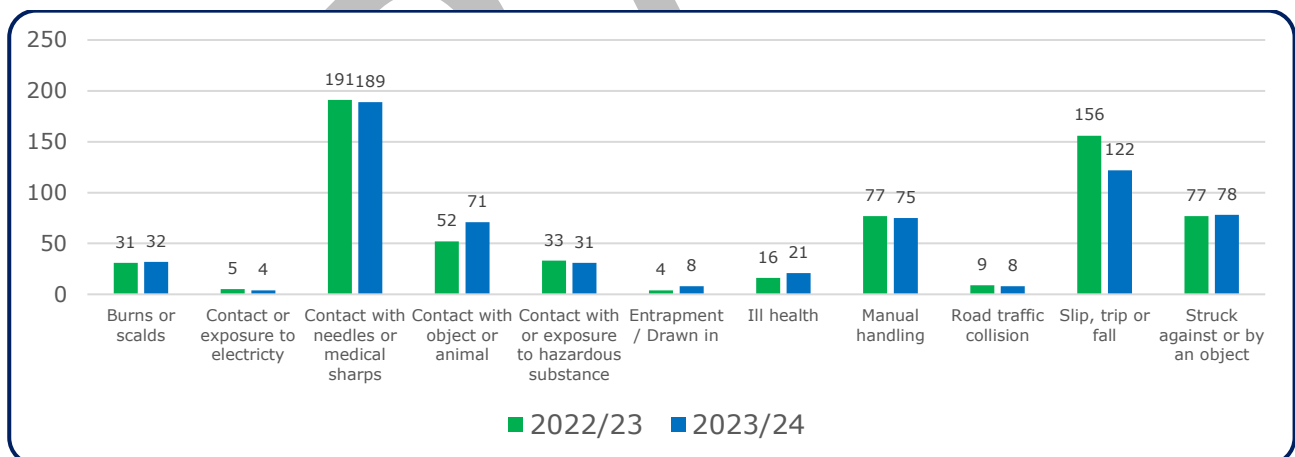


Figure 5: Type of incidents affecting staff and contractors for 2023/24

The number of sharps incidents reported in 2023/24 has reduced by 1% from the previous financial year (191 reports). The incidents from contaminated / used sharps devices have also reduced in 2023/34. (See figure 6)

It is difficult to obtain data on the number of tasks or procedures carried out across the Health Board using needles or medical sharps. However, based on the incidents reported and the significant number of tasks and procedures the incident rate would be very low.

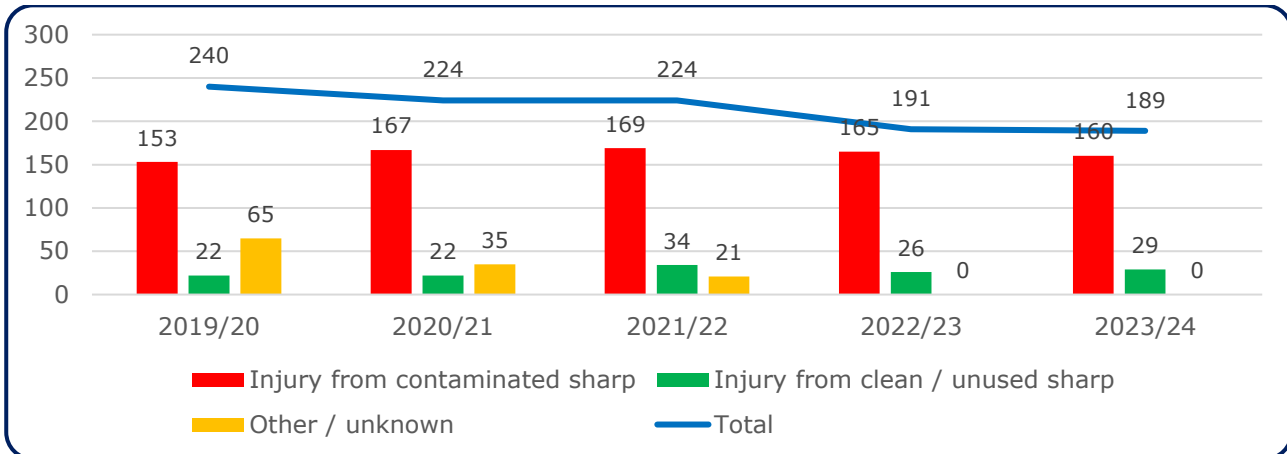


Figure 6: Total number of sharps incidents by type for 2023/24

To identify learning outcomes from sharps incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix system.

The revitalisation of the health and safety monitoring programme included an assessment of clinical area's adherence to best practices for the safe use of sharps. This assessment was designed to ensure that areas comply with the standards set out within the Health Boards Sharps Policy, and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

As part of the inspection process, wards were specifically monitored for their procedures regarding sharps use and disposal of sharps. This includes the availability of safety engineered devices, the availability and correct use of sharps trays and sharps containers and adherence to protocols designed to reduce the likelihood of needlestick injuries and other sharps related incidents.

Throughout the inspections, instances of good practice were routinely identified. These practices provide assurances of compliance with best practice guidelines and legislative requirements. The findings of these inspections have also supported the development of training information such as Ward Talk Safety Talk on the Safe Use of Sharps in order to further reinforce best practices.

The outcomes of the monitoring are reported to the Health and Safety Committee.

Slip, trip or falls is the second highest reported health and safety incident category affecting staff or contractors (122 incidents). (See figure 6)

The number of slips, trips and falls incidents to staff, contractors or visitors reported in 2023/24 has decreased by 20.1% from the previous financial year (139 reports). (See figure 7) These types of incidents continue to be the highest reported to the HSE in accordance with RIDDOR and personal injury claims.

Most of the reports in 2023/24 were categorised as 'Fall on a slippery or wet surface' (32), 'Trip or fall over an object or obstacle' (16) or 'Fall on uneven ground' (9) which is a significant reduction from the previous year's reporting.

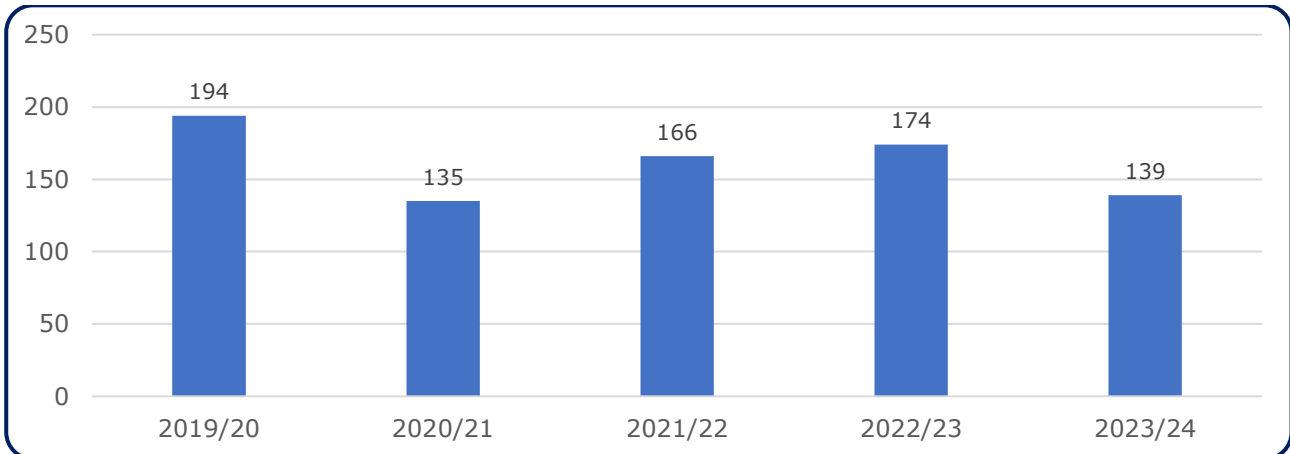


Figure 7: Number of reported slips, trips and falls incidents affecting staff, visitors and contractors for the past five financial years

10.3 Face Fit Testing

The Covid-19 Pandemic has brought an increased requirement for the use of Personal Protective Equipment (PPE) and Respiratory Protective Equipment (RPE) within healthcare settings. Where personal protective equipment and respiratory protective equipment is used, it must be able to provide adequate protection for individual wearers.

Face Fit testing ensures that the equipment selected is suitable for the wearer. Face fit testing is a mandatory requirement as prescribed by Health & Safety Executive Control of Substances Hazardous to Health Regulations Approved Code of Practice (ACoP) L5 and associated guidance documents that support the relevant statutory provisions.

The delivery of Face Fit Testing continues to remain a key tasking for the Corporate Health and Safety Department with weekly Face Fit Testing sessions being offered across the Health Board. Since March 2020 the Corporate Health & Safety Department have conducted over 15,000 individual Face Fit Tests.

To enable the Health Board to maintain compliance with Face Fit Testing requirements a comprehensive review of the Health Boards Face Fit Testing Strategy and Face Fit Testing resource allocation has been undertaken. The review was endorsed by the Infection Prevention & Antimicrobial Stewardship Group and requires escalation to the Executive Committee for consideration.

11 FIRE SAFETY

Fire safety is an umbrella term covering fire prevention and fire precautions. The principal requirements of fire safety legislation are:

- To reduce the probability and severity of a fire occurring within a building.
- To ensure that persons are kept safe or can safely evacuate a premises in the event that a fire occurs.

Fire has the potential to cause widescale damage and disruption of NHS services that could have a serious consequence for service users. Therefore, in addition to life safety, property protection and business continuity are key aims of the Health Board fire safety policy.

The principal legislation governing fire safety in the UK is The Regulatory Reform (Fire Safety) Order 'RRO', that came into force on 1st October 2006. The RRO places liability on responsible persons within an organisation to take general fire precautions for the protection of the relevant persons.

The legislation applies a system of vicarious liability to organisational leaders. The responsible persons in the Health Board are principally directorate and departmental leaders.

The Executive Director of AHPs & Health Science is the Executive Director with delegated responsibility to ensure compliance with Fire guidance, current fire safety legislation and responsibility for ensuring that fire safety issues are highlighted at Board level. In particular they will ensure, by delegation to The Fire Safety Manager that fire safety policy is promulgated, and that Fire Risk Assessments are completed to record the general fire precautions required for all areas.

Individual Board Level Directors and The Board as a collective are responsible for ensuring compliance with the Health Board Fire Safety Policy and that the general fire precautions are applied within the scope of their areas of control.

The following summary profile gives brief details of this Health Boards development towards compliance with the minimum mandatory requirements for the NHS in Wales.

11.1 Provision of Officers with Specific Fire Safety Responsibilities

Health Boards are required to provide a structure of Fire Safety Management within their organisations aligned with WHTM 05:01.

The structure is based on delegated responsibility of fire safety functions to functional roles within the organisation. The nominated officers are accountable for fire safety functions assigned to them.

Fire Safety Protocol 031 Roles and Responsibilities for Implementation details the roles and delegated responsibilities for fire safety within the Health Board. An update to this protocol is required. The current protocol contains some ambiguity where responsibilities overlap and are assigned to multiple roles. In addition, a more robust method of communicating responsibilities to the duty holders is required.

In addition to the designated roles mentioned above, it should be understood that leaders are accountable for adherence to fire policy in any areas that are under their control or influence.

11.2 Fire Safety Risk Management

The Health Board are legally required to carry out and record fire risk assessments at all sites. The legislation requires that assessments are to be *suitable and sufficient* and reviewed on a regular risk-based approach.

Fire risk assessments must be carried out when staff first occupy an area, and reviewed:

- When staff change venue
- When structural changes are made to a work area
- If new hazards are reported or become apparent
- Periodically to ensure accuracy is maintained as set out in the table below

Type of Area to be Assessed	Frequency of Assessment
Buildings or parts of buildings that provide sleeping or inpatient accommodation	12 months
Other than above but areas provided for public access such as outpatient facilities	24 months
Other than above. Areas not provided for public access such as offices, plantrooms etc.	36 months

During the period April 2023 to March 2024 the Fire Safety Team completed 258 programmed fire safety risk assessment reviews. This represents 96% of the programmed assessments. The figures for major sites are displayed in the table below:

Hospital	Annual Assessments	Bi-annual Assessments	Tri-Annual Assessments
County Hospital	5	8	2
Grange University Hospital	26	2	1
Nevill Hall Hospital	20	12	7
Royal Gwent Hospital	28	19	10
St Cadocs Hospital	7	1	8
St Woolos Hospital	8	0	7
Ysbyty Aneurin Bevan	5	0	2
Ysbyty Ystrad Fawr	11	13	0

In addition to the above the Fire Safety Team completed fire risk assessments to:

- Support various moves of departments at the Royal Gwent, St Woolos and Nevill Hall Hospitals.
- Assess and record hazards associated with RAAC at Nevill Hall Hospital.
- Support the opening of The Bevan Heath and Welling Centre and the new Breast Care Unit at Ysbyty Ystrad Fawr.

A register of the risks identified during the assessment process is handled by the Fire Safety Team and recorded on the DatixWeb system. The table below highlights the current fire safety risks by category.

Fire Safety Category	Number of risks
Fire Alarm Systems	26
Fire Door Replacement/Upgrade	37
Compartmentation	23
Hazard Room Protection	10
Fire Door Fastenings	12
Other	29

The decision taken by the Health Board to provide sprinkler protection at new hospitals has produced massive benefits for the management of fire safety at the relevant premises. The hospitals are relatively risk free with no significant fire safety issues.

The major fire safety risks held on the system are legacy fire risks at older building stock including Royal Gwent and Nevill Hall Hospitals. These premises remain a priority for resolution and are likely to dominate the Fire Safety Discretionary Capital spend for the foreseeable future.

11.3 Planning and Implementing Fire Safety Improvement Works

The duties of the Fire Safety Manager include planning and implementing a programme of improvement works to remove or mitigate fire risks carried by the organisation.

During 2023/24 improvements have been made in the following areas to ensure the Health Board meets minimum safety standards and fulfils its legal requirements.

Site	Area	Improvement
Nevill Hall Hospital	First Floor	Replacement fire alarm system
Royal Gwent Hospital	Whole Site	Installation of a fibre optic cable network and new <i>Gent</i> fire alarm panels
Royal Gwent Hospital	Various Departments	Installation of new fire detectors connected to the new <i>Gent</i> panel system and controlled by a graphical interface monitor

In addition to the above there has been a continued incremental improvement across all building stock.

11.4 Key Fire Risks

The key residual fire risks carried by the Health Board are related to management of the aging infrastructure and degradation of fire protection at older acute hospitals, namely the Royal Gwent and Nevill Hall Hospitals.

The safety of large numbers of inpatients at these hospitals relies on the capability of the alarm systems to give early warning of fire and the capability of fire walls and fire doors to stop the spread of fire through the buildings.

Fire Alarm Systems: The fire alarm systems at both hospitals have safety issues. At Nevill Hall Hospital the detectors in the inpatient areas and the staff residencies are 4 years older than their recommended life. In other 'backroom' areas 28-year-old detectors that have a 14-year recommended lifespan are still in use.

At the Royal Gwent Hospital, the situation is more severe. The control panels that monitor the detectors on the system are obsolete and spare parts are no longer being manufactured. On two occasions in 2023/24 fire alarm panels have failed resulting in the loss of detection to whole departments. On these occasions spare parts were obtained and repairs were made but there are no guarantees that this will continue to be the case.

A network of replacement panels is in place alongside the obsolete panels and some mitigation can be provided by systematically installing new detection in areas, transitioning to the new system and harvesting the replaced older panels for spare parts. This process has commenced but is facing significant obstacles including a lack of a clear funding strategy.

Fire Walls and Fire Doors: The safety of inpatients at the Royal Gwent and Nevill Hall Hospitals relies on the ability of the structure of the buildings to withstand fire and stop fire spread between wards.

Management of fire barriers fitted across hospital sites is problematic. The Fire Safety Team are working collaboratively with Facilities to introduce measures to ensure that fire barriers are effectively managed and protected.

A survey conducted at Nevill Hall Hospital has identified extensive works that is required to fix damage to the fire walls.

Applications for funding in 2023/24 to carry out remedial works at Nevill Hall Hospital and commission a compartmentation survey at The Royal Gwent Hospital were unsuccessful.

11.5 Emerging Risks

Capital investment is required to mitigate fire safety risks in the following areas.

- Expand the new fire alarm system at Royal Gwent Hospital and reduce the number of areas covered by the old system
- Replacement of end-of-life fire detectors on Levels 3 & 4 at Nevill Hall Hospital
- Replacement of end-of-life fire detectors at County Hospital
- Replacement of end-of-life fire detectors at Ysbyty Aneurin Bevan
- Replacement of the fire alarm system in the old hospital buildings at St Woolos Hospital (the system is not acceptable to modern standards, however clarity on the future use of the buildings is required before a commitment to spend circa £300k on a replacement system can be made)
- Establishment of a system to manage compartmentation to avoid a damage and repair cycle.
- Risks associated with aging electrical infrastructure on older sites.
- Risks associated with aging ventilation infrastructure (Fire Dampers) for inpatient areas on older sites.

11.6 Planned Improvements

The following improvement schemes are planned to be completed in 2024/25.

- Partial replacement of the fire alarm system at Royal Gwent Hospital Site including fitting new detection and transition of levels 6 & 7 C & D Block to the new fire alarm network.
- Full replacement of the fire alarm system at St Cadocs Hospital.
- Repairs to fire partitions on Ward 4/1 at Nevill Hall Hospital.
- Replacement of 30-minute fire doors with 60-minute fire doors on ward 4/1 at Nevill Hall Hospital.
- Replacement of out-of-date detectors on level 4, including wards 4/1, 4/2, 4/3 and 4/4 at Nevill Hall Hospital

11.7 Future Challenges and Priorities for the Fire Safety Team

The strategic goals for the Fire Safety Team are to improve fire strategies at older hospitals while replacing older, complex and costly alarm systems with modern systems incorporating graphics information displays that are easier to manage and more economical to maintain.

A lack of available information on safety systems at these buildings continue to pose challenges in the move away from generic fire safety strategies to the provision of detailed, site specific fire safety building strategies. Continued improvement will rely on acquisition of reliable documents such as:

- Fire Zone Plans
- Fire Alarm Cause and Effect Matrices
- As Fitted Fire Alarm System Device Drawings
- Fire Damper Plans
- Detailed Fire Evacuation Plans
- Detailed Fire Evacuation Notices for Staff and Visitors
- Detailed Fire Response procedures

11.8 Fire Safety Advice and Support for Internal and External Partners

The Fire Safety Team provides advice and support to both internal and external partners across a variety of issues affecting fire safety.

Internal queries include advice and assessment of risk posed by shutting off areas to allow building work and application of building regulations for the repurposing of individual areas within a hospital.

External queries range from assessment of the suitability of fire safety building materials, design of cause and effect for fire alarm systems to active consultation with project managers on fire safety building regulations and fire strategies during the planning phase of new builds.

On completion of projects the Fire Safety Team provide training, risk assessment and updated fire safety strategies for new or repurposed areas and buildings.

The Fire Safety Team has been involved in the following projects currently being progressed or completed within the last financial year:

- Adoption of Chepstow Community Hospital from PFI
- Extension to Emergency Department (ED) at the Grange University Hospital
- Satellite Radiology Unit at Nevill Hall Hospital
- Newport East Wellbeing Centre and Temporary Accommodation
- Upgrade to Pharmacy at Royal Gwent Hospital
- Decontamination Suite at Royal Gwent Hospital
- Crisis Hub at St Cadocs Hospital
- Replacement Roof Glen Usk Suite at St Cadocs Hospital
- The Bevan Health and Wellbeing Centre

11.9 Fire Safety National Groups

In addition to their duties for the Health Board the Fire Safety Team are actively engaged as members of The National Association of Healthcare Fire Officers (NAHFO). Fire advisors attend regular meetings of the Wales Branch of NAHFO where they receive updates on fire safety building regulations and legislation and discuss common issues and best practice with colleagues from the other health boards in Wales and Shared Services fire advisors.

The Fire Safety Team are also involved in the All-Wales Fire Safety Managers Group. The group is engaged in the development of a number of All Wales Fire Safety protocols, the Health Board currently chair the working group on Control of Ignition Sources and contribute to groups working on Fire Safety Training and Fire Safety Considerations for Bariatric Patients on Healthcare Premises.

11.10 Fire Safety Incident Reporting

There has been a reduction in the number of fires in 2023/24 compared with 2022/23.

The number of unwanted fire signals (UwFS) reported in 2023/24 has seen a 22.6% increase compared with 2022/23 (See figure 8).

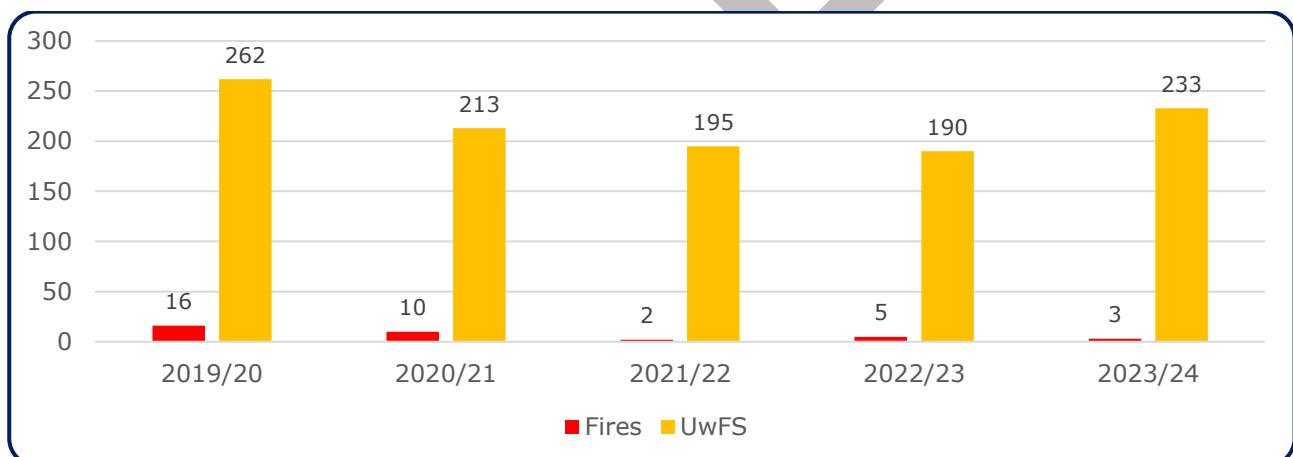


Figure 8: Number of reported fire safety incidents for the past five financial years

The increase in unwanted fire signals is largely due to the rise in fire activations at County Hospital (56.5%) & Royal Gwent Hospital (33.9%). Figure 9 provides a comparison on the number of unwanted fire signals by hospital.

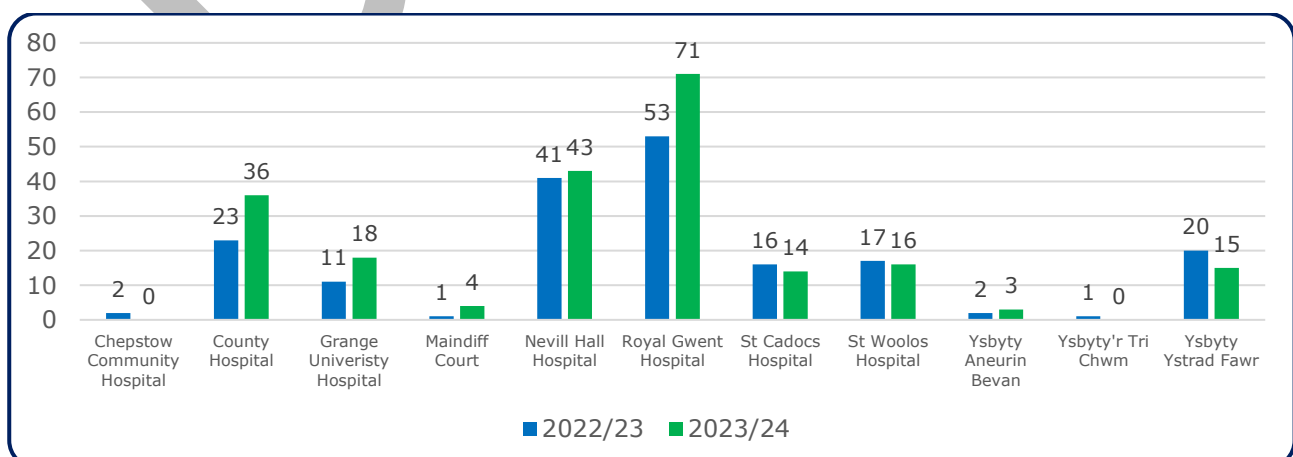


Figure 9: Number of reported unwanted fire signals by Hospital

Although the largest percentage increase in unwanted fire signals during 2023/24 has been reported against the Grange University Hospital the performance is regarded as acceptable (See figure 10).

Hospital	False alarms including UwFS	Actuation devices	Grade
Chepstow Community Hospital	0	504	no incidents
County Hospital	36	1018	C - 40% reduction in UwFS
Grange University Hospital	18	2978	A - performance should be maintained
Llanfrehfa Grange	6	400	B - 10% reduction in UwFS
Maindiff Court Hospital	4	388	B - 10% reduction in UwFS
Monnow Vale Health & Social Care Facility	0	169	no incidents
Nevill Hall Hospital	43	2850	B - 10% reduction in UwFS
Royal Gwent Hospital	72	4560	B - 10% reduction in UwFS
St Cadoc's Hospital	14	1225	B - 10% reduction in UwFS
St Woolos Hospital	16	953	B - 10% reduction in UwFS
Ysbyty Aneurin Bevan	3	1150	A - performance should be maintained
Ysbyty Tri Chwm	0	130	no incidents
Ysbyty Ystrad Fawr	15	2267	A - performance should be maintained

Figure 10: Unwanted fire signals performance indicators by Hospital for 2023/24

The performance calculations are based on the size of the systems as well as the number of unwanted signals. On this basis, Grange University Hospital generated 0.60 false alarms per 100 devices for 2023/24 compared with 3.54 at County Hospital and 1.56 at the Royal Gwent Hospital (See figure 11).

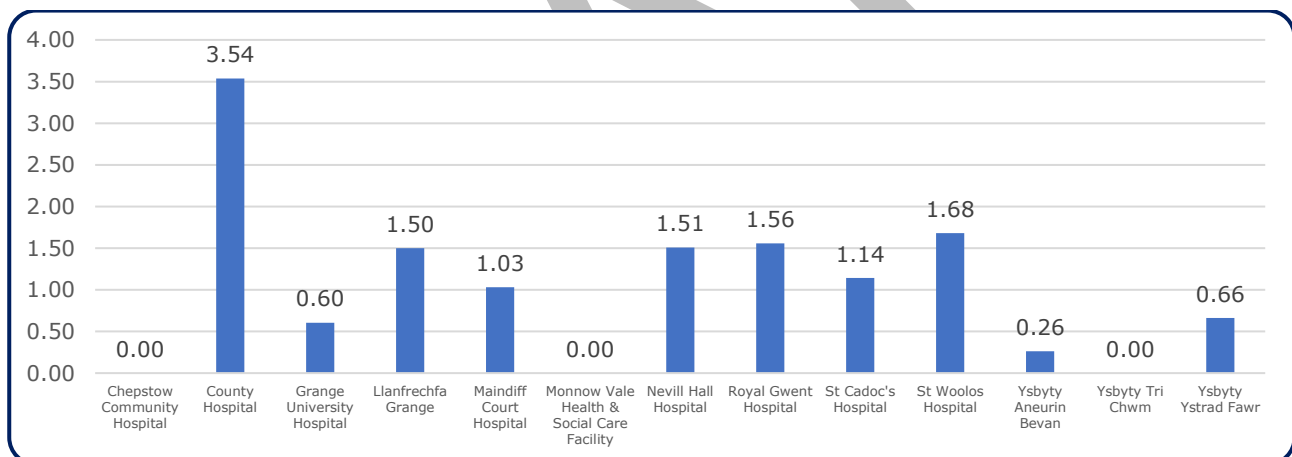


Figure 11: Number of unwanted fire signals per 100 devices

The Fire Safety Team investigate all fires, unwanted fire signals and incidents that are related to fire or any report or incident that may affect fire response.

The purpose of the investigations is to provide data to facilitate a reduction in false alarms and a reduction in the number and severity of fire incidents.

A significant proportion of the unwanted fire signals generated at County and Royal Gwent Hospitals in the period 2023/24 are directly related to the age and condition of the fire alarm systems.

At County Hospital 26 of the 36 unwanted signals were generated by old detectors that are due for replacement. Of the 72 false alarms at Royal Gwent Hospital 12 activations were directly attributed to faults on panels and another 15 to unspecified system faults.

Conversely, the number of unwanted fire signals caused by patients activating call points at County Hospital have reduced from 11 in 2021/22 to 1 in 2023/24 following a project to fit covers to the call points.

During 2023/24 the Health Board experienced two fires of note and two very minor incidents caused by discarded cigarettes in external areas on hospital grounds.

The first notable incident occurred at the Grange University Hospital in a sprinkler pump room in December 2023. One of two heating fans fitted to the room to ensure that the system does not freeze overheated and caught fire. The fire was quickly extinguished using an extinguisher and damage limited to the fan itself. The cause was attributed to a fault in the equipment. A survey was carried out of all heaters used for this purpose and all fans of this type were replaced with alternative models.

The second incident involved a domestic toaster that was in use in a staff kitchen at an office premises. The toaster developed a fault while in use that caused the plastic body to melt and ignite. The item was quickly extinguished using an extinguisher with no damage to the surrounding area. In response a safety notice was circulated to reinforce the policy that domestic toasters are not to be used on Health Board premises and that toasters procured via Procurement must have metal bodies and side panels.

12 MANUAL HANDLING & ERGONOMICS

The Manual Handling Team continue to provide mandatory training to support the education strategy, including providing expert advice as required i.e. selection of key equipment.

Based on current demands the Team's activity is primarily focused on training and improvements in compliance.

12.1 Manual Handling National Meetings

Manual Handling subject matter experts across NHS Wales meet on a quarterly basis to identify and support each NHS organisation with manual handling learning, best practice and action plan going forward.

12.2 Manual Handling Incident Reporting

The number of manual handling incidents reported in 2023/24 has reduced compared with previous years reporting (See figure 12). However, there has been a shift in the number of patient handling incidents and inanimate load handling incidents. Patient handling incidents reported this financial year has reduced by 35.1% from 2022/23.

There has been a 56.5% increase in inanimate load handling incidents in 2023/24 compared with the previous year.

To identify learning outcomes from manual handling incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix system.

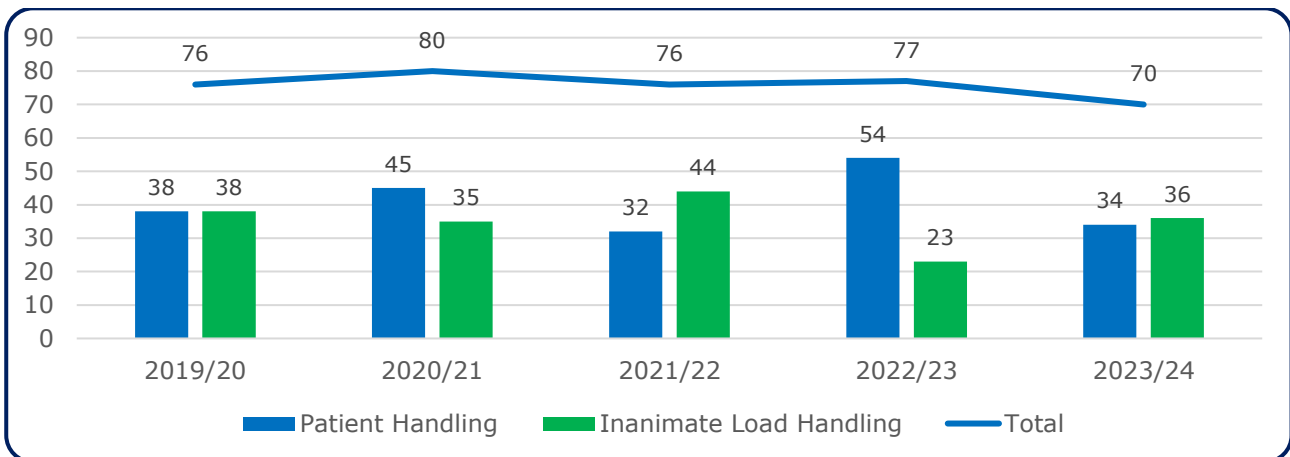


Figure 12: Number of reported manual handling incidents affecting staff for the past five financial years

12.3 Manual Handling Equipment

The Manual Handling Team lead on providing the necessary advice and support to the Health Board in the selection of manual handling equipment to aid in the delivery of care to patients.

All manual handling equipment and its accessories require the necessary testing, inspection or examination to ensure compliance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) or the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The service and maintenance of the manual handling equipment is contracted to an external provider. The service contract supports the Health Board to meet its legal requirements and identifies the need for investment in new equipment.

'Insight' assessments are planned for 2024/25 across all Acute and Community Hospitals. The assessments assess the mobility levels of patients, the type, age and condition of patient handling equipment available and service and routine maintenance information.

The findings will provide the Health Board with the following information:

- Patient handling equipment assessments.
- Identification of aged/obsolete equipment with limited/no service support.
- The need for new equipment to meet patient functional levels and care processes.

12.4 Manual Handling Patient Handling Risk Assessments

The Manual Handling Team have contributed to the implementation of the patient handling Welsh Nursing Care Record (WNCR).

12.6 Display Screen Equipment (DSE)

Since the outbreak of Covid-19 more Health Board Staff are working in an agile manner across the Health Board at various sites and from private premises, whilst the increased flexibility of agile working can provide many benefits to both the individual and Health Board, the legal requirement for the Health Board to ensure the health, safety and welfare of its employees continues to apply in agile working situations.

To ensure that the risks associated with agile working are properly identified and managed, a series of guidance documents and policy amendments have been developed as a means to support individuals who are identified as agile workers. This includes amendments to the Health Boards Policy for Workstation Display Screen Equipment (DSE) and Display Screen Equipment Risk Assessment Form.

The Corporate Health and Safety Department in collaboration with the Occupational Health Department have conducted DSE risk assessments for the more complex cases.

13 VIOLENCE & AGGRESSION

It is recognised that NHS staff (Hospital, Ambulance, Community and Primary Care) are among those most likely to face violence and abuse during the course of their employment and there is a strong public interest in prosecuting those who verbally and physically assault NHS staff deliberately.

Following a short hiatus, the Anti-Violence Collaborative (AVC) has been established. Following the group's reinstatement, there was a commitment to refresh the 'Obligatory responses to violence in healthcare document'. The document sets out the responsibilities of healthcare organisations when dealing with incidents relating to violence or aggression in the NHS.

Its focus is on those incidents that need to be addressed by the criminal justice system that includes:

- Improving the reporting of violent incidents.
- Strengthen the investigation and prosecution process by improving the quality and timeliness of shared information.
- Improve victim and witness care and confidence.
- Raise the issues of violence and aggression against NHS staff as well as the action that will be taken by all parties.

The Health Board is committed to the delivery of a safe and secure environment for staff and patients, so that the highest possible standard of care can be delivered. The Health Board plans to launch a new awareness campaign in 2024/25.

13.1 Violence & Aggression National Meetings

The Violence and Aggression Case Managers Group has been established as a Sub-group of the NHS Wales Health and Safety Management Steering Group. The group plays a crucial role in ensuring the safety of both staff and patients by developing and implementing strategies to prevent and respond to violence and aggression.

The purpose of the group is to:

- To provide a collaborative support to NHS V&A Case Managers.
- Ensuring that National Frameworks and Guidance associated with Violence and Aggression Management is successfully embedded and implemented across organisations. E.g. Obligatory Response to Violence and Aggression in Healthcare (ORV) and associated Welsh Health Circular.
- Establish Task and Finish Groups that will be responsible for the development of National Violence and Aggression Standard Operating Procedures/Guidance that can be adopted by NHS Wales E.g. Violence and Aggression Risk Management/

Assessment.

- The Group is also a forum for partner agencies from the CPS and the four Police Services in Wales, Health and Safety Executive to attend and participate, in order to foster good relationships and to ensure compliance with the aims of the ORV.
- Develop and agree Datix Violence and Aggression related codes. Review coding and changes to the Datix reporting system when necessary.
- Support and contribute to the review of the Violence and Aggression Training Passport and Information Scheme. Particularly in relation to risk assessment module.
- In support of the V&A Case Managers professional development, this Group will facilitate information and training opportunities for its members to participate, either as part of normal agenda or occasional separate events.
- To develop a minimum standard Job Description and Specification for a Violence and Aggression Case Manager.
- To inform the Anti-Violence Collaborative (AVC) of any relevant developments and concerns relating to the management of violence and aggression within NHS Wales organisations and seek support from the collaborative in influencing partner agencies in meeting the principles of the ORV.

13.2 Violence & Aggression Incident Reporting

Reported incidents of violence and aggression have increased in 2023/24 from the previous year by 2.7%. (See figure 13).

Approximately 53% of violence and aggression incidents in 2023/24 were reported from the Mental Health and Learning Disabilities Division. This is the same as the previous year (2022/23).

The increase in physical assaults reported in 2023/24 compared with 2022/23 is comparable with those reported between 2019/20 to 2021/22.

There has been a significant increase (283%) in the number of sexual assaults / sexual inappropriate behaviour incidents reported in 2023/24 compared with 2022/23. The data prior to 2022/23 has not been reviewed. A thematic review of sexual safety incidents is planned for 2024/25.

To ensure quality data is available the Corporate Health and Safety Department will validate all reported incidents of violence and aggression.

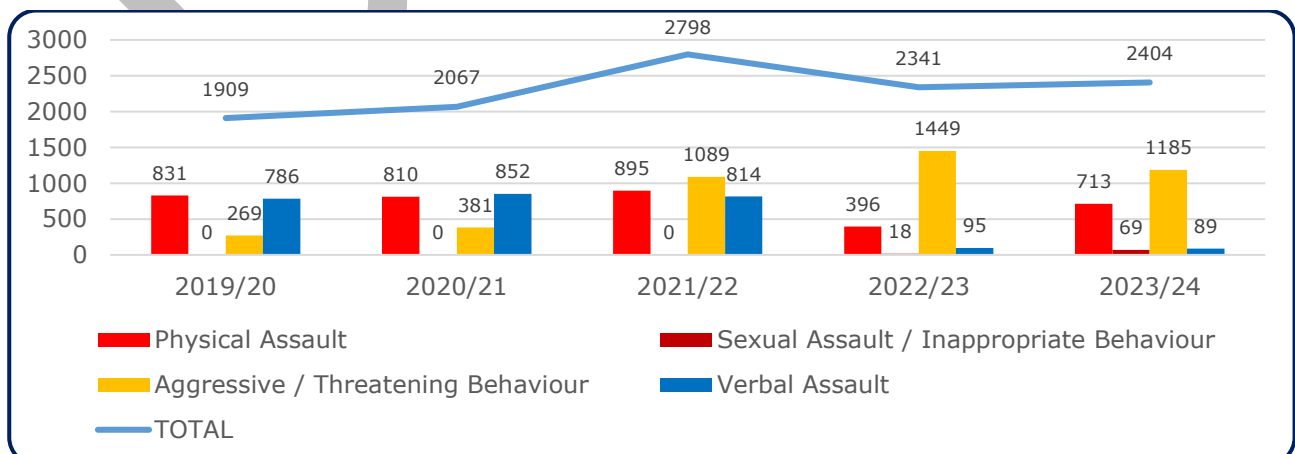


Figure 13: Number of reported violence and aggression incidents for the past five financial years

13.3 Support for NHS Staff Members

The Violence & Aggression Case Management Team continue to support staff who have been subjected to incidence of workplace violence & aggression and where matters relating to personal safety are identified.

Where incidents are reported via Datix Cymru, a Violence & Aggression Case Manager is assigned to the incident and will provide advice in relation to the investigation of the incident, signposting to relevant support services. A new collaborative approach to supporting victims of crime has been implemented and includes Wellbeing Services, Occupational Health and Connect Gwent to offer specialist and bespoke support to Health Board employees.

Between April 2023 and March 2024, the Violence & Aggression Case Management Team has been actively involved in 1,146 incidents, demonstrating their critical role in supporting Health Board Employees who have been subjected to incidents of workplace violence and aggression.

Figure 14 illustrates the Violence & Aggression Incidents with V&A Case Manager Involvement during 2023/24.



Figure 14: Number of violence and aggression incidents with V&A Case Manager involvement

13.4 Engagement with Gwent Police

During 2023/24 the Health Board has further improved its working relationship with Gwent Police, which has resulted in increased collaboration and wider partnership engagement.

As part of these improved relationships the Health Board has also been able to implement a new ABUHB and Gwent Police Violence and Aggression Incident Review group which brings together key Health Board Employees and Gwent Police colleagues where the aim of the group is to implement a multi-agency approach to incidents of violence and aggression to reduce risks and attempt to achieve the safest outcome for the person, emergency services workers and members of the public.

13.5 Police Outcomes

Following a review of reported incidents, the Health Board is engaging with the NWSSP Once for Wales Programme Team to progress enhancements to Datix Cymru to enable accurate recording of outcomes e.g. civil, criminal sanctions in relation to violence and aggression incidents.

The alignment of the terminology used by the Police and Crown Prosecution Service (CPS) with the language used by the Health Board when recording outcomes of crimes will support more accurate and consistent reporting and enable more effective partnership working.

13.6 All Wales Violence Prevention and Reduction Standard

During the period 2023/24, significant progress was made on an All-Wales basis to enhance the management and prevention of violence and aggression within NHS Wales.

A key focus has been on the comprehensive review of the NHS England Violence Prevention and Reduction Standard, with the aim of updating and adopting it as a new Welsh standard.

This collaborative effort has involved stakeholders from across NHS Wales, including health boards, and other key partners such as the Anti-Violence Collaborative. The review process has entailed a detailed assessment of the existing standard, with particular attention to its relevance and applicability within the Welsh healthcare context. This has included evaluating current best practices, identifying potential areas for improvement, and ensuring that the standard aligns with the unique operational, cultural, and regulatory environment of NHS Wales.

The adoption of this updated standard is anticipated to bring several significant benefits to the Health Board, including:

Enhanced Safety for Staff and Patients: By implementing a robust and comprehensive framework for violence prevention and reduction, the updated standard will contribute to a safer working environment for staff and a more secure care environment for patients.

Consistency Across NHS Wales: A standardised approach will ensure that all NHS Wales organisations adhere to the same high standards, reducing variability in practices and enhancing the overall quality of violence prevention and management across NHS Wales.

Improved Reporting and Accountability: The new standard will establish clearer protocols for reporting incidents of violence and aggression, leading to better data collection, analysis, and accountability. This will enable NHS Wales to monitor trends, identify high-risk areas, and allocate resources more effectively.

Increased Staff Support and Training: The standard emphasises the importance of training and supporting staff in recognising, managing, and de-escalating violent situations. This will not only improve staff confidence and competence but also reduce the likelihood of incidents escalating to physical violence.

14 CONCLUSION

This report highlights the level of health, safety and fire focussed activity that has been undertaken during 2023/24 to improve the management of health, safety and fire in the Health Board.

The Health and Safety Committee continues to promote the health and safety programme.

The Corporate Health and Safety Department works to actively support the delivery of safe and compliant systems within the context of a health and safety culture. Failure to embed an interdependent and mature health and safety culture presents a risk to the Health Board.

The internal health and safety monitoring programmes are continuously improving as is the ongoing health and safety training programme.

There are challenges in relation to the current level of resource available within the Corporate Health and Safety Department to support the delivery of the legal requirements of health, safety and fire.

The implementation of the health, safety and fire improvement plan in 2023/24 provided a focus for the Health Board on key risk areas. This had a positive reduction on the risk level associated with each area.

An improvement plan will be developed for 2024/25 to address the risk areas for focus. Implementation of the actions, outlined in the improvement plan will support the Health Board to demonstrate continuous improvement and compliance with its legal responsibilities.

An Internal Audit is planned for quarter 4 of 2024/25 to assess the health and safety arrangements within the Health Board.

RISK THEME	COMPLIANCE AND SAFETY				
SRR 010	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974			Publication Status	Public
Strategic Threat	A. Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.		Risk Appetite Level - MINIMAL. Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.		
Impact	- Unintended physical harm; - Punitive actions from the Health and Safety Executive (HSE); - Increased levels of staff sickness; - Loss of estate due to unsafe environments; - Financial implications; - Adverse publicity; and, - Reputational damage		Risk Appetite Threshold - 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.		
			SUMMARY The current risk level is OUTSIDE of target level and OUTSIDE appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
			Expected Date Target Score will be Achieved –		
			18 Months		
Lead Director	Director of Allied Health Professions and Health Science	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	01 December 2023	Impact	4 (Major)	3 (Moderate)	
Last Reviewed	01 November 2024	Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (Quarterly based on risk score)	01 January 2025				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. - Health and Safety Policies and Procedures - Dedicated Health and Safety site on ABPULSE - Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 ‘Health and Safety Assistance’. - Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) - Partial Programme of Health and Safety Monitoring (Active & Reactive) - Corporate and Directorate Health and Safety Risk Register established. - Board Training /development (Completed 24 April 2024) - Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. - Health and Safety Governance and reporting arrangements (Health and Safety Committee)	- Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System - Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) - Consultation and communication with the workforce regarding compliance with the Act - New ways of working with Divisions to ensure accountability for health and safety is recognised. - Implement key performance indicators to monitor health and safety compliance. - Review the governance arrangements for the Health & Safety Committee - Health and Safety Policies and Procedures to be reviewed. - Onboard further Manual Handling trainers across the organisation to improve compliance. - Scope for training non-Health Board staff - Learning from events to be documented and communicated to the organisation.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
Health and Safety compliance data extracted from ESR and Datix and reported	- Implementation of a health and safety performance report - Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. - Compliance on completion of risk assessments and mitigating actions	- Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. - Review the membership and ToRs of the Health and Safety Committee - Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		

- Established monitoring of H&S at the Executive Committee - Corporate H&S report risk and assurance to the Health and Safety Committee - Established monitoring of H&S at the PQSO Committee				
Level 3 Independent (Implemented by both auditors internal and external independent bodies)				
Internal Audit 2024/25 Plan - H&S processes - Performance reviews at All Wales Health and Safety Management Steering Group - South Wales Fire & Rescue Service fire safety audit programme. - Health and Safety Executive reviews/inspections.				
Assurance Rating (Overall Assessment of controls and assurances)				
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance	

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Electronic Prescribing & Medicines Administration Programme Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Solloway – Director of Digital
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Solloway – Director of Digital

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

To provide an update on the NHS Wales Electronic Prescribing & Medicines Administration programme (ePMA) and the implementation across Aneurin Bevan University Health Board.

ADRODDIAD SCAA

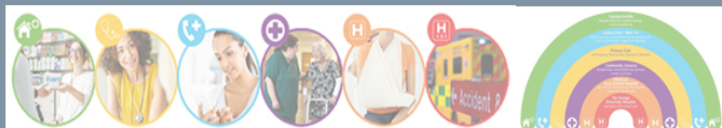
SBAR REPORT

Sefyllfa / Situation

The Health Board is currently running a digital programme of work to procure and implement a new ePMA solution. The primary aim of the ePMA solution is to remove paper-based processes from prescribing and medicines administration to significantly improve patient safety and quality of care. In addition, an electronic system will improve the Health Boards medicine management processes and enhance medicines optimisation and drug expenditure. This will enable greater control over what is prescribed, where it is prescribed and how it is prescribed and administered.

The implementation of a new ePMA solution will be a significant transformational change for the Health Board. It is estimated that the ePMA system will be accessed by approximately 6,500 members of staff. The successful implementation will be heavily reliant on the adoption and support of staff from all clinical areas covering Medicine, Nursing and Pharmacy.

To date Welsh Government, via its Digital Priorities Investment Fund (DPIF), has fully funded the pre implementation phase of the local programme, supporting a procurement exercise and business case development, and has recently



confirmed the first year of implementation funding for financial year 2024/2025, with further funding expected for financial year 2025/2026.

Following approval of the Full Business Case in December 2024 the Health Board signed a contract with Better Meds UK to purchase their ePMA solution, enabling the programme to progress to the implementation phase. This paper provides a detailed update on the programme's current position and plan for the coming months.

Cefndir / Background

The ePMA programme seeks to implement an electronic platform for prescribing and medicines administration across Health and is split into three distinct delivery programmes:

- Electronic Prescription Service (EPS) in Primary Care to enable the electronic transfer of prescriptions between primary care and community pharmacies
- Shared Medicines Record (SMR) to provide sharing of medicines, allergies and intolerances between NHS Wales organisations
- Implementation in secondary care settings to digitise medicine management processes

The above will be supported by the NHS Wales app to provide patients with access to their medication record, to be able to enter medicines taken at home and to select their preferred pharmacy.

Within secondary care, a new ePMA system will provide:

- Greater knowledge through improved data recording and availability of rich, routinely collected data, for clinical surveillance, audits and analytics
- A reduction in adverse events made through prescribing, transcribing and administration
- Improved monitoring, recording and checking by having a single source of truth e.g., for prescribed medications, allergies and Venous Thromboembolism (VTE) risks
- Time saving - accessing paper charts, admission assessments, drug rounds and re-writing charts
- Increased time available for direct patient care
- Improved administration records
- Reduction in omitted medications / doses
- Improved pharmacy order management
- Reduced expenditure – annual drug spend and paper related spend (purchasing and filing)

The ePMA solution scope will be hospital-based services including, but not limited to inpatients, outpatients, paediatrics including neonatal, Mental Health and Urgent / Unscheduled / Emergency Care. Scope also includes community hospital sites and Minor Injury Units where medicines are administered and prescribed.



The strategic drivers for the programme are multi-faceted. The delivery of a high-quality service to patients in Wales in the future will increasingly rely on the provision of efficient and effective information systems to underpin care delivery; *Informed Health and Care – A digital health and social care strategy for Wales* within the Welsh Government Programme details this.

Implementing ePMA systems in hospitals is one way to promote the safe and effective use of medicines for patients and is in line with the principles of prudent healthcare set out by Welsh Government. Introducing an ePMA solution is also one of the planned outcomes in the All-Wales Medicines Strategy Group's (AWMSG) five-year strategy 2013-2018 to improve patient care and the patient's experience of medicines in Wales.

To support the implementation of ePMA across Wales, an NHS EPMA procurement framework, with 3 selected suppliers was developed. As part of the framework agreement, Digital Health and Care Wales (DHCW) were identified as the framework operator with each individual health board being responsible for its own call off agreement with its chosen supplier, based on its own business requirements.

Following a significant piece of work to identify local requirements, the Health Board released a tender in September 2023. Following closure of the tender a full evaluation took place, and Better Meds UK were chosen as the preferred supplier. The full Business Case was approved by the Health Board in September 2024 and confirmation of funding from Welsh Government for financial year 24/25 was received shortly afterwards. Contract award was scheduled for October 2024, but this was delayed due to changes Better Med UK had requested to make. Following negotiations, the Health Board signed the contract on 18th December 2024.

To date the ePMA Programme has been working to timelines which directly correlate to Welsh Government funding via its DPIF funding stream. Reporting against funding milestones is overseen by DHCW.

Asesiad / Assessment

Current Position:

Funding

Funding has been received for financial year 2024/2025 and confirmation of Welsh Government (WG) funding for financial year 2025/2026 is awaited:

Capital	Revenue
Full allocation £320,554 (100% awarded on receipt of signed funding letter – letter signed 14/10/24)	Full allocation £754,414 (70% awarded initially with the remaining 30% to be paid upon achievement of funding milestones)

ABUHB's 24/25 Financial Year DPIF Funding Award

Contract



The Health Board and Better Meds UK signed the contract in December 2024 following delays due to negotiations around proposed changes by Better Meds UK; contract schedules will be finalised by the end of January 2025.

ICT / Hardware

Wi-fi assessment work has commenced and is a critical dependency for the programme. 18 Pharmacy micro-PC’s have also been delivered and are being trialled on wards at the Grange University Hospital (GUH) week commencing 13th January 2025.

Recruitment

The below posts were scheduled for recruitment in financial year 24/25.

Position	Start Date
Senior Responsible Owner (SRO)	3rd February 2025
Clinical Lead	In post
Programme Manager	20 th January 2025
Lead Pharmacist	1 st February 2025
Senior Digital Nurse	15 th February 2025
Senior Applications Specialist	Recruited, start date TBC
Digital Service Manager	1 st February 2025
Senior Project Manager	3 rd February 2025
Senior End User Compute Engineer	Started 13 ^h December 2024
ICT Senior Network & Security Analyst	Interviews W/C 6 th January 2025
Business Change Manager	In post
Programme Support Officer	In post

There are some positions scheduled for recruitment during the financial year 2024/2025 that are now at risk, due to the above key positions not starting until January/February 2025:

Role	Update
Specialist Nurse	Due to commence January 2025 – the Senior Digital Nurse will recruit this position when they commence in post
SRO	Due to commence January 2025 - Health Board to nominate SRO for the local programme
Specialist Consultant Lead	Due to commence January 2025 – a review of when this position needs to be recruited needs to be undertaken with the clinical lead

Finance Update

Forecast for financial year 2024 / 2025:

	Capital Funding	Revenue Funding
DPIF funding	£320,554	£754,414
*Total Budget (ABUHB & DPIF)	£320,554	£1,113,407



Spend to date	£224,441	£351,087
Forecast spend for remainder of year 24 / 25	£96,113	£761,996
Total expected spend for 24 / 25	£320,554	£1,113,083
Forecast Under/Overspend 24/ 25	£0	(£324)

*Total budget includes 30% of funding due to be paid upon delivery of funding milestones

Risks / Issues

Risk	Mitigation	Score
Because there are competing priorities across Wales and the DPIF fund is due to come to an end, there is a risk that WG funding could be re-prioritised for 2025-2026 and / or requested funding not allocated fully or at all, this will have a financial implication for the Health Board as costs will need to be picked up locally	• Collaborative working with WG • Completing WG finance returns on time and monitoring funding milestones • Maximising opportunities to reduce costs	10
Better Meds UK will be working with 3 Health Boards at the same time to implement ePMA, there is only a limited number of staff that work for Better Meds UK meaning there is a risk the supplier will have limitations with the support it can provide for ABUHB's implementation, this will result in programme delays and / or issues with the quality of support from the supplier	• Robust planning • Collaborative working with supplier • Close monitoring and management of risks / issues • Working collaboratively with other Health Boards and sharing lessons learnt	9
The signing of the ePMA contract scheduled for completion October 2024 was not done until the end of December 2024, due to negotiation in relation to some of the terms and conditions, therefore there is a risk that the programme will be extended beyond the planned end date of March 2028, this could result in additional unknown costs for the Health Board	• Robust planning • Consideration of tasks that can be transferred to the business-as-usual product delivery team • Close monitoring and management of risks / issues	6
There is currently no local SRO for the programme meaning that there is a risk in relation to ownership, governance and Health Board buy-in for the ePMA programme, this could result in business/project objectives not being	Health Board to appoint an SRO for the local programme	6

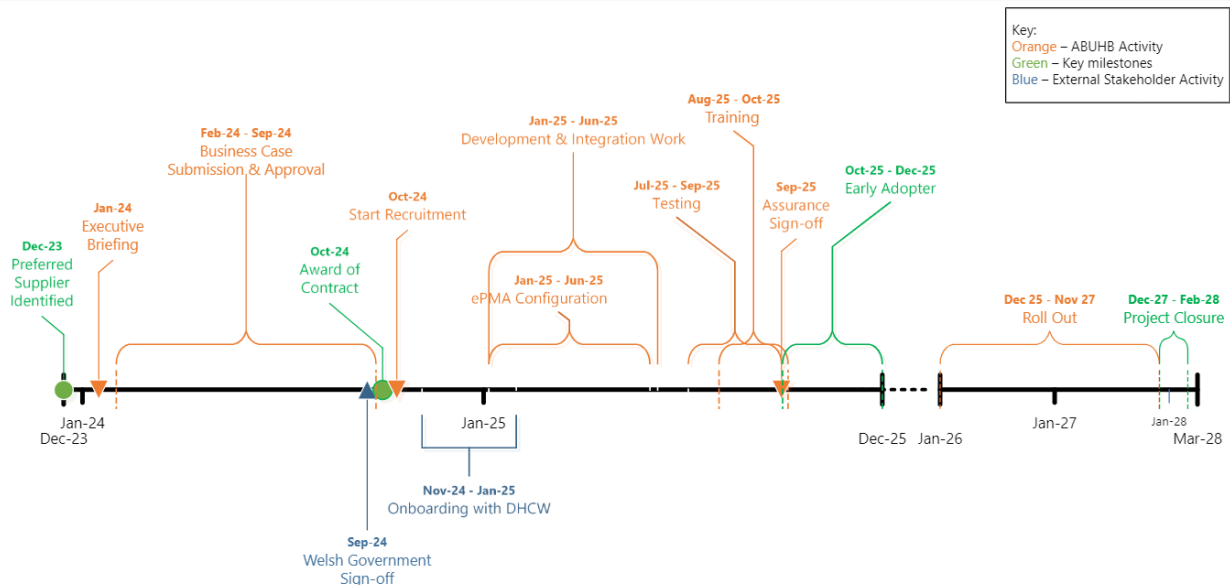


met due to lack of engagement, decision making and leadership		
Now the programme is able to commence with the detailed implementation planning, there is a risk that programme timelines have been under/overestimated, this could impact the project schedule either negatively or positively	Develop detailed plan with supplier and confirm timeline / critical path	6

Future / Implementation Plan:

Timeline review

The business case timeline that the programme is working towards is set out below. As detailed above there have been some delays with the signing of the contract, meaning that this timeline will need to be reviewed and updated when key project team members have taken up post.



Planning

Now that the contract has been signed the focus for the programme team over the next couple of months will be planning the full programme, taking a pragmatic approach to commence implementation tasks alongside. Where possible the plan will correlate to the overall timeline presented within the business case, aiming for an end date of March 2028. Any deviations that would extend the programme timeline will be communicated and managed appropriately through robust programme and digital governance in place.

Recruitment planned for financial year 2025 / 2026:

Position	Planned Start Date
Application Support	August 2025
Service Desk	August 2025
Pharmacy Technician x 2	August 2025
Pharmacy Technician	June 2025



Data Analyst	April 2025
Digital Nurse Support x 3	June 2025
Digital Nurse Support	April 2025
Project Implementation Manager	April 2025
Site Lead	April 2025
Senior Pharmacy Technician	April 2025
Senior Digital Pharmacist	June 2025
Junior Doctor	October 2025

There are also other relief / supporting roles (not defined) that have been funded and will need to be determined through planning over the coming months.

Shared Medicines Record

The ePMA programme team is working closely with DHCW on the development of their Shared Medicines Record. The Shared Medicines Record will enable a single shared record of medicines for every patient in Wales that will be easily accessed by healthcare staff and will bring all medication information for a patient together in one place, including current and previous medicines.

This information will help support clinical decisions and reduce risk at points of transfer of care by capturing, storing, collating and sharing data from Health Board ePMA systems.

The Shared Medicines Record is currently undergoing testing and has been made available for suppliers to test including those health boards who are currently implementing ePMA systems.

In January test migrations of patient allergies and intolerances to the Shared Medicines Record is also planned.

Primary Care Electronic Prescription Service (EPS)

The Primary Care EPS has commenced roll out in Wales and is currently live in four GP practices in Gwent. Further roll out is scheduled throughout 2025 with the current high-level plan shared below. Each go live can take 12-16 weeks:

GP Practice	Projected Go-Live
W93057 Abersychan Medical Group, Pontypool	w/c 20th January 2025
W93024 Oak Street Surgery, Cwmbran	w/c 17th February 2025
W93004 Tudor Gate Surgery, Abergavenny	w/c 24th February 2025
W93115 Blaina Medical Practice	w/c 12th May 2025
W95068 Bryntirion Surgery	w/c 2nd June 2025
W95081 Meddygfa Cwm Rhymni Practice	w/c 16th June 2025
W93018 Isca Medical Centre	w/c 30th June 2025
W93068 Brynmawr Medical Practice	w/c 7th July 2025
W93058 Pontypool Medical Centre	w/c 28th July 2025
W93039 St Paul's Clinic	w/c 11th August 2025
W93048 Bellevue Surgery	w/c 1st September 2025
W96012 Llanfyllin Group Practice	w/c 1st September 2025
W97018 St Davids Court Surgery	w/c 1st September 2025



W93054 St David's Clinic	w/c 8th September 2025
W93051 Malpas Brook Health Centre	w/c 15th September 2025
W93045 Westfield Medical Centre	w/c 15th September 2025
w93063 Tredegar Medical Practice	w/c 29th September 2025
W93040 Park Surgery	w/c 29th September 2025

The Health Board is supporting this as required alongside the National Digital Medicines Transformation Portfolio and attends a national EPS advisory group which seeks to agree the ongoing implementation across Gwent.

Dispensing suppliers, including EMIS, are undergoing national assurance activities, which is a dependency on future roll out plans. To date, four of the seven suppliers have had assurance completed. Each assurance process takes four months to complete.

To date across Wales the rollout is currently at:

- 25 out of 371 GP practices
- 88 out of 689 pharmacies
- 500,000 prescription items have been dispensed

Other activities

Marketing, engagement and promotional activity has commenced however this needs to be planned and taken forward over the coming months.

Argymhelliad / Recommendation

The Board is asked to NOTE progress made to date.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 3.1 Safe and Clinically Effective Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety



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 prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	AWMSG - All-Wales Medicines Strategy Group DHCW – Digital Health and Care Wales DPIF – Digital priorities investment fund ePMA - Electronic prescribing & medicines administration EPS - Electronic Prescription Service (EPS) GUH – Grange University Hospital SMR – Shared Medicines Record SRO – Senior Responsible Owner VTE - Venous thromboembolism WG – Welsh Government
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb	No does not meet requirements



Equality Impact Assessment (EIA) completed	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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Winter Resilience Plan 2024/25 Progress Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Executive Director Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Chris Dawson-Morris, Deputy Director Strategy, Planning and Partnerships

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

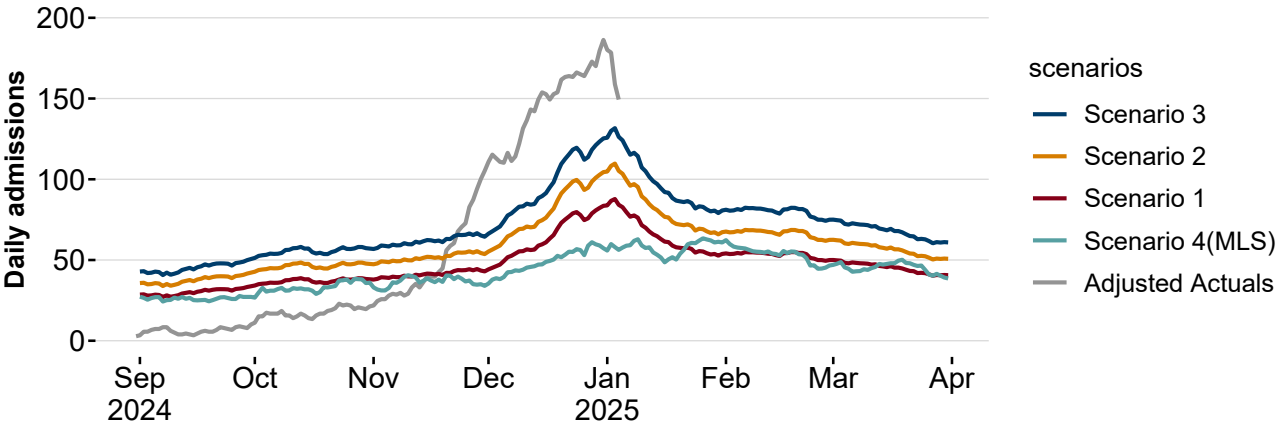
This paper sets out how the Health Board, with partners, has been responding to the challenges which have been faced by the health and care system over the recent months. This report provides an interim review of progress of implementation of the Winter plan and the status of the current Health and Care system position. A full review of Winter will be provided to the Board in July.

Cefndir / Background

Current Situation

The Health Board is under significant operational pressure with impacts on staff and activity. The pressure is being driven by higher than projected flu admissions. This is impacting across UK Health systems. The graph below sets out the actual admissions against the national modelled scenarios provided by Public Health Wales and Welsh Government.

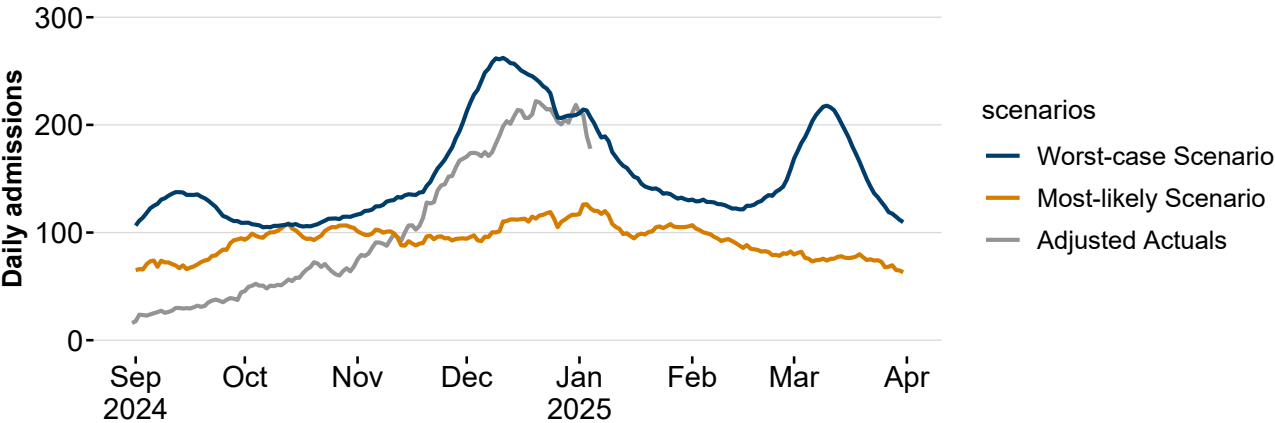
Daily Influenza Winter 2024/25 admissions scenarios, data until 04 Jan 2025



Scenario	Description
Scenario 1	Average of non-pandemic years (2017/18, 2018/19, 2019/20, 2022/23 and 2023/24)
Scenario 2	Scenario 1 multiplied by 1.25
Scenario 3	Scenario 1 multiplied by 1.5
Scenario 4	Repeat of last year's data (2023/24)

The overall impact of respiratory viruses is therefore following the modelled worst-case scenario, significantly above the most-likely scenario for respiratory admissions and earlier than anticipated.

Daily Combined Winter 2024/25 admissions scenarios, data until 04 Jan 2025



The system remains under significant pressure. Notably staff absences from respiratory conditions across health and social care are impacting on ability to flow patients through the system and the consequential infection (IPC) restricts access to capacity in a number of places.

In the Winter plan provided to the Board in November, the organisation set out the following metrics which would be monitored to understand the impact of activity to mitigate respiratory and wider winter challenges.

Measures
Vaccination rates – Public and Staff
Length of Stay
Bed Occupancy
Delayed Pathways of Care
ED Demand
Staff Absence

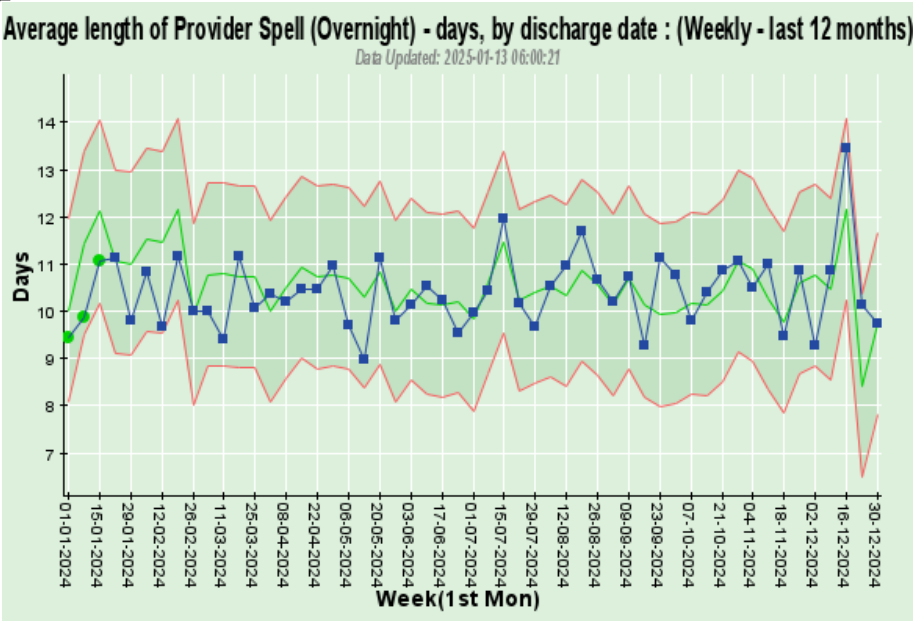
Updates on these metrics is set out below:
Vaccinations

Summary of progress to date:

COVID-19 (as of 2 nd Jan)	• 47.24% coverage, higher than all Wales figure of 43.22%. • 75.78% uptake amongst care home residents, higher than all Wales figure of 72.33%. • 60.91% uptake amongst adults over 65, higher than all Wales figure of 56.15%.
Flu (as of 2 nd Jan)	• 70.9% uptake amongst adults aged 65 and older, higher than all Wales figure of 67.9%. • 37.4% uptake amongst people at clinical risk aged 6 months to 64, higher than all Wales figure of 33.8%. • 34.5% uptake amongst ABUHB staff as of 14th week of campaign.
RSV (December Report)	• 33.7% uptake amongst adults reaching 75th birthday between 1st Sep 2024 and 31st Aug 2025, higher than all Wales figure of 22.0%. • 1.13% uptake amongst adults aged 75-79 as at 1st Sep 2024, lower than all Wales figure of 17.45%.

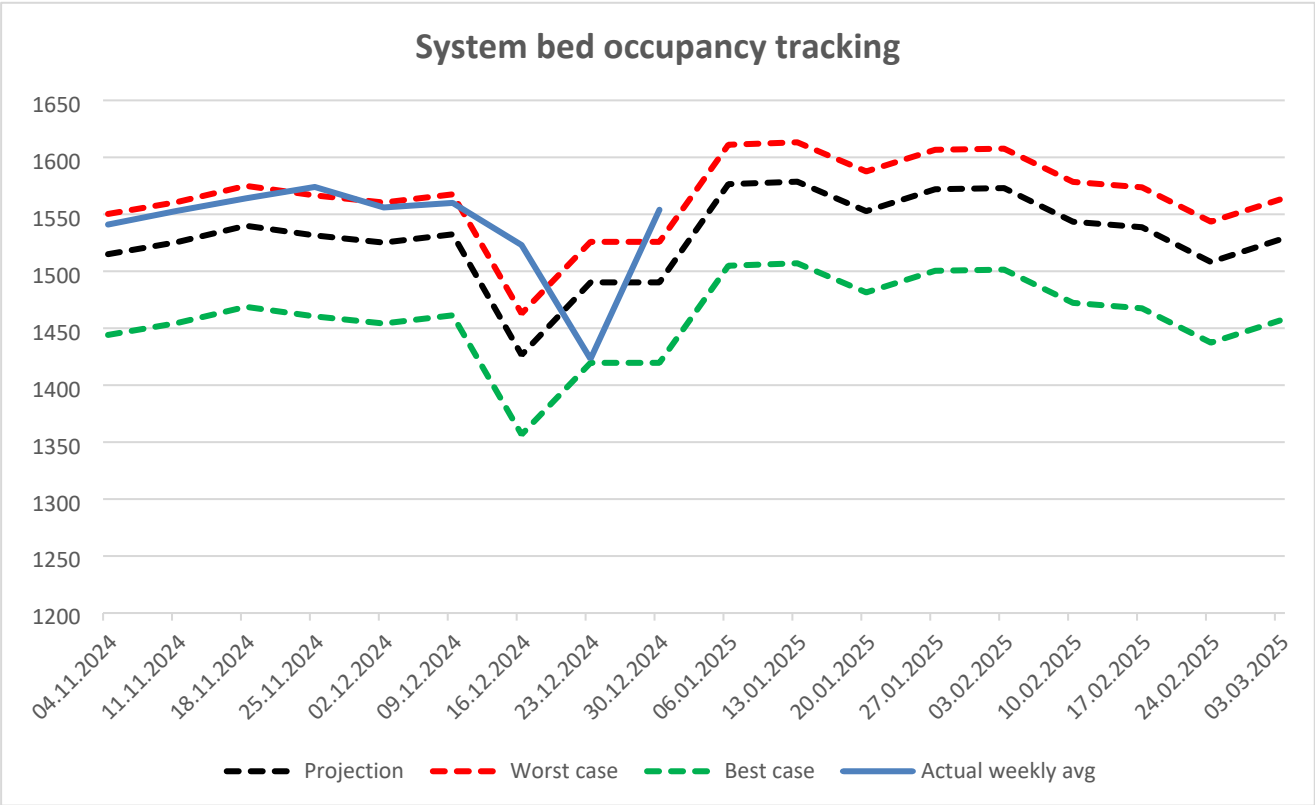
Whilst the Heath Board benchmarked well on these metrics against the all Wales figures, coverage is lower than previous years in the Health Board which presented increased risk to the system.

Length of Stay



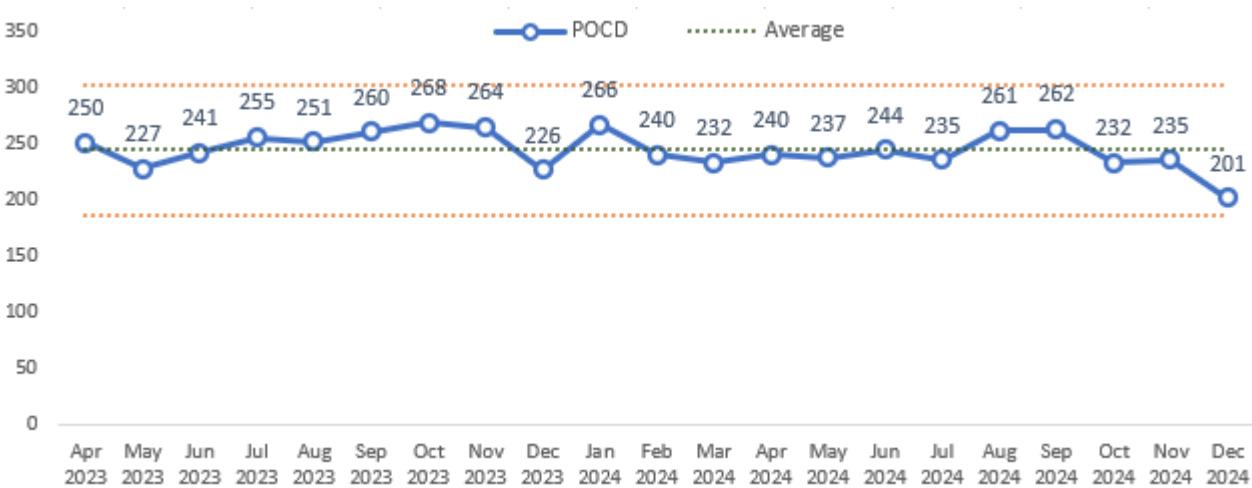
The graph above shows average Provider (whole spell) length of stay for patients with at least a single overnight stay, by discharge date. Performance has been relatively stable throughout 2024, however there was a spike in the lead up to Christmas driven by an increased volume of discharges for those with longer lengths of stay.

Bed occupancy



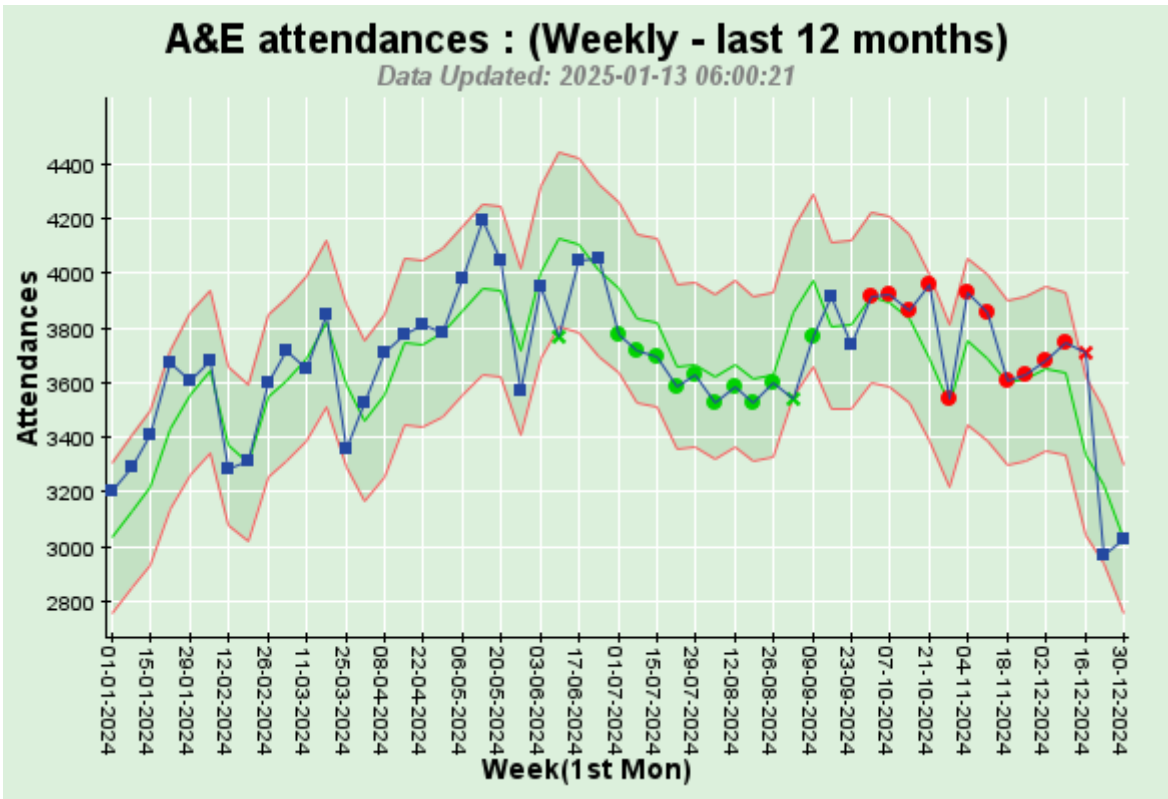
Bed occupancy had been broadly tracking close to the upper limit of what was forecast in the lead up to the end of the calendar year. There was a significant decrease during Christmas week, followed by a sharp rise a week later which has been driven by a surge in demand for medical beds. This has continued into the new year with indications for w/c 6th Jan that average weekly occupancy will be at or slightly higher than the upper limit of what was forecast (1,611).

Pathway of Care Delays



Pathways of Care Delays (POCDs) decreased significantly from November to December, which is a trend seen for the same months in the historic data. There had been sustained improvement over Quarter three with a reduction of 23% in recorded POCDs. There are several actions in place as part of the 50-day challenge detailed later in this paper to proactively manage and enable the reduction of POCDs, particularly focussed on those with the longest delays.

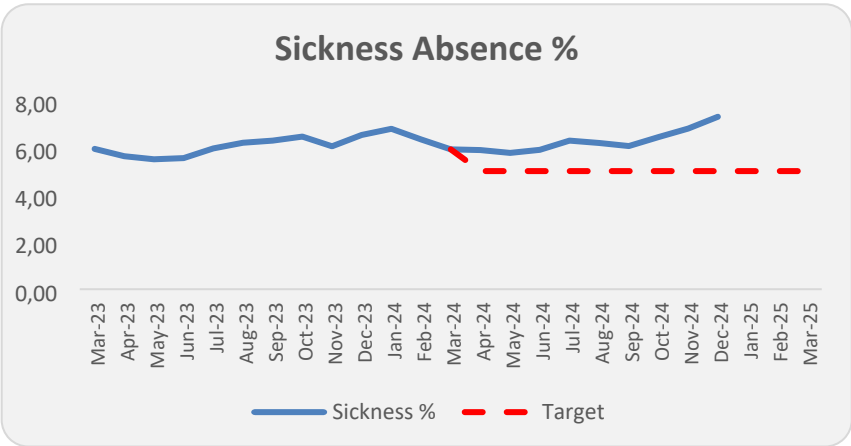
Emergency Department Demand



ED demand profile had been higher than expected from October to mid-December, although largely still within control limits (one data point outside). Attendances decreased as expected during the final two weeks of the year, early indications for

w/c 6th Jan are that demand is back up to levels seen in early Dec which will be higher than typically seen/forecast.

Staff Absence



Sickness Absence in December 2024 was 7.30% (965wte lost) which was an increase of 0.50% (67wte) compared with November 24. The most notable rises in absence were in divisions with frontline contact roles for example a 2% rise in urgent care, 1.47% rise in continuing health and funded nursing care and a 0.8% rise in primary and community care.

Stroke Services

The Health Board was alerted in late December 2024 to an urgent service change being triggered in neighbouring Cwm Taf Morgannwg Health Board regrading acute stroke services. On 8 January 2025 the acute stroke service in Prince Charles hospital in Merthyr moved to the Royal Glamorgan Hospital in Llantrisant. This was in response to significant workforce challenges. The modelling suggests that the impact on the Grange University Hospital (GUH) will equate to an additional 2 patients a week as Powys patients and northern Caerphilly and Blaenau Gwent borough patients are now (in accordance with clinical standards on timely access) to be redirected into the GUH. Further work is required to understand the actual impact of this change in an already pressured acute stroke pathway at GUH.

Summary

This data reflects the impact of respiratory infection on our system with high medical occupancy, increased ED attendances in addition to lower than previous years vaccination coverage and increases in staff absence.

Asesiad / Assessment

Meeting the challenge

The Winter plan was focused around:

- Health Board actions – primary and community services and hospital system,
- Partnership Actions - the 50 day challenge and RPB actions
- Prevention actions – vaccination and communication
- Resources – the focus of workforce and OD and financial implications

As set out in the November 2024 Board paper the challenge was to mitigate the potential equivalent of between **85 and 130** hospital beds based on the likely modelled scenarios. The following section sets out the intended actions to support this mitigation.

Progress to date is set out in the following sections supported by the detail in Appendices A and B. This provides an interim update on the implementation of the plan. A full review will be undertaken for July Board.

HEALTH BOARD ACTIONS

Appendix A includes a table detailing progress against the key Health Board actions. Main points to note from this detail are:

- *Urgent & Primary Care Resource* – Enhanced mobile GP support has been put in place available during out of hours period. The additional capacity provided a further 53 weekend home visits in October and 33 in November supporting admission avoidance.
- *Community Rapid Response resource* – Extension of the hours for referring into the 7 day a week community CRT and enhancement with medical staff. December saw an increase of 30 referrals compared to with the same period last year.
- *Integrated Front Door* - Community front door therapies team (CAATT) launched 7 day coverage at the Grange from 6th January. Acute Frailty saw 105 referrals in November, increasing to 30 referrals in December.
- *Winter Ward capacity* – 23 bedded Community ward opened on Sunday 5th January in the Royal Gwent Hospital.
- *Same Day Emergency Care (SDEC) "medical first" pilot* - Substantial increase in medical patients throughput into SDEC utilising an 'SDEC first' principle. In October 24 there were 211 Medical patients assessed in SDEC; in November that number rose to 538 and 497 in December.

Operational Framework

The Operational Framework has been designed to enhance the quality and safety of patient care by addressing systemic challenges in patient flow and ambulance handover times.

The primary aim of this framework is to ensure timely patient handovers from ambulances to hospital services, particularly during high demand periods and seasonal peaks. It clearly lays out the expectations for all parts of the system, helping us to maintain patient safety, minimise risks, and normalise operations post-escalation.

The framework covers roles and responsibilities across four key areas:

1. **Pre-Hospital** - This area focuses on optimising patient flow within community settings.
2. **Acute Front End** - Aims to improve efficiency in emergency departments, medical assessment units, and surgical assessment units, with an emphasis on timely patient reviews and discharges.
3. **Transport** - Discusses the services provided by the Welsh Ambulance Services NHS Trust, including emergency medical services, inter-site transfers, and non-emergency patient transport.

4. **Discharge Planning** - Ensures effective discharge planning, involving clear communication with patients and families, timely preparation of medicines, and coordination with nursing and residential homes.

Additionally, the framework highlights the importance of planned care capacity by identifying times when escalated actions are required. It sets out processes for decision-making to balance risks between urgent and planned services.

To support this, we have conducted ward visits across all sites led by an Executive to test the elements of the operational framework. These visits took place in December and aimed to identify any obstacles, assess how the framework is being embedded, and explore opportunities to simplify complex discharges. The formal debrief workshop that followed these visits has agreed upon further actions and development areas which will be progressed in the coming weeks. The framework was tested in real time during the recent Critical Incident (see below).

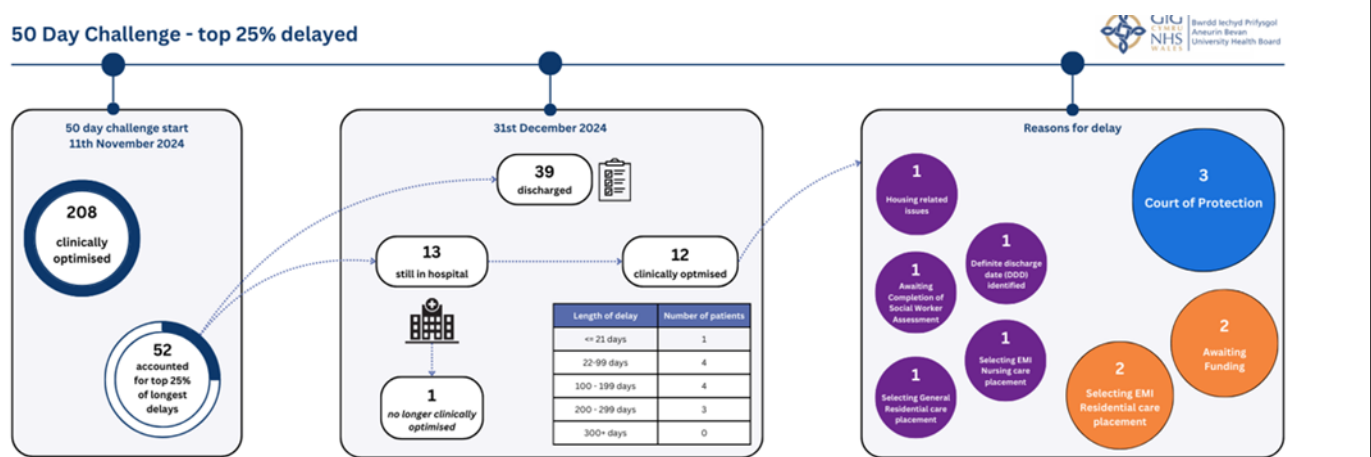
PARTNERSHIP ACTIONS

The System Resilience Plan actions have been managed through the Gwent Adult Strategic Partnership (GASP) which has delegated authority from RPB to manage this funding pot from RIF. Many of the scheme have been funded on an 18 month basis up to March 2025.

All Regional Partnership Boards were required to participate in the **50 Day Integrated Care Winter Challenge** with the aim of accelerating evidence based high impact actions that work but are not standardised across the region to further bolster system resilience in the lead up to the turn of the year.

The ambition of Welsh Government was for a 25% reduction in the longest pathways of care delays.

The 50 day challenge ran until Christmas day, progress against the target is set out in this infographic.



Appendix B details the progress against the core System Resilience Plan and the additional 50 day challenge actions which were introduced to complement the SRP. Key progress includes:

- *Step Closer to Home (SCTH) - Ad Hoc Spot Purchasing & Hospital to Home* – A decline in demand for ad hoc spot purchasing has led to a redeployment of this resource. Conversely the Hospital to Home work has expanded with extra “runs” being put on to support timely discharge, referrals via the front and admission avoidance.
- *Hospital to Healthier Home (H2HH) Expansion* - The service offers rapid home adaptations for patients leaving the hospital due to housing issues. 60 additional people are being supported each quarter due to the expansion of this service.
- *7 day working for Health & Social care* - Progress in all Local Authority areas to increase capacity over winter period to support assessments.
- *Enhanced oversight and focus* – revised structures in place to ensure more senior oversight and grip on complex patients and pathways. Deep dives undertaken with all Local authorities at individual patient level.

Additional 50-Day Challenge Funding:

Investment plan funding submitted to Welsh Government on 24th December 2024 to include:

- Health Board allocation of £764k, **community transition and assessment beds**, D7W at RGH, 23 additional beds
- Health Board allocation of £955k, **high risk patient cohort**, management of the most high-risk patient cohort identified in GP practices
- Local Authority allocation of £1,7m, **Reablement and Domiciliary Care Capacity** to provide addition short-time capacity

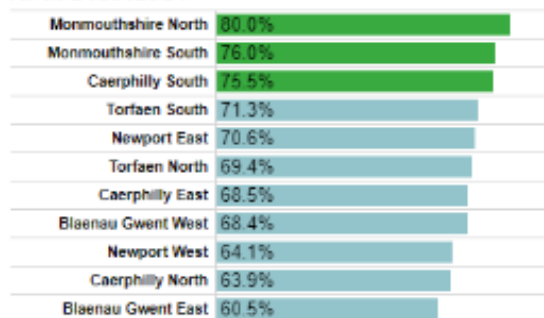
The Integrated Discharge Board is the agreed local delivery vehicle for the 50 Day Integrated Care Challenge and is being held on a fortnightly basis. An update on the 50 Day challenge was received by the RPB on 14th January.

PREVENTION ACTIONS

There is considerable variation across NCNs with a particularly low uptake in Blaenau Gwent East, Newport West and Caerphilly North There is also significant variation in uptake at GP practice level, with some practices having around 50-55% uptake compared with others delivering over 75% uptake.

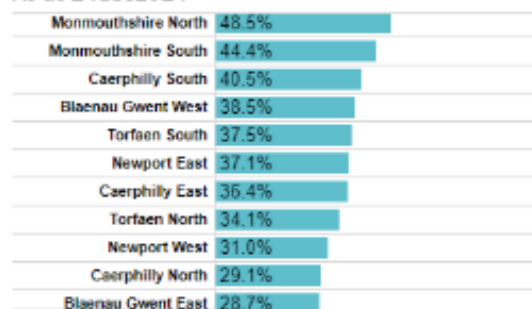
Figure 1: Variation in influenza vaccination uptake between NCNs

Aneurin Bevan UHB cluster summary
Flu immunisation uptake in: Patients 65y and older
As at 24dec2024



* Target 75% for 65y and older and all risk groups

Aneurin Bevan UHB cluster summary
Flu immunisation uptake in: Clinical risk patients
<65y
As at 24dec2024



* Target 75% for 65y and older and all risk groups

On 12 November 2024, in response to the letter from Welsh Government, the Winter Respiratory Vaccination Group agreed the following mitigating actions to improve influenza vaccination uptake in primary care:

- GP practices with concerning low uptake to be contacted by the Primary Care Contracting Team to: (a) highlight the recent modelling that suggests a peak in influenza levels early Dec; (b) understand the reasons for low uptake and steps being taken by the practice to improve their offer and take up of vaccination (c) discuss any additional support the practice may require from the ABUHB Vaccination Service in order to improve uptake
- Additional capacity to be provided from the ABUHB Vaccination Service to district nursing teams who are not confident they will complete influenza vaccinations for housebound patients by the start of Dec 2024.
- Pop-up clinics to be provided in areas with low uptake – particularly Blaenau Gwent East, Newport West and Caerphilly North – offering walk-in vaccinations for all cohorts. Targeted community engagement and communications aim to optimise access to these clinics.

RESOURCES

Workforce & Organisational Development

Despite some success with recruitment and retention campaigns this year due to local and national skills shortages there remain challenges with vacancies and higher staff absence during the winter months. The Health Board continues to expedite and prioritise the actions within the People Plan 2021-25 and support our partners in delivery of the Gwent Workforce Board programme of work.

Supporting employee wellbeing over the winter will continue to be a priority. The Employee Wellbeing Service and Organisational Development hosts evidence-based initiatives that contribute to improving and protecting staff biopsychosocial wellbeing across the Health Board.

The 12-month accumulative sickness absence rate of 6.4% (December 2024) is higher than last year at 6.29%. December actual sickness rate was 7.3% and equates to 965 WTE staff lost per month through sickness absence.

It is predicted that levels of absence over the winter period will rise further with a forecasted peak at 7.6% in January 2025. This is based on current sickness levels, previous trends and local intelligence. This will result in increased reliance on

temporary staffing solutions through bank and agency including block booking agency workers.

The winter ward has been established and opened with a mixture of block booking agency, bank and substantive staff.

There has been successful recruitment of 72 HCSW to the bank. 5 have started in a substantive capacity to support the winter. Start dates are planned for January, February and March 25.

Workforce forecasting has been undertaken on Health Roster shift fill rates with some mitigating actions being developed.

Critical Incident

In spite of the actions and progress outlined above, a combination of the impact of the earlier peak of respiratory presentations, lower levels of vaccination rates, occupancy tracking at worst case scenario consistently and the consequential IPC challenges and staff absences led to the Health Board calling a Critical Incident on Monday 13 January. Unabating pressure across many parts of the system resulted in:

- At the time nearly 60 calls awaiting an ambulance response in the community with the longest wait reaching 40 hours awaiting an ambulance to arrive.
- Long ambulance delays at the Emergency Department with some days seeing some patients waiting up to 24 hours to get into the department
- Patients stuck in the Emergency department and medical assessment unit at GUH awaiting admission some for up to 5 days.
- Up to 60 patients waiting to leave Grange to transfer to another hospital
- Intensive Care and Resus area significantly pressured
- Medical patients boarded on wards, surgical assessment areas, theatre recovery
- High staff sickness and infection control challenges
- An increase of around 80 patients (up to circa 300) in hospital beds awaiting discharge post Christmas.

Actions in response to the incident included:

- Mobilising a "command" structure in line with best practice
- Increase of senior medical, therapy and nursing staff to assessment, ward and community areas to support timely assessment, flow and discharge
- Review of all "Operational Framework" actions and opportunities
- Step down of non essential meetings, training
- Escalation to Local authority partners support by a series of focused meetings to expedite assessments, decision making and access to packages of care,
- External and internal communications

Whilst the system remains under pressure, the Critical Incident was stood down on Monday 20 January with the continuation of a number of actions to support ongoing de-escalation.

Summary

The health and care system remains under sustained pressure. Whilst actions taken across the system have helped to mitigate the impact of the consequences of a high flu season there remain significant risks and operation challenges for staff and services.

Argymhelliad / Recommendation

The Board is asked to:

- **Note** the context with which the Health System is operating and the actions taken to mitigate the impacts of winter so far.
- **Note** that a full review of the Winter Resilience plan will come to the July Board meeting

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 4.1 Dignified Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	As set out within the paper
Rhestr Termau: Glossary of Terms:	ED Emergency Department GP General Practitioner UPC Urgent Primary Care

	IMTP Integrated Medium Term Plan GUH Grange University Hospital CRT Community Resource Team RGH Royal Gwent Hospital YYF Ysbyty Ystrad Fawr NHH Nevill Hall Hospital STW St Woolos Hospital ICU Intensive Care unit SDEC Same Day Emergency Care DVT Deep Vein Thrombosis IPC Infection, Prevention and Control
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)	
	Is EIA Required and included with this paper No does not meet requirements
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves

APPENDIX A – LOCAL HEALTH BOARD ACTIONS – PROGRESS AS AT JANUARY

25

Action	Ambition	Progress
PRIMARY AND COMMUNITY ACTIONS		
Resilient Community Resources - Rapid response capacity	Rapid response 8am-8pm model and consideration of weekend Consultant Community Resource Team support in line with GP demand. This is funded from Further Faster. Increased number of referrals and reduced risk of admission to hospital later in day and on weekends	The service is operational 8am-8pm over 7 days However, as of October, new referrals into community CRT rapid medical and nursing teams could be made up to 6pm daily, an extension of 1 hour. Medical staff 7 day working commences end of January 2025. There were 362 referrals accepted in December, an increase from 330 in December 2023.
Resilient Community Resources - District Nursing Capacity	Increase District Nursing capacity and capability over the winter period to improve resilience, plans to appoint 10WTE B4 Health Care Support Worker to provide additional resilience This is funded from Further Faster. Increase weekend activity to 60% of core in order to support weekend discharge/admission avoidance Provide planned overtime at Bank Holiday periods to continue activity across all CRT teams	Further faster funding enabled additional district nursing capacity with Uplift of 7 WTE B5 nurses to B6 over the winter period and the appointment of 10 WTE B4 Health Care support workers. Overall district nursing contacts remained stable over the period so far with an increase in contacts during October (weekday and overnight). The resources also provided additional resilience through planned overtime over the Bank Holiday periods.

Urgent Primary Care (UPC)	Robust mobile GP support available during out of hours period, with scoping of daytime hybrid model within Nevill Hall. Additional home visiting capacity during daytime hours	The additional capacity provided a further 53 weekend home visits in October and 33 in November supporting admission avoidance. December data is under review. UPC co-located with Minor Injury Unit at YYF to enhance collaboration. Access to UPC professional line given to care homes for out of hours advice
Frailty Direct Access Beds	Increase in Direct Access Pathway (DAP) beds to support increase in number of people admitted through the community CRT referrals pathways. This is delivered from reconfiguration of existing resource-resource neutral. Pilot initially at YAB from November, reconfiguration of beds to flip 8 community beds to DAP beds to better match demand providing a reduction in unnecessary admissions to the Grange/eLGHs	Direct Access Pathway beds went live as planned in November in Ysbyty Aneurin Bevan This provides capacity of 8 beds to support frail patients admitted via Community CRT teams thus avoiding acute front doors
Integrated pathway at The Grange front door	Improve operational alignment of Community Admission Avoidance Team, Home First and Acute Frailty Response teams. This is reconfiguration of existing resource. Increased admission avoidance for older / frail population Increased capacity as a result of working to a single MDT model	SOP developed to align front door teams to create a robust MDT response Plan to agree shared performance metrics and a single assessment process
Acute Frailty Response	Expansion of the service to 7 days in-reach to The Grange from 5 days - funded via Further Faster monies. Increased admission avoidance for older / frail population, in particular on weekends	Community front door therapies team (CAATT) launched 7 day coverage at the Grange from 6th January. An Integrated front door team is in development to

		establish a single process of referral for Acute Frailty, community therapist team and home first. Acute Frailty saw 105 referrals in November and 130 referrals in December.
HOSPITAL SYSTEM ACTIONS		
Action	Ambition	PROGRESS
Emergency Department Staffing Resilience	Recruitment of Six additional Emergency Department Consultants – funded via agreed business case. Ability to improve patient wait to be seen times –	Successfully recruited five additional ED consultants with staggered starting dates. Two started over winter period with the remaining three over the next two to three months
Pilot of Medical SDEC first	During November 2024, test concept of Medical patients having initial assessment in SDEC first as opposed to Medical Assessment unit – resource neutral. Increase the number of medical patients seen in SDEC and increase assess-our rate	Substantial increase in Medical patient throughput into SDEC utilizing an 'SDEC first' principle. In October there were 211 Medical patients assessed in SDEC, in November that number rose to 538 and in December 497. For Surgery patient throughput remained around 450 across the period. Further refinement is required to ensure shared resources of the unit remain equitable across specialities.
Discharge Lounge Capacity	Procurement and implementation of a discharge lounge at The Grange in line with approved Business case. Benefits	Procurement and design processes are on-going with expected

	of additional capacity at GUH to start being seen towards end of winter 24/25 – adding an extra 10 beds and 15 chairs	delivery of the discharge lounge at the end of February. The facility will be operationalised and go-live at the end of March 2025.
Ambulatory Surgical CEPOD (emergency theatre list)	Pilot of ambulatory day case pathway for patients requiring emergency surgery, allowing for prompt treatment, improved patient experience and overall system flow. – resource neutral. Increased number of cases operated on day of admission for selected treatments (abscesses, lap appendix) - reducing hospital length of stay.	As planned, an Ambulatory day case pathway from SDEC and Surgical Assessment unit was introduced for patients requiring emergency surgery. Typical conditions included abscess, lap appendix, simple hernia repair. The 3 month pilot has been successful to date with 57 procedures completed and high levels of positive patient feedback. 100% of patients were able to return home on the same day post-surgery.
Enhanced Respiratory Support to 999 / 111	Pilot enhanced support to respiratory patients in the out of hours and weekends by scheduling of patients into Respiratory Ambulatory Care - pilot resource neutral. It is anticipated that this could be beneficial to 1 – 2 patients per day avoiding ED / Assessment Unit Attendance	Collaboration with WAST to share pathways and advice line into Respiratory Ambulatory Care Unit (RACU). Paramedics are able to book a slot or access advice via consultant connect or the flow centre. Overall, there was an increase in RACU patient throughput in October and November to around 180 per month but decreased to around 110 in December.

		Further clinical audit required to assess potential demand in the out of hours period.
DVT Clinic Expansion	Review right sizing of demand to release Acute Medical unit Capacity, expand service hours to meet demand - resource neutral. Improved patient experience and additional medical assessment unit capacity	This action has been re-assigned to medium term with limited impact this winter. An option appraisal has been developed with each requiring additional resource to implement. This item will be progressed to Divisional Management Team for decision on direction.
Additional capacity for Paediatric Emergency Assessment	Pilot increasing opening hours of 'Fox pod' Paediatric assessments for primary care expected patients - resource neutral, reconfiguration of capacity. An additional 3 hours capacity to 11pm . Improved patient experience and reduction wait to be seen	Since inception of the pilot, there has been an increase in admissions to fox pod between 7-9pm. However, the use of fox pod has been utilized for inpatient beds at times of significant system pressures.
Additional Winter surge capacity	Increase winter surge bed capacity in line with modelling. Detailed work ongoing to identify capacity and workforce models. Up to 40 beds to come on line, in line with modelling from January 2025	Successfully opened winter ward on Sunday 5th January with a phased approach to admission By Tuesday 7th January the ward was at Full Capacity of 23 patients The model is Consultant led via Care of the Elderly with rehabilitation support

APPENDIX B – PARTNERSHIP ACTIONS – PROGRESS AS AT JANUARY 25

Partnerships actions funded with through System Resilience (SRP) monies of RIF		
Action / Project	Ambition	Progress
Step Closer to Home (SCTH) - Ad Hoc Spot Purchasing	The SCTH project offers a range of alternative pathways to facilitate discharge from the hospital for patients waiting for the next step of their recovery. It aims to support patients who are waiting for 3-4 domiciliary care calls per day to enable discharge from the hospital.	There has been a decline in the need for the service and referral figures are now low. Much of this can be attributed to the improved domiciliary care position across the region. <u>The funding was reprioritised as a consequence.</u>
Step Closer to Home - Hospital to Home (H2H)	The project facilitates early discharge and provides home-based care with a dedicated team of healthcare support. The project also assesses and provides support for people outside of the hospital environment, preferably in their own homes with personal care, mobility, meal preparation and medication prompting until longer-term support can be arranged.	The project is proving to be successful and has been expanded through SRP slippage to provide a preventative element to support people at home. Additional run added to support timely discharge, referrals via the front and admission avoidance. Hospital to Home, nurse assessors reorientated to sites to support demand management.
GWICES	The project employs an additional member of the team - GWICES Equipment Technician - to improve assessment turnaround, equipment reuse and tracking resulting in speedier discharges.	The GWICES Equipment Technician employed via SRP support is working to recycle the equipment. The Technician is also checking charity shops and other places for GWICES equipment to bring that back into service. GWICES has also received support for equipment via SRP slippage.
ED Well-being and Home Safe Service	The project (British Red Cross) enhances the ED experience and post-discharge transitions,	The project expansion supported by the SRP has been reconfigured as the

	offering emotional support, optimising patient flow, and connecting to community services.	division was not included in the original bid.
Community Resource Team (CRT) Pharmacy Expansion	The project provides medicine reviews, medicine deprescribing, home visits and discharge planning. SRP support has allowed the service to expand to the whole of Gwent and develop the service to take on responsibility for providing pharmacy services on wards in County and Chepstow Hospital sites which will positively affect patient flow and discharge. The project also provides home visits to frail patients identified through HRAC criteria in collaboration with GP practices.	The project has struggled to recruit but is now at full complement and starting to realise the benefits. The new pharmacy service at County hospital supported 24 discharges on Oak and Rowan wards prior to Christmas. This was previously carried out remotely by staff at RGH.
Falls Response Service Expansion	The project includes an expansion of the Gwent WAST Falls Response Service (FRS) in two ways: 1. An additional daytime vehicle to the current one operating across Gwent. (This is not currently operating). 2. The addition of night support, provided by St John Ambulance. Will link with actions in 50 day plan	Level 2 additional day time service is facing challenges due to difficulties recruiting therapy positions. Recruitment to this position has now been resolved (Nov 2024) and the additional vehicle is operating.
Hospital to Healthier Home (H2HH) Expansion	The project offers rapid home adaptations for patients leaving the hospital due to housing issues. The project expands support and secures flexible funding for complex cases, aiming to enhance patient independence and reduce readmissions.	The SRP support has improved workload management, patient service quality, and the provision of follow-up support post-hospital discharge. The project is more able to offer comprehensive support to help patients stay at home and reduce readmissions, through advocacy services,

		preventative assessments, housing repairs, and benefits advice. 60 additional people are being supported each quarter due to the SRP support.
Balancing Rights and Responsibilities Training	The project delivers a training and mentorship programme to enable a cultural shift across health and social care, ensuring the right conversations are held by the right individuals, and barriers are removed.	Project is being led by Blaenau Gwent CBC and has been expanded via SRP slippage to expand training to more members of staff. Balancing Rights and Responsibilities training plan prepared with first cohort targeting the Integrated Front Door team, 2 cohorts arranged for February 2025 for up to 60 spaces. Further role out of BR&R training across teams involved in discharge in April/May 2025.
YYF Trusted Assessor – Stroke Pathway	The project includes a Social Work Assistant who works with ward staff to screen and gather stroke pathway patient information for all the Gwent local authorities to facilitate discharge.	There have been improvements in the MDT working and communication across the LAs. This is leading to fewer discharge delays in some areas. The data shows that on average 50/60% of the patients on the Stoke Wards are from the other 4 LAs (BG/Mon/Newport/Torfaen) and the Trusted Assessor role is pivotal in undertaking screening for these patients and communicating with the person's home authority to facilitate discharge.
50 Day Challenge Actions		
	High Impact Intervention	Progress

1	Optimal Hospital Flow Framework	• Optimal Ward Model at RGH, Senior Nurse for Discharge in post from 6th January, aligned to wards D4W, D3W and C5E to embed the Optimal Hospital Flow Framework, initial focus on board rounds, digital PSAG boards and education and training • Choice letter and discharge leaflet produced, signed off by the Executive Committee on 19th December, distributed to all Division, monitoring via care home metrics • Funding secured for feasibility study for a Directory of Services/ 'Ask Annie' to be completed by end of March to support admission avoidance and discharge • Review discharge policies - reluctant discharge, step closer to home etc
2	7 day working for Health & Social care	• Blaenau- Gwent, recruited x1 agency Social Worker, additional hours offered to part-time Social Work staff, limited uptake before Christmas, more interest in the New Year • Newport, recruited x1 agency Social Worker in Home First, additional hours offered to staff, uptake from OTs, additional capacity in Home First • Monmouthshire, x2 Social Workers picking up an extra day after Christmas, x2 Social Workers and x2 OTs in each locality office on 27th December, more interest in New Year • Torfaen, no uptake from Social Workers ahead of Christmas, x3 additional OTA worked over Christmas period, more interest in New Year • Caerphilly, positive response from Social Workers/OTs area teams, SWAs aligned to AMU, locum OT to in reach to YAB, identify high risk patients on waiting lists to prevent admission • CRT medical staff 7 day working commences end Jan • Additional district nursing capacity over the weekends • Local Authorities continue to promote and refresh expressions of interest for 7 day working • Locums continue to be recruited to increase assessment capacity
3	Undertake Decision Support Tool in the Community	• Bridging funding in place to support funding for care home placements for individuals who require further health & social care assessments • Hospital to Home additional run in place to support timely discharge, referrals via the front and admission avoidance • x4 beds in Ty Glas Y Dorlan operational from 6th January • Hospital to Home, nurse assessors reorientated to sites to support demand management
4	Integrated Navigation Hubs	• Frailty (CRT) single point of access has been merged with Urgent Primary Care (UPC) call handling team • Residential homes now able to access UPC professional line overnight • Extension of UPC professional line to those care homes not covered by DES to commence 15/01/25. • 90% coverage for care home DES provision

		• Work progressing developing by DDT a Directory of Services "Ask Annie" to support admission avoidance and discharge • Workshop 19/12/24 and resulting Standard Operating Procedure is being written to facilitate a pilot approach to the development of an MDT including a GP, a frailty ANP or medic and a UPC 247 ANP/ACP
5	Regional Health & Social care weekly review of long LOS Patients	• Weekly review of >100 days delayed across Acute and Community sites • Weekly review of top 20 longest staying patients • Weekly review of LOS 21-28 days • Weekly meeting with Executive Director of Nursing to provide challenge and support • Development of a scrutiny panel to support patients with the longest LOS by end of January
6	Proactive management of 0.5% population at Risk	• NCN MDT's continue to operate with longer term data collection tool in the process of being signed off and applied to existing MDT approaches. • Pilot of methodology to identify cohort at risk agreed to commence across 4 practices during February. • DSS issued by WG, agreed with LMC and distributed to 68 practices 07/01/25: - Funding for practices to produce a list from the GP system that indicates those people who are either – frail, have COPD, have CHD and/or have diabetes. Starting with those over 80. - Funding to undertake a comprehensive, face-to-face, review of people on this list, across a number of parameters and includes the production of a Future Care Plan (FCP) - Funding to review the FCP each month to the end of funding
7	GP enhanced Service rollout for care homes and HRAC	• Residential homes now able to access UPC professional line overnight • Roll out escalation framework to all Care Homes • MDT approach in Care Homes, GP/Frailty ANP to commence January • Extend access to professional line, Monday – Friday, daytime to WAST, to commence January
8	Trusted Assessor Model for all care Settings	• Draft TA paper outlining high level plan presented at the Integrated Discharge Board on 9th January • Review of assessment code delays from POCD datasets from the last quarter • Top three areas identified and recommendations to be made to IDB for priority programmes of work; - Embedding of DST model in the community not hospital to reduce 'joint assessment' delays, December figures reduced dramatically following focus on this - Work with care homes to implement model of 'trusted assessor' for patient discharge when there is a vacancy, rather than waiting for a visit - Regional approach to accessing services where trusted assessor is already in existence • Integrated front door, in development; - Shared 'what matters' assessment front sheet to complement professional specific assessment

		- Embedding of quality conversations that promote positive risk management through the Balancing Rights and Responsibilities training plan prepared with first cohort targeting the Integrated Front Door team, 2 cohorts arranged for February 2025 for up to 60 spaces - Further role out of BR&R training across teams involved in discharge in April/May 2025
9	Home First default for all clinically optimised patients	• Discharge leaflet produced and shared with Divisions, to support 'What Matters' conversations and discharge planning at point of admission • Complete SOP to streamline referral process and access to Integrated Front Door Team at GUH by end of January • Hospital to Home continue to support Home First with discharges & admission avoidance
10	7 day community falls response	• Business case/investment template approved on 18th December by NHS Executives for £76k to fund St Johns Ambulance Cymru falls education training and lifting equipment • St Johns Ambulance Cymru providing 27 sessions from 1 Feb for 9 weeks • Audit of lifting cushions commencing across all homes • Process to service and redistribute lifting cushions to care homes in line with National Community-based Falls response document

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Integrated Performance Report – to Month 8 2024 and Month 9 where the validated data is available
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Director of Strategy, Planning and Partnerships Jennifer Winslade, Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk Assistant for Director Planning and Performance Paul Steynor Head of System Planning and Performance

Pwrrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

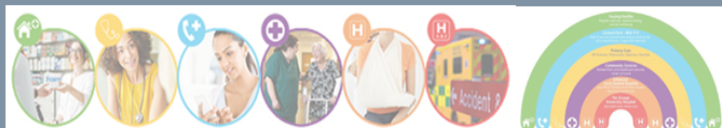
The purpose of this report is to provide the Board with an integrated overview of performance against the key Health Board and Ministerial Priorities at the end of Month 8 of 2024/25 and Month 9 where the validated data is available.

The Board is asked to:

- **Note** the progress against key performance metrics up to November 24 (and December 24 where available).
- **Note** the planned actions.

Cefndir / Background

This report focusses on specific performance against the organisation's key priorities in line with the National Performance Framework, Ministerial and Cabinet priorities.



Asesiad / Assessment

This report is structured across sections as follows:

- Performance Summary
- Section 1: Cabinet Secretary Priorities
- Section 2: Our Performance & System Change Delivery, which include the System Change Priorities
 - 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
- Quality & Patient Safety
- Workforce
- Finance

This report covers the commitments in the Annual Plan 2024/25, bringing together the wider reporting on system change priorities, value and sustainability and our enablers on a quarterly basis.

There have been a number of key highlights in Month 8 and Month 9 where the validated data is available.

- Good progress in the delivery of Planned Care in line with revised trajectories as a result of additional funding for ENT, Orthopaedics and Ophthalmology. The position for patients waiting more than 104 weeks has reduced, from 4,408 at the end of Q1 to 3929 at the end of December 24 and patients waiting more than 8 weeks for a specified diagnostic has improved, from 4,221 at the end of Q1 to 2493 at the end of December 24.
- Work is ongoing as part of the 50 day challenge with Local Authority partners to reduce delays in the system, with a particular focus on those patients with the longest delays. This includes the Optimal Ward model being piloted at 3 wards at RGH from January, increasing those accessing the Hospital 2 Home pathway, increase in 7 day working for social care, which is reflected in the performance figures for this measure
- Pathway of Care Delays (POCD) saw an improvement over Q3, reducing by almost 25%.
- Single Cancer Pathway (SCP) compliance has trended upwards overall since May reaching 63.7% in November 24.
- The 62 and 104 day backlog for the SCP has seen sustained reduction in the same time period. Tumour site specific Task and Finish groups have been instrumental in delivering improvement in the backlog position.
- The focus on improvements in the delivery of the Part 1a and 1b of the Mental Health measures is now reaping benefits.



- Adults Part 1a compliance has risen to 84% following substantial efforts made by the Division.
- CAMHS Part 1a compliance remains strong, having been over 90% each month since June
- As at Month 8, ABUHB is reporting a year-to-date deficit of £6.683m, with a forecast year end deficit of £7.356m. This position has changed significantly from the prior month following a Welsh Government letter dated 2nd December 24 notifying the Health Board of additional funding totalling £40.5m; £9.5m has been issued recurrently to support ongoing operational pressures, and £31m was also issued on a recurrent basis but conditional on the Health Board delivering against objectives specified within the letter.

There are several key areas which remained a challenge:

- Sustaining improvements made in Q1 in the Urgent and Emergency Care System has been challenging, with continued observed variability in performance across days and weeks, exacerbated by the extreme winter pressures.
- Performance against Mental Health Part 1b CAHMS compliance has been challenging, with performance at 14.7% at the end of M8 against a trajectory of 27%, whilst focus is on bringing down the tail of the waiting list. It is, however, expected that 1b compliance across both adults and CAHMS will see significant improvements in the M9 submission, with adults compliance projected to rise to 88% and CAHMS to 84.7%.
- In November 2024, sickness absence increased to 6.80% a 0.36% increase compared with October 2024 (6.44%). The 3 main reasons for sickness were Anxiety, Stress, Depression and other Psychiatric illness 33.0%, Cold, Cough, Flu-Influenza 9.2%, and other Musculoskeletal problems 8.8%.

Key areas of focus for the next period include:

- Full delivery of winter plan actions by Health Board and with partners to address performance, access and experience challenges in the urgent and emergency care system.
- Continued focus on delivery of the regional cataracts plan, the additional schemes for ENT and orthopaedic alongside delivery of all specialties to deliver 0 patients waiting over 104 weeks in line with expectations.
- Further reviews of Cancer performance with actions to improve further Single Cancer pathway compliance.
- Continued reduction of backlog for Mental Health Part 1b compliance for adults to achieve 80% by end of Q4 and, through a supported recovery programme for neurodevelopmental adapted pathways for under 5s, enable Paediatric capacity to undertake assessments and MD.

Argymhelliad / Recommendation

Board is asked to:

- **Note** the progress achieved to Month 8 2024 and Month 9 2024 where the validated data is available



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 interim 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:	As set out within the paper
Rhestr Termiau: Glossary of Terms:	As set out within the paper
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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.



Integrated Performance Report

December 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 and 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



CONTENTS

Performance Summary

Section 1: Cabinet Secretary Priorities

Section 2: Our Performance & System Change Delivery

What went well this period?

- Good progress in the delivery of Planned Care in line with revised trajectories as a result of additional funding for ENT, Orthopaedics and Ophthalmology. 104 weeks position has reduced, from 4,408 at the end of Q1 to 3,929 at the end of Q3, and patients waiting more than 8 weeks for a specified diagnostic has improved from 4,221 at the end of Q1 to 2,493 Q3.
- Pathway of Care Delays (POCD) saw an improvement over Q3, reducing by almost 25%.
- Single Cancer Pathway (SCP) compliance has trended upwards overall since May reaching 63.7% in November 24. The 62 and 104 day backlog for the SCP has seen sustained reduction in the same time period. Tumour site specific Task and Finish groups have been instrumental in delivering improvement in the backlog position.
- The focus on improvements in the delivery of the Part 1a and 1b of the Mental Health measures is now reaping benefits, with 1a compliance at 84% and 91% across adults and CAHMS respectively, and huge improvements expected in December for 1b compliance, again across both adults and CAHMS.

What were the challenges this period?

- Sustaining improvements made in Q1 in the Urgent and Emergency Care System has been challenging, with continued observed variability in performance across days and weeks, exacerbated by the extreme winter pressures.
- In November 2024, sickness absence increased to 6.80% a 0.36% increase compared to October 2024 (6.44%). The 3 main reasons for sickness were Anxiety, Stress, Depression and other Psychiatric illness 33.0%, Cold, Cough, Flu-Influenza 9.2%, and other Musculoskeletal problems 8.8%.

What actions are we taking to improve?

- Work is ongoing as part of the 50 day challenge with Local Authority partners to reduce delays in the system, with a particular focus on those patients with the longest delays. This includes the Optimal Ward model being piloted at 3 wards at RGH from January, increasing those accessing the Hospital 2 Home pathway, increase in 7 day working for social care.
- Ministerial Priorities board established to maintain oversight of continued plans for improvement across Planned Care, Cancer and Mental Health, with particular focus on delivery of the regional cataracts plan, the additional schemes for ENT and orthopaedic alongside delivery of all specialties to deliver 0 patients waiting over 104 weeks in line with expectations.
- Full delivery of winter plan actions by Health Board and with partners to address performance, access and experience challenges in the urgent and emergency care system.

What are our risks to delivery?

- Impact of winter operational pressures on capacity of teams and system
- Continued Winter pressures and potential impact on workforce capacity and resilience
- Impact of medicine pricing changes on financial forecast
- Ensuring delivery to trajectory of funded planned care activities for 104wk waits and 8wk diagnostics.
- Any unquantified risks to services affected by changes to National Insurance etc contributions, eg GP practices, pharmacies, Care homes
- Demand and acuity increases

Section 1: Cabinet Secretary Priorities

The Cabinet Secretary for Health and Social Services has set out National Programmes of work covering the priority areas of delivery. These priority areas are:

- Enhanced Care in the Community, with a focus on reducing delayed pathways of care
- Primary and Community Care, with a focus on improving access and shifting resources into Primary and Community Care
- Urgent and Emergency Care, with a focus on delivery of the 6 goals programme
- Planned Care and Cancer, with a focus on reducing the longest waits
- Mental Health, including CAMHS, with a focus on delivery of the national programme

Further to these priority areas the Welsh Government and NHS Wales have identified 8 Key Performance Indicators across Urgent and Emergency Care, Cancer, Diagnostics, Elective Care and Mental Health Services.

Section 1 provides an overview of the Health Board performance of the Key Performance Indicators outlined by Welsh Government and Health Board commitments related to the delivery of the priority areas. For a more in-depth view on performance for each priority, please follow the links in the NHS Performance Report column.

Cabinet Secretary Priorities

Priority	Aim	ABUHB Commitment	Ability to meet national standard?	In Month Performance against trajectory	Link in Performance Report
Enhanced Care in the Community	Measure: Number of delayed transfers of care. National standard/ambition: 12-month reduction trend Reporting period: Monthly	250 Mar-25	Yes	201 Dec-24 (Trajectory: 258)	Hyperlink to section
Primary and Community Care	Measure: General Medical Services (GMS) – Number of GP practices achieving core access standards National standard/ambition: 100% Reporting period: Annual – in month position for information	100%	Yes	100% Sep-24 (Trajectory: 100%)	Hyperlink to section
	Measure: General Dental Services (GDS) - % of contract value fulfilled National standard: 30% of contract value by end Q2, 100% Q4 Reporting period: Six Monthly	30% Sep-24 100% Mar-25	Yes	62% Sep-24 (Trajectory: 30%)	Hyperlink to section
Urgent and Emergency Care	Measure: Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge National standard/ambition: 20% reduction by September 2024, further 20% reduction by March 2025 Reporting period: Monthly	1,063 Dec-24 945 Mar-25	Yes	1,449 Dec-24 (Trajectory: 1,063)	Hyperlink to section
	Measure: Number of ambulance patient handovers over 1 hour National standard/ambition: 30% reduction by December 2024 Reporting period: Monthly	705 Mar-25	Yes	803 Dec-24 (Trajectory: 705)	Hyperlink to section
Planned Care and Cancer	Measure: Number of patients waiting more than 52 weeks for a new outpatient appointment National standard/ambition: 40% reduction by end of September 2024, 0 by end of March 2025 Reporting period: Monthly	16,077 Dec-24 16,500 Mar-25	No	16,868 Dec-24 (Trajectory: 16,077)	Hyperlink to section
	Measure: Number of patients waiting more than 104 weeks for referral to treatment National standard/ambition: 0 by end of December 2024 Reporting period: Monthly	3,929 Dec-24 0* Mar-25	No	3,573 Dec-24 (Trajectory: 3,929)	Hyperlink to section

	Measure: Percentage of patients starting their first definitive treatment within 62 days from point of suspicion (regardless of the referral route) National standard/ambition: 60% by end of December 2024, 70% by end of March 2025 Reporting period: Monthly	67% Dec-24 70% Mar-25	Yes	63.74% Nov-24 (Trajectory: 67%)	Hyperlink to section
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic National standard/ambition: 95% of patients waiting less than 8 weeks by end of December 2024 Reporting period: Monthly	3,286 (79.7%) Dec-24 3,016 Mar-25	No	2,493 Dec-24 (Trajectory: 3,286)	Hyperlink to section
Mental Health, including CAMHS	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years National standard/ambition: 80% by end of December 2024 Reporting period: Monthly	80% Dec-24*	Yes	14.7% Nov-24 (Trajectory: 27.4%)	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over National standard/ambition: 80% by end of December 2024 Reporting period: Monthly	92% Dec-24*	Yes	24.5% Nov-24 (Trajectory: 70%)	Hyperlink to section

Section 2: Our Performance and System Change

The Performance Report section provides detail of Health Board performance across the quadruple aims and the system change themes identified in the Annual Plan 2024/25.

Detail on what is included under each quadruple aim is provided below.

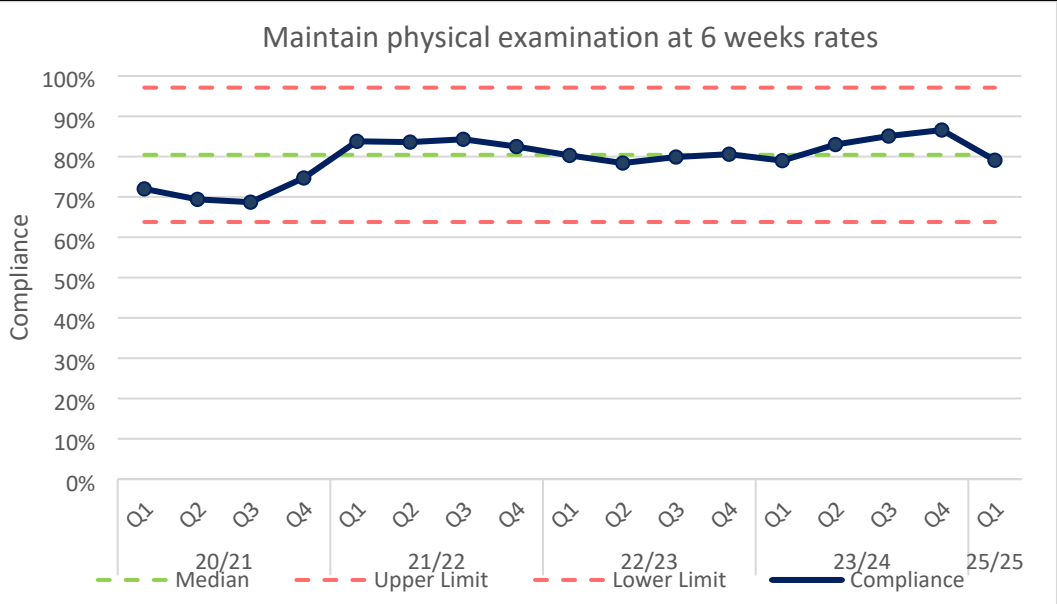
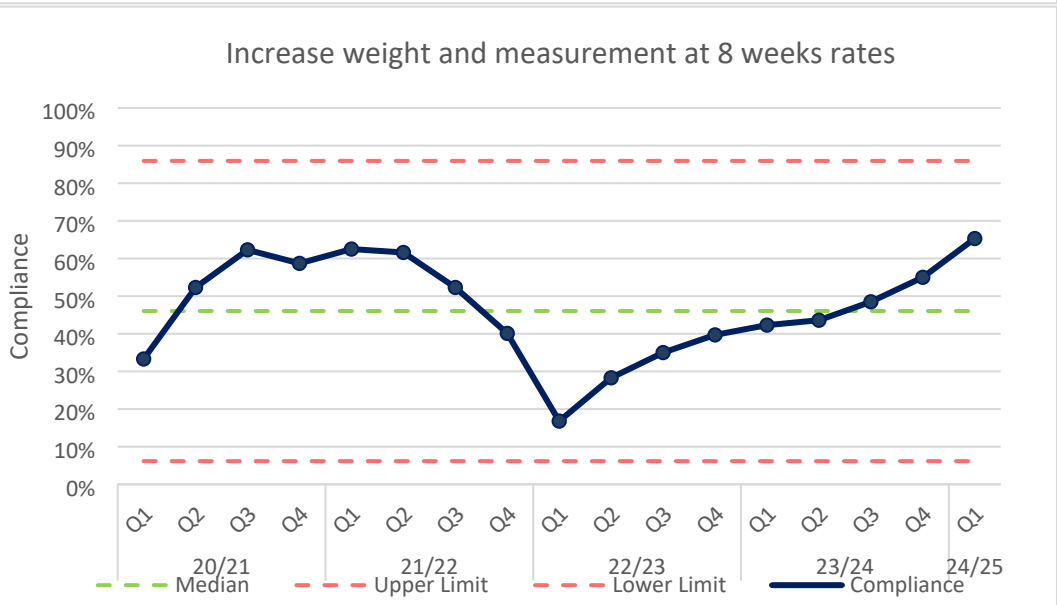
A summary of performance is provided under each aim against the Health Board's priorities and corresponding performance ambitions, including detail of annual plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim.

Quadruple Aim		Health Board's System Change Theme and Integrated Report
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Embedding Prevention and Population Health in all that we do
Aim 2	People in Wales have better quality and more accessible Health and Social Care Services, enabled by digital and supported by engagement	- Progressing place based models of care and sustainability in Primary and Community Services - Improving our Urgent and 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
Aim 3	The Health and Social Care workforce in Wales is motivated and sustainable	Workforce and Culture
Aim 4	Wales has a higher value Health and Social Care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

KEY MESSAGES & ACTIONS:

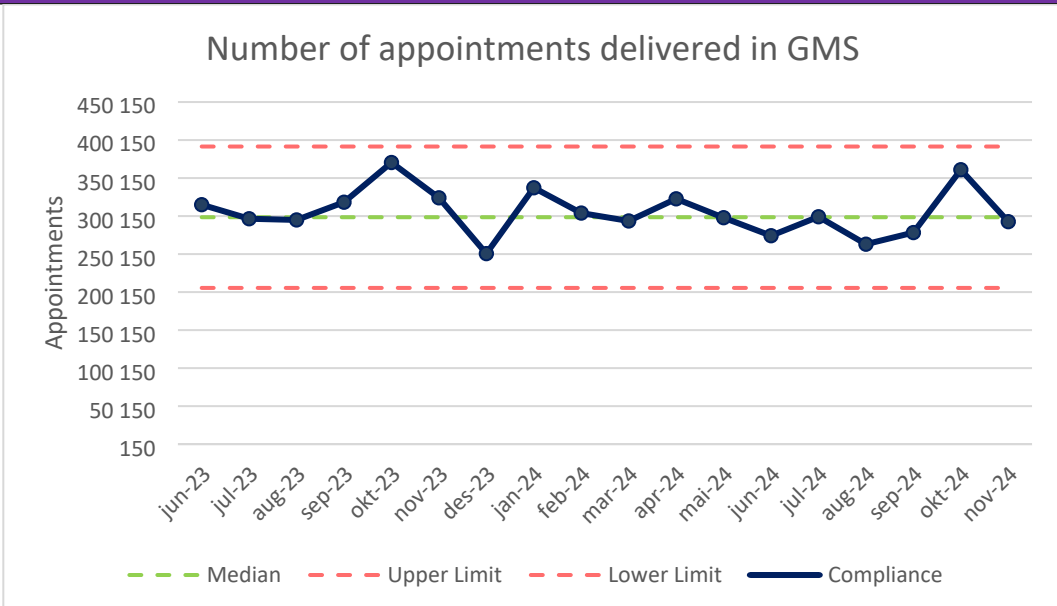
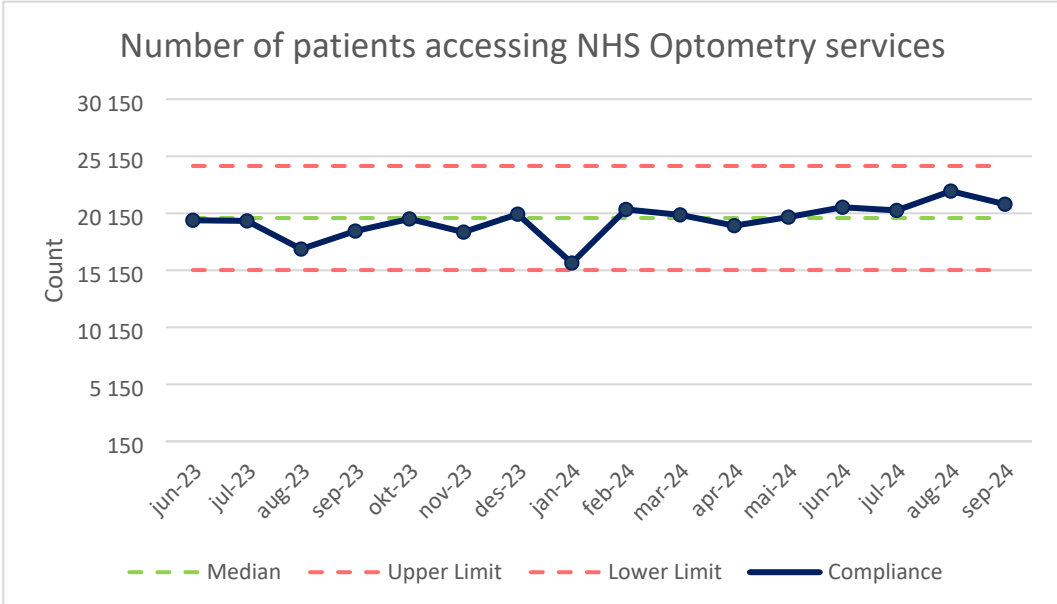
- Vaccination uptake rates for MMR and HPV has remained relatively static through the last 2 quarterly reporting periods, at 85.7% and 68.0% respectively, against targets of 95% compliance.
- Work remains underway with School Health Nurses currently undertaking a robust vaccination plan coupled with dedicated MMR catch up clinics in Vaccination Centres and pop-up clinics.
- Vaccine Inequity Framework developed for consideration in January 2025
- New roles are being recruited to address inequity of access, supporting communities to improve uptake.
- Plans in place to identify Community Champions that will assist in the education and increased uptake.
- Neighbourhood Care Networks (NCNs) are reviewing the childhood immunisation queues across the boroughs, identifying uptake in the lower performing practices and support.
- Increasing rates of weight and measurement at 8 weeks (as part of Health Child Wales) has seen sustained progress since the beginning of 22/23, with the Health Board now meeting its Annual Plan trajectory.

Priority	Performance Measure	Performance against Q2 Trajectory	Data / Trend																																																																																																																								
Health Protection & Vaccination	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)	85.7% Below Trajectory of 92.1%	% children who are up to date with the scheduled vaccinations by age 5 <table><thead><tr><th>Quarter</th><th>ABUHB (%)</th><th>Target (%)</th></tr></thead><tbody><tr><td>Q1 2023/24</td><td>87.5%</td><td>92.1%</td></tr><tr><td>Q2 2023/24</td><td>87.4%</td><td>92.1%</td></tr><tr><td>Q3 2023/24</td><td>87.9%</td><td>92.1%</td></tr><tr><td>Q4 2023/24</td><td>86.6%</td><td>92.1%</td></tr><tr><td>Q1 2024/25</td><td>85.8%</td><td>92.1%</td></tr><tr><td>Q2 2024/25</td><td>85.7%</td><td>92.1%</td></tr></tbody></table>		Quarter	ABUHB (%)	Target (%)	Q1 2023/24	87.5%	92.1%	Q2 2023/24	87.4%	92.1%	Q3 2023/24	87.9%	92.1%	Q4 2023/24	86.6%	92.1%	Q1 2024/25	85.8%	92.1%	Q2 2024/25	85.7%	92.1%																																																																																																		
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Increase percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	68.0% Below Trajectory of 87.2%	% of children receiving the HPV vaccination by the age of 15 <table><thead><tr><th>Year</th><th>Quarter</th><th>Compliance (%)</th><th>Median (%)</th><th>Upper Limit (%)</th><th>Lower Limit (%)</th><th>Target (%)</th></tr></thead><tbody><tr><td rowspan="4">20/21</td><td>Q1</td><td>88%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q2</td><td>88%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q3</td><td>87%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q4</td><td>87%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td rowspan="4">21/22</td><td>Q1</td><td>88%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q2</td><td>88%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q3</td><td>70%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q4</td><td>72%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td rowspan="4">22/23</td><td>Q1</td><td>73%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q2</td><td>75%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q3</td><td>80%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q4</td><td>80%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td rowspan="4">23/24</td><td>Q1</td><td>80%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q2</td><td>80%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q3</td><td>68%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q4</td><td>68%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td rowspan="2">24/25</td><td>Q1</td><td>68%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr><tr><td>Q2</td><td>68%</td><td>80%</td><td>58%</td><td>80%</td><td>87.2%</td></tr></tbody></table>		Year	Quarter	Compliance (%)	Median (%)	Upper Limit (%)	Lower Limit (%)	Target (%)	20/21	Q1	88%	80%	58%	80%	87.2%	Q2	88%	80%	58%	80%	87.2%	Q3	87%	80%	58%	80%	87.2%	Q4	87%	80%	58%	80%	87.2%	21/22	Q1	88%	80%	58%	80%	87.2%	Q2	88%	80%	58%	80%	87.2%	Q3	70%	80%	58%	80%	87.2%	Q4	72%	80%	58%	80%	87.2%	22/23	Q1	73%	80%	58%	80%	87.2%	Q2	75%	80%	58%	80%	87.2%	Q3	80%	80%	58%	80%	87.2%	Q4	80%	80%	58%	80%	87.2%	23/24	Q1	80%	80%	58%	80%	87.2%	Q2	80%	80%	58%	80%	87.2%	Q3	68%	80%	58%	80%	87.2%	Q4	68%	80%	58%	80%	87.2%	24/25	Q1	68%	80%	58%	80%	87.2%	Q2	68%	80%	58%	80%	87.2%
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	Q3	80%	80%	58%	80%	87.2%																																																																																																																					
	Q4	80%	80%	58%	80%	87.2%																																																																																																																					
23/24	Q1	80%	80%	58%	80%	87.2%																																																																																																																					
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24/25	Q1	68%	80%	58%	80%	87.2%																																																																																																																					
	Q2	68%	80%	58%	80%	87.2%																																																																																																																					

Best Start in Life	Maintain physical examination at 6 weeks rates (Healthy Child Wales)	79.1% Below Trajectory of 92.7%	
	Increase weight and measurement at 8 weeks rates (Healthy Child Wales)	65.3% Above Q3 Trajectory of 63.4%	

KEY MESSAGES & ACTIONS:

- GMS (GP) appointments remain close to tracking against Annual Plan ambitions.
- Contract discussions are held with GMS (GP) Contractors that are in escalation with the frequency of meetings determined by risk level.
- The number of patients accessing Optometry services is well ahead of trajectory, with the Q3 ambition having been exceeded by the end of Q2.
- The Eye Care Board has been re-established with focus on the Welsh General Ophthalmic Services (WGOS).
- Welsh Government have supported a phased approach and the Health Board is working with providers to ensure a smooth transition to WGOS 4 services.
- Performance for Common Ailment Scheme (CAS) claims is also above trajectory, with all Community Pharmacies now signed up to the scheme.
- A system is being developed for access to all GMS Practices to identify live CAS service provision in their area.
- 46 Pharmacies have now been commissioned for the Independent Prescribing service in Q2, which has increased from 35 in Q1.
- Units of Dental Activity (UDA) claimed can see relatively large fluctuations month on month, however based on the average monthly activity to date profiled to year end would get close to meeting the performance ambition.
- Performance for palliative care referrals assessed within 2 days has trended downwards since the beginning of the year, however average performance in year to date exceeds the overall performance ambition of 95%.

Priority	Performance Measure	Performance against Q2 Trajectory	Data / Trend																																																																																																
Access	Maintain the number of appointments delivered in GMS	2,389,982 (end of Nov) End of Q3 Trajectory is 2,742,601		Number of appointments delivered in GMS <table><caption>Number of appointments delivered in GMS</caption><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>jun-23</td><td>320</td><td>310</td><td>400</td><td>210</td></tr><tr><td>jul-23</td><td>300</td><td>310</td><td>400</td><td>210</td></tr><tr><td>aug-23</td><td>300</td><td>310</td><td>400</td><td>210</td></tr><tr><td>sep-23</td><td>320</td><td>310</td><td>400</td><td>210</td></tr><tr><td>okt-23</td><td>380</td><td>310</td><td>400</td><td>210</td></tr><tr><td>nov-23</td><td>330</td><td>310</td><td>400</td><td>210</td></tr><tr><td>des-23</td><td>250</td><td>310</td><td>400</td><td>210</td></tr><tr><td>jan-24</td><td>340</td><td>310</td><td>400</td><td>210</td></tr><tr><td>feb-24</td><td>310</td><td>310</td><td>400</td><td>210</td></tr><tr><td>mar-24</td><td>300</td><td>310</td><td>400</td><td>210</td></tr><tr><td>apr-24</td><td>330</td><td>310</td><td>400</td><td>210</td></tr><tr><td>mai-24</td><td>300</td><td>310</td><td>400</td><td>210</td></tr><tr><td>jun-24</td><td>280</td><td>310</td><td>400</td><td>210</td></tr><tr><td>jul-24</td><td>300</td><td>310</td><td>400</td><td>210</td></tr><tr><td>aug-24</td><td>270</td><td>310</td><td>400</td><td>210</td></tr><tr><td>sep-24</td><td>280</td><td>310</td><td>400</td><td>210</td></tr><tr><td>okt-24</td><td>370</td><td>310</td><td>400</td><td>210</td></tr><tr><td>nov-24</td><td>300</td><td>310</td><td>400</td><td>210</td></tr></table>	Month	Compliance	Median	Upper Limit	Lower Limit	jun-23	320	310	400	210	jul-23	300	310	400	210	aug-23	300	310	400	210	sep-23	320	310	400	210	okt-23	380	310	400	210	nov-23	330	310	400	210	des-23	250	310	400	210	jan-24	340	310	400	210	feb-24	310	310	400	210	mar-24	300	310	400	210	apr-24	330	310	400	210	mai-24	300	310	400	210	jun-24	280	310	400	210	jul-24	300	310	400	210	aug-24	270	310	400	210	sep-24	280	310	400	210	okt-24	370	310	400	210	nov-24	300	310	400	210
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Maintain the number of patients accessing NHS Optometry Services	122,999 (end of Q2) Above Q3 Trajectory of 122,888		Number of patients accessing NHS Optometry services <table><caption>Number of patients accessing NHS Optometry services</caption><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>jun-23</td><td>20</td><td>20</td><td>25</td><td>15</td></tr><tr><td>jul-23</td><td>20</td><td>20</td><td>25</td><td>15</td></tr><tr><td>aug-23</td><td>17</td><td>20</td><td>25</td><td>15</td></tr><tr><td>sep-23</td><td>19</td><td>20</td><td>25</td><td>15</td></tr><tr><td>okt-23</td><td>20</td><td>20</td><td>25</td><td>15</td></tr><tr><td>nov-23</td><td>18</td><td>20</td><td>25</td><td>15</td></tr><tr><td>des-23</td><td>20</td><td>20</td><td>25</td><td>15</td></tr><tr><td>jan-24</td><td>16</td><td>20</td><td>25</td><td>15</td></tr><tr><td>feb-24</td><td>21</td><td>20</td><td>25</td><td>15</td></tr><tr><td>mar-24</td><td>20</td><td>20</td><td>25</td><td>15</td></tr><tr><td>apr-24</td><td>19</td><td>20</td><td>25</td><td>15</td></tr><tr><td>mai-24</td><td>20</td><td>20</td><td>25</td><td>15</td></tr><tr><td>jun-24</td><td>21</td><td>20</td><td>25</td><td>15</td></tr><tr><td>jul-24</td><td>20</td><td>20</td><td>25</td><td>15</td></tr><tr><td>aug-24</td><td>23</td><td>20</td><td>25</td><td>15</td></tr><tr><td>sep-24</td><td>21</td><td>20</td><td>25</td><td>15</td></tr></table>	Month	Compliance	Median	Upper Limit	Lower Limit	jun-23	20	20	25	15	jul-23	20	20	25	15	aug-23	17	20	25	15	sep-23	19	20	25	15	okt-23	20	20	25	15	nov-23	18	20	25	15	des-23	20	20	25	15	jan-24	16	20	25	15	feb-24	21	20	25	15	mar-24	20	20	25	15	apr-24	19	20	25	15	mai-24	20	20	25	15	jun-24	21	20	25	15	jul-24	20	20	25	15	aug-24	23	20	25	15	sep-24	21	20	25	15											
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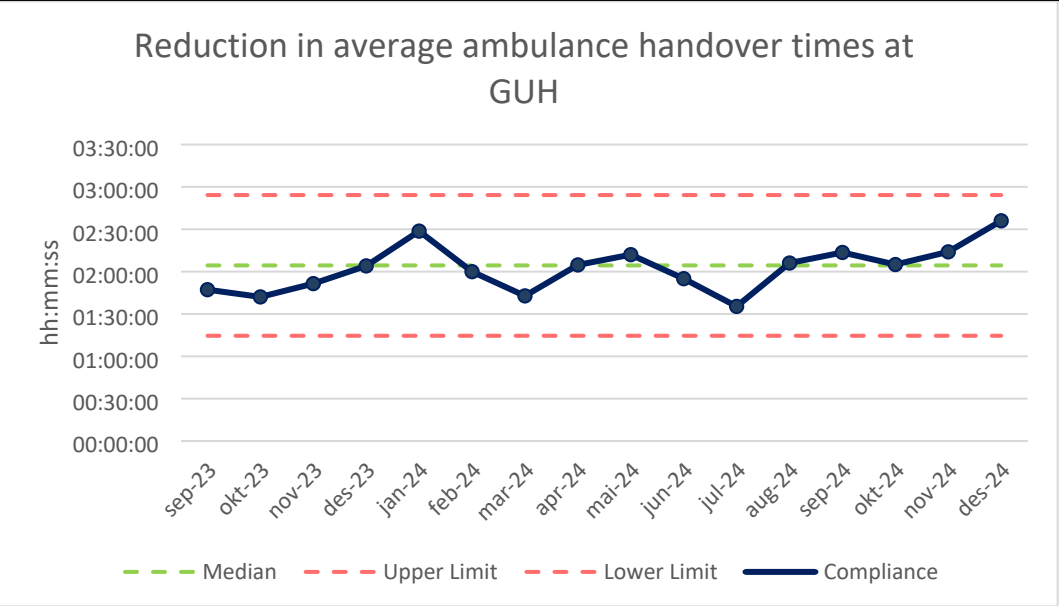
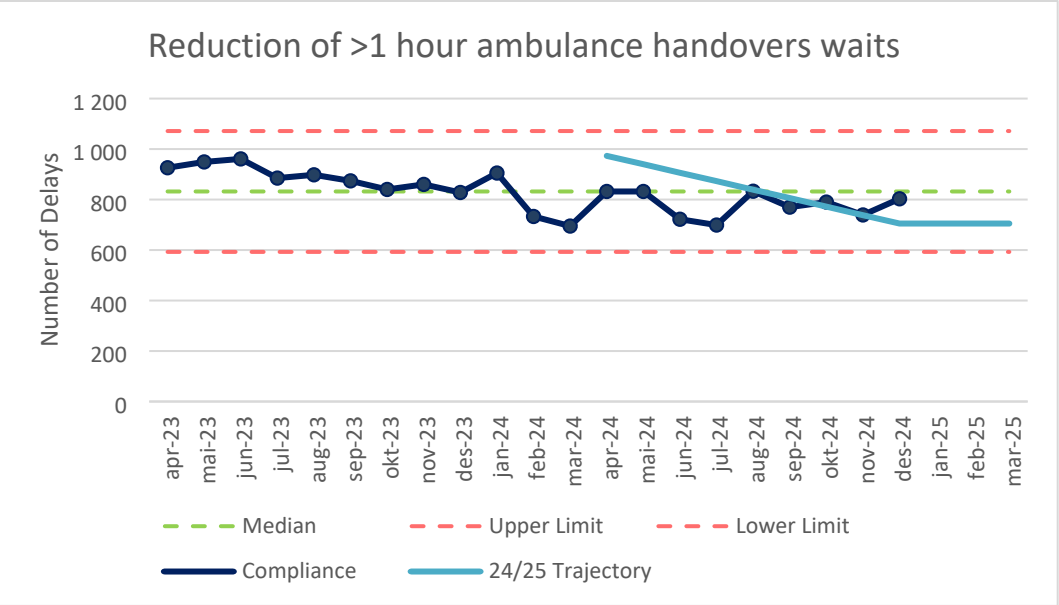
	Maintain the number of consultations undertaken by community pharmacy under the common ailments scheme	44,904 (end of Nov) Above Q3 Trajectory of 35,438	Common Ailments Scheme Claims <table><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>jun-23</td><td>7000</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>jul-23</td><td>4200</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>aug-23</td><td>3800</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>sep-23</td><td>3900</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>okt-23</td><td>3800</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>nov-23</td><td>3900</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>des-23</td><td>3900</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>jan-24</td><td>4300</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>feb-24</td><td>5000</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>mar-24</td><td>4800</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>apr-24</td><td>5100</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>mai-24</td><td>6200</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>jun-24</td><td>6800</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>jul-24</td><td>6300</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>aug-24</td><td>4800</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>sep-24</td><td>4900</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>okt-24</td><td>5500</td><td>4800</td><td>8000</td><td>2000</td></tr><tr><td>nov-24</td><td>5500</td><td>4800</td><td>8000</td><td>2000</td></tr></table>	Month	Compliance	Median	Upper Limit	Lower Limit	jun-23	7000	4800	8000	2000	jul-23	4200	4800	8000	2000	aug-23	3800	4800	8000	2000	sep-23	3900	4800	8000	2000	okt-23	3800	4800	8000	2000	nov-23	3900	4800	8000	2000	des-23	3900	4800	8000	2000	jan-24	4300	4800	8000	2000	feb-24	5000	4800	8000	2000	mar-24	4800	4800	8000	2000	apr-24	5100	4800	8000	2000	mai-24	6200	4800	8000	2000	jun-24	6800	4800	8000	2000	jul-24	6300	4800	8000	2000	aug-24	4800	4800	8000	2000	sep-24	4900	4800	8000	2000	okt-24	5500	4800	8000	2000	nov-24	5500	4800	8000	2000
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Maintain the number of Units of Dental Activity (UDA) claimed	351,599 (end of Oct) End of Q3 Trajectory is 461,756	Maintain the number of Units of Dental Activity (UDA) claimed <table><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>jun-23</td><td>52000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>jul-23</td><td>58000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>aug-23</td><td>62000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>sep-23</td><td>54000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>okt-23</td><td>57000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>nov-23</td><td>70000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>des-23</td><td>50000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>jan-24</td><td>62000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>feb-24</td><td>56000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>mar-24</td><td>85000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>apr-24</td><td>35000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>mai-24</td><td>49000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>jun-24</td><td>50000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>jul-24</td><td>64000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>aug-24</td><td>54000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>sep-24</td><td>50000</td><td>55000</td><td>88000</td><td>22000</td></tr><tr><td>okt-24</td><td>64000</td><td>55000</td><td>88000</td><td>22000</td></tr></table>	Month	Compliance	Median	Upper Limit	Lower Limit	jun-23	52000	55000	88000	22000	jul-23	58000	55000	88000	22000	aug-23	62000	55000	88000	22000	sep-23	54000	55000	88000	22000	okt-23	57000	55000	88000	22000	nov-23	70000	55000	88000	22000	des-23	50000	55000	88000	22000	jan-24	62000	55000	88000	22000	feb-24	56000	55000	88000	22000	mar-24	85000	55000	88000	22000	apr-24	35000	55000	88000	22000	mai-24	49000	55000	88000	22000	jun-24	50000	55000	88000	22000	jul-24	64000	55000	88000	22000	aug-24	54000	55000	88000	22000	sep-24	50000	55000	88000	22000	okt-24	64000	55000	88000	22000						
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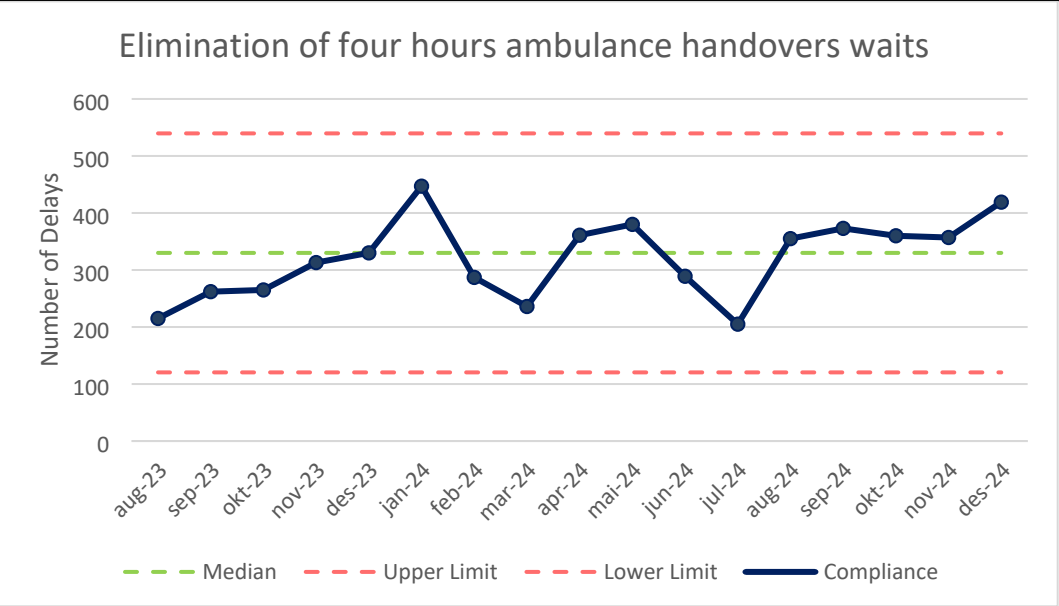
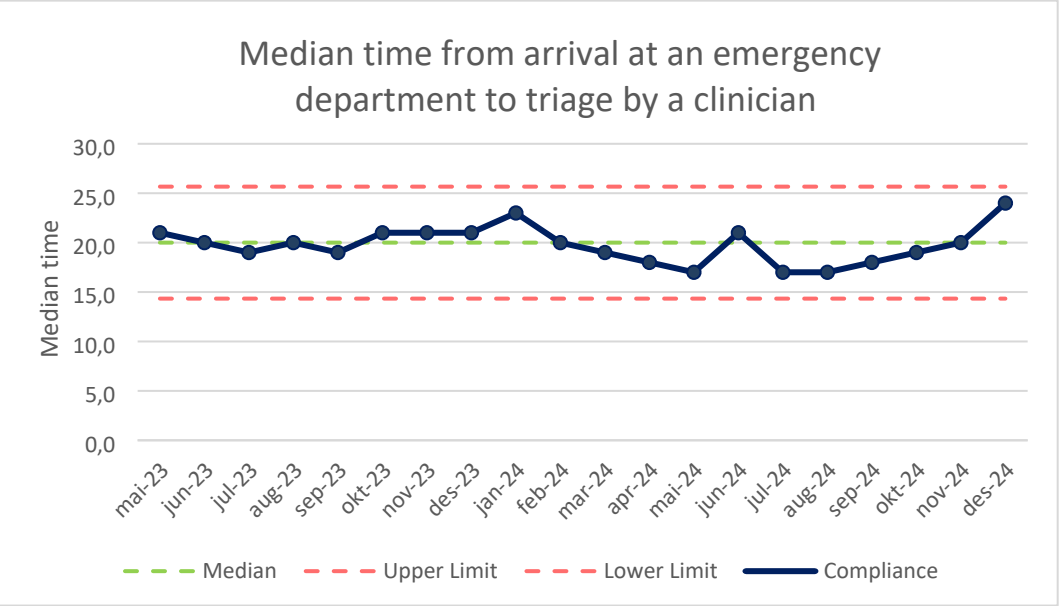
	Maintain 95% of Palliative Care referrals assessed within 2 days	92.2% (end of Nov) Below Trajectory of 95%		Maintain 95% of Palliative Care referrals assessed within 2 days 100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0% jun-23 jul-23 aug-23 sep-23 okt-23 nov-23 des-23 jan-24 feb-24 mar-24 apr-24 mai-24 jun-24 jul-24 aug-24 sep-24 okt-24 nov-24 Median Upper Limit Lower Limit Compliance	
Community Care	Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments (incl ED/MAU referrals)	6.5% (end of Q3) Below Trajectory of 10.5%		Proportion of GP referrals made to Rapid Response as a total of all medical assessments (incl ED/MAU referrals) 12% 10% 8% 6% 4% 2% 0% jun-23 jul-23 aug-23 sep-23 okt-23 nov-23 des-23 jan-24 feb-24 mar-24 apr-24 mai-24 jun-24 jul-24 aug-24 sep-24 okt-24 nov-24 des-24 Median Upper Limit Lower Limit Compliance	

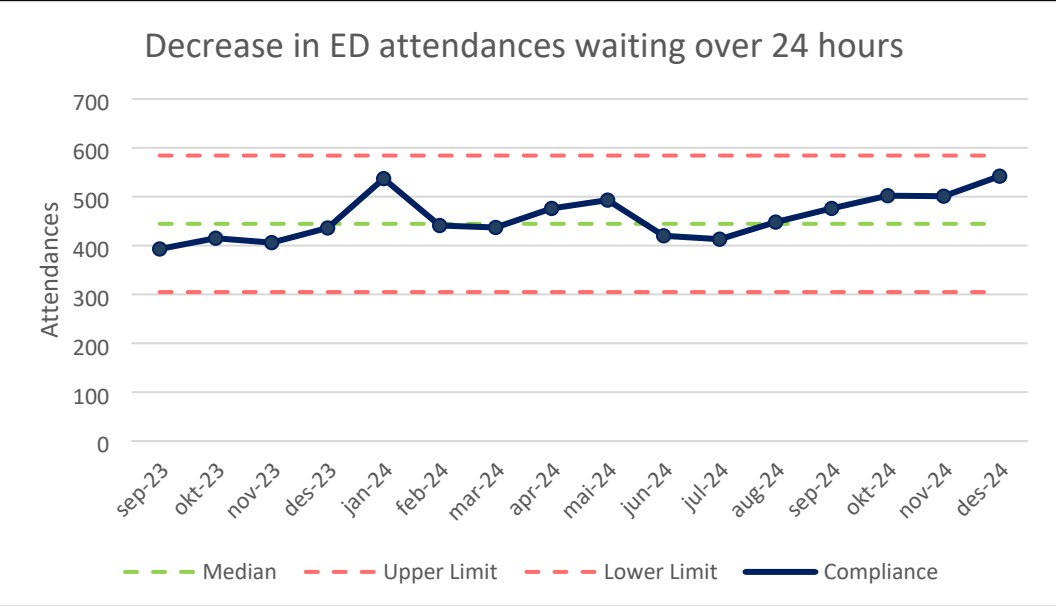
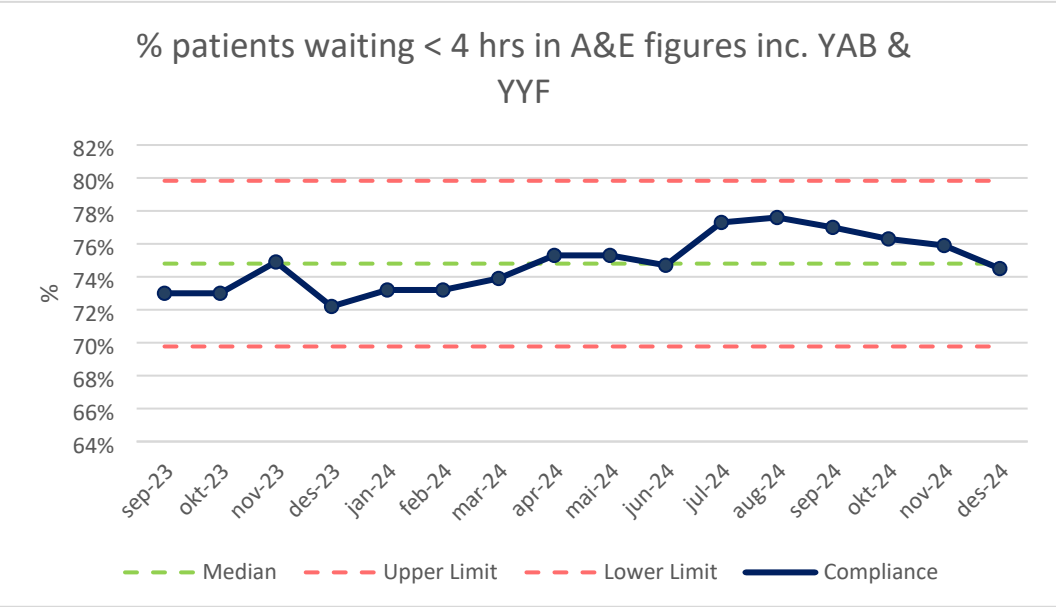
KEY MESSAGES & ACTIONS:

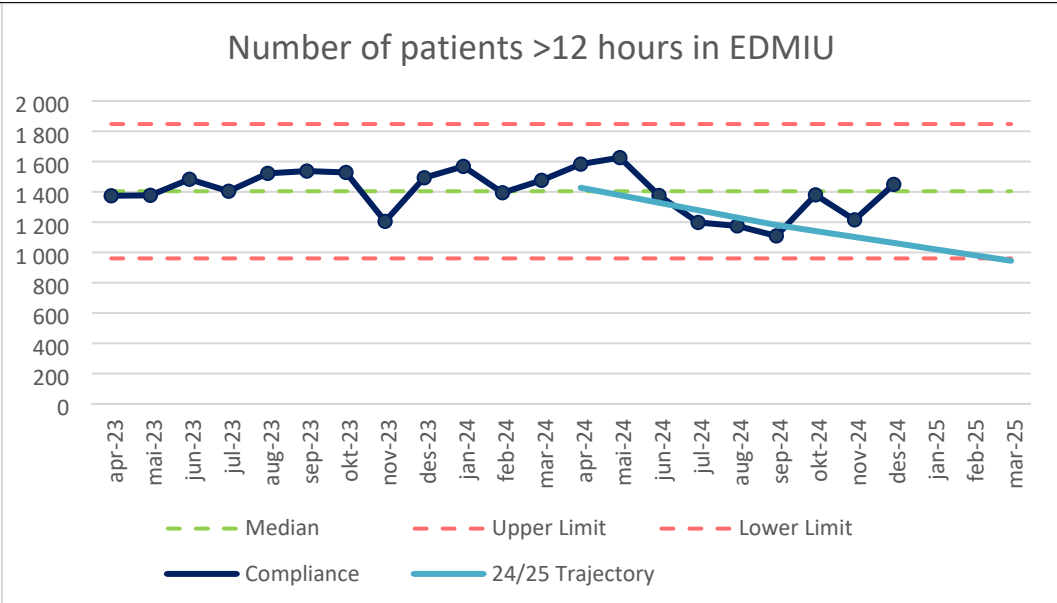
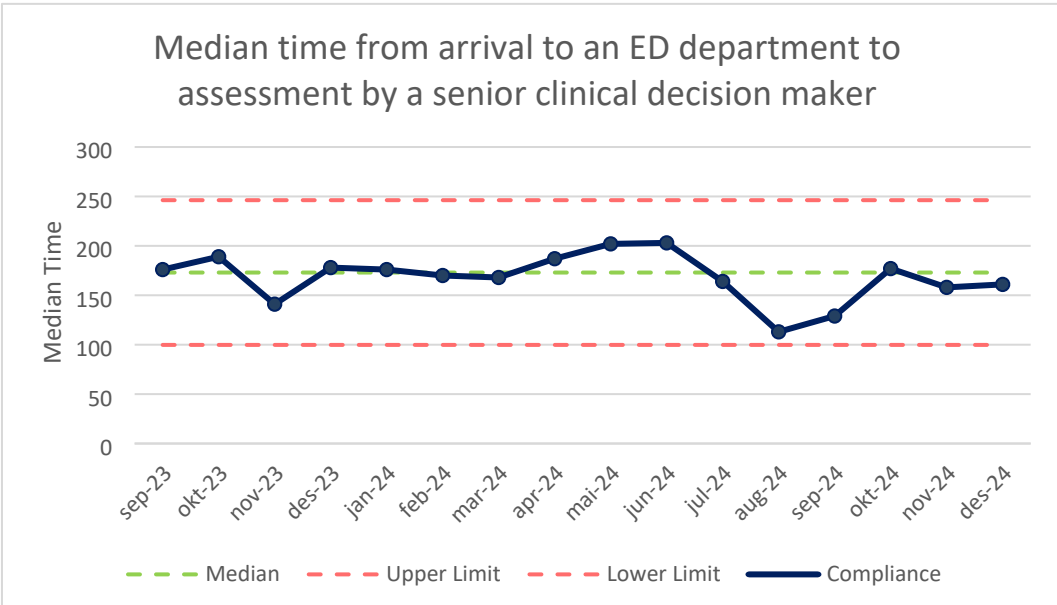
- The organisation remains in “enhanced monitoring” for ED performance in the Grange Hospital.
- Pathway of Care Delays (POCD) saw an improvement over Q3, reducing by almost 25%.
- Work is ongoing as part of the 50 day challenge with Local Authority partners to reduce delays in the system, with a particular focus on those patients with the longest delays. This includes the Optimal Ward model being piloted at 3 wards at RGH from January, increasing those accessing the Hospital 2 Home pathway, increase in 7 day working for social care.
- Over the Winter period the system has become increasingly pressured which has resulted in the deterioration of some Urgent Care measures. The Winter plan details a number of actions to support management of increased pressures.
- Expansion of the Discharge/Transfer Lounge (DTL) at GUH will be completed in February, to support timely and safe discharge/transfer of patients from inpatient wards/assessment units earlier in the day. The DTL will embrace a nurse led model of care and will provide comprehensive discharge/transfer support to patients by continuing basic levels of care, completing any final treatments, co-ordinating discharge medications and management of transport.
- 5 additional posts for ED consultants have now been recruited to and are expected to be in post by April 25. This will support 8-8 senior rapid assessment model at the GUH to reduce waiting to be seen times and decongest the ED.
- Weekly enhanced monitoring meetings remain in place to oversee and support improvements.
- A new General Internal Medicine model was implemented at GUH in November linked to a new model of care for General Medicine patients led by Respiratory.
- Ambulatory CEPOD (emergency) for same day surgery at GUH has also been implemented with the intention of scaling up, to deliver bed savings and reducing long stays in Surgical Assessment Unit.
- A stroke improvement plan is in place bringing together the 53 recommendations from GIRFT, HIW and the Welsh Government, the workstreams include: imaging, staffing, rehab, prevention, patient flow, governance, education and training, community, acute stay, data capture and audit compliance.

Priority	Performance Measure	Performance against Q2 Trajectory	Data / Trend																																																																																																																																											
Timely Discharge	Reduction of number of Delayed Transfers of Care	201 (end of Q3) Below Trajectory of 254	Number of Pathways of Care Delays <table><caption>Number of Pathways of Care Delays</caption><tr><th>Month</th><th>Compliance</th><th>Trajectory</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>jun-23</td><td>245</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>jul-23</td><td>258</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>aug-23</td><td>255</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>sep-23</td><td>265</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>okt-23</td><td>270</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>nov-23</td><td>268</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>des-23</td><td>225</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>jan-24</td><td>268</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>feb-24</td><td>240</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>mar-24</td><td>235</td><td>245</td><td>245</td><td>295</td><td>195</td></tr><tr><td>apr-24</td><td>242</td><td>265</td><td>245</td><td>295</td><td>195</td></tr><tr><td>mai-24</td><td>238</td><td>265</td><td>245</td><td>295</td><td>195</td></tr><tr><td>jun-24</td><td>245</td><td>265</td><td>245</td><td>295</td><td>195</td></tr><tr><td>jul-24</td><td>238</td><td>260</td><td>245</td><td>295</td><td>195</td></tr><tr><td>aug-24</td><td>265</td><td>260</td><td>245</td><td>295</td><td>195</td></tr><tr><td>sep-24</td><td>265</td><td>260</td><td>245</td><td>295</td><td>195</td></tr><tr><td>okt-24</td><td>235</td><td>255</td><td>245</td><td>295</td><td>195</td></tr><tr><td>nov-24</td><td>238</td><td>255</td><td>245</td><td>295</td><td>195</td></tr><tr><td>des-24</td><td>205</td><td>255</td><td>245</td><td>295</td><td>195</td></tr><tr><td>jan-25</td><td></td><td>252</td><td>245</td><td>295</td><td>195</td></tr><tr><td>feb-25</td><td></td><td>252</td><td>245</td><td>295</td><td>195</td></tr><tr><td>mar-25</td><td></td><td>252</td><td>245</td><td>295</td><td>195</td></tr></table>		Month	Compliance	Trajectory	Median	Upper Limit	Lower Limit	jun-23	245	245	245	295	195	jul-23	258	245	245	295	195	aug-23	255	245	245	295	195	sep-23	265	245	245	295	195	okt-23	270	245	245	295	195	nov-23	268	245	245	295	195	des-23	225	245	245	295	195	jan-24	268	245	245	295	195	feb-24	240	245	245	295	195	mar-24	235	245	245	295	195	apr-24	242	265	245	295	195	mai-24	238	265	245	295	195	jun-24	245	265	245	295	195	jul-24	238	260	245	295	195	aug-24	265	260	245	295	195	sep-24	265	260	245	295	195	okt-24	235	255	245	295	195	nov-24	238	255	245	295	195	des-24	205	255	245	295	195	jan-25		252	245	295	195	feb-25		252	245	295	195	mar-25		252	245	295	195
	Month	Compliance	Trajectory	Median	Upper Limit	Lower Limit																																																																																																																																								
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Increase in Hospital 2 Home & Step Closer to Home Rates	44 delivered in Q2 Meeting Trajectory of quarter of quarter increase	Patients accessing Hospital 2 Home pathway <table><caption>Patients accessing Hospital 2 Home pathway</caption><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>apr-23</td><td>0.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>mai-23</td><td>0.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>jun-23</td><td>1.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>jul-23</td><td>6.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>aug-23</td><td>6.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>sep-23</td><td>6.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>okt-23</td><td>7.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>nov-23</td><td>11.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>des-23</td><td>9.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>jan-24</td><td>6.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>feb-24</td><td>7.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>mar-24</td><td>10.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>apr-24</td><td>9.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>mai-24</td><td>14.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>jun-24</td><td>13.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>jul-24</td><td>11.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>aug-24</td><td>15.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>sep-24</td><td>18.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr><tr><td>okt-24</td><td>15.5</td><td>9</td><td>24.5</td><td>-0.5</td></tr></table>		Month	Compliance	Median	Upper Limit	Lower Limit	apr-23	0.5	9	24.5	-0.5	mai-23	0.5	9	24.5	-0.5	jun-23	1.5	9	24.5	-0.5	jul-23	6.5	9	24.5	-0.5	aug-23	6.5	9	24.5	-0.5	sep-23	6.5	9	24.5	-0.5	okt-23	7.5	9	24.5	-0.5	nov-23	11.5	9	24.5	-0.5	des-23	9.5	9	24.5	-0.5	jan-24	6.5	9	24.5	-0.5	feb-24	7.5	9	24.5	-0.5	mar-24	10.5	9	24.5	-0.5	apr-24	9.5	9	24.5	-0.5	mai-24	14.5	9	24.5	-0.5	jun-24	13.5	9	24.5	-0.5	jul-24	11.5	9	24.5	-0.5	aug-24	15.5	9	24.5	-0.5	sep-24	18.5	9	24.5	-0.5	okt-24	15.5	9	24.5	-0.5																																							
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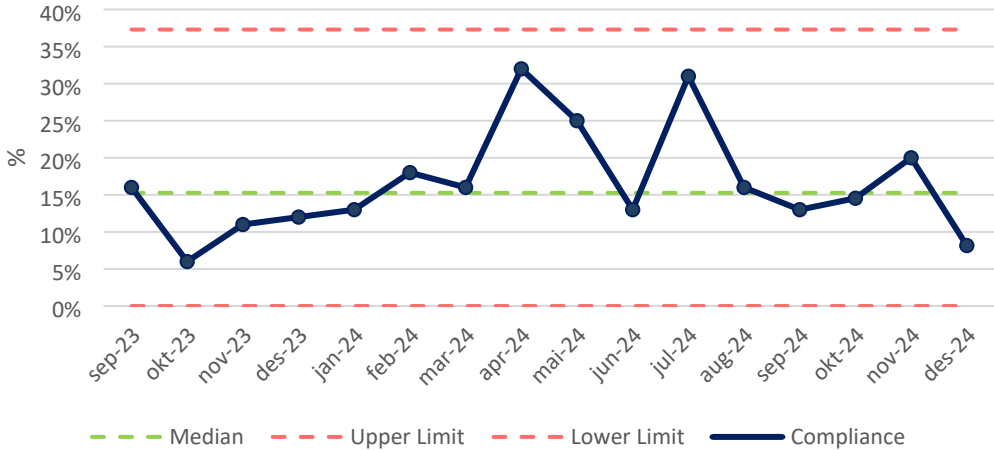
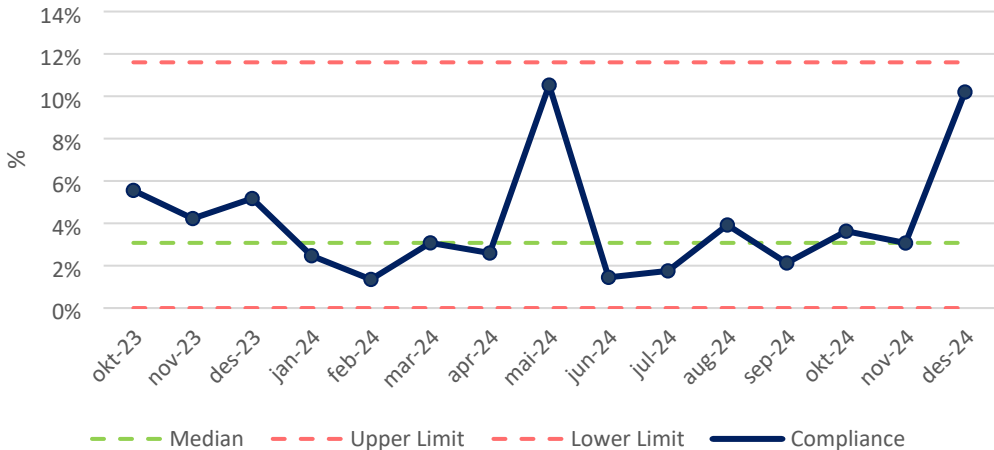
Enhanced Monitoring	Reduction in average ambulance handover times at GUH	156 mins (end of Q3) Above Trajectory of 65 mins	
	Reduction of ambulance patient handovers over 1 hour	803 (end of Q3) Above Trajectory of 705	

	Elimination of four hours ambulance handovers waits	419 (end of Q3) Above Trajectory of 0	
	Reduction in time from arrival to ED triage - no waits over 30 minutes	Median 24 mins (end of Q3) Median Wait Below Trajectory of 30 mins No Waits Above Trajectory 0> 40mins	

	Decrease in ED attendances waiting over 24 hours	542/6.9% >24hrs (end of Q3) Above Trajectory of 1.9% >24hrs	
	Increase and maintain national target of the percentage of patients waiting <4 hours in ED	74.5% (end of Q3) Above Trajectory of 73.4%	

	Reduction in number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	1,449 (end of Q3) Above Trajectory of 1,063	Number of patients >12 hours in EDMIU <table><caption>Number of patients >12 hours in EDMIU</caption><tr><th>Month</th><th>Compliance</th><th>24/25 Trajectory</th></tr><tr><td>apr-23</td><td>1400</td><td>1400</td></tr><tr><td>mai-23</td><td>1400</td><td>1400</td></tr><tr><td>jun-23</td><td>1500</td><td>1400</td></tr><tr><td>jul-23</td><td>1400</td><td>1400</td></tr><tr><td>aug-23</td><td>1550</td><td>1400</td></tr><tr><td>sep-23</td><td>1550</td><td>1400</td></tr><tr><td>okt-23</td><td>1550</td><td>1400</td></tr><tr><td>nov-23</td><td>1250</td><td>1400</td></tr><tr><td>des-23</td><td>1500</td><td>1400</td></tr><tr><td>jan-24</td><td>1600</td><td>1400</td></tr><tr><td>feb-24</td><td>1400</td><td>1400</td></tr><tr><td>mar-24</td><td>1500</td><td>1400</td></tr><tr><td>apr-24</td><td>1600</td><td>1400</td></tr><tr><td>mai-24</td><td>1650</td><td>1400</td></tr><tr><td>jun-24</td><td>1400</td><td>1350</td></tr><tr><td>jul-24</td><td>1200</td><td>1300</td></tr><tr><td>aug-24</td><td>1200</td><td>1250</td></tr><tr><td>sep-24</td><td>1150</td><td>1200</td></tr><tr><td>okt-24</td><td>1400</td><td>1150</td></tr><tr><td>nov-24</td><td>1250</td><td>1100</td></tr><tr><td>des-24</td><td>1500</td><td>1050</td></tr><tr><td>jan-25</td><td></td><td>1000</td></tr><tr><td>feb-25</td><td></td><td>950</td></tr><tr><td>mar-25</td><td></td><td>900</td></tr></table> Median time from arrival to an ED department to assessment by a senior clinical decision maker <table><caption>Median time from arrival to an ED department to assessment by a senior clinical decision maker</caption><tr><th>Month</th><th>Compliance</th></tr><tr><td>sep-23</td><td>180</td></tr><tr><td>okt-23</td><td>190</td></tr><tr><td>nov-23</td><td>145</td></tr><tr><td>des-23</td><td>180</td></tr><tr><td>jan-24</td><td>180</td></tr><tr><td>feb-24</td><td>175</td></tr><tr><td>mar-24</td><td>170</td></tr><tr><td>apr-24</td><td>190</td></tr><tr><td>mai-24</td><td>205</td></tr><tr><td>jun-24</td><td>205</td></tr><tr><td>jul-24</td><td>165</td></tr><tr><td>aug-24</td><td>115</td></tr><tr><td>sep-24</td><td>135</td></tr><tr><td>okt-24</td><td>180</td></tr><tr><td>nov-24</td><td>160</td></tr><tr><td>des-24</td><td>165</td></tr></table>	Month	Compliance	24/25 Trajectory	apr-23	1400	1400	mai-23	1400	1400	jun-23	1500	1400	jul-23	1400	1400	aug-23	1550	1400	sep-23	1550	1400	okt-23	1550	1400	nov-23	1250	1400	des-23	1500	1400	jan-24	1600	1400	feb-24	1400	1400	mar-24	1500	1400	apr-24	1600	1400	mai-24	1650	1400	jun-24	1400	1350	jul-24	1200	1300	aug-24	1200	1250	sep-24	1150	1200	okt-24	1400	1150	nov-24	1250	1100	des-24	1500	1050	jan-25		1000	feb-25		950	mar-25		900	Month	Compliance	sep-23	180	okt-23	190	nov-23	145	des-23	180	jan-24	180	feb-24	175	mar-24	170	apr-24	190	mai-24	205	jun-24	205	jul-24	165	aug-24	115	sep-24	135	okt-24	180	nov-24	160	des-24	165	Reduction in time from arrival to ED to seen by clinician	Median 161 mins (end of Q3) 13.8% >6hrs Above Trajectory of 0 >4.5hrs
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Urgent Primary Care	Maintain the number of Urgent Primary Care contacts (inc. virtual)	50,924 (end of Oct) Above Q3 Trajectory of 33,128		Urgent Primary Care Cases - Total Contacts <table><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>jun-23</td><td>6800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>jul-23</td><td>7800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>aug-23</td><td>7500</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>sep-23</td><td>7800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>okt-23</td><td>8000</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>nov-23</td><td>7500</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>des-23</td><td>10200</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>jan-24</td><td>9200</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>feb-24</td><td>7800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>mar-24</td><td>9800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>apr-24</td><td>7800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>mai-24</td><td>7800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>jun-24</td><td>7200</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>jul-24</td><td>6800</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>aug-24</td><td>7200</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>sep-24</td><td>7000</td><td>7500</td><td>10500</td><td>4800</td></tr><tr><td>okt-24</td><td>7500</td><td>7500</td><td>10500</td><td>4800</td></tr></table>	Month	Compliance	Median	Upper Limit	Lower Limit	jun-23	6800	7500	10500	4800	jul-23	7800	7500	10500	4800	aug-23	7500	7500	10500	4800	sep-23	7800	7500	10500	4800	okt-23	8000	7500	10500	4800	nov-23	7500	7500	10500	4800	des-23	10200	7500	10500	4800	jan-24	9200	7500	10500	4800	feb-24	7800	7500	10500	4800	mar-24	9800	7500	10500	4800	apr-24	7800	7500	10500	4800	mai-24	7800	7500	10500	4800	jun-24	7200	7500	10500	4800	jul-24	6800	7500	10500	4800	aug-24	7200	7500	10500	4800	sep-24	7000	7500	10500	4800	okt-24	7500	7500	10500	4800
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Stroke	% of patients directly admitted to an Acute Stroke Ward <4hrs of clock start	8.16% (end of Q3) Below Trajectory of 18.2%	% of patients directly admitted to an acute stroke ward <4hrs of clock start <table><tr><th>Month</th><th>Compliance (%)</th></tr><tr><td>sep-23</td><td>17</td></tr><tr><td>okt-23</td><td>7</td></tr><tr><td>nov-23</td><td>12</td></tr><tr><td>des-23</td><td>13</td></tr><tr><td>jan-24</td><td>14</td></tr><tr><td>feb-24</td><td>19</td></tr><tr><td>mar-24</td><td>17</td></tr><tr><td>apr-24</td><td>33</td></tr><tr><td>mai-24</td><td>26</td></tr><tr><td>jun-24</td><td>14</td></tr><tr><td>jul-24</td><td>32</td></tr><tr><td>aug-24</td><td>17</td></tr><tr><td>sep-24</td><td>14</td></tr><tr><td>okt-24</td><td>15</td></tr><tr><td>nov-24</td><td>21</td></tr><tr><td>des-24</td><td>9</td></tr></table>	Month	Compliance (%)	sep-23	17	okt-23	7	nov-23	12	des-23	13	jan-24	14	feb-24	19	mar-24	17	apr-24	33	mai-24	26	jun-24	14	jul-24	32	aug-24	17	sep-24	14	okt-24	15	nov-24	21	des-24	9
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des-24	9																																				
% of unique stroke patients given Thrombectomy (all stroke types)	10.2% (end of Q3) Above Trajectory of 5%	% of stroke patients given thrombectomy (all stroke types) <table><tr><th>Month</th><th>Compliance (%)</th></tr><tr><td>okt-23</td><td>5.8</td></tr><tr><td>nov-23</td><td>4.5</td></tr><tr><td>des-23</td><td>5.5</td></tr><tr><td>jan-24</td><td>2.8</td></tr><tr><td>feb-24</td><td>1.5</td></tr><tr><td>mar-24</td><td>3.5</td></tr><tr><td>apr-24</td><td>2.8</td></tr><tr><td>mai-24</td><td>10.5</td></tr><tr><td>jun-24</td><td>1.5</td></tr><tr><td>jul-24</td><td>2.0</td></tr><tr><td>aug-24</td><td>4.2</td></tr><tr><td>sep-24</td><td>2.2</td></tr><tr><td>okt-24</td><td>3.8</td></tr><tr><td>nov-24</td><td>3.5</td></tr><tr><td>des-24</td><td>10.2</td></tr></table>	Month	Compliance (%)	okt-23	5.8	nov-23	4.5	des-23	5.5	jan-24	2.8	feb-24	1.5	mar-24	3.5	apr-24	2.8	mai-24	10.5	jun-24	1.5	jul-24	2.0	aug-24	4.2	sep-24	2.2	okt-24	3.8	nov-24	3.5	des-24	10.2			
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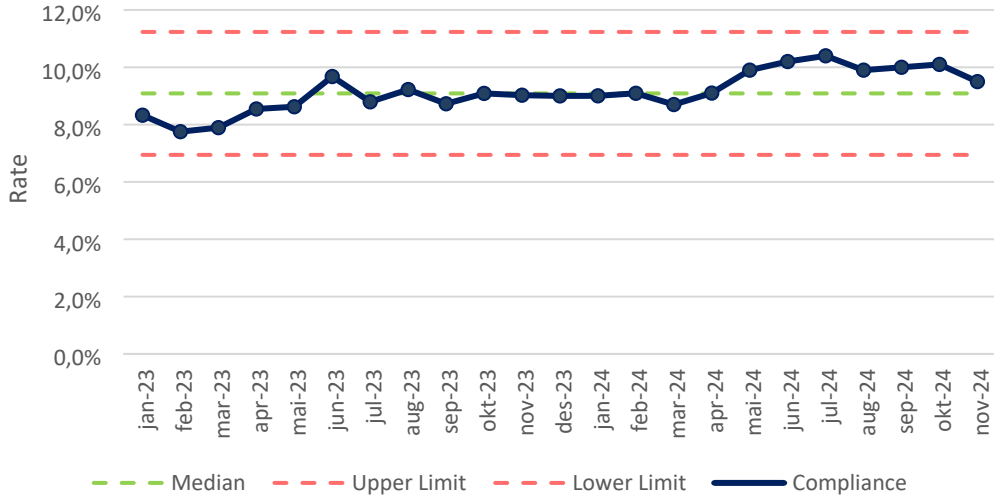
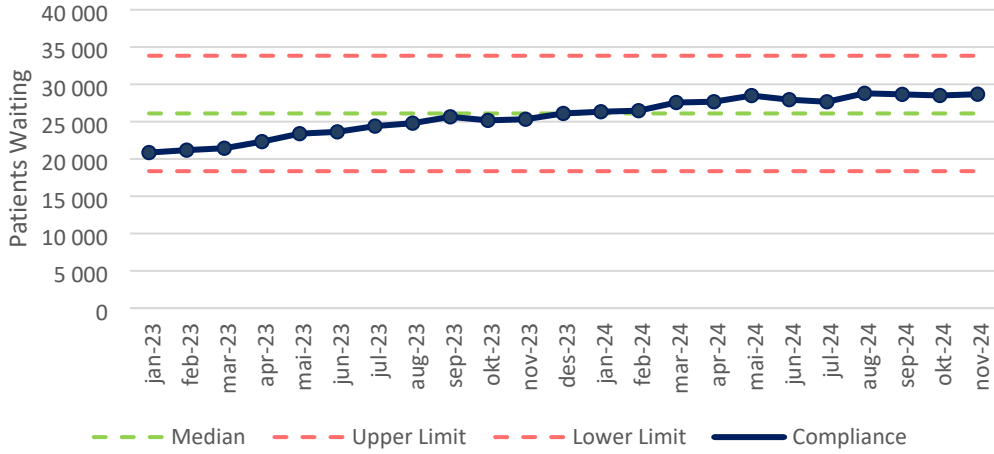
KEY MESSAGES & ACTIONS:

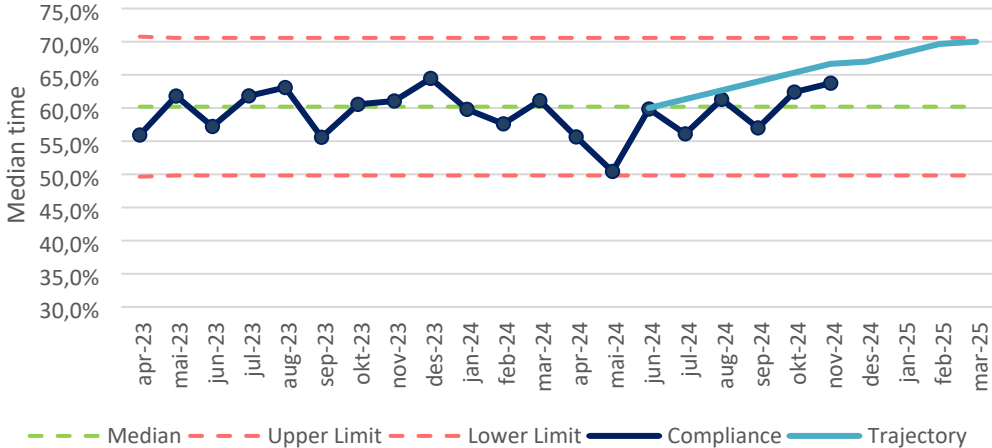
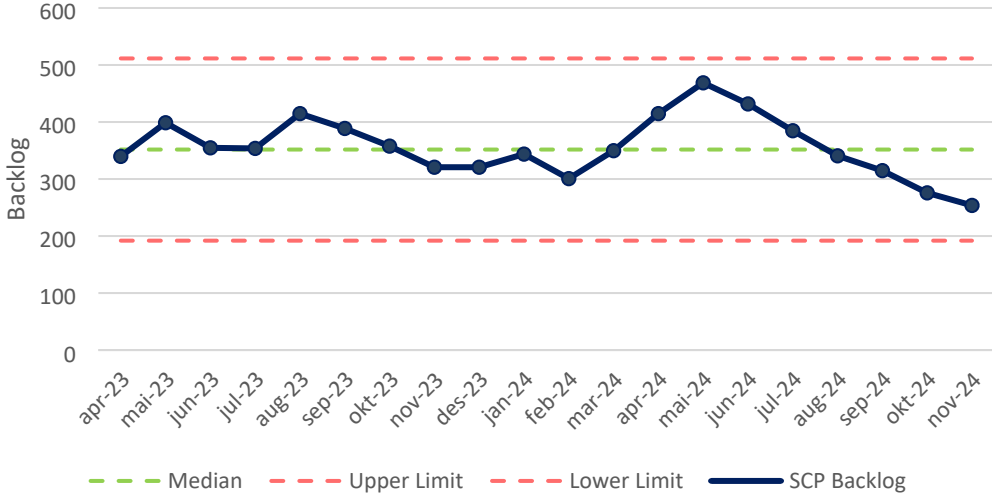
- In December 24 the ministerial priority of no patients waiting more than 156 weeks was achieved.
- 104+ weeks position is tracked in line with the revised trajectory and funded initiatives across ENT, Orthopaedics and Ophthalmology to deliver a zero position by the end of the year. Significant progress has been made in mobilising the schemes to deliver this additionality although there remain a number of risks, including impact of winter pressures, procurement timescales and mobilising access to external capacity. These are being closely monitored at local and national level.
- The 8 week diagnostics position is ahead of the revised trajectory reflecting the additional funding made available to support the reduction in the numbers of people waiting more than 8 weeks for a diagnostic.
- Single Cancer Pathway (SCP) compliance has trended upwards overall since May reaching 63.7% in November 24.
- The 62 and 104 day backlog for the SCP has seen sustained reduction in the same time period. Tumour site specific Task and Finish groups have been instrumental in delivering improvement in the backlog position.
- Theatres have delivered sustained improvements in scheduling KPI's with significant improvement in list utilisation.
- General Surgery high volume, low complexity lists (HVLC) at NHH are transitioning from pilot to "BAU" from January onwards.
- The development of Health Pathways continues. 94 localised pathways live as of mid-December. The Health Board is engaging in national work on the Evaluation Framework for the system.
- In respect of Outpatient development, CWS developments for eAdvice to run from January to mid-February, with anticipated completion by end of March/early April.
- Following successful launch of Keeping Well Service, this is now rolling out to orthopaedic hip patients, with plans to move onto knee patients

Priority	Performance Summary	Performance against Q2 Trajectory	Data

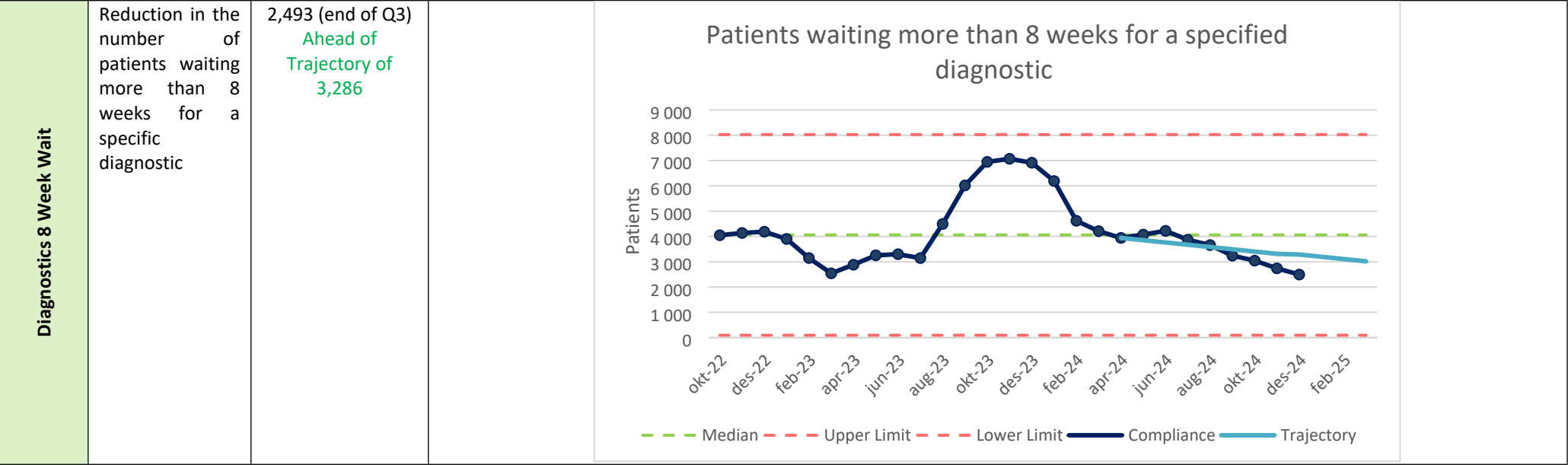
Longest waiting patients	Numbers of patients waiting over 52 weeks (all stages)	28,397 (end of Q3) Below Trajectory of 32,156	Patients waiting more than 52 weeks- all stages
	Number of patients waiting more than 52 weeks for a new outpatient appointment	16,868 (end of Q3) Above Trajectory of 16,077	Number of patients waiting more than 52 weeks for a new outpatient appointment

	Numbers of patients waiting over 104 weeks (all stages)	3,573 (end of Q3) Meeting revised EOY Trajectory, Q4 to be 0	Patients waiting more than 104 weeks - all stages <table><caption>Approximate data for Patients waiting more than 104 weeks</caption><thead><tr><th>Month</th><th>Compliance</th><th>EOY trajectory</th></tr></thead><tbody><tr><td>apr-23</td><td>3500</td><td>3500</td></tr><tr><td>mai-23</td><td>3600</td><td>3600</td></tr><tr><td>jun-23</td><td>3700</td><td>3700</td></tr><tr><td>jul-23</td><td>3800</td><td>3800</td></tr><tr><td>aug-23</td><td>3700</td><td>3700</td></tr><tr><td>sep-23</td><td>4000</td><td>4000</td></tr><tr><td>okt-23</td><td>4000</td><td>4000</td></tr><tr><td>nov-23</td><td>3900</td><td>3900</td></tr><tr><td>des-23</td><td>4000</td><td>4000</td></tr><tr><td>jan-24</td><td>4200</td><td>4200</td></tr><tr><td>feb-24</td><td>4400</td><td>4400</td></tr><tr><td>mar-24</td><td>4200</td><td>4200</td></tr><tr><td>apr-24</td><td>4300</td><td>4300</td></tr><tr><td>mai-24</td><td>4400</td><td>4600</td></tr><tr><td>jun-24</td><td>4500</td><td>4400</td></tr><tr><td>jul-24</td><td>4300</td><td>4300</td></tr><tr><td>aug-24</td><td>4100</td><td>4200</td></tr><tr><td>sep-24</td><td>3800</td><td>4100</td></tr><tr><td>okt-24</td><td>4000</td><td>4000</td></tr><tr><td>nov-24</td><td>4000</td><td>4000</td></tr><tr><td>des-24</td><td>3800</td><td>3800</td></tr><tr><td>jan-25</td><td>3500</td><td>3500</td></tr><tr><td>feb-25</td><td>0</td><td>0</td></tr><tr><td>mar-25</td><td>0</td><td>0</td></tr></tbody></table>	Month	Compliance	EOY trajectory	apr-23	3500	3500	mai-23	3600	3600	jun-23	3700	3700	jul-23	3800	3800	aug-23	3700	3700	sep-23	4000	4000	okt-23	4000	4000	nov-23	3900	3900	des-23	4000	4000	jan-24	4200	4200	feb-24	4400	4400	mar-24	4200	4200	apr-24	4300	4300	mai-24	4400	4600	jun-24	4500	4400	jul-24	4300	4300	aug-24	4100	4200	sep-24	3800	4100	okt-24	4000	4000	nov-24	4000	4000	des-24	3800	3800	jan-25	3500	3500	feb-25	0	0	mar-25	0	0
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	Elimination of total waits over 156 weeks (all stages)	0 (end of Q3) Meeting Trajectory of 0	Patients waiting more than 156 weeks - all stages <table><caption>Approximate data for Patients waiting more than 156 weeks</caption><thead><tr><th>Month</th><th>Compliance</th></tr></thead><tbody><tr><td>apr-23</td><td>650</td></tr><tr><td>mai-23</td><td>550</td></tr><tr><td>jun-23</td><td>450</td></tr><tr><td>jul-23</td><td>320</td></tr><tr><td>aug-23</td><td>280</td></tr><tr><td>sep-23</td><td>250</td></tr><tr><td>okt-23</td><td>240</td></tr><tr><td>nov-23</td><td>140</td></tr><tr><td>des-23</td><td>60</td></tr><tr><td>jan-24</td><td>50</td></tr><tr><td>feb-24</td><td>50</td></tr><tr><td>mar-24</td><td>40</td></tr><tr><td>apr-24</td><td>60</td></tr><tr><td>mai-24</td><td>60</td></tr><tr><td>jun-24</td><td>60</td></tr><tr><td>jul-24</td><td>40</td></tr><tr><td>aug-24</td><td>30</td></tr><tr><td>sep-24</td><td>20</td></tr><tr><td>okt-24</td><td>10</td></tr><tr><td>nov-24</td><td>10</td></tr><tr><td>des-24</td><td>0</td></tr></tbody></table>	Month	Compliance	apr-23	650	mai-23	550	jun-23	450	jul-23	320	aug-23	280	sep-23	250	okt-23	240	nov-23	140	des-23	60	jan-24	50	feb-24	50	mar-24	40	apr-24	60	mai-24	60	jun-24	60	jul-24	40	aug-24	30	sep-24	20	okt-24	10	nov-24	10	des-24	0																															
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Outpatient Transformation	Increase in the rate of See On Symptom (SOS) and Patient Initiated Follow-ups (PIFU)	9.5% (end of Nov) Below Q2 Trajectory of 13.60%	% Rate of SOS / PIFU <table><tr><th>Month</th><th>Compliance (%)</th><th>Median (%)</th><th>Upper Limit (%)</th><th>Lower Limit (%)</th></tr><tr><td>jan-23</td><td>8.5</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>feb-23</td><td>8.0</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>mar-23</td><td>8.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>apr-23</td><td>8.8</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>mai-23</td><td>8.8</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>jun-23</td><td>9.8</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>jul-23</td><td>8.8</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>aug-23</td><td>9.5</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>sep-23</td><td>8.8</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>okt-23</td><td>9.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>nov-23</td><td>9.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>des-23</td><td>9.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>jan-24</td><td>9.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>feb-24</td><td>9.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>mar-24</td><td>8.8</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>apr-24</td><td>9.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>mai-24</td><td>10.0</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>jun-24</td><td>10.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>jul-24</td><td>10.5</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>aug-24</td><td>10.0</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>sep-24</td><td>10.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>okt-24</td><td>10.2</td><td>9.5</td><td>11.5</td><td>7.5</td></tr><tr><td>nov-24</td><td>9.5</td><td>9.5</td><td>11.5</td><td>7.5</td></tr></table>	Month	Compliance (%)	Median (%)	Upper Limit (%)	Lower Limit (%)	jan-23	8.5	9.5	11.5	7.5	feb-23	8.0	9.5	11.5	7.5	mar-23	8.2	9.5	11.5	7.5	apr-23	8.8	9.5	11.5	7.5	mai-23	8.8	9.5	11.5	7.5	jun-23	9.8	9.5	11.5	7.5	jul-23	8.8	9.5	11.5	7.5	aug-23	9.5	9.5	11.5	7.5	sep-23	8.8	9.5	11.5	7.5	okt-23	9.2	9.5	11.5	7.5	nov-23	9.2	9.5	11.5	7.5	des-23	9.2	9.5	11.5	7.5	jan-24	9.2	9.5	11.5	7.5	feb-24	9.2	9.5	11.5	7.5	mar-24	8.8	9.5	11.5	7.5	apr-24	9.2	9.5	11.5	7.5	mai-24	10.0	9.5	11.5	7.5	jun-24	10.2	9.5	11.5	7.5	jul-24	10.5	9.5	11.5	7.5	aug-24	10.0	9.5	11.5	7.5	sep-24	10.2	9.5	11.5	7.5	okt-24	10.2	9.5	11.5	7.5	nov-24	9.5	9.5	11.5	7.5
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Reduction in the number of patients waiting 100% past Outpatient follow-up target date	28,677 (end of Nov) Above Q2 Trajectory of 16,011	Reduction in the number of patients waiting 100% past target for follow-up <table><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>jan-23</td><td>21,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>feb-23</td><td>21,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>mar-23</td><td>22,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>apr-23</td><td>23,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>mai-23</td><td>24,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>jun-23</td><td>24,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>jul-23</td><td>25,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>aug-23</td><td>25,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>sep-23</td><td>26,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>okt-23</td><td>25,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>nov-23</td><td>25,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>des-23</td><td>26,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>jan-24</td><td>26,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>feb-24</td><td>26,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>mar-24</td><td>28,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>apr-24</td><td>28,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>mai-24</td><td>29,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>jun-24</td><td>28,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>jul-24</td><td>28,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>aug-24</td><td>29,500</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>sep-24</td><td>29,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>okt-24</td><td>29,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr><tr><td>nov-24</td><td>29,000</td><td>26,000</td><td>34,000</td><td>19,000</td></tr></table>	Month	Compliance	Median	Upper Limit	Lower Limit	jan-23	21,000	26,000	34,000	19,000	feb-23	21,500	26,000	34,000	19,000	mar-23	22,000	26,000	34,000	19,000	apr-23	23,000	26,000	34,000	19,000	mai-23	24,000	26,000	34,000	19,000	jun-23	24,500	26,000	34,000	19,000	jul-23	25,000	26,000	34,000	19,000	aug-23	25,500	26,000	34,000	19,000	sep-23	26,000	26,000	34,000	19,000	okt-23	25,500	26,000	34,000	19,000	nov-23	25,500	26,000	34,000	19,000	des-23	26,500	26,000	34,000	19,000	jan-24	26,500	26,000	34,000	19,000	feb-24	26,500	26,000	34,000	19,000	mar-24	28,000	26,000	34,000	19,000	apr-24	28,000	26,000	34,000	19,000	mai-24	29,000	26,000	34,000	19,000	jun-24	28,500	26,000	34,000	19,000	jul-24	28,000	26,000	34,000	19,000	aug-24	29,500	26,000	34,000	19,000	sep-24	29,000	26,000	34,000	19,000	okt-24	29,000	26,000	34,000	19,000	nov-24	29,000	26,000	34,000	19,000	
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Single Cancer Pathway	Increase in Single Cancer Pathway (SCP) 62-day compliance	63.74% (end of Nov) Below Trajectory of 64%	% Patients starting first definitive cancer treatment within 62 days from point of suspicion <table><caption>% Patients starting first definitive cancer treatment within 62 days from point of suspicion</caption><tr><th>Date</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>apr-23</td><td>57%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>mai-23</td><td>63%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>jun-23</td><td>58%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>jul-23</td><td>63%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>aug-23</td><td>64%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>sep-23</td><td>56%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>okt-23</td><td>62%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>nov-23</td><td>62%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>des-23</td><td>65%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>jan-24</td><td>61%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>feb-24</td><td>58%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>mar-24</td><td>62%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>apr-24</td><td>56%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>mai-24</td><td>51%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>jun-24</td><td>61%</td><td>61%</td><td>72%</td><td>51%</td></tr><tr><td>jul-24</td><td>57%</td><td>63%</td><td>72%</td><td>51%</td></tr><tr><td>aug-24</td><td>62%</td><td>64%</td><td>72%</td><td>51%</td></tr><tr><td>sep-24</td><td>58%</td><td>65%</td><td>72%</td><td>51%</td></tr><tr><td>okt-24</td><td>63%</td><td>66%</td><td>72%</td><td>51%</td></tr><tr><td>nov-24</td><td>64%</td><td>67%</td><td>72%</td><td>51%</td></tr><tr><td>des-24</td><td>68%</td><td>68%</td><td>72%</td><td>51%</td></tr><tr><td>jan-25</td><td>70%</td><td>69%</td><td>72%</td><td>51%</td></tr><tr><td>feb-25</td><td>71%</td><td>70%</td><td>72%</td><td>51%</td></tr><tr><td>mar-25</td><td>71%</td><td>71%</td><td>72%</td><td>51%</td></tr></table>	Date	Compliance	Median	Upper Limit	Lower Limit	apr-23	57%	61%	72%	51%	mai-23	63%	61%	72%	51%	jun-23	58%	61%	72%	51%	jul-23	63%	61%	72%	51%	aug-23	64%	61%	72%	51%	sep-23	56%	61%	72%	51%	okt-23	62%	61%	72%	51%	nov-23	62%	61%	72%	51%	des-23	65%	61%	72%	51%	jan-24	61%	61%	72%	51%	feb-24	58%	61%	72%	51%	mar-24	62%	61%	72%	51%	apr-24	56%	61%	72%	51%	mai-24	51%	61%	72%	51%	jun-24	61%	61%	72%	51%	jul-24	57%	63%	72%	51%	aug-24	62%	64%	72%	51%	sep-24	58%	65%	72%	51%	okt-24	63%	66%	72%	51%	nov-24	64%	67%	72%	51%	des-24	68%	68%	72%	51%	jan-25	70%	69%	72%	51%	feb-25	71%	70%	72%	51%	mar-25	71%	71%	72%	51%
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Reduction in backlog of patients waiting over 62 days (SCP)	254 (end of Nov) Below Q3 Trajectory of 270	SCP 62 Day Backlog <table><caption>SCP 62 Day Backlog</caption><tr><th>Date</th><th>SCP Backlog</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>apr-23</td><td>350</td><td>360</td><td>520</td><td>200</td></tr><tr><td>mai-23</td><td>410</td><td>360</td><td>520</td><td>200</td></tr><tr><td>jun-23</td><td>360</td><td>360</td><td>520</td><td>200</td></tr><tr><td>jul-23</td><td>360</td><td>360</td><td>520</td><td>200</td></tr><tr><td>aug-23</td><td>430</td><td>360</td><td>520</td><td>200</td></tr><tr><td>sep-23</td><td>400</td><td>360</td><td>520</td><td>200</td></tr><tr><td>okt-23</td><td>370</td><td>360</td><td>520</td><td>200</td></tr><tr><td>nov-23</td><td>330</td><td>360</td><td>520</td><td>200</td></tr><tr><td>des-23</td><td>330</td><td>360</td><td>520</td><td>200</td></tr><tr><td>jan-24</td><td>350</td><td>360</td><td>520</td><td>200</td></tr><tr><td>feb-24</td><td>310</td><td>360</td><td>520</td><td>200</td></tr><tr><td>mar-24</td><td>360</td><td>360</td><td>520</td><td>200</td></tr><tr><td>apr-24</td><td>430</td><td>360</td><td>520</td><td>200</td></tr><tr><td>mai-24</td><td>480</td><td>360</td><td>520</td><td>200</td></tr><tr><td>jun-24</td><td>440</td><td>360</td><td>520</td><td>200</td></tr><tr><td>jul-24</td><td>390</td><td>360</td><td>520</td><td>200</td></tr><tr><td>aug-24</td><td>350</td><td>360</td><td>520</td><td>200</td></tr><tr><td>sep-24</td><td>330</td><td>360</td><td>520</td><td>200</td></tr><tr><td>okt-24</td><td>280</td><td>360</td><td>520</td><td>200</td></tr><tr><td>nov-24</td><td>260</td><td>360</td><td>520</td><td>200</td></tr></table>	Date	SCP Backlog	Median	Upper Limit	Lower Limit	apr-23	350	360	520	200	mai-23	410	360	520	200	jun-23	360	360	520	200	jul-23	360	360	520	200	aug-23	430	360	520	200	sep-23	400	360	520	200	okt-23	370	360	520	200	nov-23	330	360	520	200	des-23	330	360	520	200	jan-24	350	360	520	200	feb-24	310	360	520	200	mar-24	360	360	520	200	apr-24	430	360	520	200	mai-24	480	360	520	200	jun-24	440	360	520	200	jul-24	390	360	520	200	aug-24	350	360	520	200	sep-24	330	360	520	200	okt-24	280	360	520	200	nov-24	260	360	520	200																					
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	Reduction in backlog of patients waiting over 104 days (SCP)	62 (end of Nov) Below Q3 Trajectory of 68	SCP 104 Day Backlog <table><tr><th>Month</th><th>SCP Backlog</th></tr><tr><td>apr-23</td><td>105</td></tr><tr><td>mai-23</td><td>128</td></tr><tr><td>jun-23</td><td>105</td></tr><tr><td>jul-23</td><td>108</td></tr><tr><td>aug-23</td><td>138</td></tr><tr><td>sep-23</td><td>125</td></tr><tr><td>okt-23</td><td>130</td></tr><tr><td>nov-23</td><td>115</td></tr><tr><td>des-23</td><td>100</td></tr><tr><td>jan-24</td><td>118</td></tr><tr><td>feb-24</td><td>92</td></tr><tr><td>mar-24</td><td>90</td></tr><tr><td>apr-24</td><td>102</td></tr><tr><td>mai-24</td><td>115</td></tr><tr><td>jun-24</td><td>150</td></tr><tr><td>jul-24</td><td>115</td></tr><tr><td>aug-24</td><td>102</td></tr><tr><td>sep-24</td><td>108</td></tr><tr><td>okt-24</td><td>82</td></tr><tr><td>nov-24</td><td>62</td></tr></table>	Month	SCP Backlog	apr-23	105	mai-23	128	jun-23	105	jul-23	108	aug-23	138	sep-23	125	okt-23	130	nov-23	115	des-23	100	jan-24	118	feb-24	92	mar-24	90	apr-24	102	mai-24	115	jun-24	150	jul-24	115	aug-24	102	sep-24	108	okt-24	82	nov-24	62
	Month	SCP Backlog																																											
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Increase in rate of cancer diagnosis or discharges within 28 days	85% (end of Nov) Above Q3 Trajectory of 80%	% Compliance - Decision to Treatment 28 Day Rate <table><tr><th>Month</th><th>Compliance</th></tr><tr><td>apr-23</td><td>82%</td></tr><tr><td>mai-23</td><td>84%</td></tr><tr><td>jun-23</td><td>81%</td></tr><tr><td>jul-23</td><td>84%</td></tr><tr><td>aug-23</td><td>86%</td></tr><tr><td>sep-23</td><td>79%</td></tr><tr><td>okt-23</td><td>83%</td></tr><tr><td>nov-23</td><td>87%</td></tr><tr><td>des-23</td><td>85%</td></tr><tr><td>jan-24</td><td>81%</td></tr><tr><td>feb-24</td><td>79%</td></tr><tr><td>mar-24</td><td>86%</td></tr><tr><td>apr-24</td><td>79%</td></tr><tr><td>mai-24</td><td>86%</td></tr><tr><td>jun-24</td><td>89%</td></tr><tr><td>jul-24</td><td>87%</td></tr><tr><td>aug-24</td><td>89%</td></tr><tr><td>sep-24</td><td>84%</td></tr><tr><td>okt-24</td><td>89%</td></tr><tr><td>nov-24</td><td>85%</td></tr></table>	Month	Compliance	apr-23	82%	mai-23	84%	jun-23	81%	jul-23	84%	aug-23	86%	sep-23	79%	okt-23	83%	nov-23	87%	des-23	85%	jan-24	81%	feb-24	79%	mar-24	86%	apr-24	79%	mai-24	86%	jun-24	89%	jul-24	87%	aug-24	89%	sep-24	84%	okt-24	89%	nov-24	85%	
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KEY MESSAGES & ACTIONS:

- The focus on improvements in the delivery of the Part 1a and 1b of the Adult Mental Health measures is now reaping benefits.
- Adults Part 1a compliance has risen to 84% following substantial efforts made by the Division.
- Adults Part 1b compliance remains below trajectory as of November submission however, following significant efforts by the Division, end of Q3 (Dec) projected compliance is 88% (as yet unconfirmed).
- The waiting lists for both measures have decreased significantly through the year, with 1a going from ~1,350 to under 700 and 1b from ~2,750 to under 400.
- Part 2 compliance for adults is tracking trajectory and have been relatively stable throughout 24/25, always over 80%.
- The use of Robotic Process Automation (RPA) has contributed towards improved performance through impact on booking processes and addressing backlog.
- There is further work to be done with regards to provision of psychological therapies in secondary care including validation of waiting lists and implementation of newmodel and pathway.
- CAMHS Part 1a compliance remains strong, having been over 90% each month since June.
- Resource is now being reallocated to support improvements in Part 1b compliance, which is below trajectory as of November submission however end of Q3 compliance is projected to rise to 84.7%.
- For CAMHS Neurodevelopment, compliance is on an overall upwards trend, having now achieved over 50% compliance with the under 26 weeks standard and meeting their trajectory.
- A dedicated ND clinician will be in place to support with ND recovery from January - March 2025 along with dedicated admin support, and to hold additional clinics to held at evenings and weekends in order to continue the progress over the final part of the year.

Priority	Performance Summary	Performance against Q2 Trajectory	Data																																																																											
	Increase in Part 1a to national target for Adult MH (assessment completed within 28 days)	84% (end of Nov) Above Q3 Trajectory of 45%	Adults 1a: Assessment by LPMHSS within 28 days of referral. <table><caption>Adults 1a: Assessment by LPMHSS within 28 days of referral</caption><thead><tr><th>Month</th><th>Compliance (%)</th><th>Trajectory (%)</th></tr></thead><tbody><tr><td>apr-23</td><td>10</td><td></td></tr><tr><td>mai-23</td><td>8</td><td></td></tr><tr><td>jun-23</td><td>9</td><td></td></tr><tr><td>jul-23</td><td>10</td><td></td></tr><tr><td>aug-23</td><td>15</td><td></td></tr><tr><td>sep-23</td><td>8</td><td></td></tr><tr><td>okt-23</td><td>12</td><td></td></tr><tr><td>nov-23</td><td>6</td><td></td></tr><tr><td>des-23</td><td>8</td><td></td></tr><tr><td>jan-24</td><td>7</td><td></td></tr><tr><td>feb-24</td><td>10</td><td></td></tr><tr><td>mar-24</td><td>8</td><td></td></tr><tr><td>apr-24</td><td>20</td><td>15</td></tr><tr><td>mai-24</td><td>42</td><td>15</td></tr><tr><td>jun-24</td><td>60</td><td>15</td></tr><tr><td>jul-24</td><td>65</td><td>18</td></tr><tr><td>aug-24</td><td>62</td><td>22</td></tr><tr><td>sep-24</td><td>55</td><td>25</td></tr><tr><td>okt-24</td><td>65</td><td>30</td></tr><tr><td>nov-24</td><td>85</td><td>35</td></tr><tr><td>des-24</td><td></td><td>45</td></tr><tr><td>jan-25</td><td></td><td>55</td></tr><tr><td>feb-25</td><td></td><td>65</td></tr><tr><td>mar-25</td><td></td><td>80</td></tr></tbody></table>	Month	Compliance (%)	Trajectory (%)	apr-23	10		mai-23	8		jun-23	9		jul-23	10		aug-23	15		sep-23	8		okt-23	12		nov-23	6		des-23	8		jan-24	7		feb-24	10		mar-24	8		apr-24	20	15	mai-24	42	15	jun-24	60	15	jul-24	65	18	aug-24	62	22	sep-24	55	25	okt-24	65	30	nov-24	85	35	des-24		45	jan-25		55	feb-25		65	mar-25		80
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Increase in Part 1b to national target for Adult MH (interventions completed within 28 days)	24.5% (end of Nov) Below Trajectory of 70%	Adults 1b: Interventions ≤ 28 days following assessment by LPMHSS <table><caption>Adults 1b: Interventions ≤ 28 days following assessment by LPMHSS</caption><thead><tr><th>Month</th><th>Compliance (%)</th><th>Trajectory (%)</th></tr></thead><tbody><tr><td>apr-23</td><td>5</td><td></td></tr><tr><td>mai-23</td><td>6</td><td></td></tr><tr><td>jun-23</td><td>8</td><td></td></tr><tr><td>jul-23</td><td>5</td><td></td></tr><tr><td>aug-23</td><td>10</td><td></td></tr><tr><td>sep-23</td><td>25</td><td></td></tr><tr><td>okt-23</td><td>25</td><td></td></tr><tr><td>nov-23</td><td>12</td><td></td></tr><tr><td>des-23</td><td>15</td><td></td></tr><tr><td>jan-24</td><td>18</td><td></td></tr><tr><td>feb-24</td><td>10</td><td></td></tr><tr><td>mar-24</td><td>8</td><td></td></tr><tr><td>apr-24</td><td>10</td><td>15</td></tr><tr><td>mai-24</td><td>15</td><td>18</td></tr><tr><td>jun-24</td><td>20</td><td>22</td></tr><tr><td>jul-24</td><td>25</td><td>25</td></tr><tr><td>aug-24</td><td>25</td><td>28</td></tr><tr><td>sep-24</td><td>20</td><td>35</td></tr><tr><td>okt-24</td><td>25</td><td>45</td></tr><tr><td>nov-24</td><td>25</td><td>65</td></tr><tr><td>des-24</td><td></td><td>90</td></tr><tr><td>jan-25</td><td></td><td>95</td></tr><tr><td>feb-25</td><td></td><td>92</td></tr><tr><td>mar-25</td><td></td><td>95</td></tr></tbody></table>	Month	Compliance (%)	Trajectory (%)	apr-23	5		mai-23	6		jun-23	8		jul-23	5		aug-23	10		sep-23	25		okt-23	25		nov-23	12		des-23	15		jan-24	18		feb-24	10		mar-24	8		apr-24	10	15	mai-24	15	18	jun-24	20	22	jul-24	25	25	aug-24	25	28	sep-24	20	35	okt-24	25	45	nov-24	25	65	des-24		90	jan-25		95	feb-25		92	mar-25		95	
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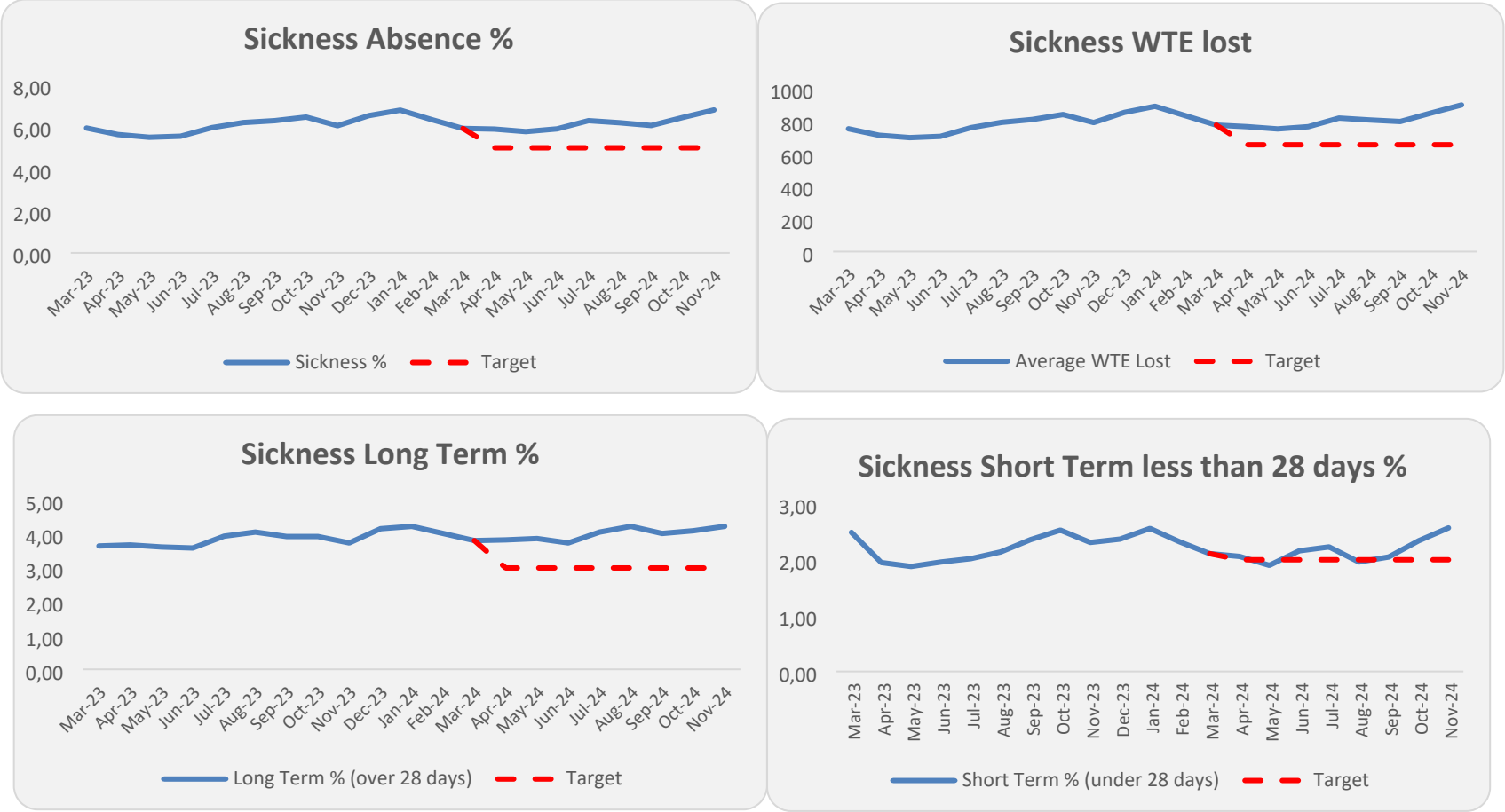
Children and Young People	Maintain Part 2 rates for Adult MH (number of individuals with a valid care and treatment plan)	85% (end of Nov) Above Trajectory of 68.3%	Adults Part 2: Percentage of residents in receipt of a valid care and treatment plan ≥ 18ys <table><tr><th>Month</th><th>Compliance</th><th>Median</th><th>Upper Limit</th><th>Lower Limit</th></tr><tr><td>apr-23</td><td>72%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>mai-23</td><td>72%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>jun-23</td><td>71%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>jul-23</td><td>71%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>aug-23</td><td>70%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>sep-23</td><td>71%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>okt-23</td><td>70%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>nov-23</td><td>69%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>des-23</td><td>70%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>jan-24</td><td>68%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>feb-24</td><td>69%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>mar-24</td><td>70%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>apr-24</td><td>83%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>mai-24</td><td>84%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>jun-24</td><td>85%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>jul-24</td><td>86%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>aug-24</td><td>87%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>sep-24</td><td>89%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>okt-24</td><td>86%</td><td>70%</td><td>95%</td><td>45%</td></tr><tr><td>nov-24</td><td>87%</td><td>70%</td><td>95%</td><td>45%</td></tr></table>	Month	Compliance	Median	Upper Limit	Lower Limit	apr-23	72%	70%	95%	45%	mai-23	72%	70%	95%	45%	jun-23	71%	70%	95%	45%	jul-23	71%	70%	95%	45%	aug-23	70%	70%	95%	45%	sep-23	71%	70%	95%	45%	okt-23	70%	70%	95%	45%	nov-23	69%	70%	95%	45%	des-23	70%	70%	95%	45%	jan-24	68%	70%	95%	45%	feb-24	69%	70%	95%	45%	mar-24	70%	70%	95%	45%	apr-24	83%	70%	95%	45%	mai-24	84%	70%	95%	45%	jun-24	85%	70%	95%	45%	jul-24	86%	70%	95%	45%	aug-24	87%	70%	95%	45%	sep-24	89%	70%	95%	45%	okt-24	86%	70%	95%	45%	nov-24	87%	70%	95%	45%
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	Maintain Child and Adolescent Mental Health Services (CAMHS) Part 1a national target compliance (assessment completed within 28 days)	91.1% (end of Nov) Above Q3 Trajectory of 80%	CAHMS 1a: Assessment by LPMHSS within 28 days of referral <table><tr><th>Month</th><th>Compliance (%)</th><th>Median (%)</th><th>Upper Limit (%)</th><th>Lower Limit (%)</th></tr><tr><td>apr-23</td><td>65</td><td>90</td><td>100</td><td>62</td></tr><tr><td>mai-23</td><td>72</td><td>90</td><td>100</td><td>62</td></tr><tr><td>jun-23</td><td>92</td><td>90</td><td>100</td><td>62</td></tr><tr><td>jul-23</td><td>95</td><td>90</td><td>100</td><td>62</td></tr><tr><td>aug-23</td><td>93</td><td>90</td><td>100</td><td>62</td></tr><tr><td>sep-23</td><td>90</td><td>90</td><td>100</td><td>62</td></tr><tr><td>okt-23</td><td>89</td><td>90</td><td>100</td><td>62</td></tr><tr><td>nov-23</td><td>90</td><td>90</td><td>100</td><td>62</td></tr><tr><td>des-23</td><td>90</td><td>90</td><td>100</td><td>62</td></tr><tr><td>jan-24</td><td>91</td><td>90</td><td>100</td><td>62</td></tr><tr><td>feb-24</td><td>83</td><td>90</td><td>100</td><td>62</td></tr><tr><td>mar-24</td><td>79</td><td>90</td><td>100</td><td>62</td></tr><tr><td>apr-24</td><td>83</td><td>90</td><td>100</td><td>62</td></tr><tr><td>mai-24</td><td>86</td><td>90</td><td>100</td><td>62</td></tr><tr><td>jun-24</td><td>95</td><td>90</td><td>100</td><td>62</td></tr><tr><td>jul-24</td><td>100</td><td>90</td><td>100</td><td>62</td></tr><tr><td>aug-24</td><td>100</td><td>90</td><td>100</td><td>62</td></tr><tr><td>sep-24</td><td>95</td><td>90</td><td>100</td><td>62</td></tr><tr><td>okt-24</td><td>99</td><td>90</td><td>100</td><td>62</td></tr><tr><td>nov-24</td><td>91.1</td><td>90</td><td>100</td><td>62</td></tr></table>	Month	Compliance (%)	Median (%)	Upper Limit (%)	Lower Limit (%)	apr-23	65	90	100	62	mai-23	72	90	100	62	jun-23	92	90	100	62	jul-23	95	90	100	62	aug-23	93	90	100	62	sep-23	90	90	100	62	okt-23	89	90	100	62	nov-23	90	90	100	62	des-23	90	90	100	62	jan-24	91	90	100	62	feb-24	83	90	100	62	mar-24	79	90	100	62	apr-24	83	90	100	62	mai-24	86	90	100	62	jun-24	95	90	100	62	jul-24	100	90	100	62	aug-24	100	90	100	62	sep-24	95	90	100	62	okt-24	99	90	100	62	nov-24	91.1	90	100	62
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Children and Young People	Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	14.7% (end of Nov) Below Trajectory of 27%	CAMHS 1b: Interventions ≤ 28 days following assessment by LPMHSS <table><caption>CAMHS 1b: Interventions ≤ 28 days following assessment by LPMHSS</caption><tr><th>Month</th><th>Compliance</th><th>Trajectory</th></tr><tr><td>apr-23</td><td>5%</td><td>5%</td></tr><tr><td>mai-23</td><td>2%</td><td>2%</td></tr><tr><td>jun-23</td><td>20%</td><td>20%</td></tr><tr><td>jul-23</td><td>15%</td><td>15%</td></tr><tr><td>aug-23</td><td>20%</td><td>20%</td></tr><tr><td>sep-23</td><td>25%</td><td>25%</td></tr><tr><td>okt-23</td><td>30%</td><td>30%</td></tr><tr><td>nov-23</td><td>40%</td><td>40%</td></tr><tr><td>des-23</td><td>38%</td><td>38%</td></tr><tr><td>jan-24</td><td>15%</td><td>15%</td></tr><tr><td>feb-24</td><td>10%</td><td>10%</td></tr><tr><td>mar-24</td><td>5%</td><td>5%</td></tr><tr><td>apr-24</td><td>5%</td><td>5%</td></tr><tr><td>mai-24</td><td>2%</td><td>2%</td></tr><tr><td>jun-24</td><td>5%</td><td>5%</td></tr><tr><td>jul-24</td><td>5%</td><td>5%</td></tr><tr><td>aug-24</td><td>5%</td><td>5%</td></tr><tr><td>sep-24</td><td>5%</td><td>5%</td></tr><tr><td>okt-24</td><td>10%</td><td>10%</td></tr><tr><td>nov-24</td><td>15%</td><td>15%</td></tr><tr><td>des-24</td><td>80%</td><td>80%</td></tr><tr><td>jan-25</td><td>80%</td><td>80%</td></tr><tr><td>feb-25</td><td>80%</td><td>80%</td></tr><tr><td>mar-25</td><td>80%</td><td>80%</td></tr></table>	Month	Compliance	Trajectory	apr-23	5%	5%	mai-23	2%	2%	jun-23	20%	20%	jul-23	15%	15%	aug-23	20%	20%	sep-23	25%	25%	okt-23	30%	30%	nov-23	40%	40%	des-23	38%	38%	jan-24	15%	15%	feb-24	10%	10%	mar-24	5%	5%	apr-24	5%	5%	mai-24	2%	2%	jun-24	5%	5%	jul-24	5%	5%	aug-24	5%	5%	sep-24	5%	5%	okt-24	10%	10%	nov-24	15%	15%	des-24	80%	80%	jan-25	80%	80%	feb-25	80%	80%	mar-25	80%	80%
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Maintain CAMHS Part 2 national target compliance	100% (end of Nov) Above Q3 Trajectory of 90%	CAMHS Part 2: Percentage of residents in receipt of a valid care and treatment plan <18ys <table><caption>CAMHS Part 2: Percentage of residents in receipt of a valid care and treatment plan <18ys</caption><tr><th>Month</th><th>Compliance</th><th>Median</th></tr><tr><td>apr-23</td><td>85%</td><td>85%</td></tr><tr><td>mai-23</td><td>85%</td><td>85%</td></tr><tr><td>jun-23</td><td>85%</td><td>85%</td></tr><tr><td>jul-23</td><td>88%</td><td>85%</td></tr><tr><td>aug-23</td><td>85%</td><td>85%</td></tr><tr><td>sep-23</td><td>88%</td><td>85%</td></tr><tr><td>okt-23</td><td>85%</td><td>85%</td></tr><tr><td>nov-23</td><td>90%</td><td>85%</td></tr><tr><td>des-23</td><td>85%</td><td>85%</td></tr><tr><td>jan-24</td><td>80%</td><td>85%</td></tr><tr><td>feb-24</td><td>75%</td><td>85%</td></tr><tr><td>mar-24</td><td>75%</td><td>85%</td></tr><tr><td>apr-24</td><td>75%</td><td>85%</td></tr><tr><td>mai-24</td><td>78%</td><td>85%</td></tr><tr><td>jun-24</td><td>82%</td><td>85%</td></tr><tr><td>jul-24</td><td>82%</td><td>85%</td></tr><tr><td>aug-24</td><td>85%</td><td>85%</td></tr><tr><td>sep-24</td><td>82%</td><td>85%</td></tr><tr><td>okt-24</td><td>95%</td><td>85%</td></tr><tr><td>nov-24</td><td>100%</td><td>85%</td></tr></table>	Month	Compliance	Median	apr-23	85%	85%	mai-23	85%	85%	jun-23	85%	85%	jul-23	88%	85%	aug-23	85%	85%	sep-23	88%	85%	okt-23	85%	85%	nov-23	90%	85%	des-23	85%	85%	jan-24	80%	85%	feb-24	75%	85%	mar-24	75%	85%	apr-24	75%	85%	mai-24	78%	85%	jun-24	82%	85%	jul-24	82%	85%	aug-24	85%	85%	sep-24	82%	85%	okt-24	95%	85%	nov-24	100%	85%													
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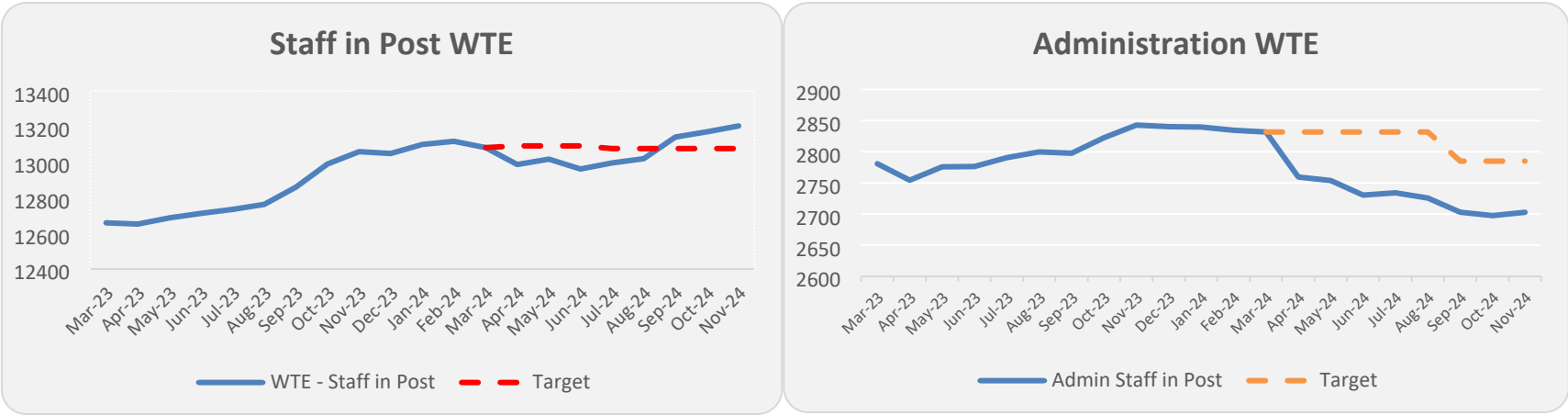
	Improvement in Neurodevelopment (iSCAN) compliance	51.1% (end of Q3) Meeting Q3 Trajectory of 51%	SPACE Wellbeing ND RTT Compliance (≤26 weeks) <table><tr><th>Month</th><th>Compliance (%)</th></tr><tr><td>apr-23</td><td>38</td></tr><tr><td>mai-23</td><td>35</td></tr><tr><td>jun-23</td><td>37</td></tr><tr><td>jul-23</td><td>44</td></tr><tr><td>aug-23</td><td>44</td></tr><tr><td>sep-23</td><td>40</td></tr><tr><td>okt-23</td><td>36</td></tr><tr><td>nov-23</td><td>36</td></tr><tr><td>des-23</td><td>31</td></tr><tr><td>jan-24</td><td>31</td></tr><tr><td>feb-24</td><td>35</td></tr><tr><td>mar-24</td><td>36</td></tr><tr><td>apr-24</td><td>41</td></tr><tr><td>mai-24</td><td>41</td></tr><tr><td>jun-24</td><td>39</td></tr><tr><td>jul-24</td><td>44</td></tr><tr><td>aug-24</td><td>43</td></tr><tr><td>sep-24</td><td>49</td></tr><tr><td>okt-24</td><td>50</td></tr><tr><td>nov-24</td><td>54</td></tr><tr><td>des-24</td><td>52</td></tr></table>	Month	Compliance (%)	apr-23	38	mai-23	35	jun-23	37	jul-23	44	aug-23	44	sep-23	40	okt-23	36	nov-23	36	des-23	31	jan-24	31	feb-24	35	mar-24	36	apr-24	41	mai-24	41	jun-24	39	jul-24	44	aug-24	43	sep-24	49	okt-24	50	nov-24	54	des-24	52
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Maintain 80% compliance of SCAMHS Choice Assessments within 28 days from referral	89% (end of Dec) Above Q3 Trajectory of 80%	sCAMHS Choice RTT <table><tr><th>Month</th><th>RTT Compliance (%)</th></tr><tr><td>apr-23</td><td>91</td></tr><tr><td>mai-23</td><td>90</td></tr><tr><td>jun-23</td><td>91</td></tr><tr><td>jul-23</td><td>77</td></tr><tr><td>aug-23</td><td>70</td></tr><tr><td>sep-23</td><td>58</td></tr><tr><td>okt-23</td><td>79</td></tr><tr><td>nov-23</td><td>92</td></tr><tr><td>des-23</td><td>75</td></tr><tr><td>jan-24</td><td>100</td></tr><tr><td>feb-24</td><td>96</td></tr><tr><td>mar-24</td><td>100</td></tr><tr><td>apr-24</td><td>100</td></tr><tr><td>mai-24</td><td>96</td></tr><tr><td>jun-24</td><td>93</td></tr><tr><td>jul-24</td><td>98</td></tr><tr><td>aug-24</td><td>87</td></tr><tr><td>sep-24</td><td>95</td></tr><tr><td>okt-24</td><td>100</td></tr><tr><td>nov-24</td><td>89</td></tr></table>	Month	RTT Compliance (%)	apr-23	91	mai-23	90	jun-23	91	jul-23	77	aug-23	70	sep-23	58	okt-23	79	nov-23	92	des-23	75	jan-24	100	feb-24	96	mar-24	100	apr-24	100	mai-24	96	jun-24	93	jul-24	98	aug-24	87	sep-24	95	okt-24	100	nov-24	89			
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The Health Board’s *People Plan, 2022 -2025, ‘Putting People First’*, outlines the Workforce and Organisational Development (OD) strategy in relation to workforce improvement, capability, and expertise with a clear focus on wellbeing, inclusion, and engagement of our people. The full Workforce and Culture update will be included in the Q3 Integrated Board Performance Report. Key highlights from the November 2024 Workforce Dashboard include:

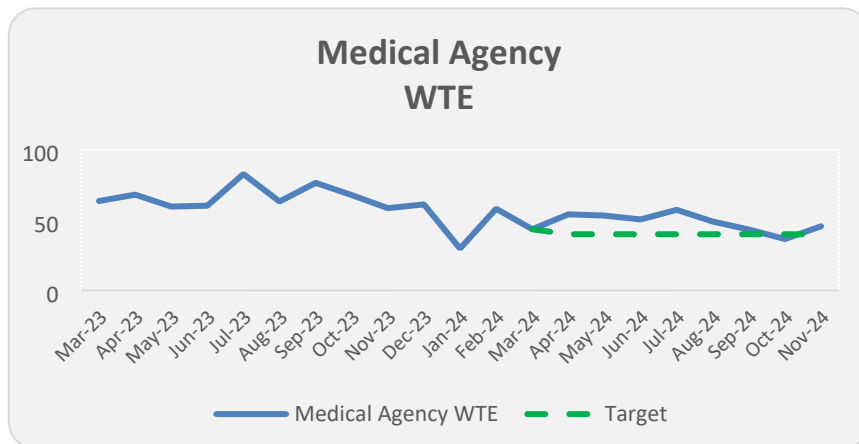
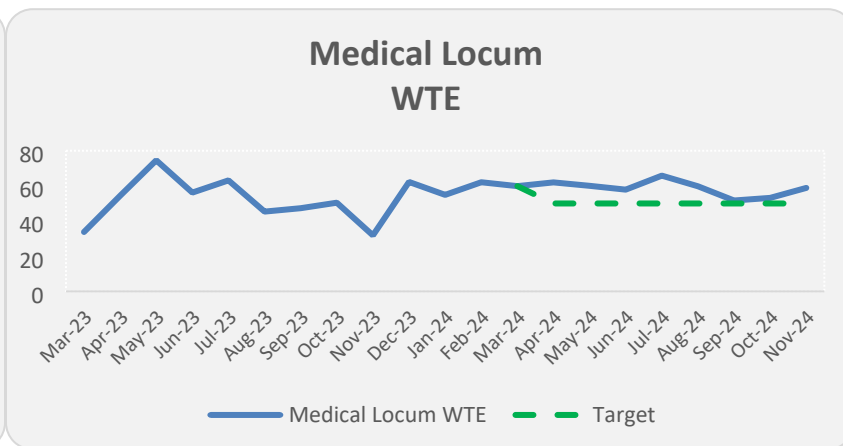
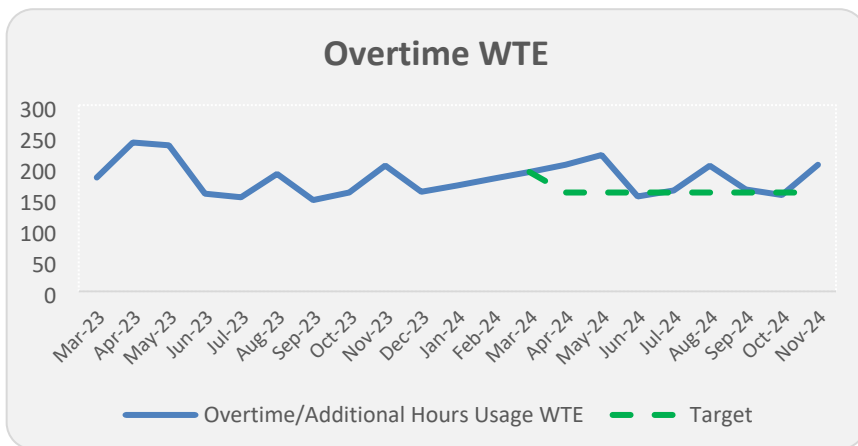
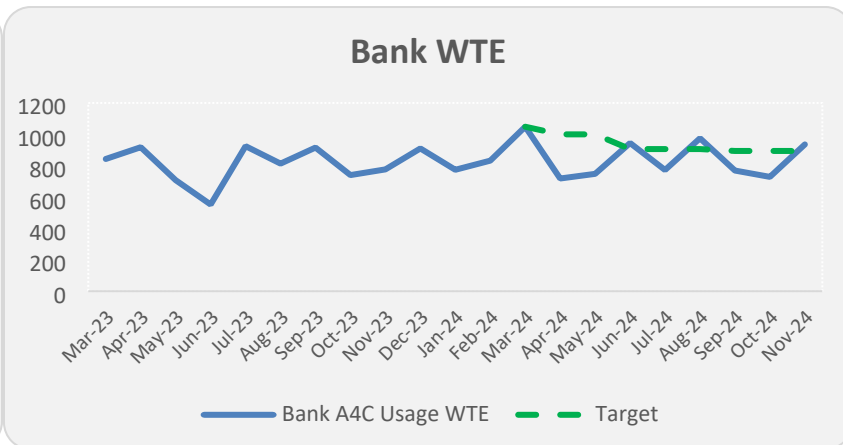
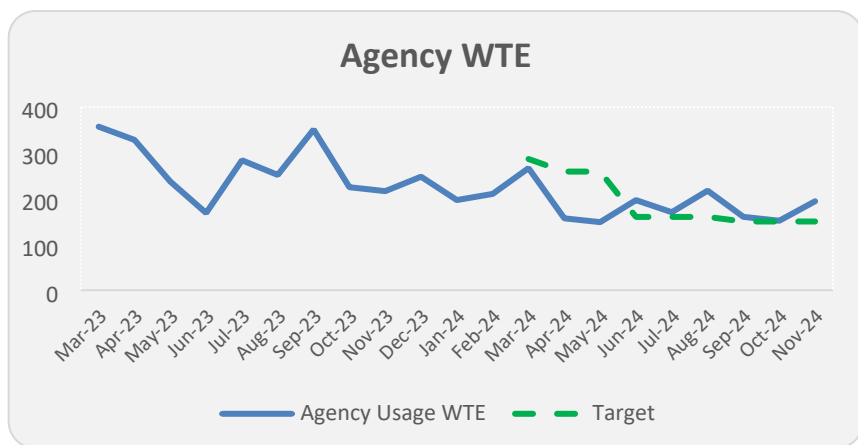


- In November 2024, sickness absence increased to 6.80% a 0.36% increase compared to October 2024 (6.44%). The 3 main reasons for sickness were Anxiety, Stress, Depression and other Psychiatric illness 33.0%, Cold, Cough, Flu-Influenza 9.2%, and other Musculoskeletal problems 8.8%.

- The 12-month cumulative sickness absence of 6.32% remained static compared with the previous year. The three highest sickness groups were, Additional Clinical Services (HCSW) 9.59%, Estates and Facilities 9.40% and Nursing and Midwifery 7.00%.
- Short term sickness increased in November 2024 to 2.57% compared to October 2024 (2.34%).
- The number of staff not in work due to sickness absence in November 2024 was 898wte, an increase compared to October 2024 (848wte) and also an increase compared to the previous year of 790wte.
- The 12-month total % for turnover was 9.02% compared to 9.30% at the same time last year, a decrease of 0.28%. Nursing and Midwifery have the lowest turnover rate of 6.43%.
- PADR remained below the target of 85%, with compliance for November 2024 at 74.54%, an increase of 0.65% from last month (73.89%). PADR compliance has improved by 3.42% when compared to 71.12% in November 2023.
- Statutory and Mandatory training has decreased slightly from 82.50% in October 2024 to 81.94% in November 2024. Statutory and Mandatory training compliance has seen an increase by 2.04% compared to 79.90% in November 2023.



- Staff in post in November 2024 was 13,203wte (16,835 people) compared to 13,059wte (16,566 people) in November 2023. The top staff group increases in November 2024 were in Nursing & Midwifery by 16.87wte and Allied Health Professionals by 7.25wte and Admin & Clerical by 5.28wte.
- Administration and Clerical staff in post increased from 2,697.55wte in October 2024 to 2,702.83wte in November 2024, an increase of 5.28wte.



- Variable pay usage increased in November 2024 to 1,130wte in comparison to 880.60wte in October 2024, an increase of 249.40wte.
- Work to reduce bank and agency usage continues with the main reasons for Registered Nurse and Health Care Support Workers usage to cover vacancies, sickness and enhanced care.
- Medical bank and agency usage in November 2024 was 104.54wte, an increase of 14.76wte compared to 89.78wte in October 2024. The current usage split is 56% Locum and 44% agency.
- Since the e-Locum bank implementation on 01 December 2023 the usage has remained consistent, on average 50-60 wte per month, 41% of locum usage is within Junior Grades.
- The new Medical Agency Management System was implemented on 01 May 2024. Agency usage remains fairly static, however, in November 2024 usage was 45.69wte, an increase of 9.08wte when compared to October 2024.
- The Workforce & OD Team are continuing to work with Divisions to input their Job Plans onto the new Job Planning E-System. Currently, overall Job Planning compliance is 25%, Consultants is at 27%, a decrease of 1.53% from 22% in October and SAS Doctors 25% an increase of 3% from 22% in October.
- 188 job plans have been completed in the new system. However, there are 398 job plans that are work in progress and 57 job plans awaiting signatures.
- Reducing time to hire – the time to hire is now above the target of 71 days for the first time since July 2024 (72 days) and is currently at 75.9 days.

Occupational Health Update

- The performance against the KPI target of 80% for the first offered appointment date to be within 29 calendar days of the date the referral was received has decreased from 56.8% in September 2024 to 39% in October 2024.
- The performance against the KPI target of 80% where consent is agreed during consultation for the report to be sent to the manager on the same day of the appointment was 100% in September but decreased slightly to 99.4% in October 2024.
- Completion of pre-placement health assessment within 7 calendar days has increased from 81.1% in September 2024 to 85.3% in October 2024 against an 80% target.
- Waiting times for Occupational Health as of 7 December 2024 were OH Physicians 8 weeks, a reduction of 2 weeks since September 2024; OH Nurses practitioners 8 weeks, an increase of 4 weeks since September 2024; Occupational Therapist 8 weeks, an increase of 2 weeks since September 2024 and replacement Health clearances 12 days, an increase of 2 days since September 2024, if an appointment is not required.

- To address a reduction in waiting times, £4,500 approved bank nurse money has been transferred to support the Flu Programme and to enable the purchase of 3 additional Physician days in December 2024. A request for a further 2 Physician days for December 2024 has been submitted as part of the Winter Plan response, which will provide 5 extra Physician days in total. A further request for an Occupational Health Nurse Advisor has been made for 3 days and an additional 2 days of physician appointment. Current analysis of demand is in progress to ascertain cover aligned to vacancies.

The quality, safety and experience key measures are picked up in a separate report.

This update sets out the financial performance of Aneurin Bevan University Health Board, as at the 30th November 2024 (month 8) for the financial year 2024/25. The 2024/25 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met. As at Month 8, ABUHB is reporting a year-to-date deficit of £6.683m, with a forecast year end deficit of £7.356m. This position has changed significantly from the prior month following a Welsh Government letter dated 2nd December 24 notifying the Health Board of additional funding totalling £40.5m; £9.5m issued recurrently to support ongoing operational pressures, and £31m also issued on a recurrent basis but conditional on the Health Board delivering against objectives specified within the letter. The Health Board has anticipated the total funding of £40.5m on a recurrent basis, reflected the year-to-date impact in the reported position, and adjusted the underlying and forecast positions accordingly.

There remain risks associated with this forecast position, particularly full achievement of saving opportunities, prescribing / drug cost growth, receipt of anticipated allocations and operational demand & workforce pressures.

The 2024/25 forecast of £7.356m is consistent with the revised Welsh Government control total following the additional funding of £40.5m. The Health Board is expected to achieve the control total as a minimum.

The Board has made improvements to the financial forecast and has “de-risked” a number of pipeline opportunities. Work continues to progress further opportunities to minimise operational and savings delivery risks and to develop plans for the 2025/26 IMTP.

Nov-24
Performance against key financial targets 2024/25
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Year-end Forecast	Movement
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of its funding in each financial year. <i>This confirms the YTD and forecast variance.</i>	£'000	(23,202)	6,683	7,356	
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. <i>This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.</i>	£'000	(3,449)	35,883	0	
	£65,258	-5.3%	55.0%		
Public Sector Payment Policy To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	98.8%	97.7%	>95%	

Performance against requirements 23/24		21/22	22/23	23/24	3 Year Aggregate (21/22 to 23/24)
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	x	(249)	36,842	49,754	86,347
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	(50)	(43)	(41)	(134)
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	x				

Underlying Financial Position (Brought Forward ULP)	21/22	22/23	23/24	24/25 Forecast
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	£20.914m Deficit	£89.6m Deficit	£81.4m Deficit	£14.5m Deficit



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Outcomes Framework Quarter One – Three (Oct – Dec 2024)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> The Health and Care Quality Standards provide a clear framework to help the planning, delivery and monitoring of healthcare services in Aneurin Bevan University Health Board. The Quality Report is mapped to the six domains of quality and the six quality enablers and are structured under the Health Board's Six Pillars of Quality. The outcomes and indicators reported are a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover aspects of care, clinical outcomes, patient safety and patient experience. The Quality Outcomes Framework (QOF) report for Q3 2024/25 evaluates the Health Board's progress on quality and safety metrics. It aligns with ministerial priorities and emphasises patient experience, learning, and safety improvements.
<u>Cefndir / Background</u> The Quality Outcomes Framework report for Q3 2024/25 provides an overview of the Health Board's performance against quality and safety metrics. It highlights achievements, areas of concern, and ongoing initiatives, aligned with Ministerial priorities and the Duty of Quality.

The Quality Report provides current data on quality and patient safety as mapped against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

Asesiad / Assessment

Areas of Achievement/ Improvement:

- **Patient and Staff Experience and Stories:** There has been 86% positive emotional responses reported via the CIVICA feedback platform this exceeds the 85% benchmark. For the 'All Surveys' benchmark the response is 90% positive. Work continues on improving involvement with patients and the introduction of patient participation panels, as well as further development of PALS and bereavement services.
- **Risk-Adjusted Mortality Index (RAMI):** remained stable at 101.91, below the All-Wales peer average. Crude mortality in hospital, while improving, requires closer scrutiny of trends and factors.
- **Incident Reporting:** Sharing incident data with divisional teams has improved education on medication safety.
- **Complaints, Concerns, and Compliments:** Ongoing improvements are underway in complaints handling and incident investigations. Early Resolution performance has achieved a 76% success rate for completion of complaints within December.
- **Infection Prevention and control:** Hand hygiene and environmental cleaning has focused on continuous improvement in compliance with infection control standards. Improvement actions have focused on infection-specific faculty groups for Staph Aureus and C. difficile.
- **Safeguarding: Training Compliance:** Level 1 safeguarding training compliance is 87% for adults and 85% for children.
- **Sepsis Management:** An improvement programme is in place for Sepsis management with workshops and task groups actively addressing patient deterioration. Work to develop patient information and advice is in progress
- **Ward Accreditation:** has continued to roll out across several divisions, with several wards now formally accredited to Bronze level.
- **Theatres Safety Programme** continues with a focus on continuous improvement

- **Bereavement Focus:** Continued increased focus on bereavement and future care planning following the collaborative events.

These improvements highlight our commitment to enhancing patient care and safety across the Health Board.

Areas of Focus in Quarter Three:

There are several issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. For Board consideration the areas are summarised below: -

- **Patient and Staff Experience and Stories:** Themes of dissatisfaction in complaints include communication issues and delays in discharge processes. The need for consistent engagement with staff feedback to support service improvements is required. Further work on patient stories will take place during 2025.
- **Incident Reporting:** Though most falls (99%) resulted in no or low harm, there is an ongoing upward trend in falls. Moderate harm medicines incidents increased slightly in Q3, requiring further analysis and action.
- **Complaints, Concerns, and Compliments: PTR Performance:** 30-day compliance for complaints averaged at 55%, below the target of 75%. There is an extensive programme of work in place with Divisions and the PTR team to improve long delays in complaint responses and quality of response. Themes of Concerns include Clinical treatment, communication, and attitude/ behaviour remain recurring issues.
- **Health, Safety, and Security: Violence Prevention,** focused work is in progress with the development of a Health Board-wide Violence Prevention & Reduction Strategy underway.
- **Health, Safety, and Security: Training Compliance:** Manual handling training remains low at 69% with improvement plans in place to improve access for frontline staff. Part 1 of IOSH Safety for Executives and Directors has been completed for senior leaders
- **Infection Control and Prevention: Infection Rates:** The Health Board continues to be in a challenging position from an Infection Prevention and Control Perspective. Additional oversight and governance is in place through an oversight group chaired jointly by the Medical Director and Director of Nursing. C. difficile cases have increased by 36%, with a rate of 50.05 per 100,000 population. Staph Aureus bloodstream infections rose by 63%. Pseudomonas cases increased by 77%. The Winter has been a challenging period for infection outbreaks and there have been a number of ward closures. Key improvements that have been put into place include enhanced cleaning, antimicrobial stewardship, and monitoring of rates via a dashboard. There has also been focus on infection control through education, monitoring, and compliance with national policies.

- **Safeguarding: Incident Reviews:** Challenges in timely safeguarding incident reporting and follow-up has required additional focus with frontline clinicians.

These areas of focus demonstrate our commitment to enhancing patient care and safety across the Health Board.

Learning and Improvement:

- Review of the quality assurance framework and reporting planned
- Continuation of the Learning and Improvement Forum, implementation of the Listening and Learning Framework. Emphasis on the importance of shared learning platforms and forums.
- Workshops and Campaigns: Sepsis and deteriorating patient workshops identified barriers and set improvement strategies.
- "Big Conversation for Future Care Planning" event initiated public engagement on future healthcare planning.
- Patient and Staff Engagement: CIVICA feedback system highlighted recurring themes for improvement. Continuous emphasis on involving patients in service redesign and decision-making.

As part of this work, we will continue to strengthen our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

Argymhelliad / Recommendation

The Board is requested to NOTE the progress of the quality performance report and to take assurance from this report.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:
Datix Risk Register Reference and Score:

Strategic Risk Register

Safon(au) Gofal ac Iechyd:
Health and Care Standard(s):

3. Effective Care
3.1 Safe and Clinically Effective Care
3.3 Quality Improvement, Research and Innovation
Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
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 prioritise areas where evidence shows take up of services is lower or outcomes are worse 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:	As within the paper
Rhestr Termiau: Glossary of Terms:	As within the paper
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Patient Quality, Safety and Outcomes Committee

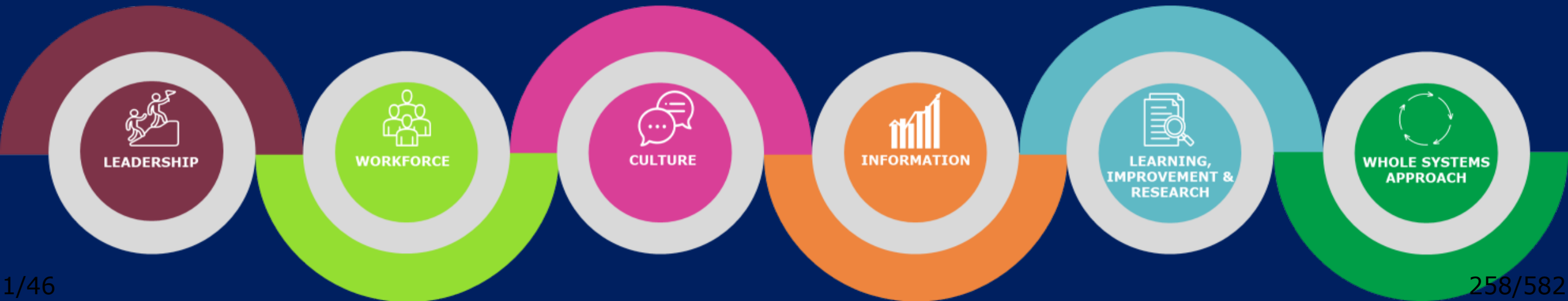
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for 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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



Quality Outcomes Framework

Quarter One to Quarter Three: 2024/25





This is a combined report that includes the measures within quality outcomes framework (QOF) and an update of narrative, themes and learning. This provides the Board / Committee with an overview of the Health Board’s quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality.

This also covers the Health Board’s quality priorities including the Quality and Safety Pillars, as included in the Quality Strategy, ensuring that the Patient Experience and Involvement Strategy has been embedded throughout the report.

For quarter three the existing QOF indicators have been mapped where possible. Some of these indicators are still being refined. Work will continue with Digital, Data and Technology Directorate, with an ambition to produce automated reporting and enable reports to be standardised. The use of iconography will provide detail on trends.

This reports focuses on learning and improvement throughout quarter three 2024/25. It includes:

Quality and Safety Pillars

- Indicators mapped to the refined Quality Outcomes Framework, proposed for 2024/25
- Narrative on indicators
- Additional information is available in the report to provide assurance against these standards

Escalated Risk Concerns

Clinical Effectiveness

Information

- Learning and Improvement Forum highlights
- Additional indicators as defined as potential indicators are being mapped as part of the
- iterative process of refining the reporting of the QOF





- Continue to work with Digital, Data and Technology to enable automation of the Quality Outcomes Framework (QOF). The refinement includes a smaller number of metrics which demonstrate assurance and compliance. Ensure triangulation of data.
- The patient engagement and involvement strategy continues to progress the delivery of person-centred care, which included patient participation panels, PALS and bereavement services.
- Strengthened Divisional learning/reporting through Governance structures and standardised agendas. Supporting a culture of shared learning and a triangulated approach to quality, patient safety and experience.
- The listening and learning framework, a learning and improvement forum and learning repository have all been implemented. The Listening and Learning Forum meets to look at shared learning across the Health Board thereby strengthening the learning and listening infrastructure.
- Quality Improvement approach supported through the Quality Strategy.
- Review alignment of Datix Management System is underway.
- The Safe Care Partnership (SCP) event, a collaboration between Improvement Cymru and Health Boards across Wales, aimed to shape the future of their work. The launch event was held on the 22nd of October 2024. Key initial themes for the next steps included: a clearer definition of the work and importance of listening to and learning from patients and the public. There is a necessity of collecting and using meaningful measures that make a difference.



6 Pillars of Quality



Section 4

Background



These 'Pillars of Quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

We must put the quality and safety of our health services above everything else. This strategy signals our intention to progress these six pillars of quality to establish our level of performance. The pillars will be our quality markers in our Quality Management System. Strengthening our Quality Management System helps us make sure our decision-making focuses on improving the quality of health services.

These measures of quality will allow standardised agendas for Divisions to report on quality measures.

PATIENT AND STAFF EXPERIENCE AND STORIES

Through the introduction of CIVICA – an electronic Citizen Feedback platform that will help people who are using our services to tell us what they think about their care. Providing feedback on our services will help us learn, make changes where we need to and celebrate what we do well. Staff will also be able to feedback on a regular basis, helping them to make improvements in their areas.

Analysis of patient experience data including complaints and compliments will provide a comprehensive picture of areas of positive performance and areas for improvement.

COMPLAINTS, CONCERNS AND COMPLIMENTS

Our commitment to patients is, wherever possible, to respond to their complaints timely and provide the information requested in an open and transparent way. Where it is not possible to provide immediate resolution, we commit to agree an appropriate investigation and to carry out that investigation to a high standard and on time. To ensure that all complainants have access to an investigating officer and are contact regularly.

INFECTION PREVENTION AND CONTROL

The Health Board is committed to zero tolerance of preventable Healthcare Associated Infections (HCAIs). Welsh Government sets reduction expectations for healthcare acquired infections which are achieved via collaboration from experts across healthcare. The Health Board are committed to providing clear programmes of work and evidence-based Policies which sets the expectation on the organisation. Our workforce will be skilled and trained to deliver against national, local and organisational objectives. We will monitor outcomes and reporting compliance/ learning through the Reducing Nosocomial Transmission Group (RNTG), Patient Safety Operational Group and Committee.

INCIDENT REPORTING

Through our 'Pillars of Quality' Programme, we will continue to focus on incident reporting as a key enabler of organisational learning and improvement. We will co-ordinate a comprehensive rolling Programme of quality improvement initiatives which strive to reduce avoidable harm with a focus on falls, pressure ulcers, deteriorating patients, mortality, end of life care, medicines management, discharge and safe transfers of care.

Our commitment to staff is to have a **just** culture, where staff feel safe to report concerns, incidents and near misses, knowing this will result in a timely, fair, comprehensive investigation. Our incident reporting system 'Datix' is a key component in providing insights to data gathering and learning actions.

HEALTH, SAFETY AND SECURITY

We are committed to ensuring that the fundamental standards of health, safety and security are continuously improved. We have a committed workforce of operational leaders who we will educate to ensure they have the advanced skills to deliver safe services. We will support the development of local policies and practices through our Health, Safety and Security Practitioners. We will conduct reviews of all sites and an annual snapshot of health and safety. Our focus for the duration of this strategy will be to reduce staff harm from lifting and handling, violence and aggression and slips, trips and falls.

SAFEGUARDING

Safeguarding is everybody's responsibility. We will demonstrate reasonable steps to ensure the safety of children and adults at risk. The Health Board's Strategy and Policy sets the expectation of accessing services. The workforce will be skilled and trained to deliver national, local and organisational objectives. The Health Board will support and enable operationalisation through provision of tools and direct support from the corporate safeguarding team, as the workforce undertakes its duties in relation to safeguarding. We will monitor outcomes and report effectiveness through effective audit and clear governance processes.

PILLAR 1

Patient and staff experience and stories

Civica

Bereavement Collaboratives

Patient Stories

IPAC Dashboards

Volunteer to Career

Chaplaincy

Volunteering

Patient Advice and Liaison Service (PALS)

Leadership, Accountability and Culture

Deprivation of Liberty Safeguards/ Mental Capacity Act

Cultural Competence Accreditation Scheme

Dementia Standards

Listening Meetings

QOF Metrics

Included in report:

- CIVICA data
 - Total new responses
 - Patient satisfaction %
 - positive emotion trend, negative emotion trend

Developing metrics not yet reported:

- Staff culture – metric TBC
- Themes from patient stories – AI repository development

QOF Metric Pillar ONE - CIVICA data total new responses Patient Experience Feedback April 2024 – December 2024

All Surveys

5461

Responses

Export Options

90%

Satisfaction

Export Options

Response Trend PCC

Person Centred Care (PCC) Survey

4936

Responses

Export Options

91%

Satisfaction

Export Options

Response Trend ED

Emergency Department (ED) Survey

288

Responses

Export Options

68%

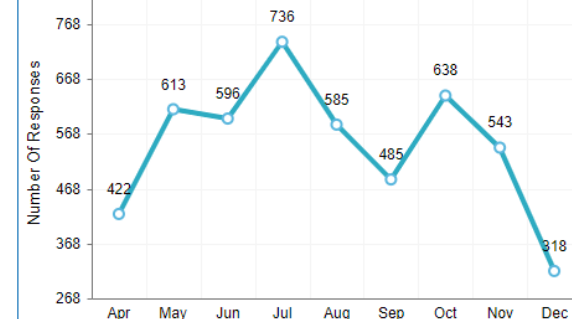
Satisfaction



Responses Trend Graph PCC

Health Board Wide - 01/04/2024 to 31/12/2024

All Questions (Person Centred Care - Standard)

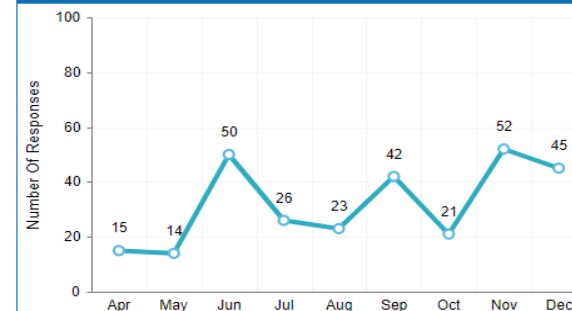


Export Options

Responses Trend Graph ED

Urgent Care - 01/04/2024 to 31/12/2024

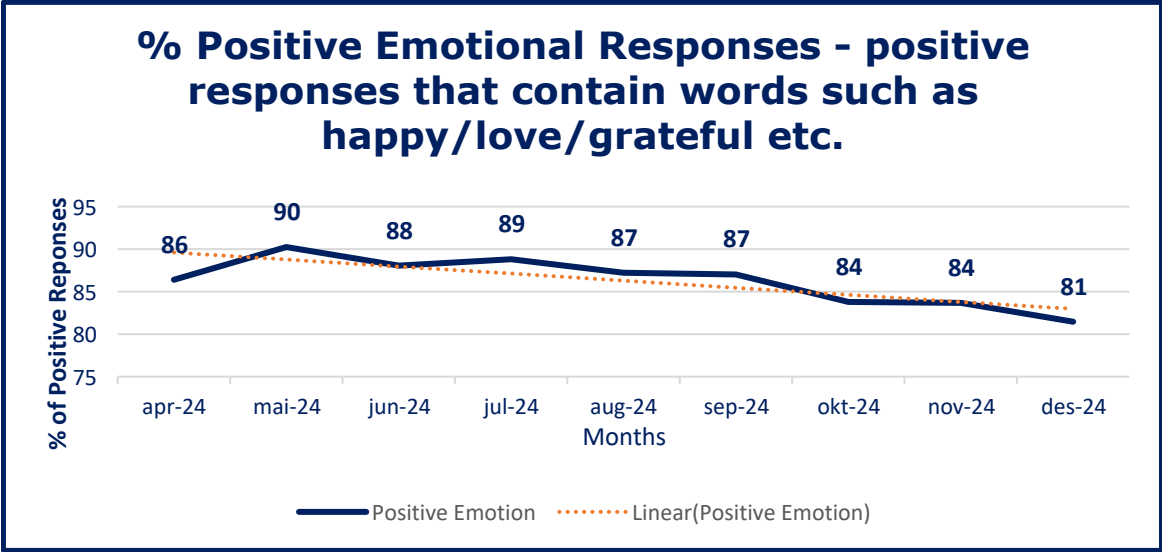
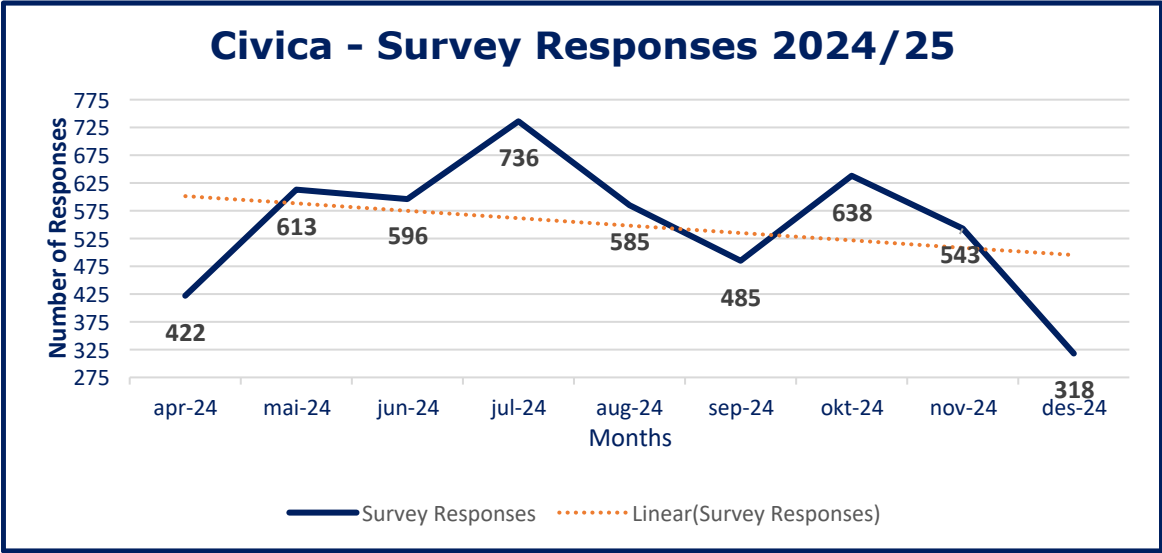
All Questions (Emergency Department Survey - Standard)



Export Options

QOF Metric Pillar ONE - CIVICA Data Total Responses

Civica YTD – 2024/25



Quarter	Number of Responses	% Difference	
Q1	1631	-	
Q2	1806	11%	↑
Q3	1499	17%	↓

Total Responses YTD (2024/25)
4936

Quarter	Positive Emotional Responses	% Difference	
Q1	88%		
Q2	88%	1%	↓
Q3	83%	5%	↓

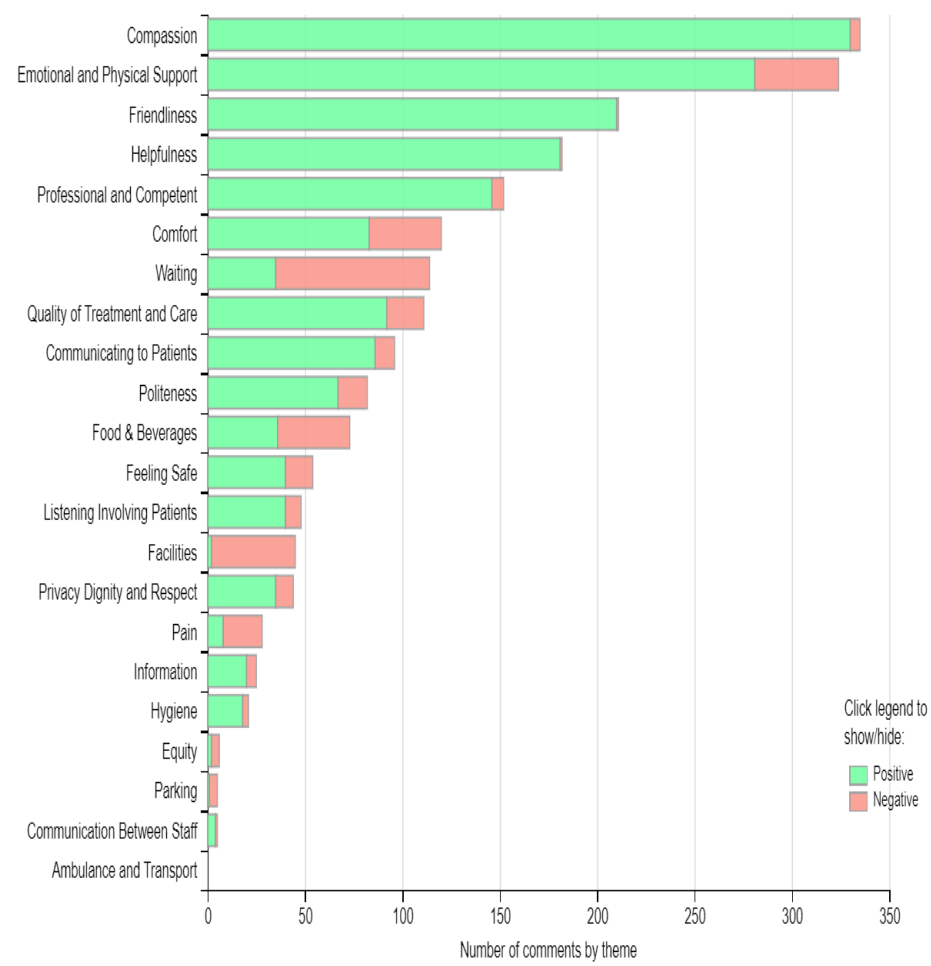
% Positive Emotional Response (2024/25)
86%

Average 86% is higher than 85% benchmark

QOF Metric Pillar ONE - CIVICA Data Patient Satisfaction, % Emotion Trend

Civica Responses Q3 – 2024/25

All Used Categories Pos/Neg Count



What did we do well?

Top 3 – Positive Comments

330 comments around **Compassion**

281 comments around **Emotional and Physical Support**

210 comments around **Friendliness**

What could we have done better?

Top 3 – Negative Comments

60 comments around **Waiting**

43 comments around **Emotional and Physical Support**

37 comments around **Comfort**



PILLAR 2

Incident Reporting Falls Pressure Ulcers Medicines Management Mortality

Leadership, Accountability and Culture	Never Events	Deteriorating Patient	Patient Safety Incident process	QPSE Dashboards
Pressure Ulcers / Medicines Management	Staff Training	Datix (validation)	Falls Panel	Duty of Candour
Learning, Monitoring & Assurance	Just Culture/ Psychological Safety	Mortality	Risk Registers	Human Factors

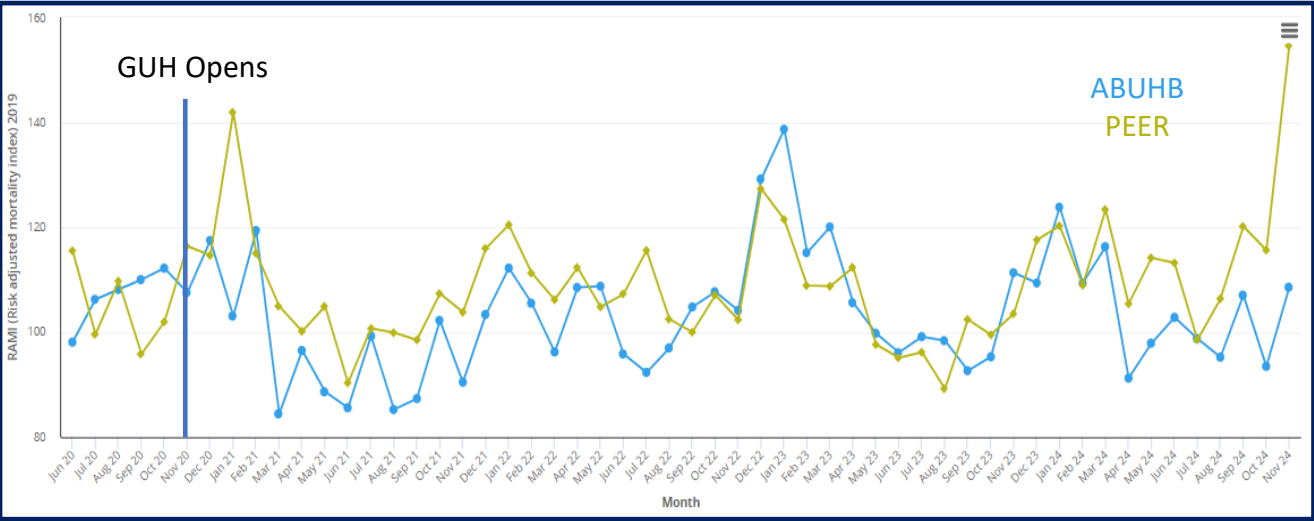
Proposed Metrics: -

- Mortality – Crude mortality and RAMI
- Incidents presented as – level of harm and closure date of incident
 - Global category of incident to ensure themes care captured – PUs, falls, HATs, medicines, H&S, RIDDOR
 - Trends in severe medicines incidents
- Nationally reportable incidents & compliance with closure timeframes
- Duty of candour – Datix numbers
- Thematic analysis of Patient Safety Incidents graded severe
- Thematic analysis of Regulation 28 reports
- Number of inquests that take place face to face (compared to the number completed on paper), ensuring meeting family needs

Developing Metrics: -

- Investigate the possibility of capturing incidents related to urgent care delays / flow in DATIX.

QOF Metric - Pillar Two Mortality RAMI (Risk Adjusted Mortality Index)



RAMI has been consistent with All Wales peer organisations and remains below their levels. The Health Board’s RAMI is 101.91 for Q3 2024/25.

The RAMI continues to fluctuate. For Q3 AB RAMI – 96.1 for October 2024. AB RAMI – 108.52 for November 2024. AB RAMI –December currently unavailable.

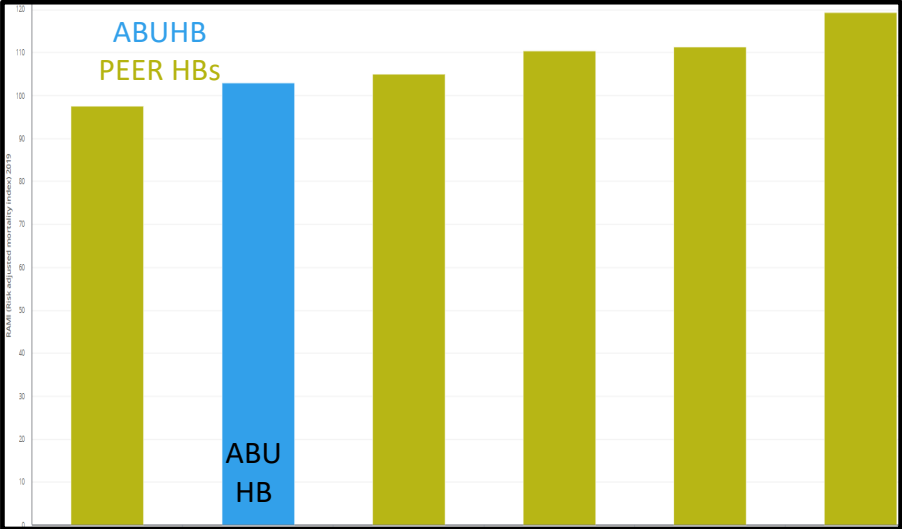
Currently performing 2nd of 6 within All Wales peer group

RAMI accounts for individual patient risk factors and comorbidities, enabling comparisons across different organisations. A RAMI less than 100 indicates the observed mortality is lower than the expected mortality rate for the population. Suggesting it is performing better than expected in terms of outcomes. The accuracy of RAMI relies heavily on the completeness and precision of clinical coding. Completeness of coding is more accurate after 8 weeks, which often results in a decrease of RAMI. **The latest Learning From Death report has been produced and provides a deeper analysis of Mortality within the Health Board.**

Quarter	RAMI	% Difference	
Q1	97.23	-	
Q2	100.35	3.12%	↑
Q3	100.09	0.26%	↓

An increasing RAMI as seen in Q2 is a decline and a lower RAMI is an improvement, as seen in Q3.

Chart displays RAMI for Quarter Three 2024/25



QOF Metric - Pillar Two Mortality: Crude Mortality in Hospital



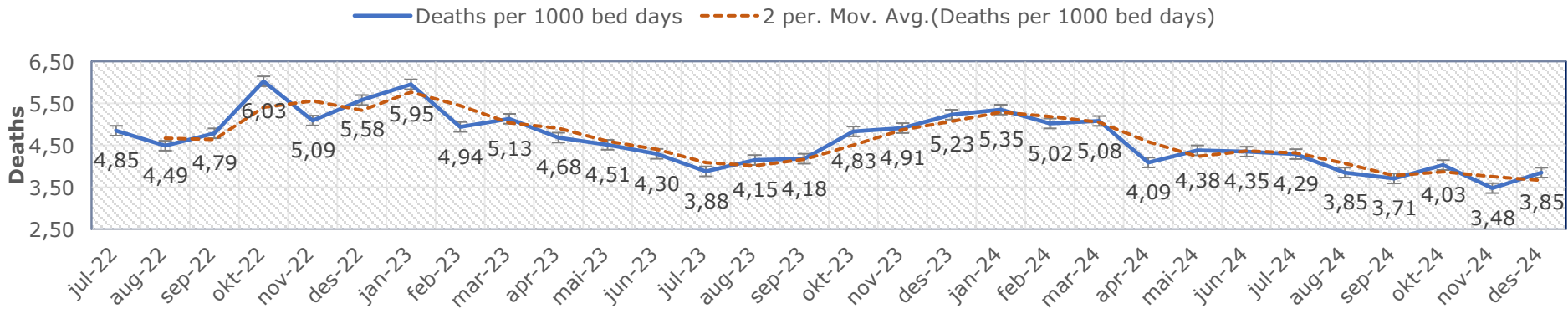
Quarter	Crude Mortality in Hospital	% Difference	
Q1	232	-	
Q2	194	38%	↓
Q3	181	13%	↓

Crude Mortality (In Hospital) for December 2024 was the lowest since August 2024, at 168.
Crude Mortality (In Hospital) for Q3 2024 was an average of 181, compared to 184 for Q3 2023, and down from a Q2 2024 average of 194.

The Green arrow indicates an improvement with less deaths for both charts.

Quarter	Death per 1000 Bed Days	% Difference	
Q1	4.27	-	
Q2	3.96	0.31%	↓
Q3	3.78	0.18%	↓

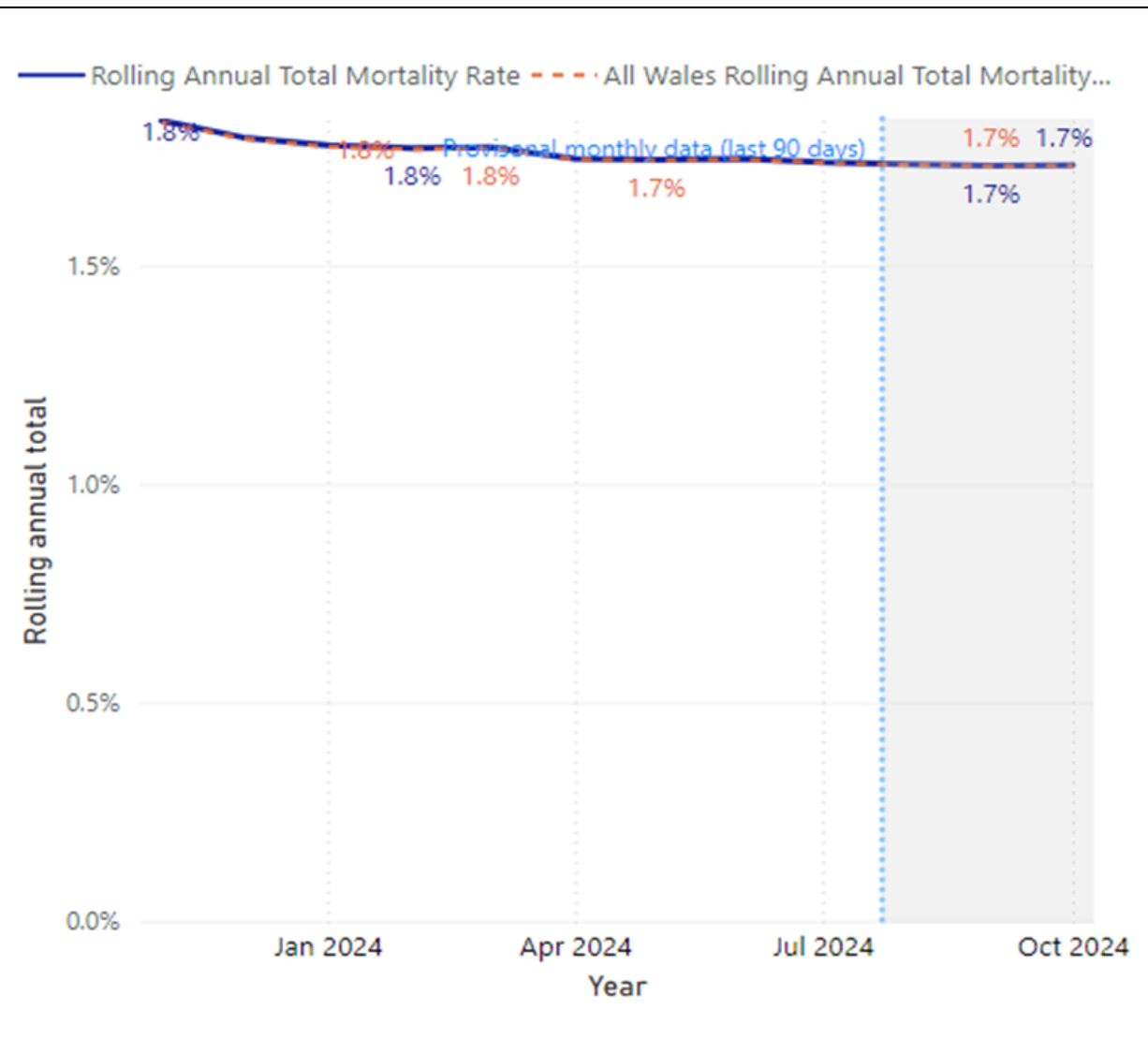
Deaths per 1000 occupied bed days



Deaths per 1000 occupied bed days for December 2024 was 3.84.
Deaths per 1000 occupied bed days for Q3 2024 was an average of 3.78, compared to 4.99 for Q3 2023, and down from a Q2 2024 average 3.96.



QOF Metric - Pillar Two Mortality: Crude Mortality Rate



ABUHB	Mortality Rate
April 2024	1.41%
May 2024	1.47%
June 2024	1.55%
July 2024	1.44%
August 2024	1.37%
September 2024	1.45%
October 2024	1.35%

October 2024 is the latest data available due to the 8-week reporting cycle. The Health Board’s mortality rate has remained stable, showing a flat trend. Actual in-hospital deaths decreased during Q3 2024.

The Health Board’s Learning From Death report presented at this month’s Committee meeting demonstrates a blended approach to mortality that incorporates multiple sources of information; such as mortality reviews, national benchmarking, and national audits, in addition to RAMI.

The report supports adopting diverse methods to assess performance. This approach ensures quality improvement and assurance around mortality without relying solely on retrospective aggregated data like RAMI. Additional mortality indicators are included for reporting to enhance this process.



QOF Metric - Pillar Two: Post Investigation Harm Assessment and Closure Date of Incident Average Time to Close



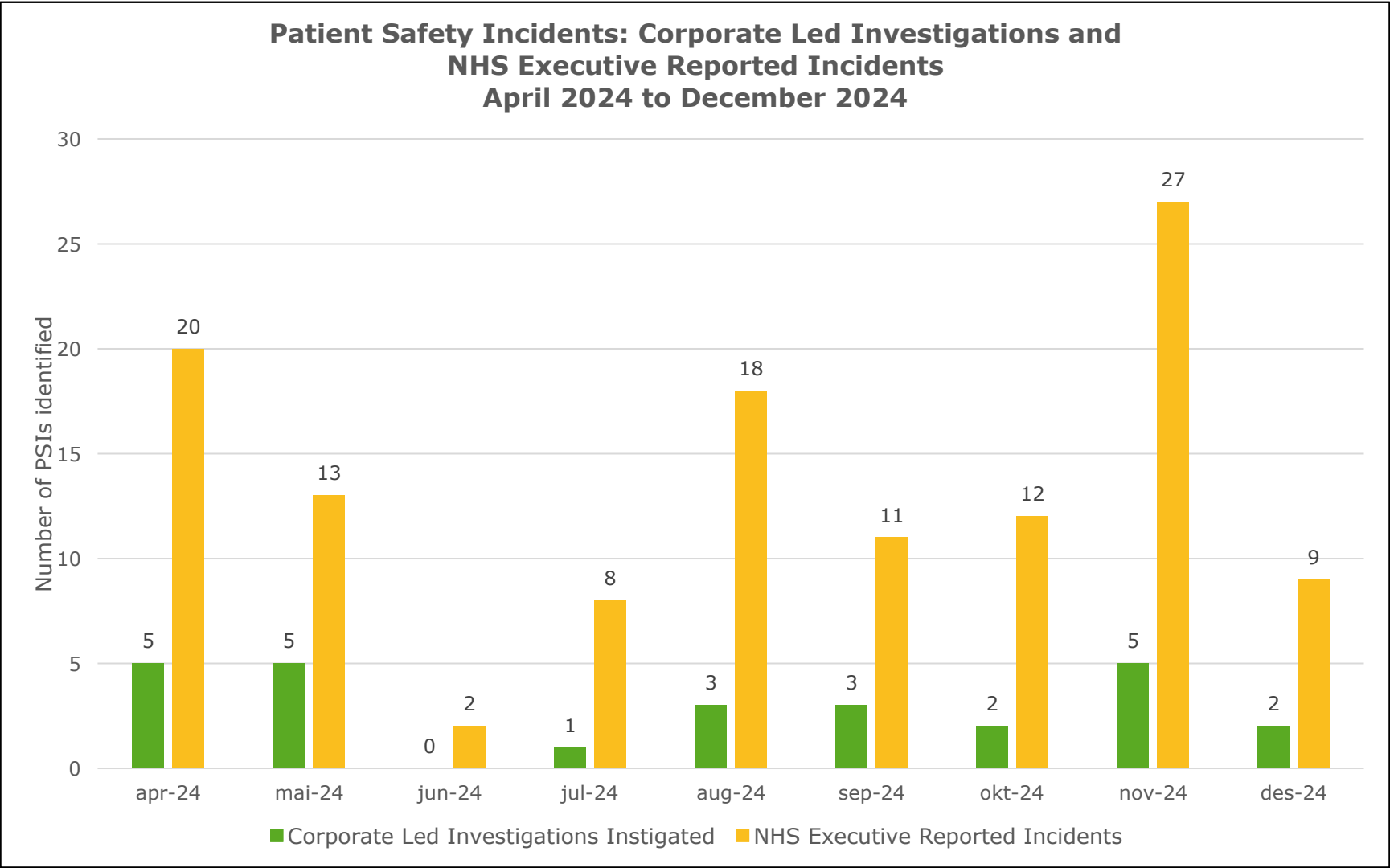
The total numbers of incidents closed during April to December 2024 was 25,212. 381 of these had a Post Investigation Harm Assessment coded as Moderate or above.

The table below provides details on the closed incidents by Quarters 1, 2 and 3 of 24/25 by Post Investigation harm assessment for Moderate or above. The average time to closure is calculated in days.

Post Investigation harm assessment	Quarter 1 24/25	Average time to closure	Quarter 2 24/25	Average time to closure	Quarter 3 24/25	Average time to closure
Catastrophic / Death	22	143	26	76	42	85
Severe	14	299	14	281	15	293
Moderate	124	177	78	126	46	119
Low	4,648	74	3,580	42	3,961	47
None	4,596	85	3,814	47	4,228	46
TOTAL	9,404		7,512		8,292	



QOF Metric - Pillar Two: Patient Safety Incidents



Quarter	PSI's Identified	% Difference	
Q1	110	-	
Q2	128	15%	↑
Q3	145	9%	↑

A total of 383 Patient Safety Incidents (PSIs) (moderate and above harm), that met the criteria for either Corporate or Divisional led Investigation, were identified between April and December 2024. This is lower compared to the same period of 2023, with 415 PSIs.

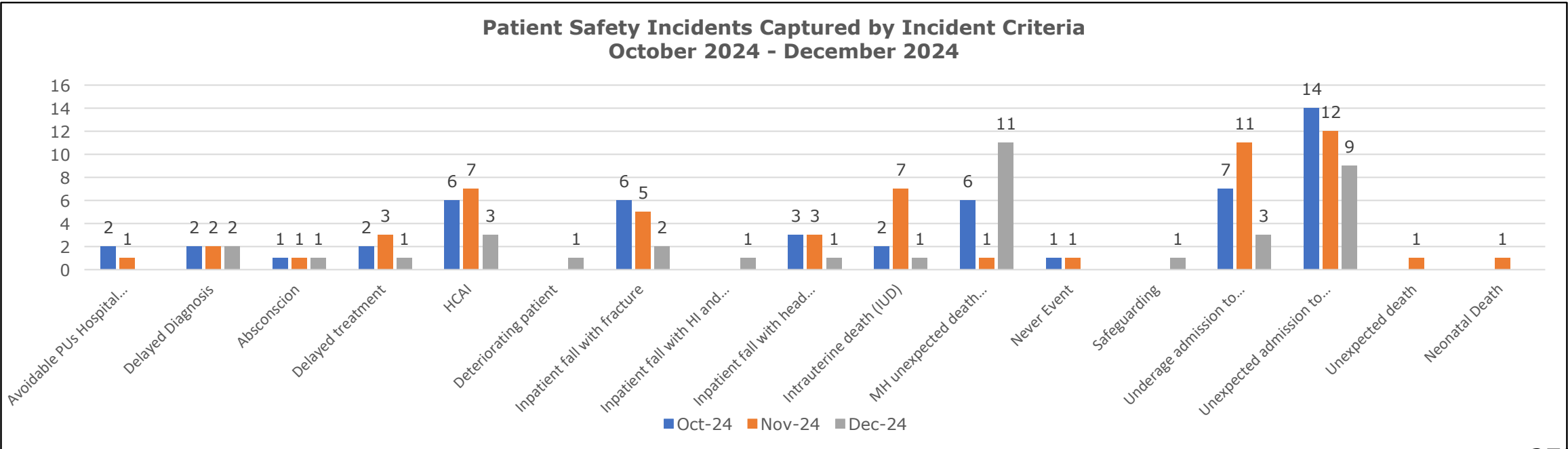
The PSI team continue to provide bespoke sessions to provide support and guidance with current investigations.



Patient Safety Incidents

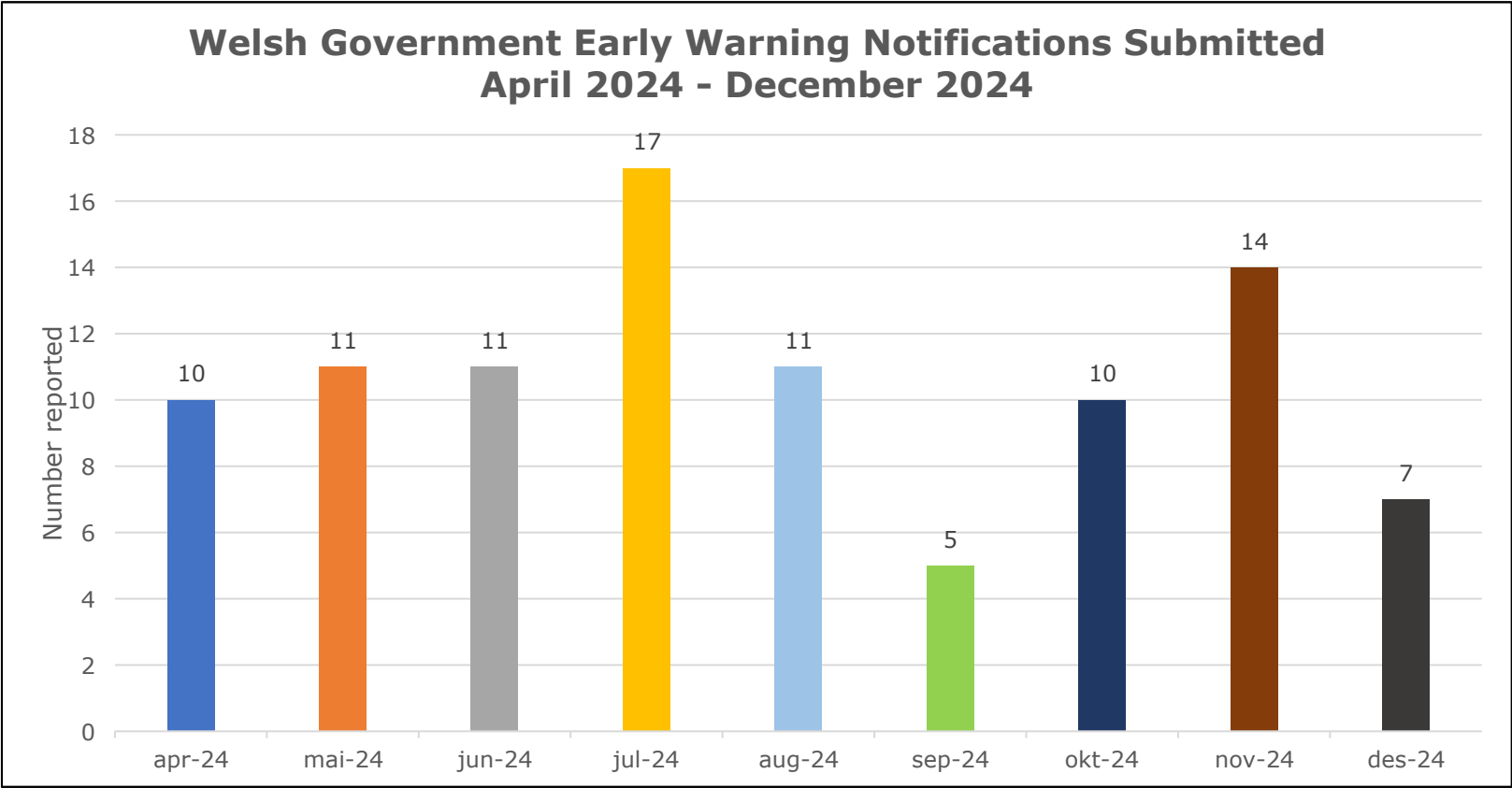


- **145** Patient Safety Incidents were identified during October-December 2024 that were taken forward as a Corporate or Divisional PSI, Concise, or Focused reviews.
- **48** incidents met the NHS Executive reporting criteria with **9** initiated as Corporately led investigations and **39** incidents led by the divisions.



QOF Metric - Pillar Two: Patient Safety Incidents – Early Warning Notifications

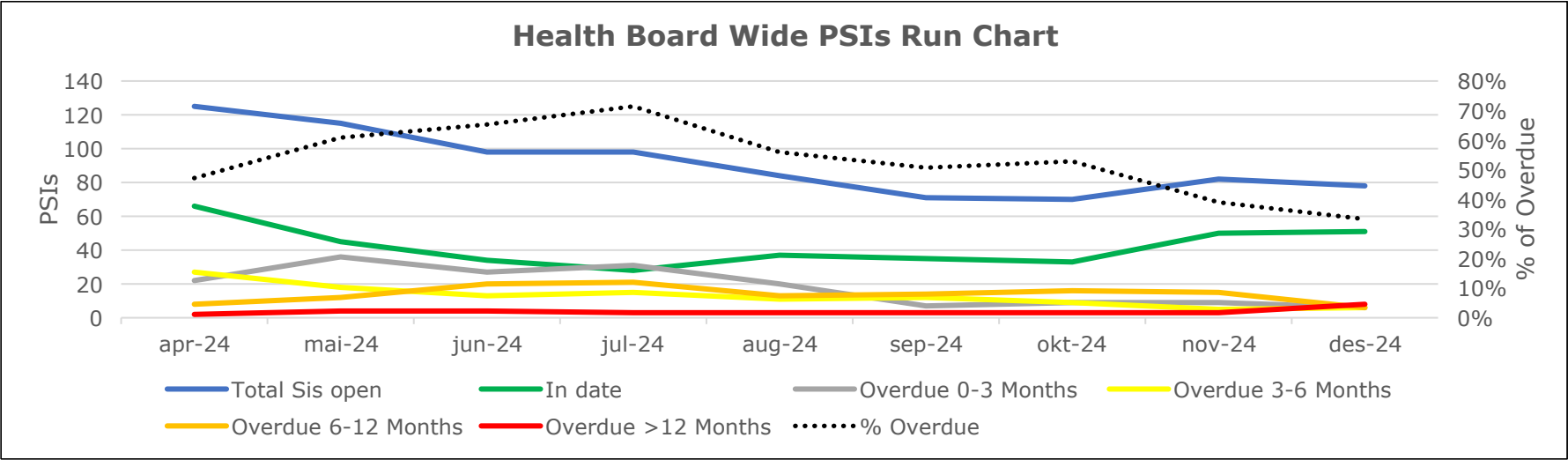
There were 96 Early Warning Notifications (EWNs) reported to Welsh Government (WG) between April to December 2024. Themes included safeguarding concerns and patient absconsions. 79 EWNs were submitted for the same period in 2023.



Quarter	Early Warning Notifications	% Difference
Q1	32	-
Q2	33	3%
Q3	31	6%

QOF Metric - Pillar Two

Patient Safety Incidents - National Reportable Incidents



Quarter	PSIs	% Difference	
Q1	338	-	
Q2	253	28%	↓
Q3	230	9%	↓

Overdue NRIs decreased from 71% (July 2024) to 33% (December 2024) - a 38% improvement. There continues to be a focus on the management of the PSI process. Recommendations for improving compliance include robust progress monitoring and monthly reporting to divisional teams.

The PSI team provide additional training for Investigating Officers and have been running drop-in virtual training sessions for Investigating Officers to provide support and discuss any concerns. In addition the Corporate PSI Team will be delivering investigating officer training and offering bespoke support.

The PSI Team meet weekly with the Divisional Quality & Patient Safety (QPS) Teams to discuss PSIs, Medical Examiner Cases, and any incidents awaiting harm reviews. This initiative aims to help Divisions monitor their progress and ensure adherence to incident reporting standards.

Bespoke strategy meetings chaired by a clinical executive for complex and potentially challenging incidents, are proving to be successful in progressing investigations appropriately.



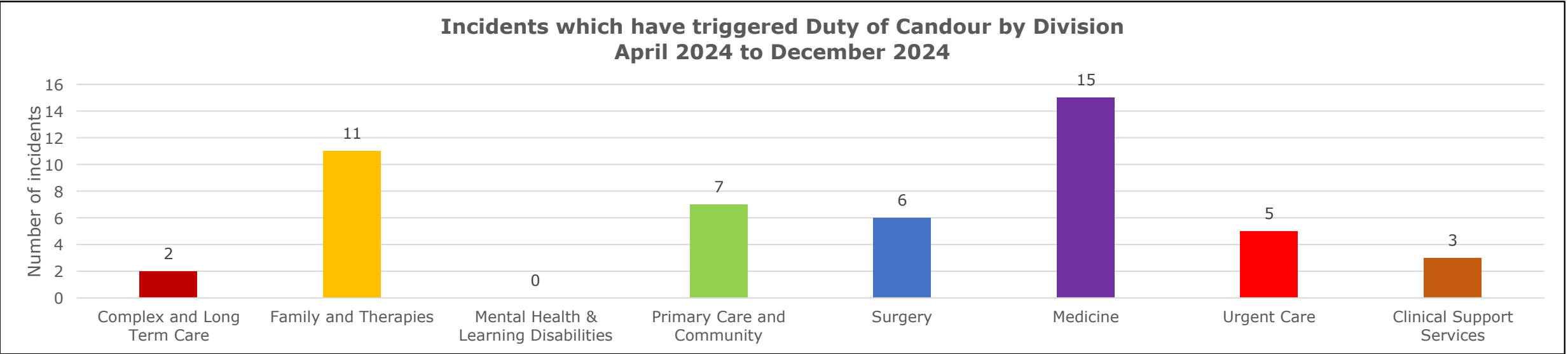
QOF Metric - Pillar Two: Duty of Candour



Between April and December 2024 there were 19711 incidents affecting patients reported on the Datix Cymru system. This is in comparison to **23178** incidents for the same period in 2023.

There have been **49** incidents that have triggered Duty of Candour. *This figure is based on the question - **Was Healthcare provided a factor?***

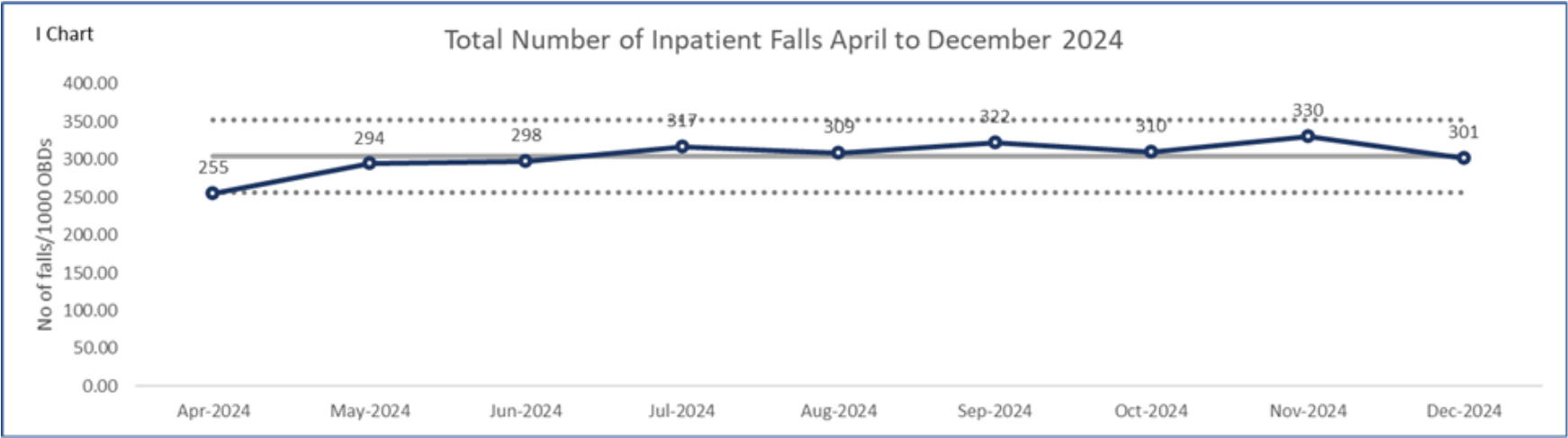
These incidents involved inadequate supervision leading to a fall, post-operative complications, issues with communication around discharges, prescribing errors, and maternity incidents. All these incidents have triggered the Duty of Candour (DoC) process.



The way in which Duty of Candour is captured on RL Datix, has been refined for the 2024/25 reporting. In the 2023/24 period DoC was triggered when the management review had, been undertaken, and harm assessed at that time as moderate and above. Therefore, **151** incidents triggered for the same period in 23/24. The introduction of the question of 'was a healthcare a factor' focuses the investigator on the essence of DoC harm, in that it is the delivery or lack of delivery of healthcare that has led to the harm caused to the patient/ service user.



QOF Metric - Pillar Two: Health Board Wide Inpatient Falls



Quarter Average	Inpatient Falls	% Difference	
Q1	282	-	
Q2	316	11.36%	↑
Q3	314	0.63%	↓

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	For the given period of analysis, the mean average of fall incidents is 302 which represents a decrease since the last report in October 2024. Since April 2024 there has been a gradual upward trajectory with November being the highest number of reported falls incidents since April 2024.	

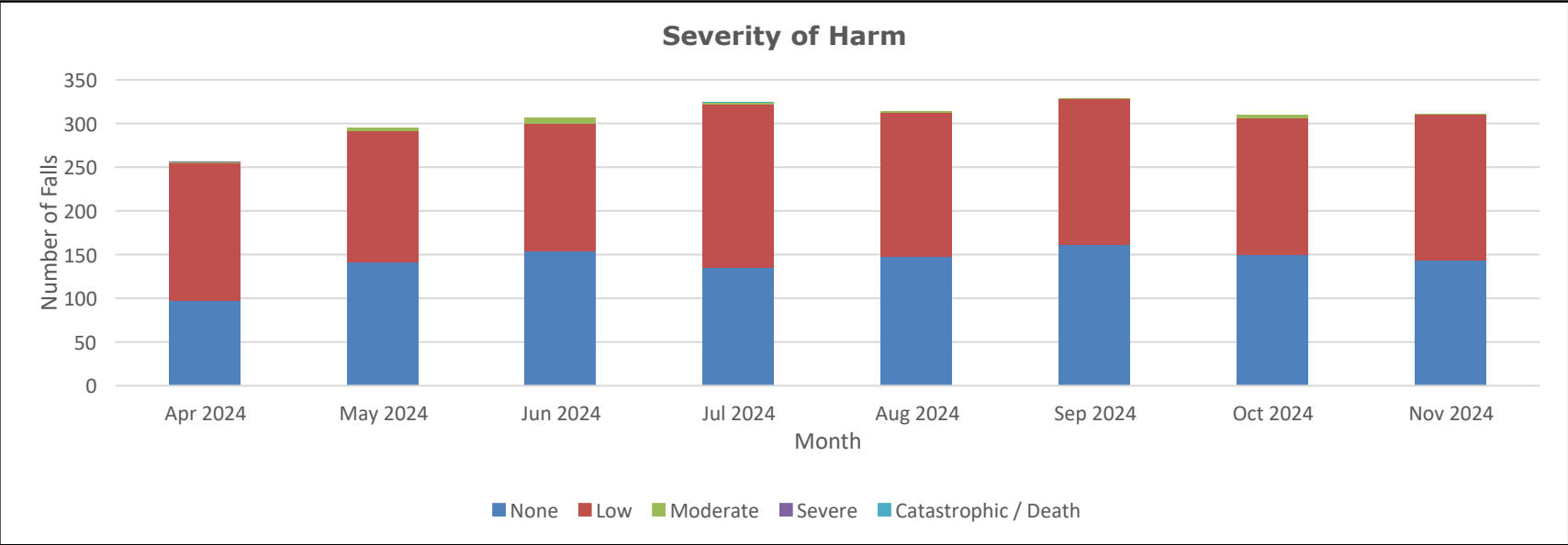
Q3 2024/25 - Context

The data used in this chart has been retrieved from RLDatix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period April to December 2024. This period length for this data is selected to ensure the analysis is statistically valuable.



QOF Metric - Pillar Two: Health Board Wide Inpatient Falls Severity of Harm



Quarter	Inpatient Falls Severity of Harm (Severe or More)	% Difference	
Q1	1	-	
Q2	1	-	
Q3	0	100%	

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 3983. Of this figure the following is identified: • 99% No or low harm • 0.8% - Moderate harm • 0.1% Severe harm • 0.1% Catastrophic	The severity data is reflective of the identified level of harm recorded post investigation.

Q3 2024/25 - Context

The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period November 2023/24.

Falls Improvement Aims



- Improve system wide compliance with procedures, policies etc. and to define specific parameters of measurement and compliance levels.
- To establish mechanisms to share the outcomes of falls incidents in a meaningful way across the organisation to support learning and improvements for all employees.
- To engage through a MDT approach to ensure the effectiveness and confidence in the practical application of changes in policies and procedures to ensure fitness for purpose. In this context consideration needs to be given specifically to the influence of the single room environment and implementation challenges.
- Given that all the aspects of training needs identified are intrinsically linked consideration should be given to a package which is person centred and not compartmentalised into differing aspects of training relation to the patients care and their individual needs.
- Establish a competency framework and measured parameters in support of falls prevention and management training for sign off.
- To ensure ward audit outcomes, actions and subsequent improvements are disseminated and presented to wider HB audiences with the establishment of a quarterly cycle of reporting, monitoring, learning and outcomes measurement to the Falls and Bone Health Committee
- Given the complexity and challenges associated with falls and in that it remains the highest reportable incident consideration should be given to establishing a specialist team akin to other areas of the HB to drive the necessary changes and to embed the falls specific learning and improvement.
- The creation of a central fall's hub of dedicated resources with consideration be given to implementing satellite team resources to support the sites to implement the falls quality improvement strategy.
- To ensure that falls incident related action plans are specific and measurable and reported through a robust governance structure and aligned to the newly establishment of the 'Falls Strategic Oversight Panel'
- To implement swarms as the adopted methodology for spread and scale across the organisation.
- Establish a falls bundle aligned to the RCP guidance of 'Fall Safe'.
- Maximise the opportunities of ward accreditation as one platform to drive quality improvements.
- A second fall should prompt escalate to Senior Ward Management with a robust update review of the MFRA and associated care plan.



Claims and Redress – 2024/25 Activity



Quarter	Clinical Negligence	% Difference	
Q1	33	-	
Q2	38	14.1%	↑
Q3	26	37.5%	↓

Clinical Negligence:

- 86 new clinical negligence matters received during Q1, Q2 and Q3.
- The total number of open clinical negligence matters as at the end of December 2024 is 395.

There was a slight increase in clinical negligence matters received during this quarter.

Quarter	Personal Injury	% Difference	
Q1	12	-	
Q2	13	8%	↑
Q3	4	105%	↓

Personal Injury:

- 29 new personal injury matters received during Q1, Q2 and Q3.
- 80 total number of open personal injury matters as at the end of December 2024.

Personal injury claims remained steady, and at a historic low, during this quarter.

Quarter	Redress	% Difference	
Q1	6	-	
Q2	9	40%	↑
Q3	12	28%	↑

Redress:

- 28 cases were taken through the Health Board's Redress Panel during Q1, Q2 and Q3.
- 10 Redress cases were settled during Q1, Q2 and Q3.

On average, each case settled through the Redress process will save the Health Board an estimated £30,000 in costs arising had those cases become clinical negligence claims.





Inquests:

- 225 new inquests received during Q1, Q2 and Q3.
- During Q3, 105 new inquests were received.
- This represented an increase in the number of inquests received compared with Q2.
- 81 inquests were listed by the Coroner to be concluded within Q3.
- Of the 81 inquests listed, 18 inquests were held in person by the Coroner and where Health Board witnesses attended in person to give their evidence.
- Legal Services attended all 18 inquests in support of staff attending.

Of the 81 inquests listed in this Quarter, 63 inquests were concluded in writing by the Coroner. This meant Health Board staff had prepared statements which were submitted to the Coroner, but those members of staff did not need to attend the inquest in person to give oral evidence.

Quarter	Inquests
Q1	80
Q2	55
Q3	105

Reg 28: Prevention of Future Deaths Reports:

- Only 1 Regulation 28 report issued for Quarter Three.
- The Coroner was concerned with a failure to complete and monitor fluid balances.

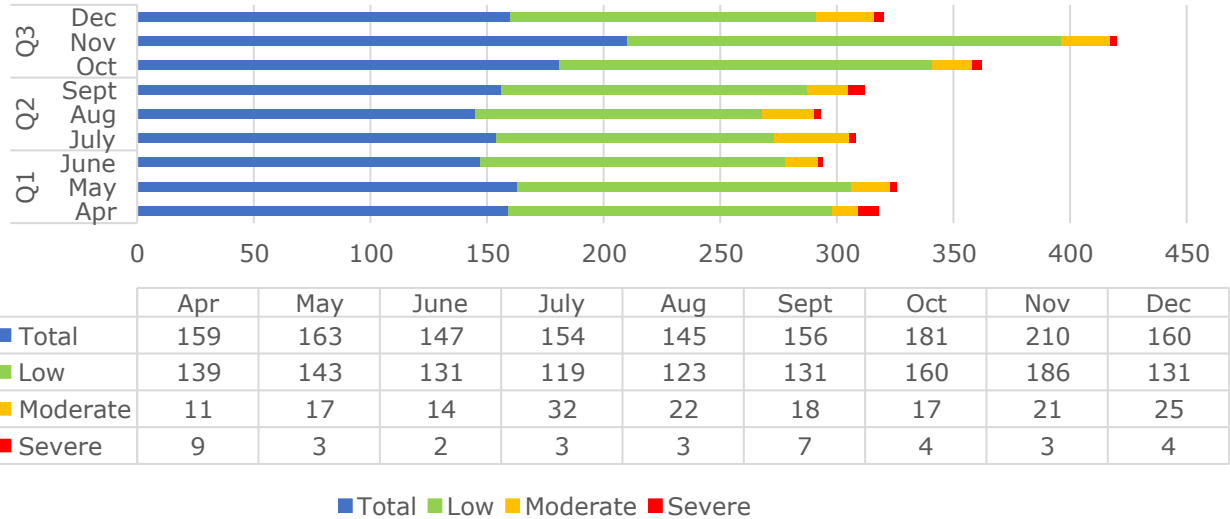
The Health Board provided the Coroner with a response within the required timescale, including details of actions taken to improve monitoring of patient fluid balance across the Health Board.



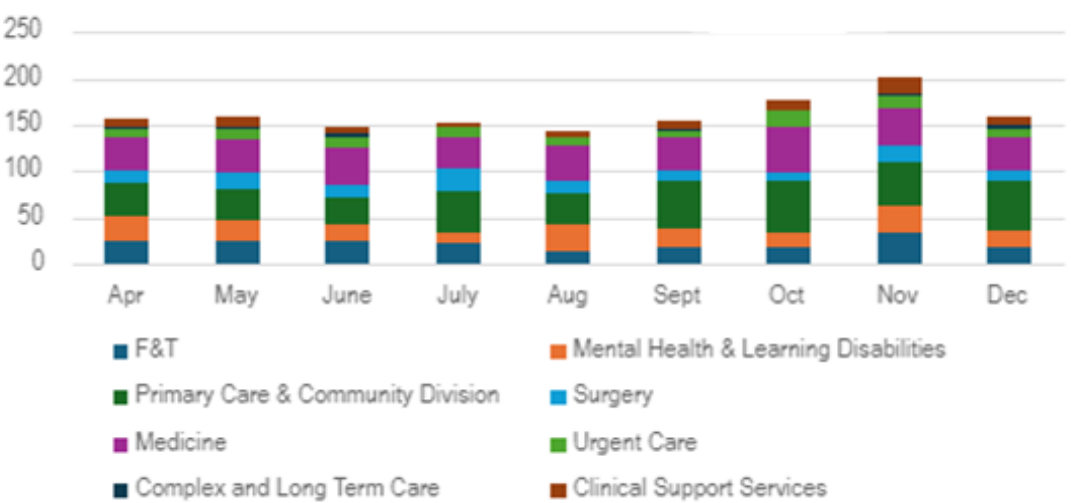
QOF Metric - Pillar Two: Trends in Medication Incidents



Reporters Initial Harm Q1 – Q3



Incident Occurrence by Division Q1 – Q3



Quarter	Medication Safety Reports Initial Harm	% Difference	
Q1	19	-	
Q2	28	38%	↑
Q3	18	44%	↓

Key Insights:	Total Incidents: There is a slight decrease in the total number of incidents from Q1 to Q3. Low Harm Incidents: These incidents form the majority and show a similar decreasing trend. Moderate Harm Incidents: There is a noticeable increase in moderate harm incidents in Q2 compared to Q1 and Q3. Severe Harm Incidents: These are relatively low but show a significant drop from Q1 to Q3.
Monthly Trends:	April to June: There is a consistent number of incidents each month. July to September: There is a peak in incidents in August, followed by a drop in September. These charts help identify trends and areas that need attention, such as the spike in incidents in August and the increase in moderate harm incidents in Q2. This information can guide targeted actions to improve medication safety.



PILLAR 3

Complaints, Concerns and Compliments

QPSE
Dashboards

PTR
Regulations

Patient and
Staff
Feedback

Complaints –
Themes and
Learning

PSOW –
Themes &
Learning

Psychological
Safety

Leadership,
Accountability
and Culture

Collaborative
Forums

Staff Training
and
Mentorship
(IO)

Early and
Regular
Contact

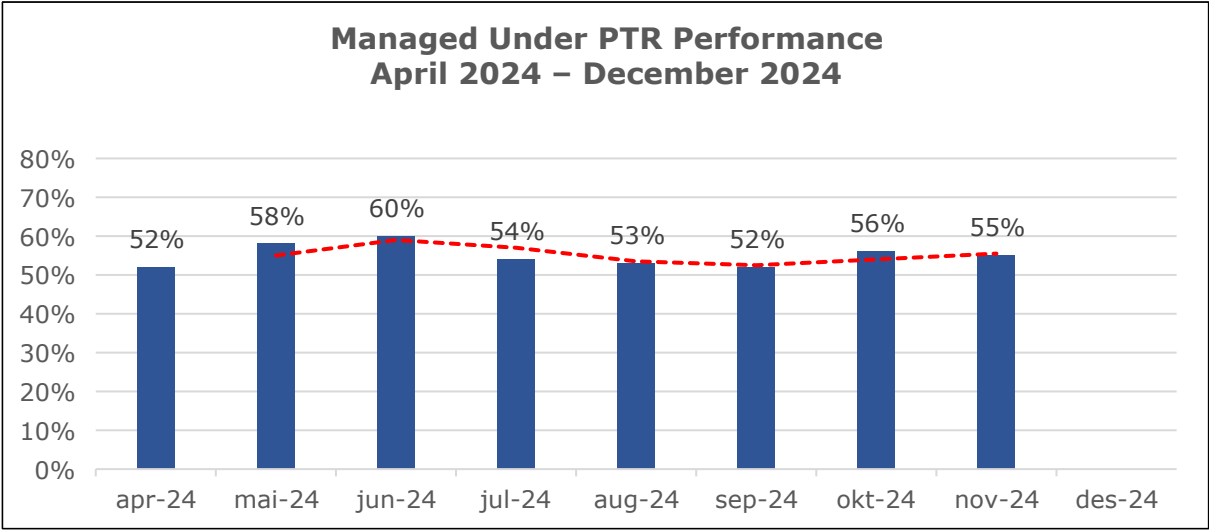
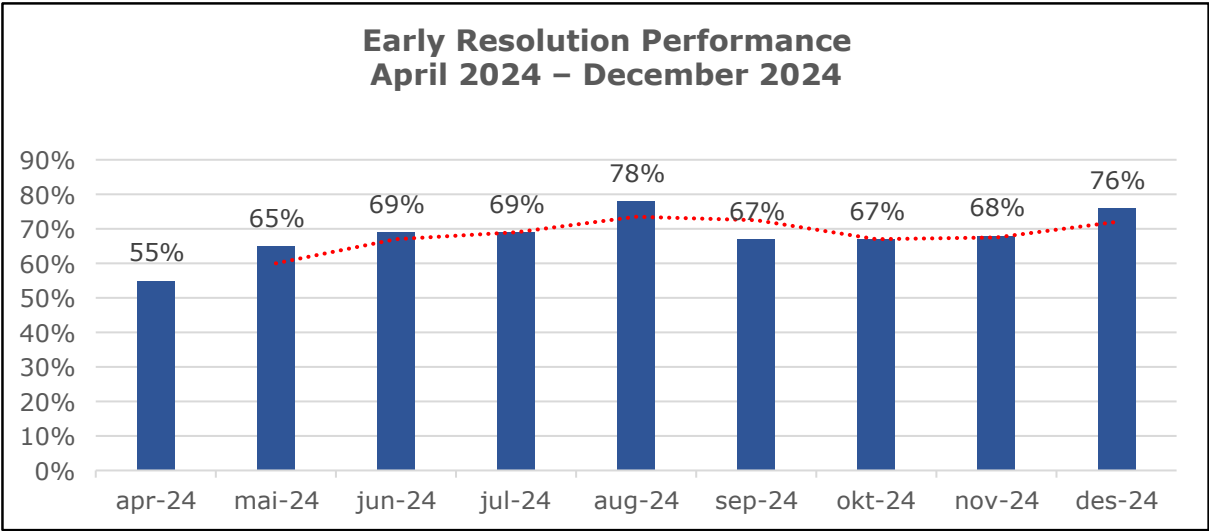
Speaking
up Safely

Metrics: -

- 30 day performance
- Concerns
 - Review layers to look at compliance and closure
- Compliments
- PALs (especially early resolution)

QOF Measure – Pillar 3

Concerns 30 day Performance Q1, Q2 & Q3 2024/25



Quarter	Early Resolution Performance	% Difference	
Q1	66%	-	
Q2	71%	5%	↑
Q3	68%	3%	↓

These measures aim to maintain high standards of patient care and service quality despite the pressures faced. Early Resolution average rate YTD – 67%. December performance was 76%

Quarter	Managed Under PTR	% Difference	
Q1	57%	-	
Q2	53%	4%	↓
Q3	Under validation		

PTR Concerns compliance rate, averaged 55% for concerns received and completed within compliance.

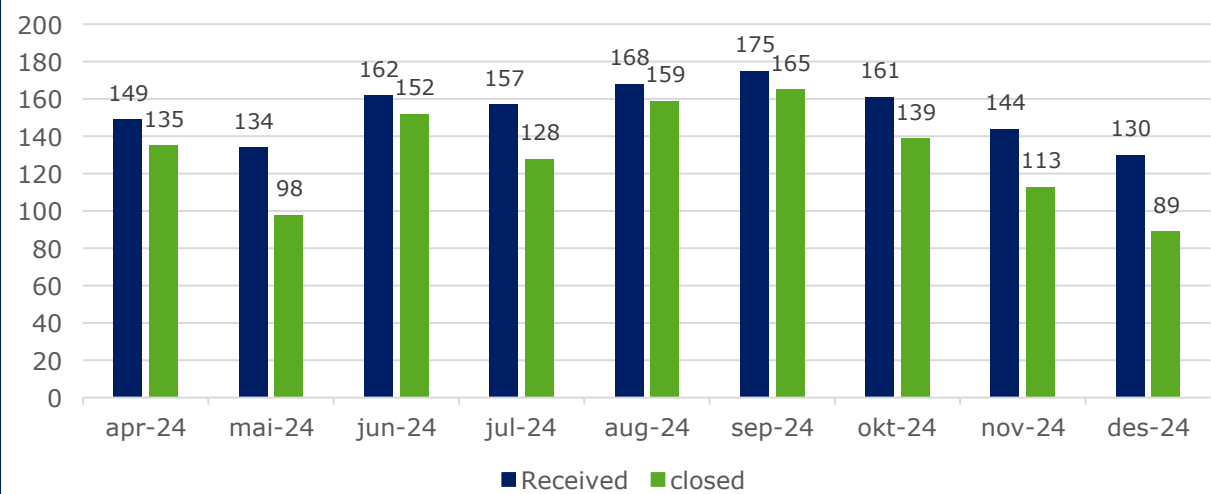


QOF Measure – Pillar 3

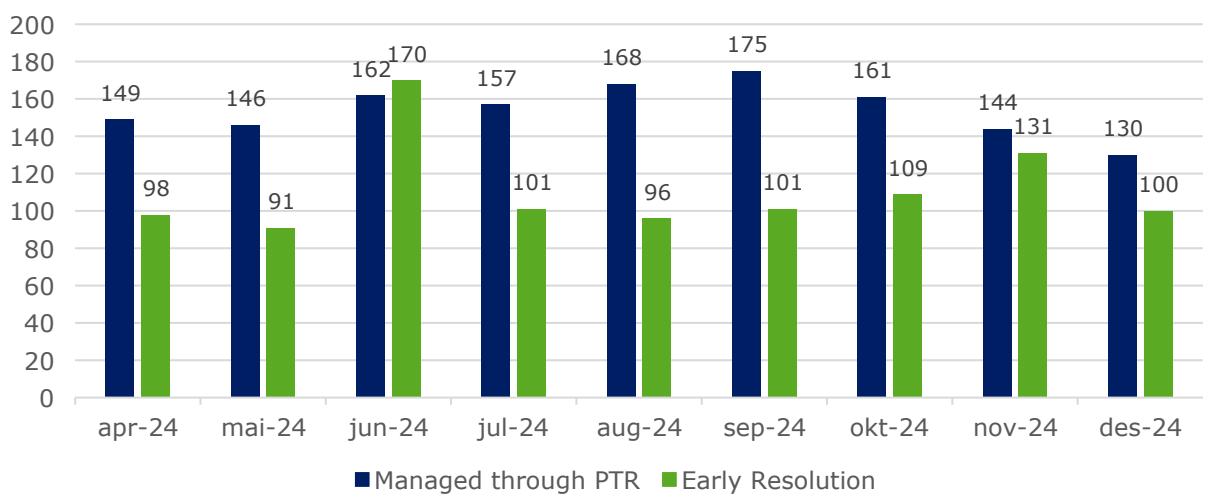
Concerns Q1, Q2 & Q3 2024/25



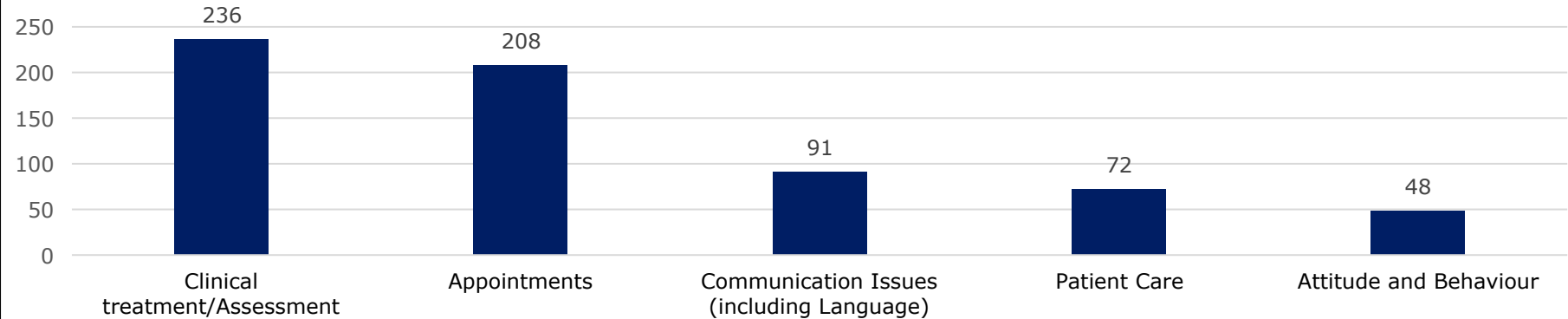
Concerns Received and Closed under PTR
April 2024 – December 2024



Concerns Received
April 2024 – December 2024



Concerns Received by Theme
October 2024 - December 2024



Across Quarter 3 appointments and clinical treatment and assessment continue to be the overriding themes in terms of the highest numbers of concerns received.

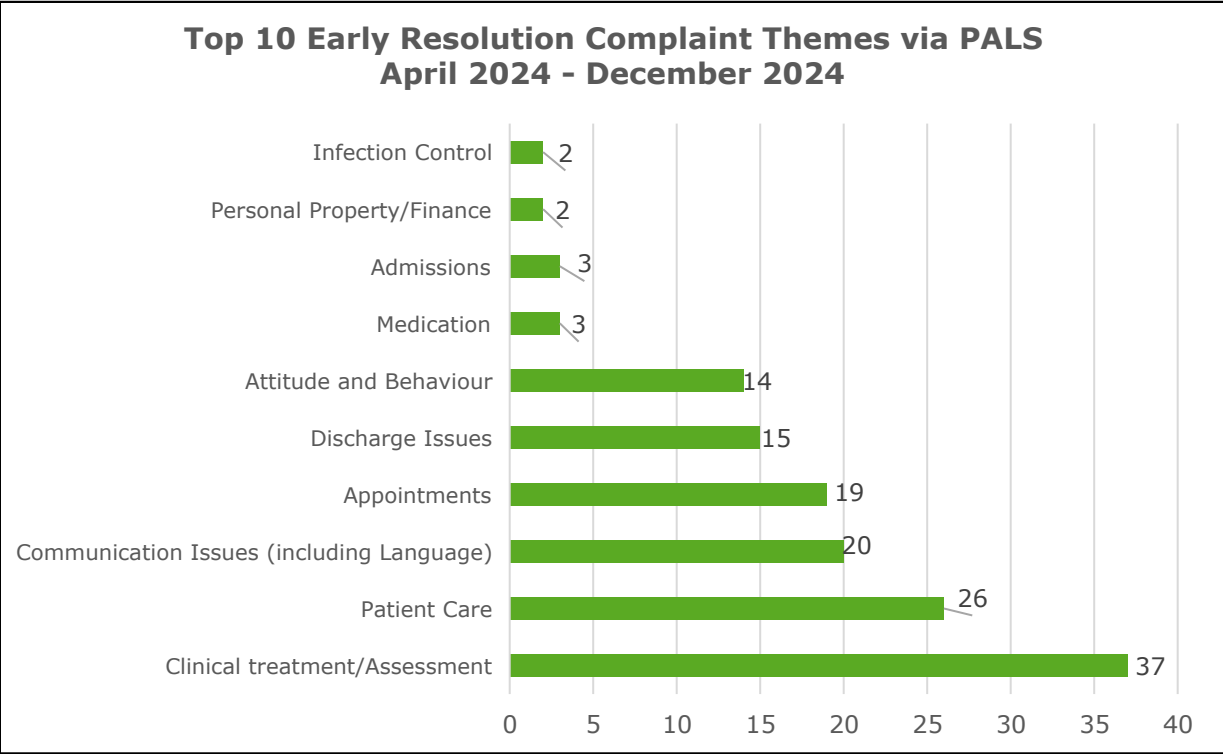
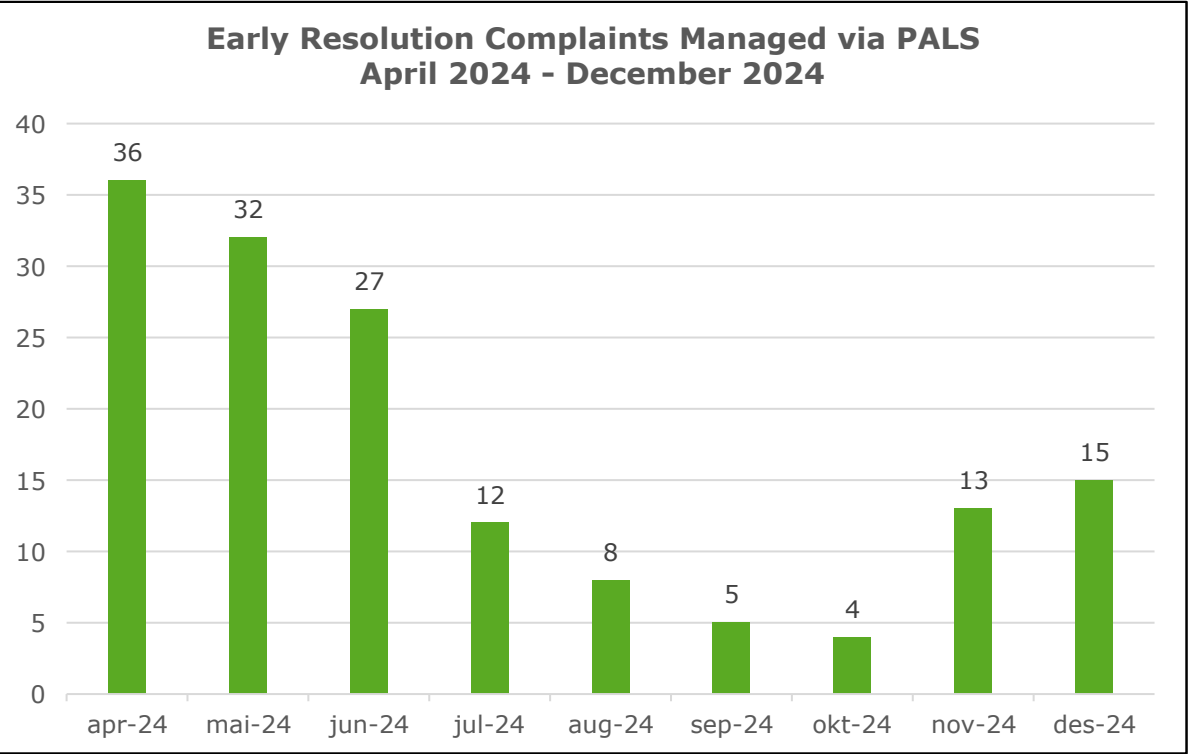




Achievements	Update
Ongoing clinical practitioner engagement sessions	Engagement sessions have been attended by the Head of Patient Safety, Quality & Learning and Senior QPS Manager to promote the changes in PTR, ensuring visibility and the support that can be offered by the team around the management of concerns and PSOW matters.
Appointment of B7 Concerns & PSOW Manager	Following a competitive recruitment process. A new Concerns Manager has been appointed, following an extended period without a Concerns Manager.
Division of Surgery/CSS and Urgent Care & Medicine aligned Divisional hub centralisation	Centralisation will reduce duplication, provide greater complaint and PTR capability, whilst also providing a more robust structure and oversight for both hub teams.



QOF Measure – Pillar 3: Patient Advice & Liaison Service – Q1-3 2024/25



Early Resolution Complaints Managed via PALS

Complaints that come directly to the PALS team are often managed via Enquires unless specifically requested “Logged as Complaint” by the complainant.

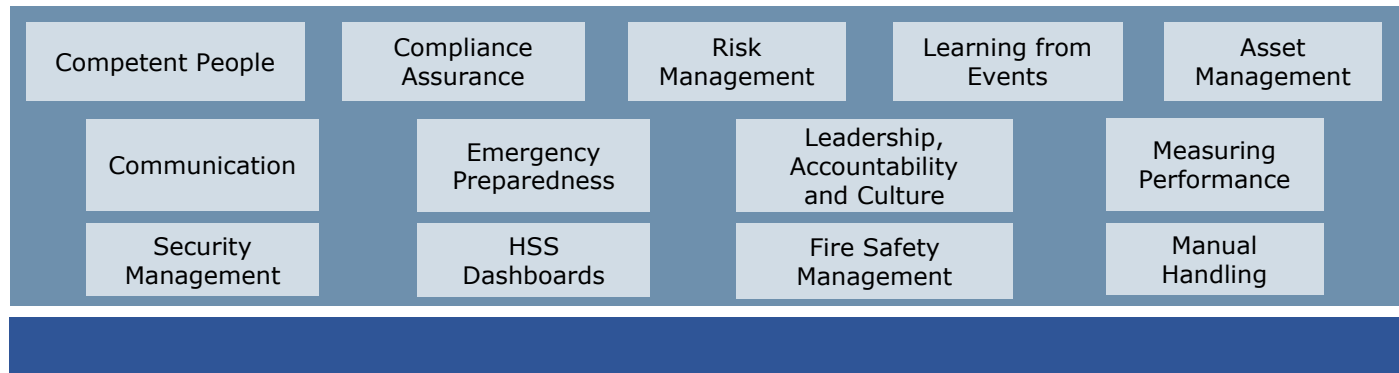
All calls that are transferred from the Putting Things Right Team since November 2024 are logged as an Early Resolution Complaint following guidance provided by Quality and Patient Safety Leads. Therefore, we are likely to see a increase in Early Resolution Complaints.

Average number of ER complaints - 17 a month over April – December 2024.

Top Theme – Clinical Treatment / Assessment 26.2% of Early Resolution Complaints.

PILLAR 4

Health, Safety and Security



Metrics: -

- RIDDOR reporting compliance (in line with HSE criteria) – target 100%
- Health & Safety statutory and mandatory training compliance – target 85% all modules
- Compliance with the Health Board Health, Safety & Fire risk assessment programme – target 100%

QOF Measure – Pillar 4

Health, Safety and Security Mandatory training



Health and Safety Statutory and Mandatory Training:

At end of December 2024 training compliance for the Health Board was reported as:

There has been a 1% increase in manual handling training compliance. There has been no movement in the other disciplines.

Health & Safety	86%
Fire Safety	83%
Violence & Aggression	86%
Manual Handling	69%

Health and Safety Training for Senior Leaders:

Part 1 of the IOSH Safety for Executives and Directors was delivered to members of the Executive Team in Q3 2024/25. Part 2 is planned for Q4 2024/25.

Health and Safety Policies:

A planned programme to review all existing health and safety policies has been developed. The plan will focus on the policies that overdue review.

Policy compliance will be significantly improved in Q1 2025/26.

Violence Prevention & Reduction Strategy:

The Health Board are currently developing a Violence Prevention & Reduction Strategy. The strategy will identify key goals for the Health Board.

The strategy will be published in Q1 2025/26.

Health and Safety Executive Engagement:

There has been no further engagement with the HSE during Q3 2024/25.

The Health Board have two active cases with the HSE, both relate to fatal patient falls reported in accordance with RIDDOR.

South Wales Fire & Rescue Service Activity:

The Health Board have complied with the requirements of the two enforcement notices relating to fire safety at Residences at Nevill Hall Hospital (Gerylyn and Bron Haul).



PILLAR 5

Infection Control and Prevention

Leadership,
Accountability
and Culture

Education

Antimicrobial
Stewardship

Dashboards

Themes and
Trends

IPAC Dashboards

Audit

Patients/Staff
Stories

IPAC Training

Actions and
Learning

National Policies

Investigation /
Themes for Learning

Environmental
Cleanliness

Collaborative Working
– Faculty's

Metrics: -

- Infection Control measures
- Welsh Government Reduction Goals
- C-Section Surgical Site Infections
- AMR prescribing trends
- Audit & Education: Respiratory Infections

Developing Metrics: -

- DECI and Hand Hygiene

Pillar 5: Infection Prevention – Welsh Government Goals



Current Count of Cases for FY 24/25

Table 1. Current FY count of specimens by HB, Apr - Dec 24

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	223	13	129	285	94	32
Betsi Cadwaladr UHB	274	11	123	401	104	19
Cardiff and Vale UHB	164	5	133	214	95	31
Cwm Taf Morgannwg UHB	131	6	94	266	86	11
Hywel Dda UHB	150	5	93	272	80	20
Powys THB	20	0	1	1	0	0
Swansea Bay UHB	205	4	93	170	90	13
Velindre NHST	4	1	1	10	8	0
Wales	1171	45	667	1619	557	126

- < than same period last FY
- = same period last FY
- > than same period last FY

Table 2. Current FY rate per 100,000 population of specimens by HB, April – Dec 24

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	50.05	2.92	28.95	63.96	21.1	7.18
Betsi Cadwaladr UHB	52.84	2.12	23.72	77.34	20.06	3.66
Cardiff and Vale UHB	43.05	1.31	34.92	56.18	24.94	8.14
Cwm Taf Morgannwg UHB	39.16	1.79	28.1	79.51	25.71	3.29
Hywel Dda UHB	51.7	1.72	32.05	93.75	27.57	6.89
Powys THB	19.83	0	0.99	0.99	0	0
Swansea Bay UHB	70.96	1.38	32.19	58.85	31.15	4.5
Velindre NHST						
Wales	49.63	1.91	28.27	68.62	23.61	5.34

- < than same period last FY
- = same period last FY
- > than same period last FY



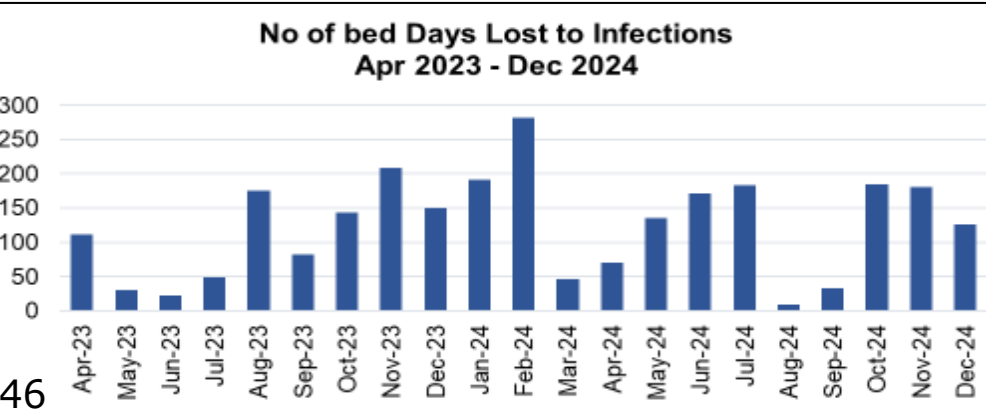
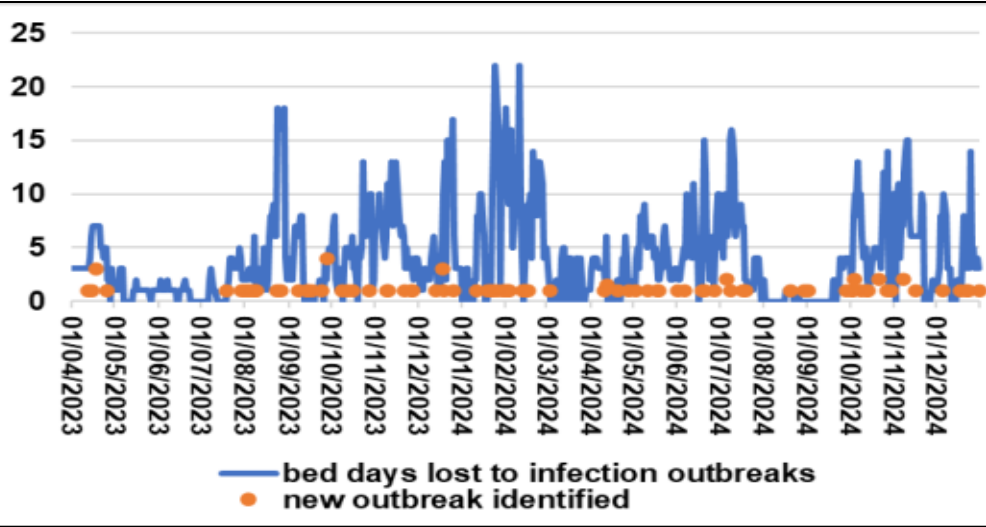
Pillar 5 Infection Prevention – Bed Days Lost



Issue

Ward closures due to infections:

- 17 = C difficile
- 21 = Covid 19
- 2 = Norovirus



Actions

C difficile

- Outbreak control meetings convened
- Samples sent for genomic sequencing to identify same strains
- One sporadic genomic sequencing & 2 cases linked from D2E indicating cross infection likely occurred
- 5 wards - no links identified
- Decant HPV clean

Covid-19

- Promoted covid safety measures
- Enhanced cleaning of touch point areas
- Patients cohorted on a like for like infection

Norovirus

- Enhanced cleaning
- Isolation of infection patients

Learning & Improvement

C difficile

- Inappropriate sample collection
- High dust
- Antibiotics not within guidelines
- Not withholding PPI while on antibiotics
- Compliance with fundamental IP

Covid-19

- Ventilation
- Symptomatic staff/visitors to wear face covering
- Visitors

Norovirus

- Shared facilities

WG Antimicrobial Targets: Primary Care

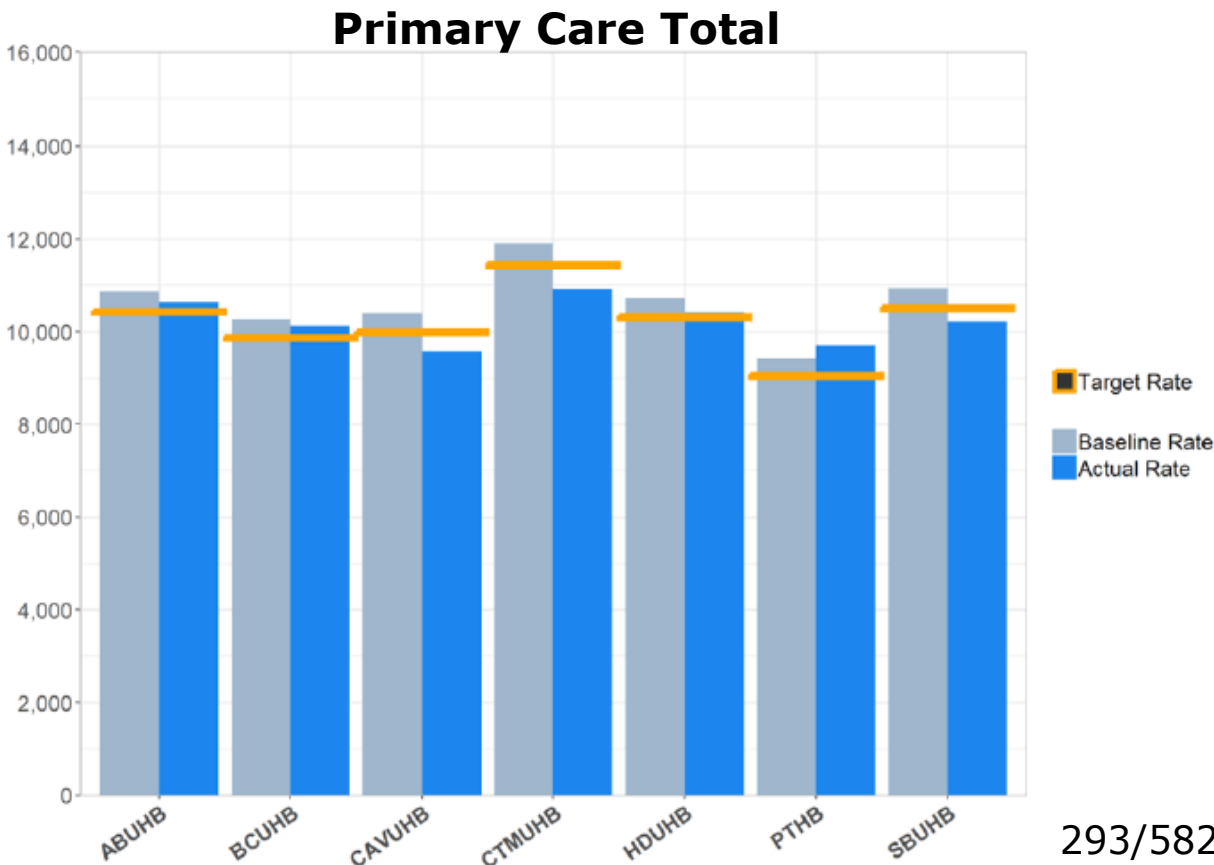
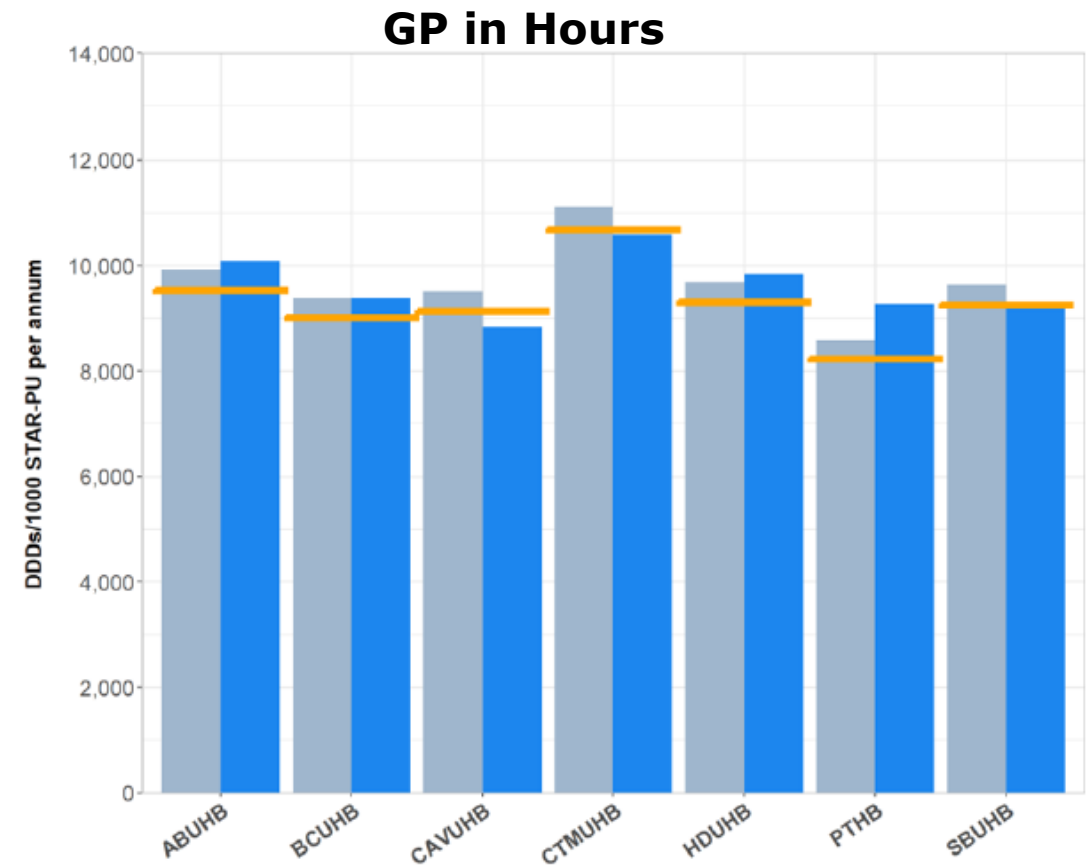


Target 11a: Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline
(measured in defined daily doses (DDDs) of antibiotics/1000 STAR-PU)

ABUHB 2023/24 FYE position received from Public Health Wales:

- GP in hours: **1.6% increase** on 2019/20 baseline
- Primary care total (GP in hours, plus, GP out of hours, independent prescribers, and the Community Pharmacy Common ailments Service UTI and sore throat test and treat services): **2.1% reduction** compared to 2019/20 baseline

Progress for all WG antimicrobial targets is reported annually

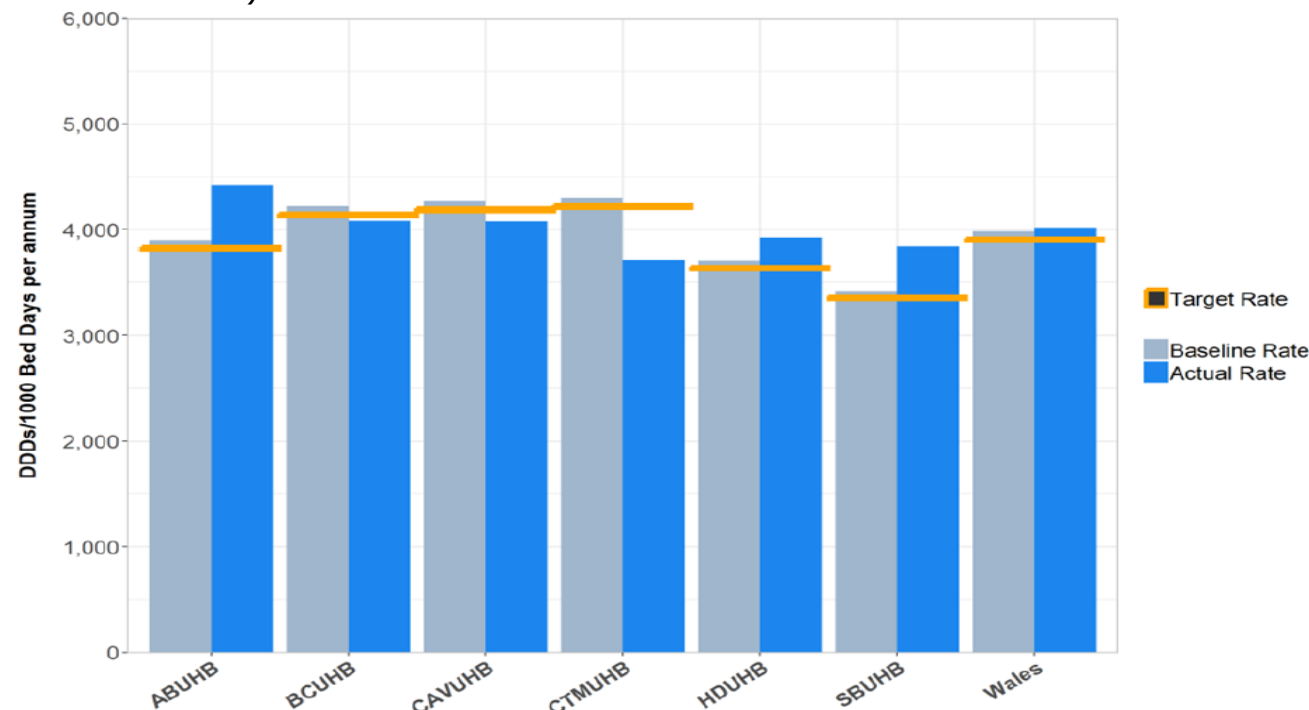


Target 11b: Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline

(measured in defined daily doses (DDDs) of antibiotics/1000 STAR-PUs)

ABUHB 2023/24 FYE position received from Public Health Wales: overall **13.3% increase** in consumption

- Positions for individual hospitals are available, *however* given movement of clinical services since the 2019/20 baseline year these should be interpreted with extreme caution:
 - Grange University Hospital **11.3% increase** (N.B. surrogate baseline used)
 - Nevill Hall Hospital **13.8% reduction**
 - Royal Gwent Hospital **5.4% reduction**
 - Ysbyty Ystrad Fawr **141.3% increase**
- E-prescribing roll out will aid progress against this target, e.g.
 - Imposing 'hard stops' of antibiotics, where antibiotics will automatically be discontinued
 - Using order sets (standard prescriptions) for specific infections that will guide users to shorter courses, e.g. 5 days of antibiotics for a pneumonia
 - Allowing searching & visualisation of patients on prolonged antibiotic courses



WG Antimicrobial Targets: Secondary Care



Target 12: WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30
(measured in defined daily doses (DDDs), equivalent to number of days of antibiotics dispensed)

ABUHB 2023/24 FYE position received from Public Health Wales: **62.9% usage in access category**

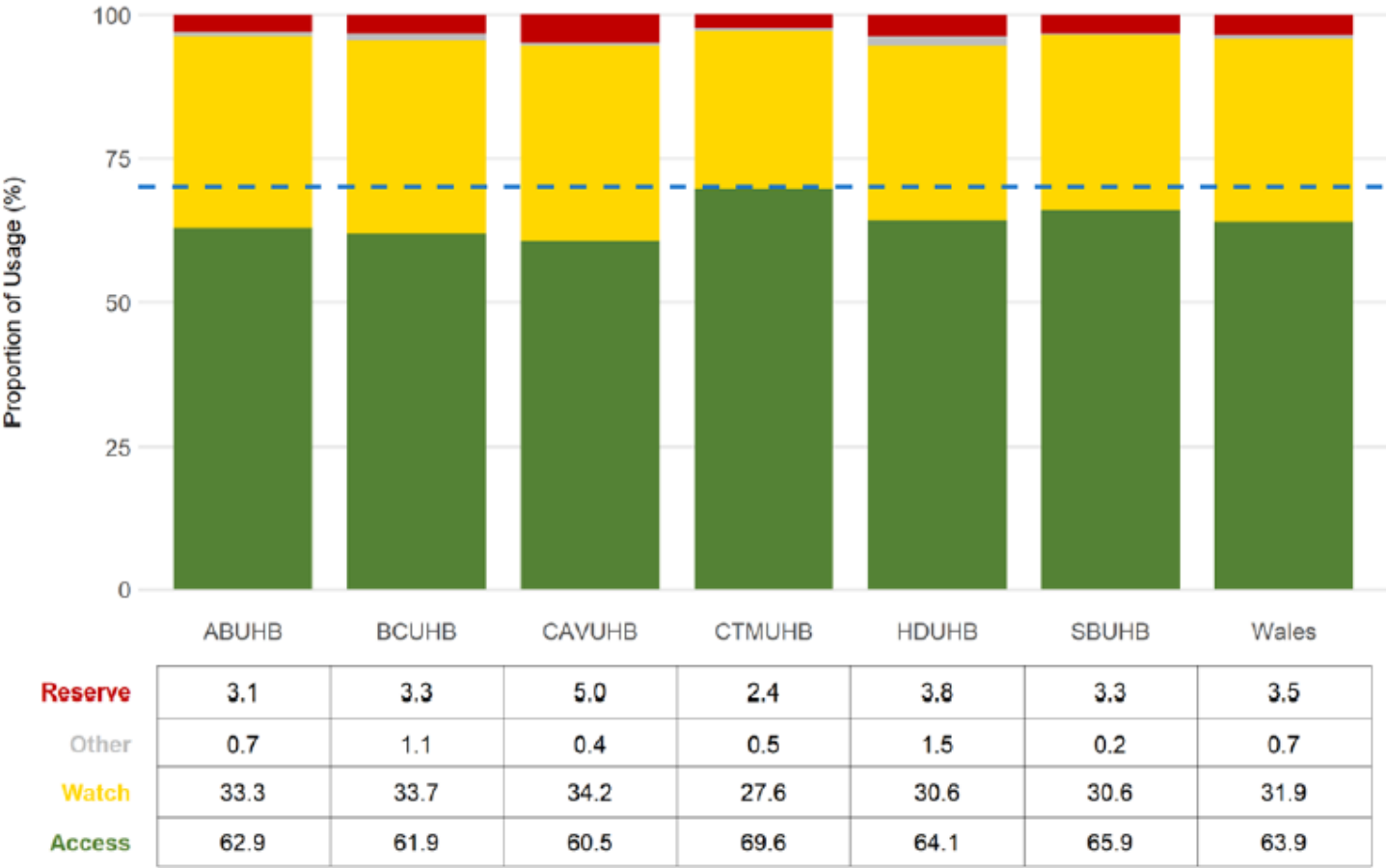
Positions for individual sites are:

- Grange University Hospital **62.7%**
- Nevill Hall Hospital **64.3%**
- Royal Gwent Hospital **63.4%**
- Ysbyty Ystrad Fawr **60.1%**

Roll out of penicillin allergy de-labelling activities in secondary care has commenced which should allow more patients to receive penicillins, most of which are in the access category

e-prescribing roll out will also aid this target e.g.

- Using order sets (standard prescriptions) for specific infections that will align prescriptions with ABUHB antimicrobial guidelines
- Allowing searching & visualisation of patients on prolonged watch/reserve courses



PILLAR 6

Safeguarding

Policy/SOP

Leadership,
Accountability and
Culture

Level 1, 2 and 3
Training

Safeguarding
Supervision

Practitioner
Concerns

Partnership
Working

Domestic Abuse
and Sexual Safety

Statutory Reviews

Metrics: -

- Adult Duty to Report / Child Duty to Report
- Training compliance

Developing Metrics:

- Themes from domestic homicide reviews and serious case reviews

Pillar 6: Safeguarding – Duty to Report



	Quarter 1			Quarter 2			Quarter 3		
	2023/2024	2024/2025	Increase	2023/2024	2024/2025	Increase	2023/2024	2024/2025	Increase
Adult Duty to Report	72	102	41%	84	90	7.5%	98	145	48%
Children Duty to Report	963	1090	13%	928	1116	20%	971	999	3%

Refresh Of Safeguarding Strategic Meetings

Over the last twelve months the Corporate Safeguarding Team, supported by leaderships from Divisions, has firmly embedded the Strategic Safeguarding Group, which has met regularly and been well attended. As a result of its success, it has been noted that work needs to be supported by sub groups, in order to manage the growing agenda.

In light of the above, it has been agreed that the following Sub Groups will be formally introduced in January 2025:

- Safeguarding Adults Operational Group
- Safeguarding Children and Transitional Safeguarding Group
- Practitioner Concerns Steering Group

Both Children and Adult Groups will have a focus on Policy Development and embedding learning from Statutory Reviews.

Each of the Groups will be meeting quarterly and will provide a formal report to the Strategic Safeguarding Group, which is Chaired by the Executive Director of Nursing and Vice-Chaired by the Deputy Director of Nursing.





Training Module	Compliance %
Adult Safeguarding Level 1	87%
Children's Safeguarding Level 1	85%
Adult Safeguarding Level 2	90%
Children's Safeguarding Level 2	89%

Safeguarding Training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.

All training for Safeguarding Level 1 and 2 is now above the required 85% compliance.

Level 3 Children’s and Adults training continues to be a challenge and further work is required across the Health Board to ensure that this is mandated to staff appropriately via ESR and that compliance data can then be analysed. A final list of staff has now been identified and the ESR team are in the process of uploading this to the system.



Quality Updates

Section 5

Sepsis Progress Report – Update



National Drivers for Deteriorating Patient:

- The **Welsh Health Circular (WHC) /2024/035** – Standardising the management of acute deterioration provided an agreement on standardisation and use of Early Warning Scores (EWS). Following the release of this circular the Health Board has been working towards implementing the recommended EWS. These will support identification of acute deterioration for patients and suggest a point at which care needs to be escalated and to define a response to escalation triggers. As current practice varies, this introduces a potential risks to patient safety. A standardised, national approach using evidence-based tools will ensure clarity, minimise risk and support improved patient outcomes.
- **Safer Care Partnership** led by NHS Executive and Improvement Cymru, there is a National focused workstream on acute deterioration. This encompasses the WHC and the need for rolling out Martha's rule (Call for Concern), which the Health Board have been planning.

Local Implementation:

- **Working Group:** To implement the standardised National Early Warning Scores (NEWS2) the Health Board's Sepsis Working Group has divided into smaller task and finish groups. This will ensure delivery and compliance of the WHC. The groups will focus on digital, education, implementation, escalation, and audit. A driver diagram is being produced at the end of January to identify barriers and actions required for successful implementation of NEWS2. A key focus area will ensure the digital specifications are scoped to enable the switch over to NEWS2, which will take place as a workshop in the next few weeks.
- **Paediatrics:** Planning for the implementation of the National Paediatric Early Warning Score (PEWS) is underway, with a target launch in April. Discussions will be held to develop an education plan to ensure staff receive training on sepsis and the new EWS.
- **Maternity and Neonatal:** An implementation workshop for the All Wales Maternity Early Warning Scores (MEWS) and New-born Early Warning Track and Trigger 2 (NEWTT2) was hosted by the NHS Executive in December 2024. A follow-up meeting in January 2025 has been held, which established groups to support with the roll out of MEWS and NEWTT2 and identifying the key stakeholders to ensure successful implementation. Groups will include: digital, education, policy review, and measurement/audit. The digital template for BadgerNet will be available for NEWTT2 in June and MEWS in September, with the group working towards implementation once available.

These efforts aim to improve sepsis awareness, treatment, and outcomes across the Health Board.



Sepsis Progress Report – Progress



- **Scoping Exercise:** This has been undertaken to establish and review the health boards existing management of sepsis and review current practices and policies in order to align with [National Institute for Health and Care Excellence \(NICE\) updated Sepsis guidance \(2024\)](#) and the [Academy of Medical Royal Colleges \(AoMRC\) guidance](#) around appropriate antimicrobial usage when treating sepsis.
- During the scoping, a number of improvement initiatives are being undertaken within Divisions, which includes the launch of a sepsis specific project on CO and a sepsis specific medical faculty group. This has highlighted further opportunities for improvement within the acute sector through reviewing incidents, complaints and exploring opportunities to learn and improve management of sepsis. Following the implementation of the EWS, the Medical Director's Quality and Patient Safety team are working collaboratively with specialities to develop sepsis expertise, scope performance targets and provide support with improvement initiatives where required. This will include sharing learning amongst the specialities with an aim of improving the standard of sepsis recognition, response and management.
- **Sepsis Screening Tool:** There has been focused task and finish groups held to review the sepsis screening tool. This has led to an agreement to test the evidence-based Sepsis Trust UK tool. By quality improvement methodology and small tests of change (through PDSA cycles) within the acute sector this will be rolled out iteratively. Following implementation of the National EWS, the tool will be reviewed to ensure compliance and ensure the effective implementation is leading to improved outcomes for patients in adult, paediatric, and maternity/neonatal environments.
- **Primary and Community Care:** Scoping has commenced, with an initial presentation delivered to the Neighbourhood Care Network to gauge stakeholder buy-in.
- **Sepsis Workshop:** A workshop was hosted in November focusing on the deteriorating patient and sepsis. There was representation from multiple divisions, which explored key questions such as why patients deteriorate within the system and what barriers hinder effective responses. The collaborative discussions laid the groundwork for mapping out improvement strategies aimed at driving better outcomes for patients. In collaboration with the ABCi team a fishbone exercise was undertaken to look at barriers and consider how to improve how we identify and respond to patient deterioration across our wards. A follow-up workshop will be held after the implementation of the Welsh mandated EWS. Additionally, a Primary and Community Care focused workshop will be delivered in Quarter 4 2025 to capture barriers outside the acute setting. More info can be found here: [Successful Workshop Held to Address Sepsis and Patient Deterioration](#)
- **Awareness Campaigns:** A sepsis campaign was launched on 29th November 2024. Initially launched internally, the campaign aims to deliver sepsis awareness information to the public in January 2025. Content includes a new public-facing sepsis website, an internal staff pulse page, and resources/assets to drive awareness. [Sepsis - Home](#)
- **National:** The Health Board continues to be represented in national sepsis forums and actively contributes to the national direction for sepsis. The NHS Executive has recently employed an Early Warning Score Implementation Lead to provide oversight and guidance to health boards, ensuring alignment with the national mandate. This includes ensuring national available resources, such as eLearning material, is reviewed and provided for staff within our Health Board.



- Steering Group re-established (Strategic). Senior clinical leadership led, comprising multi-disciplinary membership - first meeting scheduled 05/02/25.
- Two tactical sub-groups reporting to the steering group – one for food standards, and one for clinical standards.
- Steering group to report to Exec Team and PQSOC for assurance.

Examples of on-going and future work:

- Task and finish group established to produce an escalation policy for patients with nutrition and hydration needs not being met in a timely manner – this work is undertaken in response to several patient safety incidents. Policy ratification Q4 24/25.
- Task and finish group established to review and implement recommendations relating to fluid balance and hydration – this work undertaken in response to coronial Section 28 order
- Allergen management and menu development.
- Divisional patient catering groups established (Operational).
- Monitoring Health Board compliance with All Wales Standards for Hospital food and fluid provision (launching spring 2025).
- Reviewing Health Board nutrition and hydration audits and identify subsequent opportunities for quality improvement.





Ward / Team Accreditation creates a structured system to continuously raise standards of care through effective goal setting, measurement, feedback and staff engagement which brings benefit to patients, staff and the organisation.

Phase 1: Adult Wards GUH, MH & LD Wards, and Paediatric wards. (complete)

Phase 2: ED, MIU, MAU, SAU, Theatres, OPD Critical Care.

Phase 3: HV, DN, Maternity services, Specialised Teams,

Phase 2 Progress:

- Theatre audits will be live by end of January.
- Meeting ED/MIU in January to review their audit plan
- Critical care are live, met in Dec to provide support.
- MAUs/SAU are live
- OPD / clinics to be reviewed.

Independent Reviews:

- Total **14** reviews performed
- 8 achieved Bronze (6 require reassessment)
- 3 booked in Jan 2025 with a further 12 areas ready for Bronze assessment

NEXT STEPS:

- Progress with phase 2
- Coordinate timely cross divisional Independent Reviews when applicable
- Add senior nurse audits to provide further assurance prior to independent reviews.
- Develop Ward Accreditation Padlet for the Intranet
- Liaise with ABCi department to determine how they can support Wards / Teams with improvement projects: meeting in Jan 2025
- With the assistance of data analyst identify organisational themes for learning



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance Performance Report – November 2024 (2024/25 Month 8)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rob Holcombe – Executive Director of Finance, Procurement & VBHC
SWYDDOG ADRODD: REPORTING OFFICER:	Suzanne Jones – Interim Assistant Director of Finance

Pwrpas yr Adroddiad Purpose of the Report

Er Sicrwydd/For Assurance

This report sets out the following:

- The financial performance at the end of November 2024 and the forecast position against the statutory revenue and capital resource limits,
- The savings position for 2024/25,
- The revenue reserve position on the 30th November 2024,
- The Health Board's underlying financial position,
- The cash position,
- Public sector payment policy performance, and
- The Capital position.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report sets out the financial performance of Aneurin Bevan University Health Board, as at the 30th November 2024 (month 8) for the financial year 2024/25.

The 2024/25 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met.

The table below summarises these and the Health Board's performance against them.

Nov-24

Performance against key financial targets 2024/25

+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Year-end Forecast	Movement
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of its funding in each financial year. <i>This confirms the YTD and forecast variance.</i>	£'000	(23,202)	6,683	7,356	
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. <i>This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.</i>	£'000 £65,258	(3,449) -5.3%	35,883 55.0%	0	
Public Sector Payment Policy To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	98.8%	97.7%	>95%	

Performance against requirements 23/24		21/22	22/23	23/24	3 Year Aggregate (21/22 to 23/24)
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	x	(249)	36,842	49,754	86,347
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	(50)	(43)	(41)	(134)
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	x				

Underlying Financial Position (Brought Forward ULP)	21/22	22/23	23/24	24/25 Forecast
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	£20.914m Deficit	£89.6m Deficit	£81.4m Deficit	£14.5m Deficit

As at Month 8, ABUHB is reporting a year-to-date deficit of **£6.683m**, with a forecast year end deficit of **£7.356m**. This position has changed significantly from the prior month following a Welsh Government letter dated 2nd December 24 notifying the Health Board of additional funding totalling £40.5m; £9.5m issued recurrently to support ongoing operational pressures, and £31m also issued on a recurrent basis but conditional on the Health Board delivering against objectives specified within the letter. The Health Board has anticipated the total funding of £40.5m on a recurrent basis, reflected the year-to-date impact in the reported position, and adjusted the underlying and forecast positions accordingly.

There remain risks associated with this forecast position, particularly full achievement of saving opportunities, prescribing / drug cost growth, receipt of anticipated allocations and operational demand & workforce pressures.

The 2024/25 forecast of £7.356m is consistent with the revised Welsh Government control total following the additional funding of £40.5m. The Health Board is expected to achieve the control total as a minimum.

The Board has made improvements to the financial forecast and has “de-risked” a number of pipeline opportunities. Work continues to progress further opportunities to minimise operational and savings delivery risks and to develop plans for the 2025/26 IMTP.

Cefndir / Background

Key points to note for month 8 include:

- Year to date position is a deficit of **£6.683m** with a reported full year position of **£7.356m deficit**
- Income includes anticipated funding for a number of areas including;
 - conditional WG recurrent funding
 - CHC real living wage funding where the exact value is yet to be confirmed by WG
 - WG coverage for the full costs of the 23/24 Medical & Dental wage award paid in September (£12.3m) and the 24/25 award for all pay groups paid in November (£37.1m).
- Pay expenditure in-month increased by £25.8m compared with October due to payment of the 2024/25 pay award across all staff groups (£25m year-to-date impact), with the remaining £0.8m due to increases in additional hours (Medicine and Urgent Care), overtime (across a number of Divisions), and an increase in bank usage offset in part by a reduction in agency. Operational pressures including enhanced care, sickness and vacant posts continue to cause a pressure on the Health Board position.
- Non-pay expenditure (excluding capital adjustments) increased by £3.0m compared with October. Key movements in non-pay are in relation to additional payments for the Pharmacy contract following receipt of additional framework funding (£1.2m), JCC funding received in-month accounting for £1.4m of YTD spend and £0.4m movement on non-cash limited spend as a result of dispensing/prescribing adjustments. Drug cost trends in Haematology, Gastroenterology and Neurology continue to increase the forecast as in prior months.
- Savings – total annual plan savings were £40.5m with a current forecast delivery of £43.2m. The forecast delivery has reduced by £0.5m due to the delay in planned bed closures and theatre efficiencies within Surgery (in particular Machen Ward) and Primary Care (requirement to open additional beds). Overall in-month achievement is £4.0m (YTD £24.9m). This reduction is due to opening winter bed capacity and is expected to be mitigated through winter funding opportunities.

At Month 8, the reported revenue position is a £6.683m deficit and the reported capital position is break-even. Risks remain in achieving the reported forecasts.

The underlying financial deficit coming into the 2024/25 financial year was £81.4m, and the carry forward underlying deficit for 2025/26 was determined as £55m in the October report. This has now been revised to an underlying deficit of **£14.5m** following notification from Welsh Government of additional recurrent (baseline and conditional) funding of £40.5m.

Asesiad / Assessment

- **Revenue Performance**

The financial forecast deficit is summarised by the following elements:-

- Stated underlying deficit - +£81.4m
- New year cost pressures - +£59.8m
- Additional discretionary funding – (£51.8m)
- Identified savings of (£40.5m)

Annual Plan Forecast Deficit £48.9m

As at month 8 the Health Board has revised its year-end forecast to a deficit of £7.3m following Welsh Government notification of additional funding totalling £40.5m. The revised forecast of £7.3m (also the revised control total for the Health Board) reflects the £1m reduction in forecast against the annual plan submission of £48.9m deficit as at 31st of May 2024.

A summary of significant movements, updated to reflect in-month changes is as follows:

- CTM arbitration on base LTA case (£1.5m)
- CTM under-delivery at marginal rates forecast (£1.4m)
- Anticipated income for PADM's / Dispensing Dr's funding (£1.1m), Optometry contract funding (£1.1m), and international recruitment (£0.9m) – total £3.1m
- Resolution of Paediatric case (£1.3m)
- Additional prescribing costs above plan due to increased average price per item using August 24/25 PAR data (+£7.0m)
- Recognition of WHSSC current forecast over-performance (+£1.0m)
- Secondary care acute drugs (+£5.0m)
- Increase in forecast savings (+£1.0m)
- Release of reserves held for unplanned pressures and investments (£1.5m)

- Review of balance sheet liabilities, in particular CHC and FNC growth assumptions (£1m)
- Non-recurrent benefits (£4.2m), including review of Agency liabilities (£0.8m), GMS enhanced service review (£0.9m), review of CHC growth assumptions (£1.2m), and VAT on lease cars (£0.6m)
- Net operational pressures in particular Gynaecology medical staff and Nursing maternity leave (+£1.0m)
- Welsh Government additional funding notified November 24 (£40.5m)

Annual Forecast Deficit @ Month 8 - £7.356m

The table below describes the updated position following the annual plan submission (31st of May) in further detail:-

Category	March submission	May submission	Month 4	Month 5	Month 6	Month 7	Month 8
Underlying deficit b/f (£m)	81.4	81.4	81.4	81.4	81.4	81.4	81.4
Cost pressures identified (£m)	59.8	59.8	59.8	59.8	59.8	59.8	59.8
WG discretionary funding (£m)	(51.8)	(51.8)	(51.8)	(51.8)	(51.8)	(51.8)	(51.8)
Identified savings (£m)	(29.1)	(34.4)	(40.5)	(40.5)	(40.5)	(40.5)	(40.5)
Pipeline opportunities (£m)	(11.4)	(6.1)	-	-	-	-	-
24/25 additional funding notified 2nd December 24							(40.5)
Sub-total deficit (£m)	48.9	48.9	48.9	48.9	48.9	48.9	8.4
CTM arbitration case benefit & revised performance	-	-	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)
CTM under-delivery at marginal rates				(1.4)	(1.4)	(1.4)	(1.4)
Dispensing Drs, International Recruitment and Optometry funding			(1.1)	(2.8)	(2.8)	(2.8)	(3.1)
Resolution of CHC case					(1.3)	(1.3)	(1.3)
Prescribing average price per item increase and NCSO				3.1	4.5	7.0	7.0
WHSSC forecast pressure (£m)			0.7	0.7	1.0	1.0	1.0
Secondary Care acute drugs					3.2	4.5	5.0
Increase in forecast savings				(1.2)	(1.5)	(1.5)	(1.0)
Release of reserves held for unplanned pressures and investments						(1.5)	(1.5)
Review of balance sheet liabilities						(1.0)	(1.0)
Non-recurrent benefits					(2.2)	(3.5)	(4.2)
Other net operational pressures including cover for maternity leave within Maternity (15 WTE), and other variable pay (+£1.0m)			0.9	2.1	1.0	1.0	1.0
Total deficit	48.9	48.9	47.9	47.9	47.9	47.9	7.4

A summary of the year to date financial performance is provided in the following table, by delegated area.

Summary Reported position - November 2024 (M08)	Full Year Budget £000s	YTD Reported Variance - M08 £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	303,986	333	106	227
Prescribing	117,139	2,471	1,534	937
Community CHC & FNC	69,882	1,016	1,300	(284)
Mental Health & Learning Disabilities	146,132	153	166	(13)
Total Primary Care, Community and Mental Health	637,139	3,973	3,106	867
Surgery	147,376	5,818	4,542	1,277
Clinical Support Services	133,162	898	675	223
Medicine	171,373	2,838	2,101	737
Urgent Care	41,770	(171)	(256)	84
Family & Therapies	143,022	636	539	97
Estates and Facilities	95,225	(808)	(815)	7
Chief Operating Officer	9,764	(675)	(238)	(438)
Total Director of Operations	741,692	8,536	6,549	1,986
Total Operational Divisions	1,378,831	12,509	9,656	2,853
Corporate Divisions	99,244	(2,633)	(1,885)	(748)
Specialist Services	199,873	591	517	74
External Contracts	99,331	(1,759)	(1,692)	(68)
Capital Charges	50,456	(12)	(9)	(2)
Total Delegated Position	1,827,735	8,696	6,587	2,109
Total Reserves	13,077	(2,013)	23,298	(25,311)
Total Allocations	(1,828,240)	(0)	0	(0)
Other Corporate Income	(12,572)	(0)	(0)	0
Total Reported Position	0	6,683	29,885	(23,202)

Summary of key operational points for Month 8

- During November 2024, pay expenditure was £92.0m, an increase of £25.8m compared with October.
 - Substantive pay spend was £85.6m (October £60.1m).
 - Variable pay spend was £6.4m (October £6.1m).

Pay movements include:

- 2024/25 pay award for all staff groups actioned in November including arrears to 1st April 24 (+£25m)
 - increases in additional hours (Medicine and Urgent Care) and overtime (+£0.6m)
 - increase in bank usage offset in part by a reduction in agency (+£0.2m)
- Non-pay expenditure (excluding capital adjustments) increased by £3.0m compared with October. Key movements in non-pay are in relation to additional payments for the Pharmacy contract following receipt of additional framework funding (£1.2m), JCC (specialised services) funding received in-month accounting for £1.4m of YTD spend and £0.4m movement on

reimbursed non-cash limited spend as a result of dispensing/prescribing adjustments.

- On-going acute secondary care drugs growth presents a significant pressure above planned levels and continues to increase the forecast as in prior months (+£0.5m). Previous NICE indications within Haematology and Dermatology along with continued activity growth in Ophthalmology, Gastroenterology and Neurology contribute to this pressure. An analysis tool has been developed to enable the drill down of the reasons for the changes in the drugs spend, this has highlighted increased prices, increased volumes and new NICE implementations.
- Demand pressures for elective and urgent care across all services, including primary care, mental health, acute and community hospitals remains above the pre-pandemic levels. There were 235 in-patients fit for discharge at the data capture point in November (232 in October). These are reported as 59 Health delays, 79 Social care delays and 97 joint delays. The top 5 reason categories in relation to delayed days are as follows:

Awaiting Mental Health bed	10.4%
Awaiting extra care/ supported living availability	9.2%
Patient / family refusing to move to next stage of care/ discharge	7.0%
Awaiting start of new home care package	6.3%
Homeless	6.2%

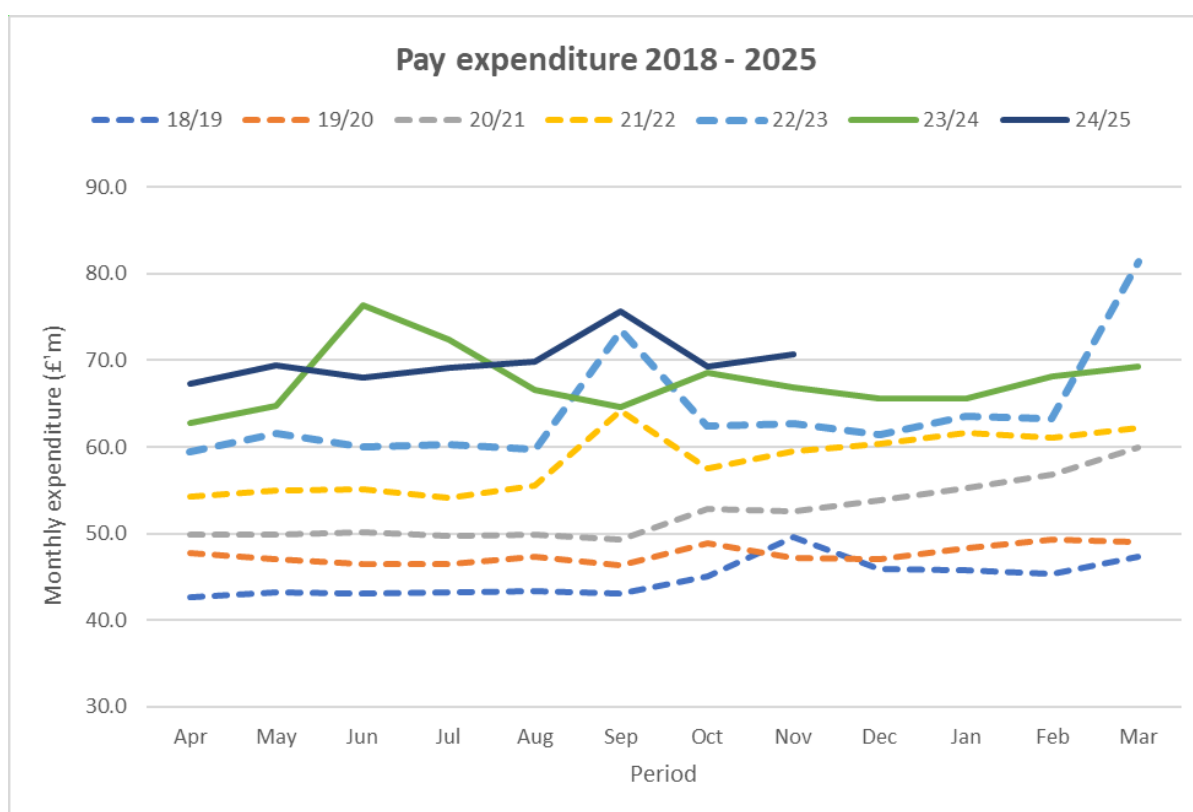
The data reflects the validated *Pathways of Care Delays* reported to Welsh Government.

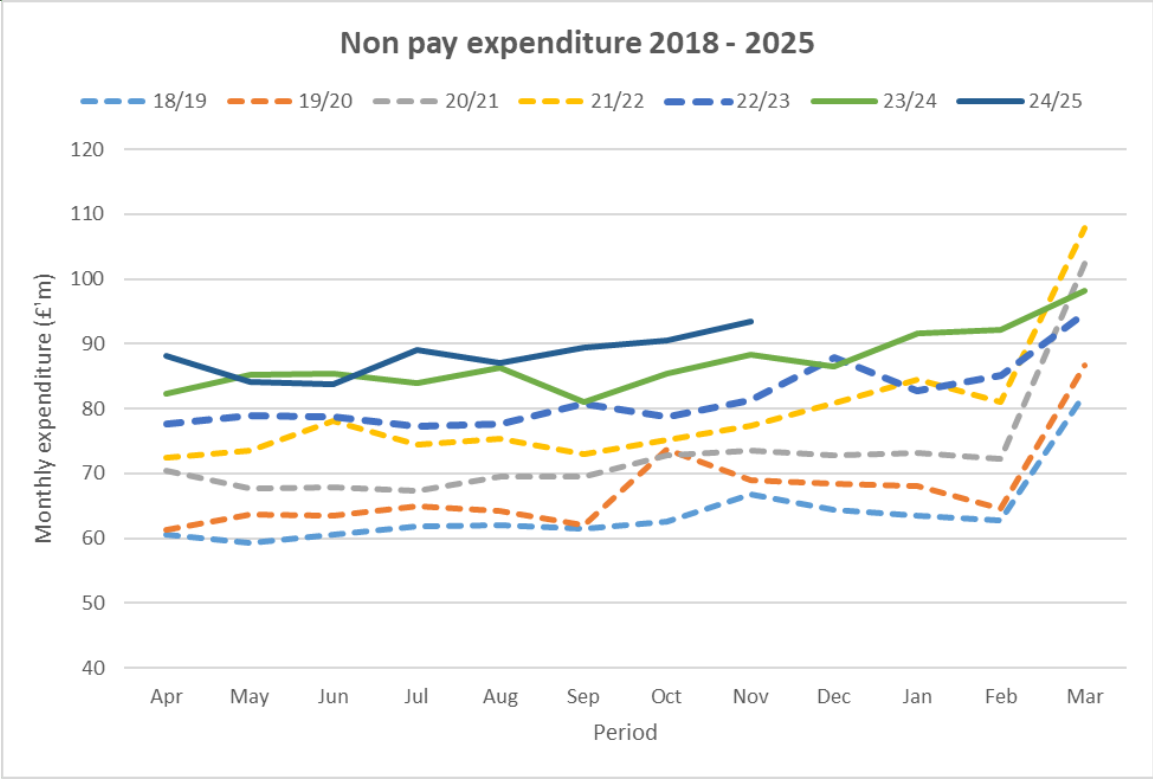
- The estimated cost for the year of continued blocked bed days for all reasons is c.£15.4m using a £200 cost per bed day. The demand and flow challenges across the Health Board drive surge bed capacity requirements which result in increased demand in high-cost temporary staff, impacting overspends and performance across the Health Board. The delays need to be reduced to avoid the requirement for this capacity and optimise appropriate bed capacity to support financial sustainability, this is being progressed through the discharge and bed reduction saving programme.
- Other in-month significant points include:-
 - Prescribing costs present a significant financial pressure compared with Annual Plan financial forecasts. The average cost per item for 2024/25 has increased from £7.29 (Annual Plan) to £7.71 (September PAR) resulting in a forecast overspend of £5.8m compared to budget of £117.1m. Growth is assumed to be 0.8% for 2024/25 and will be reviewed further using future PAR data. Compared to current M08 budget the year-to-date impact is an overspend of £2.5m.

- CHC costs for Adult Community Care, Mental Health & Learning Disabilities and Children continue to present an underlying financial pressure. This is expected to improve in future months due to the profile of savings achievement. Additional high-cost packages within Learning Disabilities and Paediatrics may present a further pressure in future months.
- On-going use of variable pay by Mental Health, Medicine and Urgent Care divisions for enhanced care due to increased acuity, as well as sickness, maternity and vacancy cover has contributed to an increase in the forecast spend of £1.2m.

Expenditure run-rates

Pay and Non-Pay expenditure run-rates for the last six financial years are shown below; assuming the current level of income, the expenditure run-rates need to reduce in order for the Health Board to meet its annual plan deficit and even more so to a break-even position in future financial years.



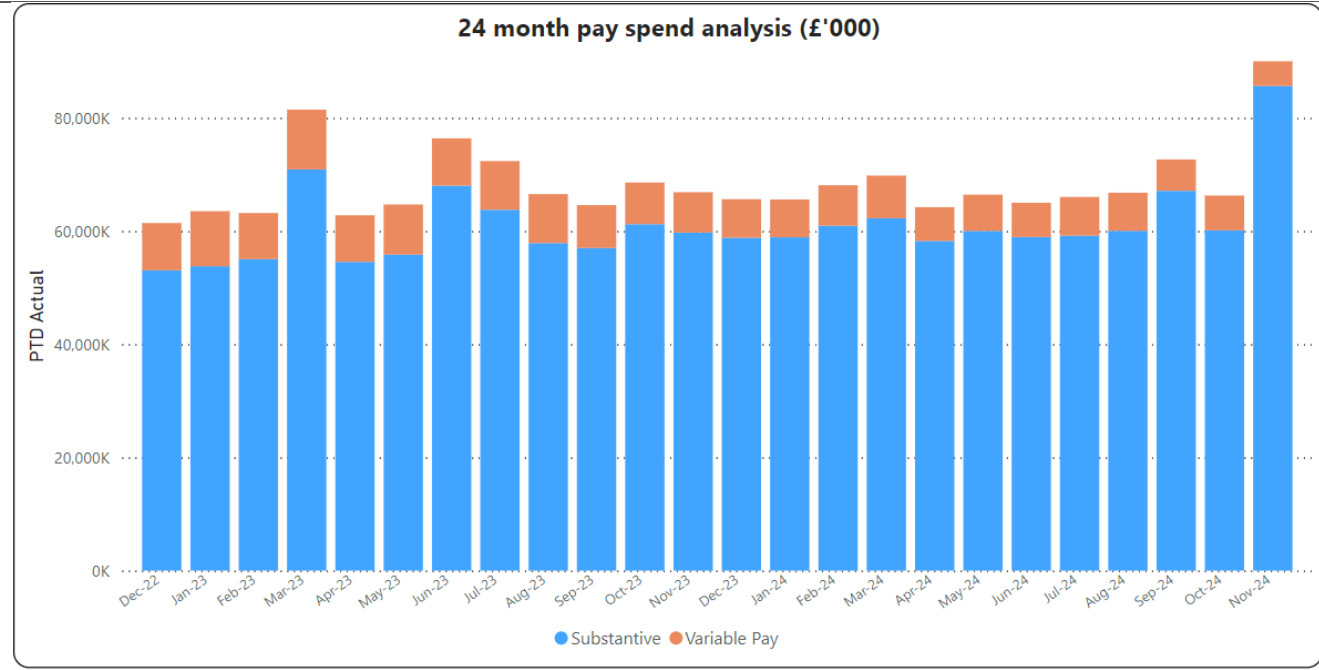


Workforce

The Health Board spent £92.0m in November, an increase of £25.8m compared with October. The overall increase compared to October is due to payment of the 2024/25 pay award across all staff groups (£25m year-to-date impact), with the remaining £0.8m due to increases in additional hours (Medicine and Urgent Care), overtime (across a number of Divisions), and an increase in bank usage offset in part by a reduction in agency. Operational pressures including enhanced care, sickness and vacant posts continue to provide a pressure on the Health Board position.

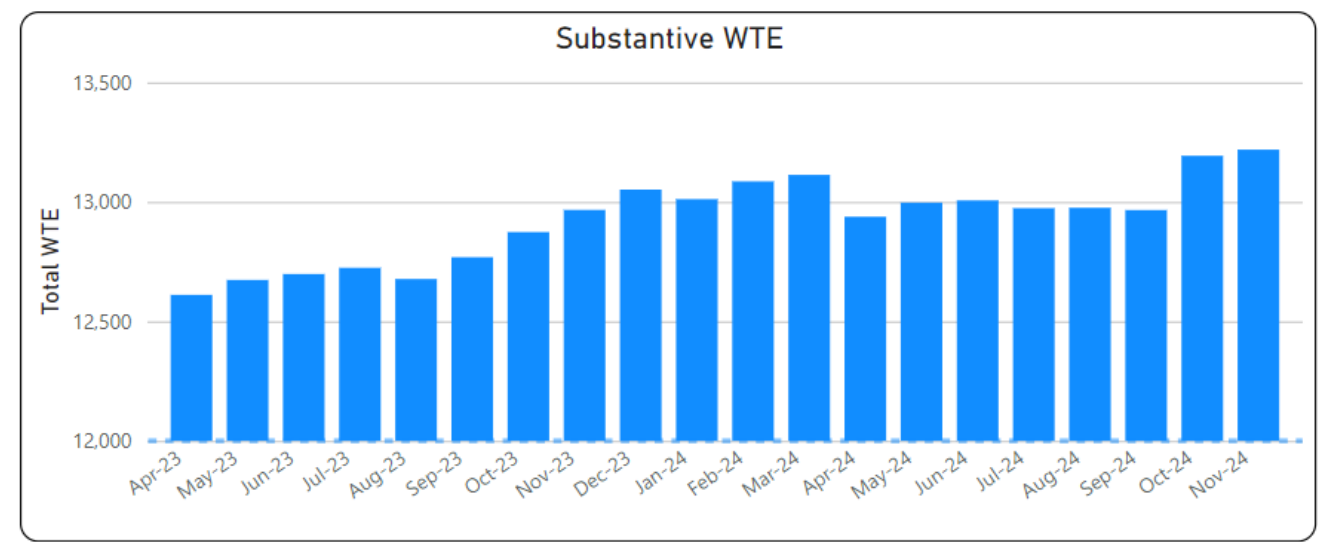
Workforce expenditure is shown below differentiating between substantive and variable pay¹:

¹ To enable useful comparisons and trends all references to 23/24 pay expenditure exclude the month 12 expenditure for additional employer pension contributions (6.3%/£32.1m).



Substantive staff

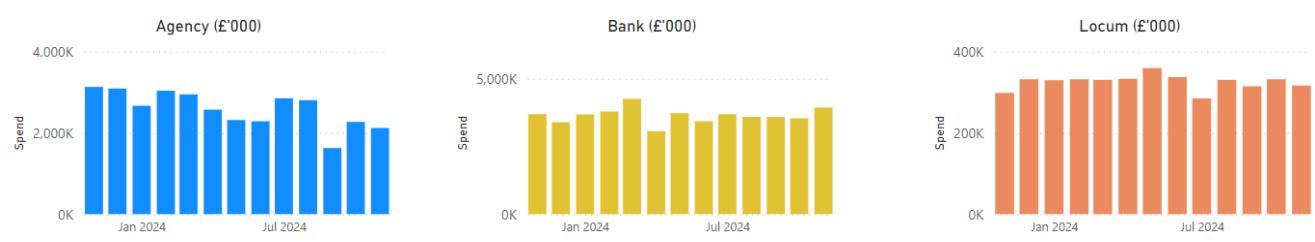
Substantive pay was £85.6m in November, an overall increase of £25.5m compared with October, due to payment of the 2024/25 pay award for all staff groups actioned in November including arrears to 1st April 24 (+£25m). Month 8 records 13,218 wte employed staff (M7=13,193).



Variable pay

Variable pay (Agency, Bank and Locum) was £6.4m in November compared with £6.1m in October. The increase shown in variable pay was mainly attributable to the 2024/25 pay award actioned in month 8 for Bank staff (£0.5m), offset with a reduction in Registered Nurse agency (£0.1m) and Domestic agency (£0.1m). The main reasons for nurse bank spend is to cover vacancies, maternity and sickness,

along with additional capacity and enhanced care. The monthly average variable pay to November is £6.3m per month (£7.75m 2023/24, £9.2m 2022/23).



Bank staff

Bank (£'000)

Month	Spend (£'000)
Jan 2024	3,500
Feb 2024	3,200
Mar 2024	3,500
Apr 2024	3,800
May 2024	3,000
Jun 2024	3,500
Jul 2024	3,200

In-month spend of £3.9m, a £0.4m increase compared with October mainly attributable to the 2024/25 pay award actioned in-month (2023/24 average monthly spend £3.9m).

- Continued pressures in Medicine wards/ Urgent Care, GUH Acute Medicine and GUH ED - £1.7m
- Facilities bank staff - £0.3m
- Community Hospitals/localities - £0.5m
- Mental Health shifts particularly linked to enhanced care / observation - £0.6m
- Continued expenditure in Surgery and Clinical Support Services linked to elective activity - £0.6m
- Family & Therapies (Maternity leave cover, Neonatal and Paediatrics) - £0.2m

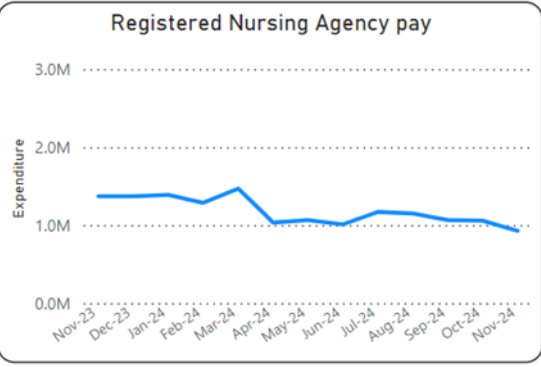
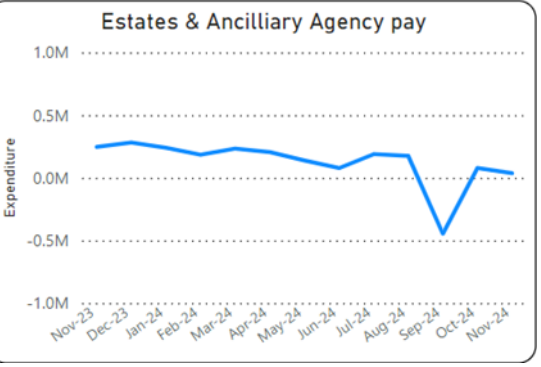
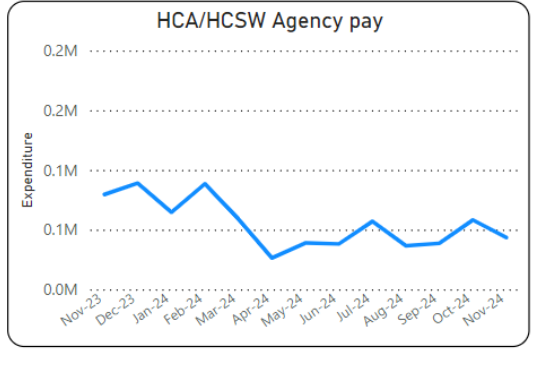
Agency

Total agency spend in September was £2.1m compared with £2.3m in October. A significant part of this reduction was seen within Mental Health and resulted from increased usage of Bank instead of Agency.

Medical and Dental Agency pay

Month	Expenditure (£M)
Nov-23	1.2
Dec-23	1.2
Jan-24	0.7
Feb-24	1.3
Mar-24	1.0
Apr-24	1.2
May-24	0.9
Jun-24	0.9
Jul-24	1.2
Aug-24	1.2
Sep-24	0.8
Oct-24	0.9
Nov-24	1.0

- In-month spend of £1.0m, an increase of £0.1m compared with October (2023/24 average monthly spend of c.£1.2m). Pressures continue at a similar level to the prior period:
 - On-going expenditure in Mental Health for vacancies (although slight reduction in November), Frailty and Community Hospitals - c.£0.2m
 - Continued pressures in Medicine wards and Urgent Care to cover operational pressures – c.£0.5m
 - Trauma & Orthopaedics costs for junior rota (vacancies), Ophthalmology vacancy cover and ENT c.£0.2m

	• In-month spend of £0.9m, a reduction of £0.1m compared to October (2023/24 average monthly spend of c.£1.5m). • Reasons for use of registered nurse agency include: ◦ Vacancy, sickness and maternity cover ◦ Additional service demand • On-going costs in GUH Emergency Department and Medicine wards (total c.£0.6m) linked to enhanced care, sickness pressures as well as vacancy cover. • Mental Health and Primary Care agency costs of c.£0.2m mainly linked to enhanced care cover.
	• In-month spend of £0.2m on Estates & Ancillary agency, a reduction of £0.1m compared with October. • Reasons for use of agency include: ◦ Meeting enhanced cleaning standards, ◦ Other additional surge capacity, ◦ Sickness, ◦ Vacancies • Estates and Ancillary agency spend averaged £0.65m per month 2023/24.
	• In month spend of £0.04m on HCSW agency, a similar level to previous months (2023/24 average monthly spend of c.£0.16m). • Areas where spend remains are: ◦ MH&LD £11k ◦ Family & Therapies (CAMHS) £23k ◦ PCCS (Community hospitals) £9k

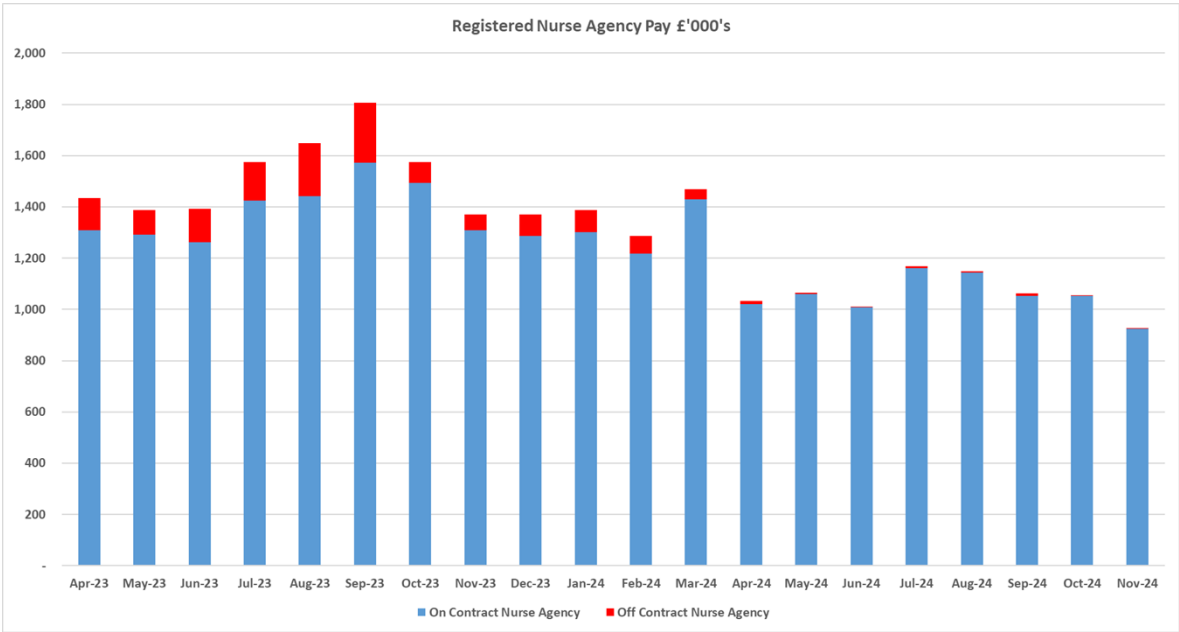
Registered Nurse Agency

Health Board spend on RN Agency in November 2024 is £0.9m, a similar level seen in October 2024. If spend continues at the average of 2024/25 levels throughout the financial year then spend on RN agency would be c.£13m.

Registered nurse agency spend totalled £17.7m in 2023/24, £22m in 2022/23, £22.8m in 2021/22, £18.1m in 2020/21 and £10.2m in 2019/20.

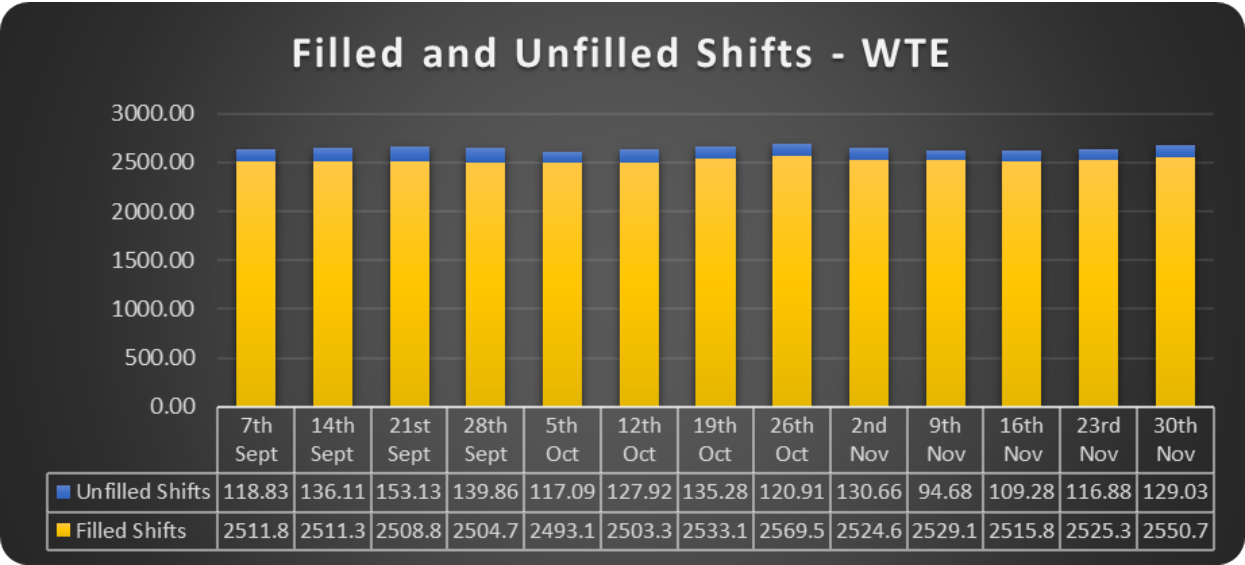
The use of “off-contract” agency i.e. not via a supplier on an approved procurement framework usually incurs higher rates of pay, is minimal but remains a last resort for the Health Board.

Off-contract Registered Nursing agency costs are now at minimal levels (£2k in November, £4k in October) which is a significant improvement compared to previous financial years. Agency costs reflect the on-going vacancy cover as well as usage for other operational pressures within Mental Health (£1.5k) and Medicine (£0.4k) for Enhanced care, sickness and vacancies.

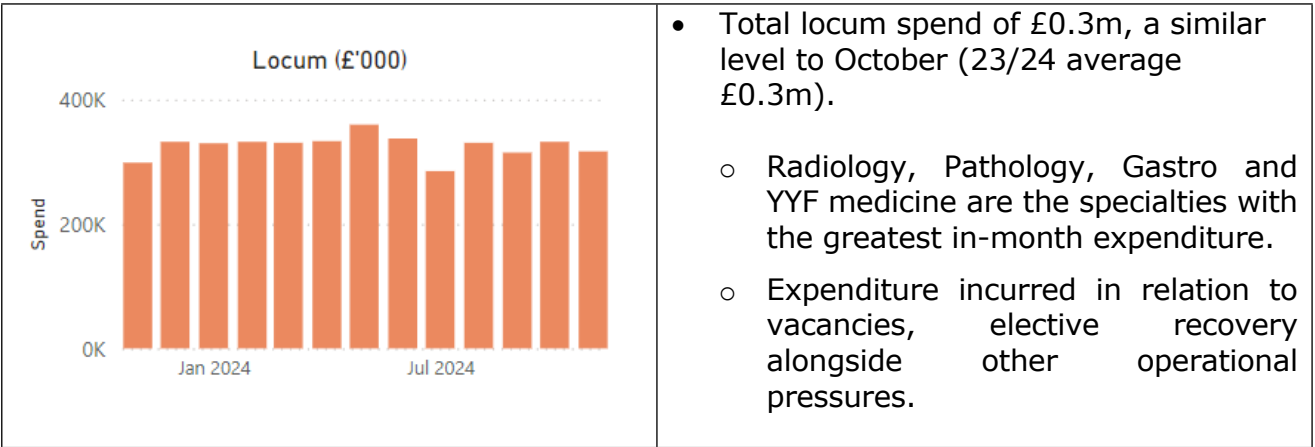


Implications of Nursing Shift 'Fill Rate'

There are high levels of unfilled shifts within the Health Board. Whilst filling these shifts may improve workforce and service provision, there would be an increased cost. In November there were approximately 98 unfilled registered nursing shifts and 480 unfilled HCSW shifts. The increase in substantive appointments continues to decrease the level of unfilled shifts which should demonstrate service improvement but presents a financial risk in terms of the variable pay saving opportunity due to possible increased availability to cover more shifts. The graph below shows the overall filled and unfilled shifts over the last 3 months.



Medical locum staff

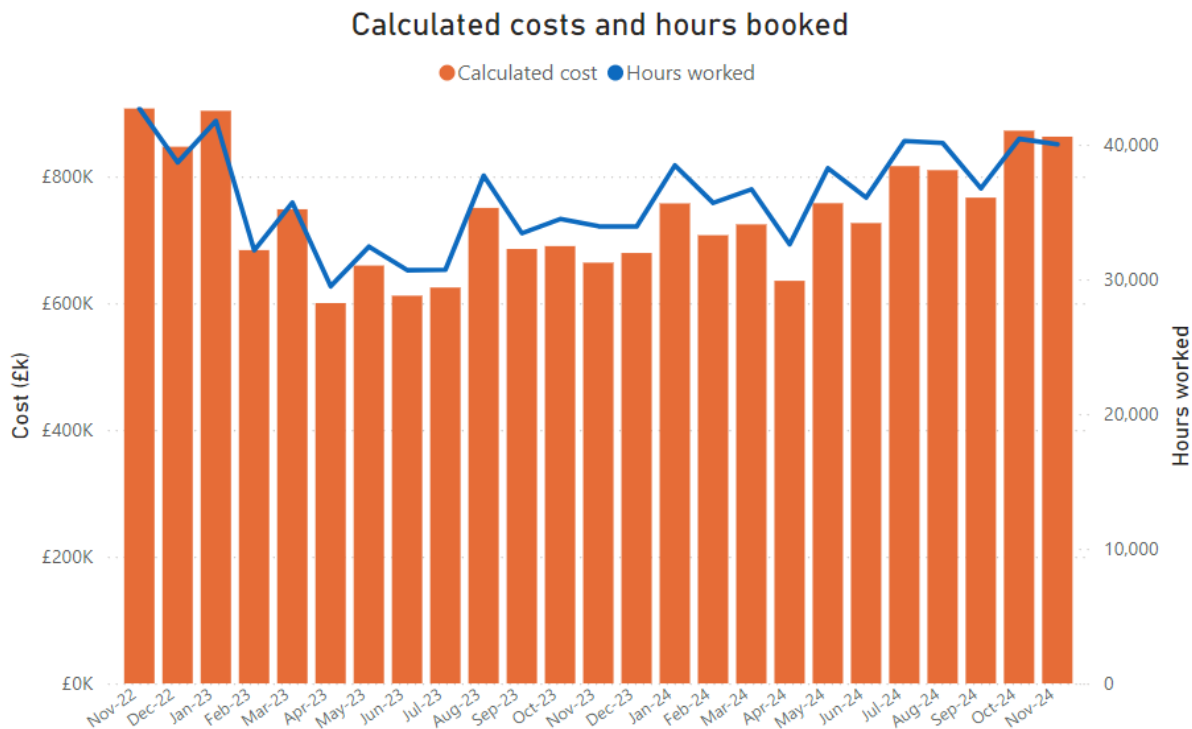


Enhanced Care

Enhanced Care, also known as 'specialling', can be provided for a variety of reasons ranging from the provision of assistance to mobilise a patient or avoid falls through one-to-one patient monitoring. Enhanced care is designed to ensure an appropriate level of safety and supervision for patients with additional care needs.

The following graph highlights the hours attributed to enhanced care and Mental Health levels of observation for the period November 2022 to November 2024 (£0.9m 'notional calculated' expenditure in November) using bank and agency registered nurses and health care support workers.

Enhanced Care (inc. MH levels of observation) bank and agency calculated costs and hours booked.



The level of the provision of enhanced care for patients within the Medicine Division for 2024/25 is shown below.

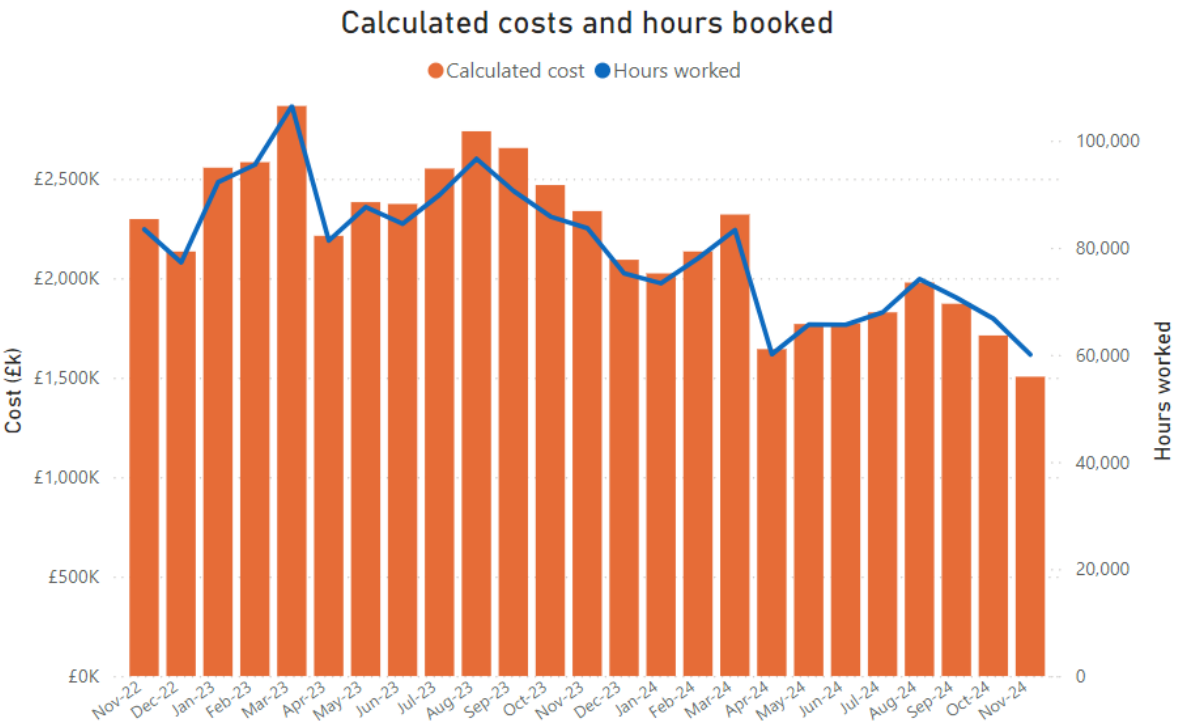
	2023/24 average	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
RGH									
Total no of Medicine beds	192	192	192	192	192	192	192	192	192
Monthly average enh care patients	34	28	26	21	21	26	25	25	24
%age of beds in receipt of enh care	18%	15%	14%	11%	11%	14%	13%	13%	13%
NHH									
Total no of Medicine beds	164	164	164	164	164	164	164	164	164
monthly average enh care patients	22	23	16	18	21	26	30	29	25
%age of beds in receipt of enh care	13%	14%	10%	11%	13%	16%	18%	18%	15%
GUH									
Total no of Medicine beds	91	91	91	91	91	91	91	91	91
monthly average enh care patients	12	13	15	12	11	13	12	12	15
%age of beds in receipt of enh care	13%	14%	16%	14%	13%	14%	13%	13%	16%
YYF									
Total no of Medicine beds	148	148	148	148	148	148	148	148	148
monthly average enh care patients	24	27	22	24	26	25	24	22	18
%age of beds in receipt of enh care	16%	18%	15%	16%	18%	17%	16%	15%	12%
Total									
Total no of beds	595	595	595	595	595	595	595	595	595
Total monthly average enh care patients	92	91	79	75	80	90	91	88	82
	15%	15%	13%	13%	13%	15%	15%	15%	14%

A review of enhanced care was presented to the Value & Sustainability Board in July. This presents a valuable opportunity to avoid costs and improve patient experience. Work is being led by the Nurse Director as a quality and savings initiative.

Nursing vacancy cover

The graph below presents the bank and agency hours and costs relating to those shifts where 'to cover vacancies' is provided as the reason for use. The graph highlights that in November 2024 variable pay relating to vacancies is c.£1.5m ('notional calculated' expenditure).

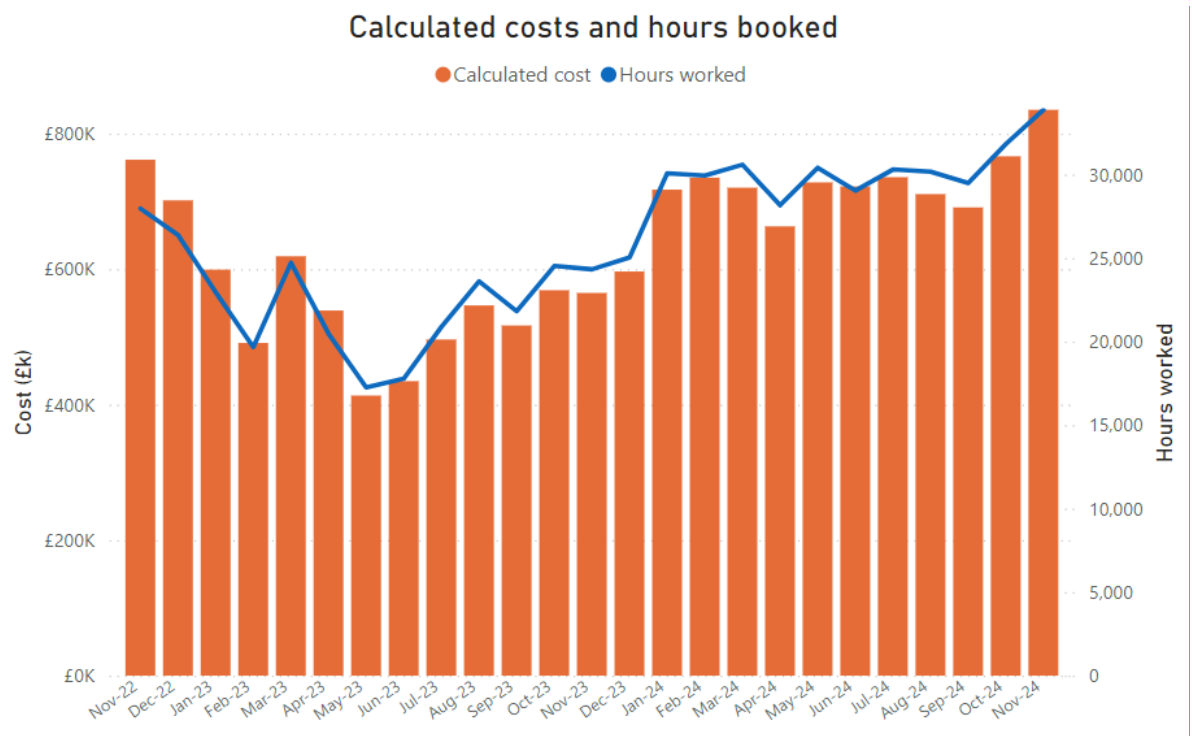
Calculated bank and agency costs / hours booked to cover shifts resulting from vacancies.



Nursing sickness cover

The graph below presents the bank and agency hours and costs relating to those shifts booked to cover sickness as input onto the e-roster system. The graph highlights that in November 2024 variable pay relating to sickness is c.£0.8m ('notional calculated' expenditure).

Calculated bank and agency costs / hours booked to cover shifts resulting from sickness.

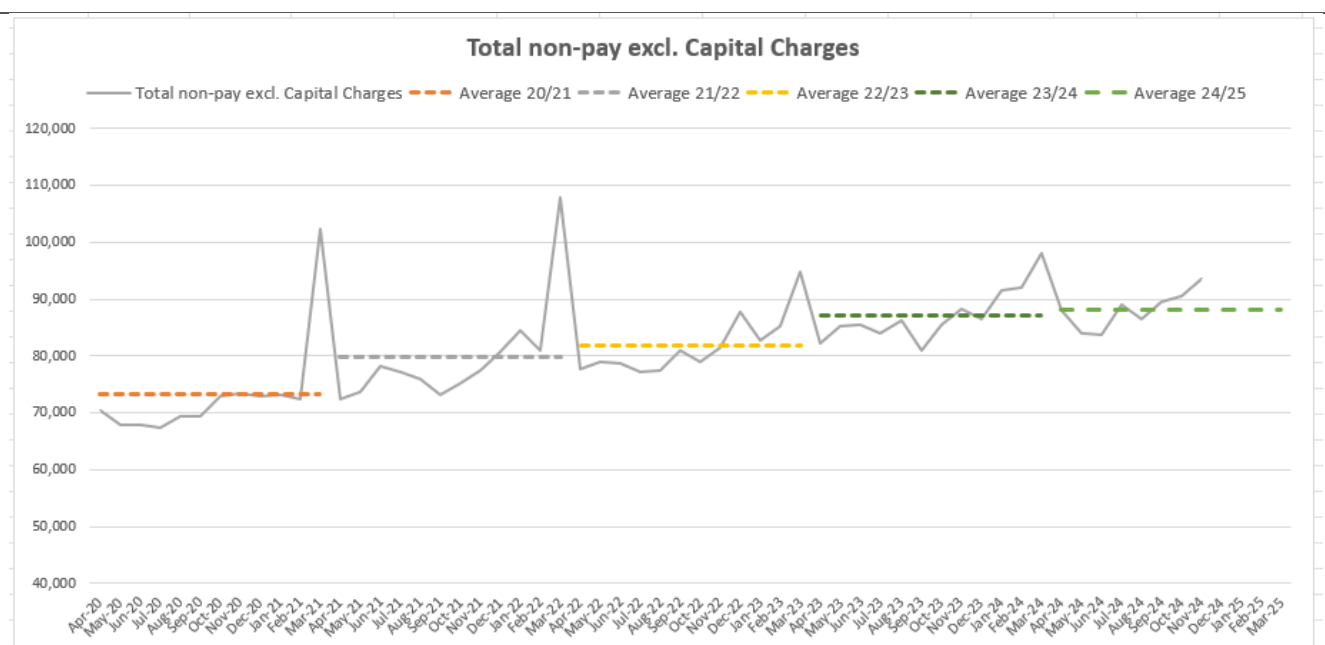


Non-Pay

Spend (excluding capital) was £93.5m in November, which is a £3.0m increase when compared with October spend (£90.5m). The increase is due to in-month items listed below:

- Pharmacy contract payments made in-month of £1.2m (£1.8m full year), based on additional Pharmacy Contract Framework funding received.
- Funded WHSSC expenditure for Vertex Q2 (£1.4m), plus WAST *Ambulance Radio Replacement Programme* (ARRP) and *Control Room Solutions* funding (£0.2m)
- non-cash limited spend as a result of dispensing/prescribing adjustments (£0.4m)

The graph below presents non-pay expenditure since April 2020 (it should be noted that the peaks are year-end adjustments and Month 12 items):



Energy

Energy costs remain a cost pressure with a forecast annual growth of £0.1m compared with 2023/24 expenditure following the last energy forecast received in June. The following table reflects the current position for 2024/25:-

Gas & Electricity	2022/23 Actuals £'000	2023/24 Actuals £'000	2024/25 Forecast £'000	2024/25 Plan £'000
Total Shared Service Contract Energy Cost	21,612	16,834	17,374	18,961
Total Other Energy costs	571	777	396	447
Total	22,183	17,611	17,770	19,408

Other energy costs outside of the shared service contract are under review. Given the volatility of non-commodity energy prices these may have further updates later in the year.

To note the budget relating to the reduced energy forecast (£1.66m) has been taken from the Estates & Facilities Division and returned to reserves to support the health board forecast.

CHC

- CHC Mental Health – the patient numbers at the end of November were 428 at a cost of £4.7m (October: 430 patients at a cost of £4.8m).
- CHC Adult / Complex Care - 553 total active placements on 30th November at a cost of £5.0m in-month (October: 539 placements at a cost of £4.9m). There was an increase in the number of D2A patients of 2 and an increase of 5 in the number of 'Step Closer to Home' (SCTH) patients in November.

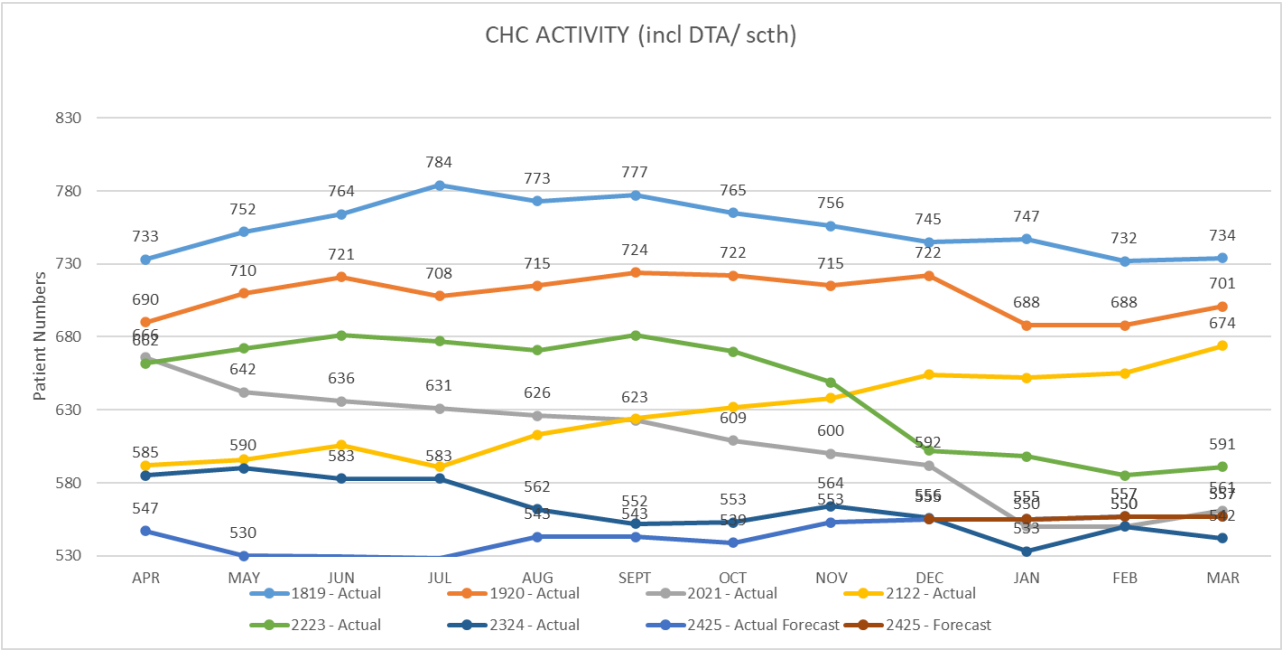
- A reduced number of patients on the step closer to home pathway is impacting the number of patients being discharged. This pathway is funded by the RPB and has previously had c.49 patients on the pathway, there are 11 in November. Utilisation is being reviewed.
- Newport Local Authority have negotiated and agreed uplifts to their nursing rates for 2024/25 (8.5% as opposed to the annual plan assumption uplift of 7.7%) which will impact the rate the Health Board pays. Care at Home staffing forecasts have decreased but continue to present a forecast financial pressure.
- The table below summarises the current position (patient numbers and costs):

Activity	November 2024	October 2024	Movement
D2A	18	16	+2
Step Closer to Home	11	6	+5
All Other CHC	524	517	+7
Total	553	539	+14

Activity	2024/25 forecast as at M8 £'000	2024/25 forecast as at M7 £'000	2023/24 out-turn position £'000
D2A	1,611	1,617	2,093
Step closer to home	207	207	407
All other CHC	41,511	41,626	41,053
Total	43,329	43,450	43,553

- FNC - currently 1,081 active placements, which is an increase of 8 compared with October (expenditure of £1m in both October and November).

Adult Complex Care CHC activity over the last seven financial years is summarised in the chart below: -



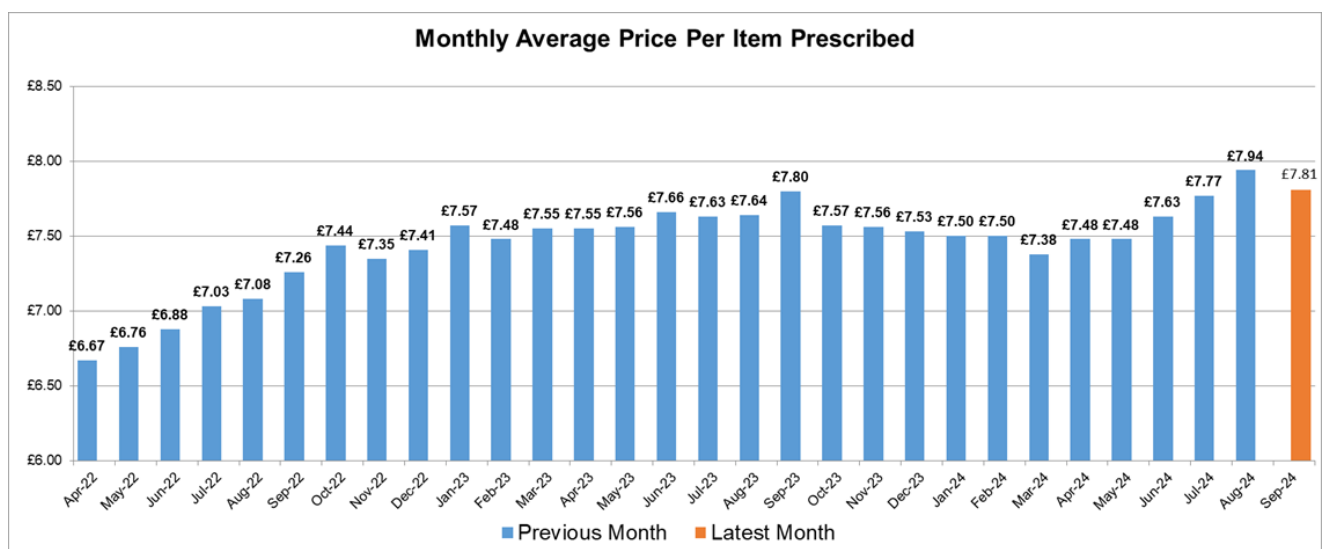
- CHC Paediatric – currently 25 Out of County patients, cost for November of c.£0.2m, a similar level compared with October. Forecast 24/25 spend is currently £0.8m which is unchanged from October. 2023/24 total cost was £4.1m, this was higher in comparison due to a number of high value backdated cases in 23/24 and a successful dispute resolution in 24/25. In addition, there are 12 internal packages (12 patients) provided during November compared with 11 packages (11 patients) in October.

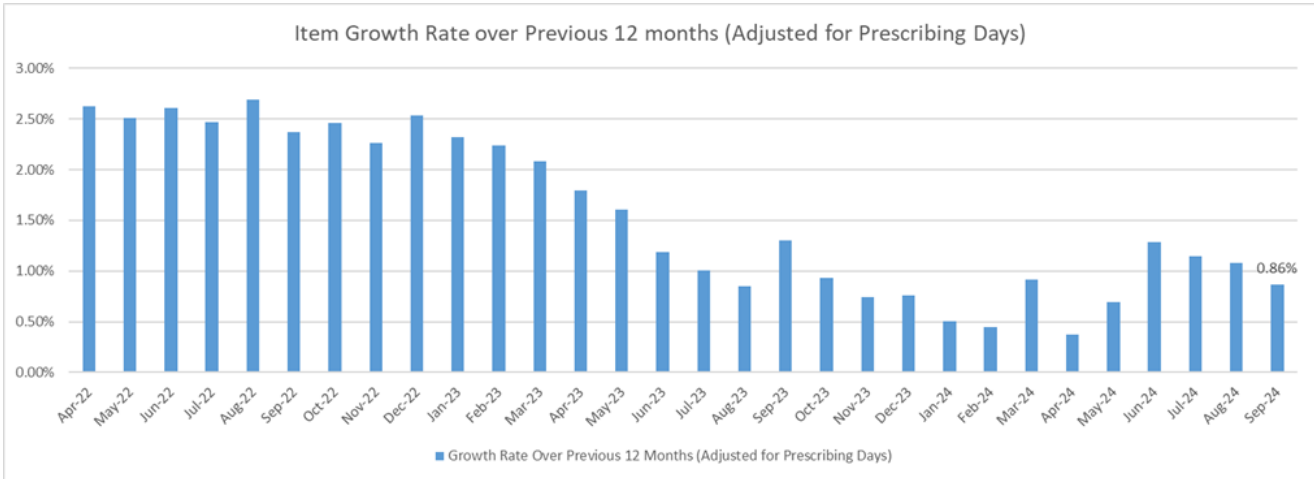
There are 9 external and 6 internal high cost packages which continue to be a cost pressure (>£100k per annum expenditure each).

Prescribing

- Primary Care prescribing – November 2024 expenditure is £10.8m, with a full year forecast cost of £123m, the annual plan forecast was £116.9m spend (2023/24 cost was £121.9m). The November 2024 costs are based on September PAR data:
 - Annual Plan item growth rate for 2024/25 of 0.8%, (forecast volume of items based on the number of prescriptions for 24/25 is c.15.9m)
 - The growth rate for the 12 months to September 2024 is 0.86%, adjusted for the number of prescribing days.
 - Forecast average cost per item for 2024/25 is £7.71 (unchanged from prior month) and is reflected in the increased forecast. The annual plan estimated £7.29 cost per item.
 - Average actual cost per item for 2022/23 was £7.21.
 - Average actual cost per item for 2023/24 was £7.57.

The graphs below show the monthly average price per item and item growth: -





Scheduled Care treatments and outpatients

Elective Treatments for November '24 is 2,151 (October '24: 2,470).

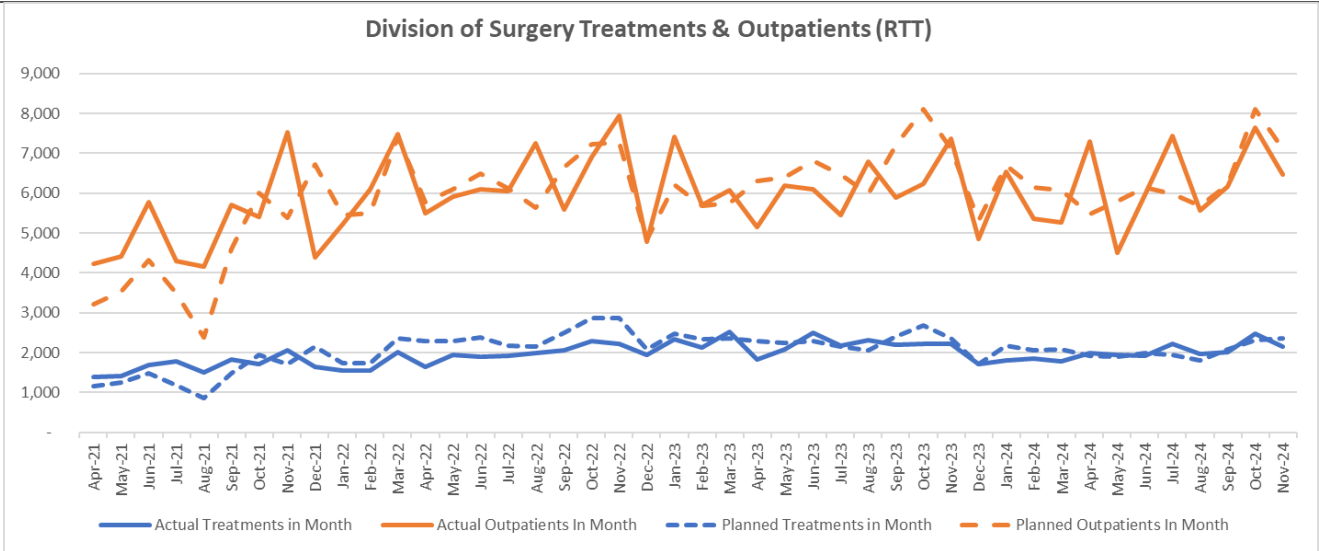
Elective Activity in November has reduced by 319 treatments compared with October (13%). The number of in month treatments are 208 below plan for November including 50 'backfill' and 27 WLI treatments. Increased activity to reduce Tier 1 waiting list targets remains a priority.

Outpatient activity for November '24 is 6,475 (October '24 was 7,646).

Outpatient activity has decreased by 1,171. Activity remains greater than previous years and includes backfill (109), WLI (323) and other activity (339) outside of core in order to reduce waiting list pressures for 104 and 156 week waits.

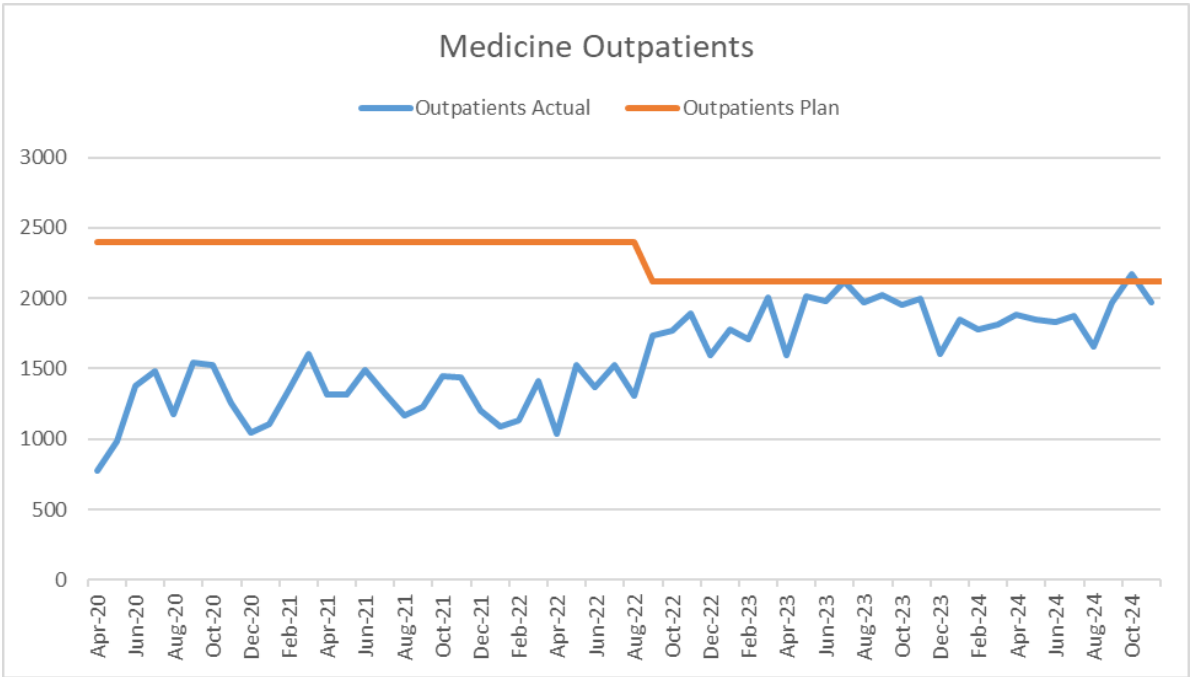
There were WLIs in-month for cancer treatments and elective work to improve the 156 week position for ENT (71 outpatients) and Max Fax (30 outpatients).

There remain significant efficiency opportunities in the delivery of elective care which need to be progressed as part of the Planned Care programme. The graph below presents performance compared to the current plan.



Medicine Outpatient Activity

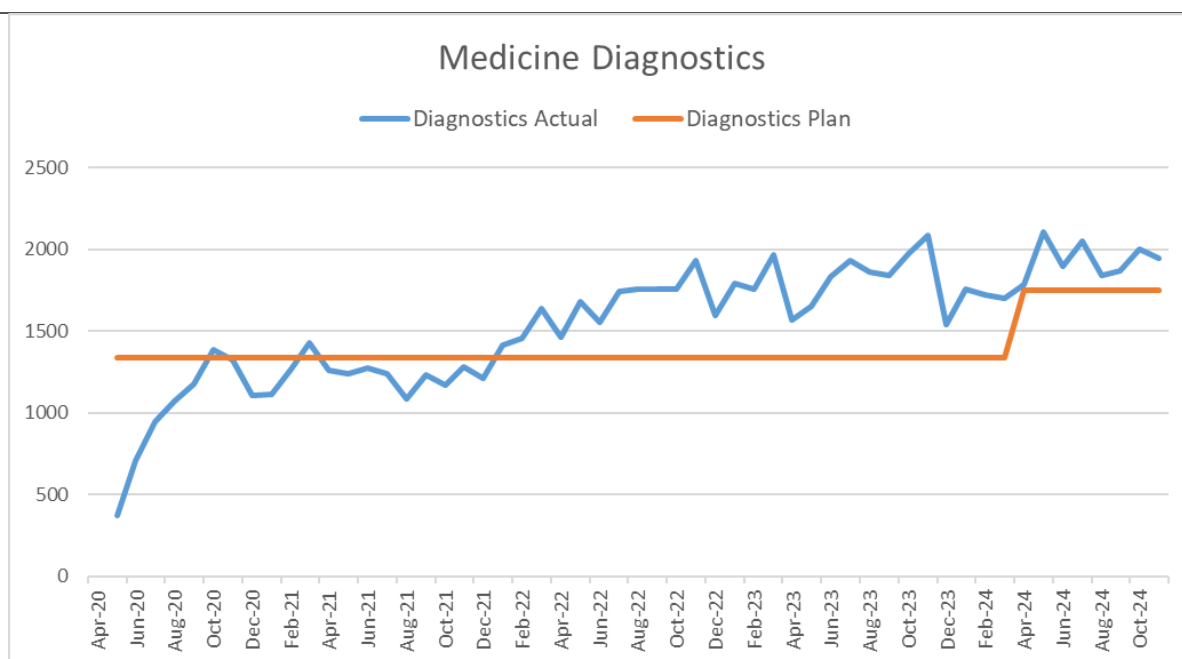
Medicine Outpatient activity for November '24 was 1,974 attendances, which was 142 below plan (October '24 was 2,169 attendances). The activity is presented below:



Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for November '24 was 1,944 procedures which is 195 cases more than the updated 2024/25 plan (October '24 activity was 1,999).

The activity undertaken since April '20 is shown below.



Divisional Forecast Analysis

Summaries of the Divisional financial positions are included in the appendices. These include expenditure and budget profiles along with a list of savings schemes and their current progress.

The table below identifies operational divisional forecasts. All budget holders are required to achieve a break-even position however a number of forecasts highlight key operational pressures and non-delivery of savings and COO budgetary stretch targets.

Summary Reported position - November 2024 (M08)	Full Year Budget £000s	Full-year Forecast at M08 £000s	Full-year Forecast at M07 £000s	Movement £000s
Operational Divisions:-				
Primary Care and Community	303,986	(518)	(424)	(94)
Prescribing	117,139	5,849	5,849	(0)
Community CHC & FNC	69,882	596	596	0
Mental Health & Learning Disabilities	146,132	81	437	(355)
Surgery	147,376	7,327	5,961	1,366
Clinical Support Services	133,162	1,350	923	426
Medicine	171,373	3,664	3,664	(0)
Urgent Care	41,770	179	178	0
Family & Therapies	143,022	2,253	2,144	109
Estates and Facilities	95,225	(483)	(483)	(0)

Key forecast movement issues include:-

- **Primary Care and Community** – Removal of recurrent community hospitals bed savings Feb/March (+£0.350m) offset by release of a non-recurrent GMS prior year provision (-£0.419m).

- **Prescribing** – increase in price offset by reduced growth so no change in the forecast for month 8 (based on September PAR).
- **Mental Health & LD** – Reduced variable pay due to reduced capacity in Older Adult wards (-£0.046m), Cedar intentionally kept vacant, CHC lower level of growth (-£0.165m) & asylum seeker income (-£0.02m).
- **Surgery** – Nursing with some increased levels of enhanced care (£0.15m), medical pay pressures (£0.138m), acute drugs (£0.541m) & removal of recurrent bed day & theatre efficiency savings (£0.3m).
- **Clinical Support services** – WLI rate increase (£0.09m), Ambulatory CEPOD (£0.05m), Pathology activity supporting endoscopy lists (£0.270m) & Theatres activity to support additional T&O lists in November (£0.035m).
- **Family & Therapies** – Gynae sickness and challenge around new rate card acceptance (£0.105m)
- **Estates and Facilities** – vacancy slippage (-£0.125m), non pay (-£0.086m) offset with maintenance (£0.089m) & energy (£0.109m)

The expectation and requirement is for Divisional forecasts to be break-even, but some of the current Divisional forecast positions present a risk to achieving the planned forecast deficit of £7.356m.

To note the forecast is underpinned by the following:

- COO £1.1m budget surplus
- Corporate Budget performance
- Budget reserves release, and
- All anticipated income

Covid-19 – 2024/25 Revenue Financial Assessment

Total Covid-19 costs are shown as £12.4m for which funding has been received as part of the Health Board's allocation letter and is broken down as follows:-

- Health Protection and Immunisation (Mass Vaccination) - £10.080m
- PPE - £1.120m
- Adferiad (Long Covid) - £1.216m

The expenditure reported is reflective of the funding.

The Health Board continues to have surge capacity open which is a legacy of Covid-19 responses. The Health Board also continues to incur legacy costs which form part of the underlying deficit linked to estates & facilities costs. The list below is not exhaustive but includes: -

- Enhanced Cleaning

- Additional security and rental of portacabins

Revenue Reserves

Health Board reserves are held by the Board, until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer. Agreed funding delegations approved by the Board in March 2024 as part of budget setting have been actioned. Those adjustments which are part of the stage 2 budget delegation process were approved on the 22nd May and have also been delegated. Some allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific commitment.

An amount of £1.426m is being held in the reserve '*Innovation and Development fund*' for approval by the CEO and Board as required for in year priorities.

A summary of all Health Board reserves on 30th November can be found in the appendices.

Long Term Agreements (LTA's)

LTAs have been agreed with all provider and commissioners with the exception of CTMUHB. This is being taken forward by the Chief Executives and Directors of Finance from each organisation.

Since month 5 Aneurin Bevan is reflecting an element of in year underperformance against the contracted activity (£1.4m) and this has been shown as a difference in the Income / Expenditure assumptions in table D between Aneurin Bevan and CTM, where CTM are only reflecting part of the underperformance.

ABUHB has recognised the JCC current end of year forecast deficit risk share at £0.887m, however there are risks reported on an overall basis, above this, that have not yet been recognised. Including:

- Savings achievement – overall plans to be found for £3m
- NHS England wage award – assumed funding from WG
- The transfer of Velindre non-specialist and drugs pass through, where funding will be transferred on a 23/24 basis – no variances against this are currently shown as it was not clarified in the JCC IMTP but could be c£1.2m pressure for ABUHB
- WAST - Risk for Technician re-bandings, if JCC choose to accept responsibility for the cost as a commissioner.
- Any over-performance as a result of meeting the Ministers KPI's i.e. plastic surgery.

JCC are working on options to a breakeven plan, they will provide a full update on the forecast to the JCC and potential options required to break even overall, this may then result in a revised forecast for ABUHB.

Underlying Financial Position (ULP)

The underlying (U/L) forecast position brought forward into 2024/25 was a deficit of £81.4m, and the carry forward underlying deficit for 2025/26 was estimated as £55m. This has now been revised to a deficit of £14.5m following notification from Welsh Government of additional recurrent (baseline and conditional) funding of £40.5m.

The underlying deficit was updated to £55m in month 4, and following the additional funding notified in November, the revised analysis of the carried-forward underlying deficit is as follows:-

Forecast 2024/25 deficit at month 4	£48.9m
Non-recurrent savings	£6.1m
Underlying deficit reported at month 4	£55.0m
Additional WG funding	(£40.5m)
Underlying deficit reported at month 8	£14.5m

The underlying deficit will be subject to review to consider further changes in year, such as non-recurrent savings and full year impacts of savings & spend.

Financial sustainability is an on-going priority and focus for the Health Board and a 3-year recovery delivery plan is being developed following the agreed route map to sustainability as part of the 2025/26 IMTP process.

The assessment indicated the cost drivers included in the table below as underpinning the c/f underlying position;

Underlying deficit 2024/25	2024/25 Deficit / (surplus) (£m)
WG 2023/24 non-recurrent funding utilised to support workforce cost growth including variable pay	14
Medical staffing cost increases due to operational acuity including ED safer staffing and demand	13
Nursing pressures - due to nurse staffing act, additional capacity resulting from DTOCs, Acuity and urgent care	12
CHC	10
Medicines management (prescribing and acute drug costs)	19
Covid legacy (estates & facilities)	7
WHSSC / EASC (service growth in excess of funded levels)	6
Total underlying deficit b/f into 2024/25	81

After budget-setting Divisions were expected to break-even whilst the annual plan deficit of £48.9m is shown as a pressure within reserves.

The pressures listed are assumed to be recurrent however will be reviewed as part of on-going underlying deficit assessments to assess whether these can be mitigated

and/or whether some of the issues can be made non-recurrent thus reducing the underlying deficit.

Underlying deficit c/f 2024/25	Primary Care & Community £m	Complex Care £m	MH&LD £m	Surgery / CSS £m	Medicine £m	Urgent Care £m	F&T £m	E&F £m	External commissioning £m	Central £m	Total £m
WG 2023/24 non-recurrent funding utilised to support workforce cost growth			3.0	3.0	5.5	1.0	1.5				14.0
Medical staffing cost increases due to operational acuity including ED safer staffing				1.0	1.5	3.0	1.0				6.5
Nursing pressures - due to nurse staffing act, additional capacity resulting from DTOCs, Acuity and Urgent Care			2.5		2.5	1.0	1.0				7.0
CHC		1.5	3.5				1.0				6.0
Medicines management (prescribing and acute drug costs)	7.0			2.0	2.0						11.0
Covid legacy (estates & facilities)								3.0			3.0
WHSSC / EASC (service growth in excess of funded levels)									5.0		5.0
Cancer additional activity delivery through WLI and additional diagnostics				2.5							2.5
Additional funding notified from WG in November										(40.5)	(40.5)
Total	7.0	1.5	9.0	8.5	11.5	5.0	4.5	3.0	5.0	(40.5)	14.5

It is important to note that although the 2023/24 mid-year support allocation funding of £64.5m (£28.9 underlying deficit + £35.6m inflationary uplift) is recurrent in the Health Board's 2024/25 allocation letter, it is **conditional** on making progress towards achievement of the WG target control total. The control total for the Health Board has been revised to £7.356m (previously £13m) following notification of the additional £40.5m of funding, however the conditional nature of the £64.5m remains a Health Board assumption until Welsh Government confirm otherwise. If this, or any other funding is clawed back by WG it will directly impact the forecast deficit.

Savings delivery

As part of the annual plan submitted by the Board to Welsh Government, the financial plan for 2024/25 identified an ambitious savings target of £40.5m.

As at month 8, forecast savings are £43.2m which supports achievement of the revised forecast of £7.356m. Mitigating actions would be required for additional operational pressures, for non-delivery of forecast savings or to improve the position and deliver further underlying improvement.

The month 8 savings forecast includes several Divisional schemes which are assumed not to deliver against their initial plan, these are included in the Appendix but include the following:-

- Administrative & Clerical savings – several divisions

- CHC contract price reductions – removed following legal advice.
- CHC hospital admissions / Premium contract cost reduction – removed following legal advice.
- Bed day and Theatre efficiencies (Surgery)
- Intersite transport (COO) – contract value likely to be higher than forecast due to additional vehicle usage.
- Bed reconfiguration and efficiency schemes – Medicine and Community Hospitals.

In addition there are savings plans which have a high level of risk given the requirement for further detailed plans and potential delays in implementation, these schemes include:-

- Theatre efficiencies - Clinical Support Services
- Other schemes including bed contract and CHC savings

Other areas are currently being examined which may develop into new savings plans to mitigate the risks described above these include:-

- CHC package reviews
- Non-pay and litigation cost reductions
- Income / funding opportunities
- Variable pay mitigation through review of pay rates and substantive appointments, including enhanced care
- Further medicines management schemes
- Service redesign and theatre efficiency
- Prescribing cost avoidance, off-patent and related reviews
- National V&SB opportunities
- RPB funding to cover reduced bed rationalisation plans due to winter pressures

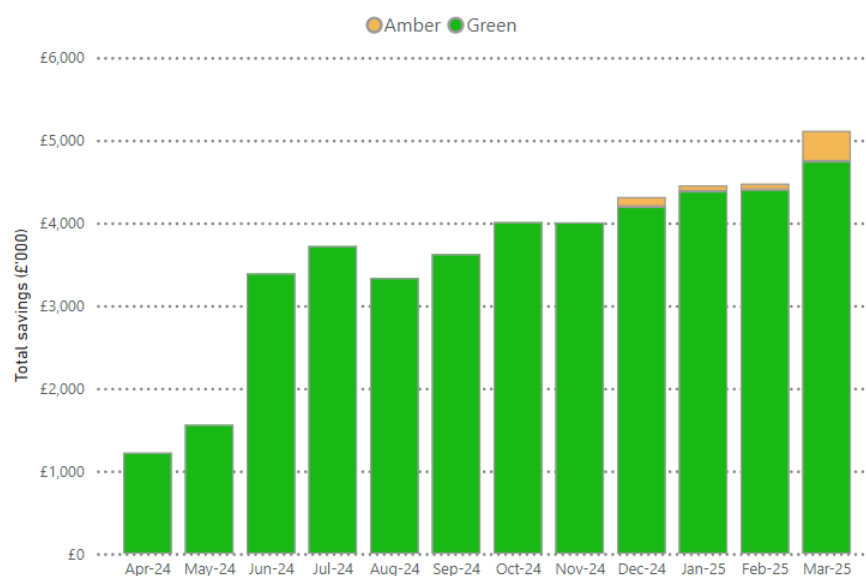
Actual savings delivered to date for 2024/25 are £24.9m.

The table below presents the updated savings plan at a Budget holder level:

Savings YTD and forecast position (£'000)

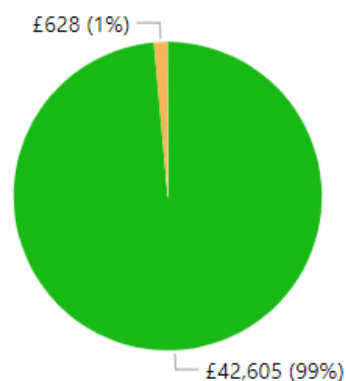
Division	% of total Plan	Annual Plan	YTD Plan	YTD Achieved	YTD Variance	Forecast	Forecast variance to Plan	% Achieved
Clinical Support Services	2.1%	£846	£457	£707	£250	£1,091	£245	128.9%
Complex Care	9.0%	£3,633	£1,712	£1,539	-£173	£2,903	-£731	79.9%
Contracting and Commissioning	1.7%	£706	£426	£1,526	£1,100	£2,356	£1,650	333.7%
Corporate	17.7%	£7,164	£4,261	£4,000	-£261	£6,271	-£893	87.5%
Estates and Facilities	6.5%	£2,640	£1,527	£2,571	£1,043	£4,166	£1,526	157.8%
Families and Therapies	2.1%	£857	£509	£460	-£50	£923	£65	107.6%
Medicine	6.9%	£2,801	£1,517	£1,835	£318	£3,836	£1,035	137.0%
Mental Health and Learning Disabilities	14.6%	£5,906	£3,127	£2,343	-£783	£4,976	-£930	84.2%
Primary Care and Community	28.1%	£11,385	£6,644	£7,158	£514	£12,600	£1,215	110.7%
Surgery	4.6%	£1,855	£980	£863	-£117	£1,269	-£586	68.4%
Urgent Care	0.2%	£81	£50	£116	£66	£211	£129	259.0%
WHSSC	6.5%	£2,633	£1,696	£1,755	£59	£2,633	-£0	100.0%
Total	100.0%	£40,508	£22,907	£24,873	£1,966	£43,234	£2,726	106.7%

Achieved / forecast savings by RAG rating



Forecast savings

(values in £'000)



Savings summary (£'000)

Value & Sustainability category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to Plan	Full-year Annual Plan	Full-year Forecast savings	Full-year Variance to plan
CHC	14	£4,154	£3,159	-£995	£8,443	£6,712	-£1,731
Medicines Management	16	£2,015	£2,506	£491	£3,518	£5,387	£1,869
Procurement & Non-pay	108	£9,065	£11,634	£2,569	£15,115	£18,566	£3,451
Service Redesign	8	£1,588	£785	-£803	£3,624	£1,852	-£1,772
Workforce	61	£6,084	£6,789	£705	£9,808	£10,717	£908
Total	207	£22,907	£24,873	£1,966	£40,508	£43,234	£2,726

WG Category	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	6,712	1,440	5,272	5,278
Commissioned Services	4,839	0	4,839	4,839
Medicines Management	5,386	1,526	3,860	5,002
Pay	11,423	1,406	10,017	11,932
Non Pay	14,874	6,984	7,889	8,490
Total	43,234	11,356	31,878	35,540

The Health Board will continue to pursue further opportunities to mitigate / offset the risk to the planned savings and increases in new operational pressures.

The Health Board continues to operate a Bi-weekly Value & Sustainability Board to identify and monitor savings delivery & new opportunities.

There are significant challenges and some opportunities to achieving the financial forecast for 2024/25, which include:

Risks

The Health Board is looking for options to 'de-risk' the forecast but risks remain.

- Continuing Healthcare fee uplifts - £0.6m
- Prescribing average price per item (and number of items) growth above September PAR data and associated forecast - £1.4m
- JCC Performance – Risk associated with WHSSC achievement of savings target. Health Board figure calculated based on risk-share agreement - £1.0m

- Additional operational and service pressures outside of the annual plan. This includes costs for acute NICE drugs, Diabetes, CAMHS, Winter and the infected blood inquiry - £2.4m
- Delivery of savings plans including mitigating actions against operational pressures – c.£0.8m
- Under delivery of 6 goals target with resultant income clawback risk - £1.4m
- Risks of non-receipt (or full receipt) of anticipated income in particular funding for Optometry and the balance of the International Nurse recruitment - £1.5m
- CTM LTA not signed by CTM and under performance not recovered £1.4m
- National Pay inflation not fully funded for either bank £0.5m or vacancies
- Non achievement of the conditions set for receiving the £30.5m new funding

In addition, there are several further significant challenges to the financial forecast for 2024/25, which are currently assumed to be mitigated by the Health Board or require further information to enable an accurate financial value to be assigned. These include:

- Ensuring full delivery of savings plans identified in the annual plan including the pipeline opportunity values,
- Receipt of all anticipated allocations including performance requirements to secure full retention,
- Workforce absence / vacancies, availability of staff for safe service delivery,
- Delayed transfers of care due to LA service challenges,
- Funding for any wage award or change in terms and conditions,
- Impact on service delivery and performance on waiting times because of savings required,
- Establishment increases relating to patient safety issues,
- Inflationary impacts including provisions and supplies,
- Additional revenue costs due to IFRS 16,
- Specific economic factors such as supply chain issues and non-pay inflation including travel expense costs.

Opportunities

The following items are listed as opportunities pending further analysis and delivery via the Value & Sustainability Board and relevant Divisions / Departments:

- Variable pay reduction linked to Administration & Clerical and Enhanced Care service review
- Service re-design – bed reductions
- Commissioning – LTAs and EASC

- VAT rebate opportunities,
- Other income / funding opportunities,
- Efficiency delivery,
- Energy forecast changes,
- Work to identify new pipeline opportunities, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.

Capital

The approved Capital Resource Limit (CRL) as at Month 8 totalled £65.258m, including disposal proceeds of £0.035m. The forecast outturn at Month 8 is breakeven.

The Health Board confirmed the CRL requirements for all All-Wales Capital Programme (AWCP) schemes at the end of October. Any slippage past this date is required to be being managed by the Health Board through brokerage with the Discretionary Capital Programme (DCP). Forecast slippage against AWCP schemes totalling £0.856m (detailed below) will now be brokered with the DCP by accelerating forward urgent discretionary schemes that would otherwise be funded in 2025/26.

The VAT reclaim for the Grange University Hospital scheme has been agreed by HMRC and included in the latest VAT return. The CRL allocation has been adjusted to (£6.481m) to reflect the repayment of the additional VAT recovery totalling £2.997m to Welsh Government.

Phase 2 of Bevan Health and Well-being Centre (demolition of the existing Health Centre and car-parking) is anticipated to complete in December 24. Additional funding totalling £2.558m has been approved by WG in month in relation to costs for inflation allowances on works and fees, EV charging, foundation changes and the brickwork supply delay. The additional funding has offset the previously reported overspend and replenished the contingency allocation to cover remaining compensation events that are yet to be agreed. The £0.100m underspend reflected at Month 8 relates to the reimbursement to the DCP for the overspend funded during 2023/24.

Slippage of £1.491m was approved in October for the works at NHH Satellite Radiotherapy Centre due to delays in relation to asbestos. The handover of the building is now expected to be delayed until April 2025. The overall scheme is forecast to be £0.363m under budget largely because of additional VAT recovery.

Construction of 19 Hills Health and Well-being Centre (Newport East) is nearing completion. Phase 1 handover is forecast to be January 2025. The overall project forecast overspend has increased in month to £0.313m due to the inclusion of forecast costs relating to S111 Highways works (£0.220m – works yet to be formally agreed). The overspend is currently being funded by the DCP.

The forecast overspend in relation to the RGH Blocks 1 & 2 Demolitions and Car Park scheme has been removed in month as the scheme is not anticipated to complete during the current financial year. The revised programme and any further slippage will be confirmed in Month 9.

The CAMHS Sanctuary Hub scheme is complete, and the building has been handed over to the Health Board. The Health Board has submitted a request to WG to obtain approval to reallocate the additional VAT recovery savings generated to fund a disabled access ramp for the unit.

Slippage of £1.881m was approved in October in relation to the Grange Emergency Department Extension scheme due to reported delays. The anticipated completion of Phase 1 is now May 2025 with Phase 2 estimated to be August 2025.

The Backlog Maintenance allocation is reporting slippage of £0.901m due to delays associated with the St Cadoc's Duct and NHH/RGH List replacement schemes. This slippage will need to be brokered via the DCP.

Additional funding of £0.818m has been received in month in relation to the approval of Centralised Decontamination Unit at RGH. The underspend of £0.139m against this scheme relates to the reimbursement to DCP for fees incurred in prior financial years. The Health Board has also received notification of a further £1.921m Diagnostic and Medical Equipment allocation approval which is expected to be included in the CRL in December.

The Health Board Discretionary Capital Programme (DCP) forecast for 2024/25 is £9.662m at Month 8 made up of:

- 2024/25 DCP Funding - £10.814m
- Less 30% EFAB contribution - (£0.725m)
- Less 2023/24 AWCP scheme brokerage - (£1.669m)
- Plus 2023/24 DCP scheme brokerage - £0.350m
- Plus 2024/25 AWCP scheme brokerage - £0.856m
- Plus Disposal Proceeds - £0.035m

During the month, the additional funding allocations detailed above for the Bevan H&WBC and RGH Centralised Decontamination schemes have reimbursed the DCP. In addition, slippage against AWCP schemes of £0.846m is now required to be brokered via DCP. This means the remaining **DCP contingency has increased to £3.547m**. A list of essential works schemes and urgent equipment and IT replacements are now being progressed via capital group for approval to fully use the remaining budget.

Cash

The cash balance at the 30th November is £3.275m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in November (98.8%) and for the year to date (97.7%). ABUHB is continuing to work with those departments where invoices are being processed outside of the 30-day payment terms and where the NHS payment rate is below target.

The Health Board performance for the number of NHS creditors within 30 days of delivery of goods in November is 93.3%, which is an improvement compared with October (90%) however remains below target. NHS Invoices in breach of the 30-day payment terms continue to be followed up accordingly with Divisional Managers as necessary. Further correspondence will be sent to other Health Board's to reiterate the need for purchase orders to be provided in advance and not retrospectively.

Category	Invoices	In Mth %	YTD %
NHS	Value	98.7	97.5
	Number	93.3	91.3
Non NHS	Value	98.3	96.3
	Number	98.8	97.7

Argymhelliad / Recommendation

The Board is asked to note for assurance:

- The financial performance at the end of November 2024 and forecast position against the statutory revenue and capital resource limits,
- The savings position for 2024/25,
- The revenue reserve position on the 30th November 2024,
- The Health Board's underlying financial position,
- The cash position,
- Public sector payment policy performance, and

- The capital position.

Note: the appendices attached providing further detailed information.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources Governance, Leadership & Accountability All Health & Care Standards Apply Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	ABUHB efficiency compendium
Rhestr Termau: Glossary of Terms:	A&C – Administration & Clerical A&E – Accident & Emergency A4C - Agenda for Change AME – (WG) Annually Managed Expenditure AQF – Annual Quality Framework AWCP – All Wales Capital Programme AP – Accounts Payable AOF – Annual Operating Framework ATMP – Advanced Therapeutic Medicinal Products B/F – Brought Forward

BH – Bank Holiday
 C&V – Cardiff and Vale
 CAMHS – Child & Adolescent Mental Health Services
 C/F – Carried Forward
 CHC – Continuing Health Care
 Commissioned Services – Services purchased external to ABUHB both within and outside Wales
 COTE – Care of the Elderly
 CRL – Capital Resource Limit
 Category M – category of drugs
 CEO – Chief Executive Officer
 CEAU – Children’s Emergency Assessment Unit
 CTM – Cwm Taf Morgannwg
 D&C – Demand & Capacity
 DCP – Discretionary Capital Programme
 DHR – Digital Health Record
 DNA – Did Not Attend
 DOSA – Day of Surgery Admission
 D2A – Discharge to Assess
 DoLS - Deprivation of Liberty Safeguards
 DoF – Director(s) of Finance
 DTOC – Delayed Transfer of Care
 EASC – Emergency Ambulance Services Committee
 ED – Emergency Department
 EDCIMS – Emergency Department Clinical Information Management System
 eLGH – Enhanced Local general Hospital
 EFAB – Estates Funding Advisory Board
 ENT – Ear, Nose and Throat specialty
 EoY – End of Year
 ETTF – Enabling Through Technology Fund
 F&T – Family & Therapies (Division)
 FBC – Full Business Case
 FNC – Funded Nursing Care
 GDS – General Dental Services
 GMS – General Medical Services
 GP – General Practitioner
 GWICES – Gwent Wide Integrated Community Equipment Service
 GUH – Grange University Hospital
 GIRFT – Getting it Right First Time
 HCHS – Health Care & Hospital Services
 HCSW – Health Care Support Worker
 HIV – Human Immunodeficiency Virus
 HSDU – Hospital Sterilisation and Disinfection Unit

H&WBC – Health and Well-Being Centre
 IMTP – Integrated Medium Term Plan
 INNU – Interventions not normally undertaken
 IPTR – Individual Patient Treatment Referral
 I&E – Income & Expenditure
 ICF – Integrated Care Fund
 LoS – Length of Stay
 LTA – Long Term Agreement
 LD – Learning Disabilities
 MH – Mental Health
 MSK – Musculoskeletal
 Med – Medicine (Division)
 MCA – Mental Capacity Act
 MDT – Multi-disciplinary Team
 MMR – Welsh Government Monthly Monitoring Return
 NCA – Non-contractual agreements
 NCN – Neighbourhood Care Network
 NCSO – No Cheaper Stock Obtainable
 NI – National Insurance
 NICE – National Institute for Clinical Excellence
 NHH – Neville Hall Hospital
 NWSSP – NHS Wales Shared Services Partnership
 ODTC – Optometric Diagnostic and Treatment Centre
 OD – Organisation Development
 PAR – Prescribing Audit Report
 PCN – Primary Care Networks (Primary Care Division)
 PER – Prescribing Incentive Scheme
 PICU – Psychiatric Intensive Care Unit
 PrEP – Pre-exposure prophylaxis
 PSNC – Pharmaceutical Services Negotiating Committee
 PSPP – Public Sector Payment Policy
 PCR – Patient Charges Revenue
 PPE – Personal Protective Equipment
 PFI – Private Finance Initiative
 RGH – Royal Gwent Hospital
 RN – Registered Nursing
 RRL – Revenue Resource Limit
 RTT – Referral to Treatment
 RPB – Regional Partnership Board
 RIF – Regional Integration Fund
 SCCC – Specialist Critical Care Centre
 SCH – Scheduled Care Division
 SCP – Service Change Plan (reference IMTP)
 SLF – Straight Line Forecast

	SpR – Specialist Registrar STW – St.Woolos Hospital TCS – Transforming Cancer Services (Velindre programme) T&O – Trauma & Orthopaedics TAG – Technical Accounting Group UHB / HB – University Health Board / Health Board USC – Unscheduled Care (Division) UC – Urgent Care (Division) ULP – Underlying Financial Position VCCC – Velindre Cancer Care Centre VERS – Voluntary Early Release Scheme WET AMD – Wet age-related macular degeneration WG – Welsh Government WHC – Welsh Health Circular WHSSC – Welsh Health Specialised Services Committee WLI – Waiting List Initiative WLIMS – Welsh Laboratory Information Management System WRP – Welsh Risk Pool YAB – Ysbyty Aneurin Bevan YTD – Year to date YYF – Ysbyty Ystrad Fawr
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Finance & Performance Committee

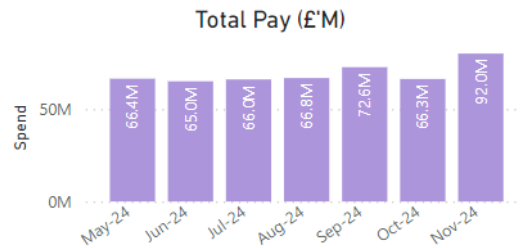
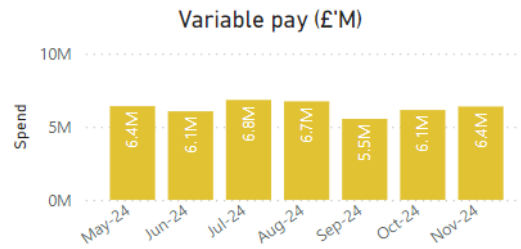
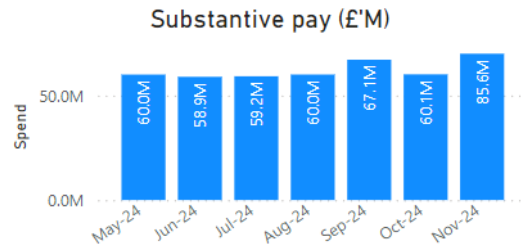
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper No does not meet requirements
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or 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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Aneurin Bevan University Health Board
Finance Report – November (Month 8) 2024/25
Appendices

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Pay Summary (1) (excluding 6.7% Pension employer costs paid in March of each year):



Substantive (£'000)

Pay category	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Change	%	Avg 23/24
ADD PROF SCIENTIFIC AND TECHNICAL	2,361	2,354	2,344	2,336	2,349	2,310	3,323	1,014	43.9%	2,245
ADDITIONAL CLINICAL SERVICES	8,320	8,054	8,118	8,214	7,890	7,990	10,637	2,647	33.1%	8,134
ADMINISTRATIVE & CLERICAL	9,847	9,619	9,572	9,659	9,409	9,546	13,353	3,807	39.9%	10,394
ALLIED HEALTH PROFESSIONALS	4,098	4,038	4,040	4,070	4,135	4,118	5,978	1,860	45.2%	4,140
ESTATES AND ANCILLIARY	3,191	3,061	3,038	3,157	3,062	3,082	3,870	788	25.6%	3,015
HEALTHCARE SCIENTISTS	1,168	1,157	1,155	1,153	1,134	1,184	1,702	518	43.8%	1,148
MEDICAL AND DENTAL	14,042	13,936	14,184	14,435	22,601	14,744	22,124	7,379	50.0%	14,112
NURSING AND MIDWIFERY REGISTERED	16,996	16,726	16,745	17,018	16,533	17,153	24,657	7,505	43.8%	16,722
STUDENTS	2	2	2	2	2	2	2	1	51.1%	3
Total	60,025	58,946	59,199	60,043	67,114	60,129	85,646	25,517	42.4%	59,912

Variable pay (£'000)

Pay category	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Change	%	Avg 23/24
Agency	2,318	2,286	2,852	2,805	1,627	2,271	2,121	-151	-6.6%	3,527
Bank	3,727	3,427	3,690	3,595	3,590	3,537	3,939	403	11.4%	3,919
Locum	360	337	285	330	315	332	317	-15	-4.7%	299
Total	6,404	6,051	6,828	6,730	5,532	6,140	6,377	237	3.9%	7,746

Total pay (£'000)

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Change	%	Avg 23/24
Pay	66,429	64,997	66,026	66,774	72,646	66,269	92,023	25,754	38.9%	67,658

Pay Summary (2): Substantive Pay: Additional pay elements

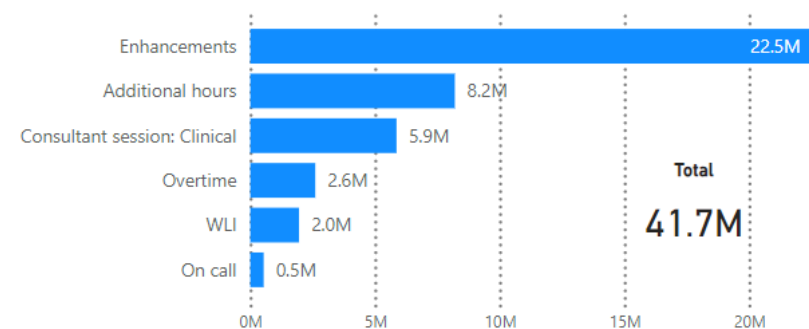
Substantive staff additional pay by period and Division



Total additional pay by Division (£'000)

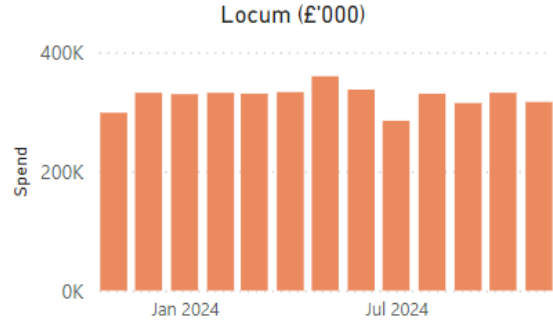
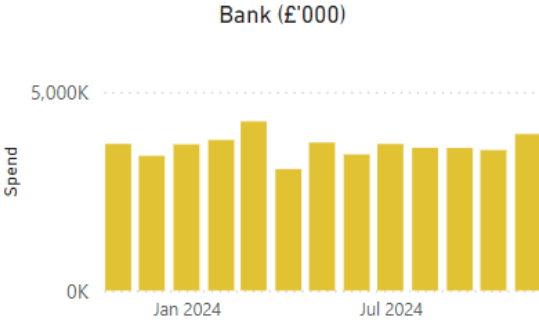
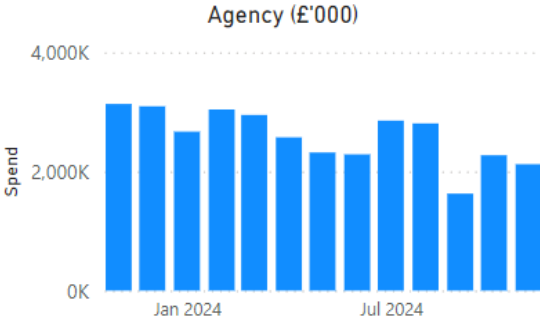
Division	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Total
Medicine	1,250	1,288	1,131	1,160	1,565	6,394
Surgery	746	823	842	748	1,000	4,158
Clinical Support Services	661	696	758	664	942	3,722
Family and Therapies	536	611	523	529	728	2,927
Urgent Care	443	460	395	415	602	2,316
Primary Care and Community	407	454	421	434	582	2,299
Estates and Facilities Division	389	446	361	396	529	2,121
Mental Health and LD	349	367	297	319	472	1,805
CHC and FNC	130	144	80	111	185	649
Corporate	58	63	57	-291	93	-21
Total	4,970	5,352	4,865	4,484	6,697	26,369

Total additional pay costs YTD 24/25

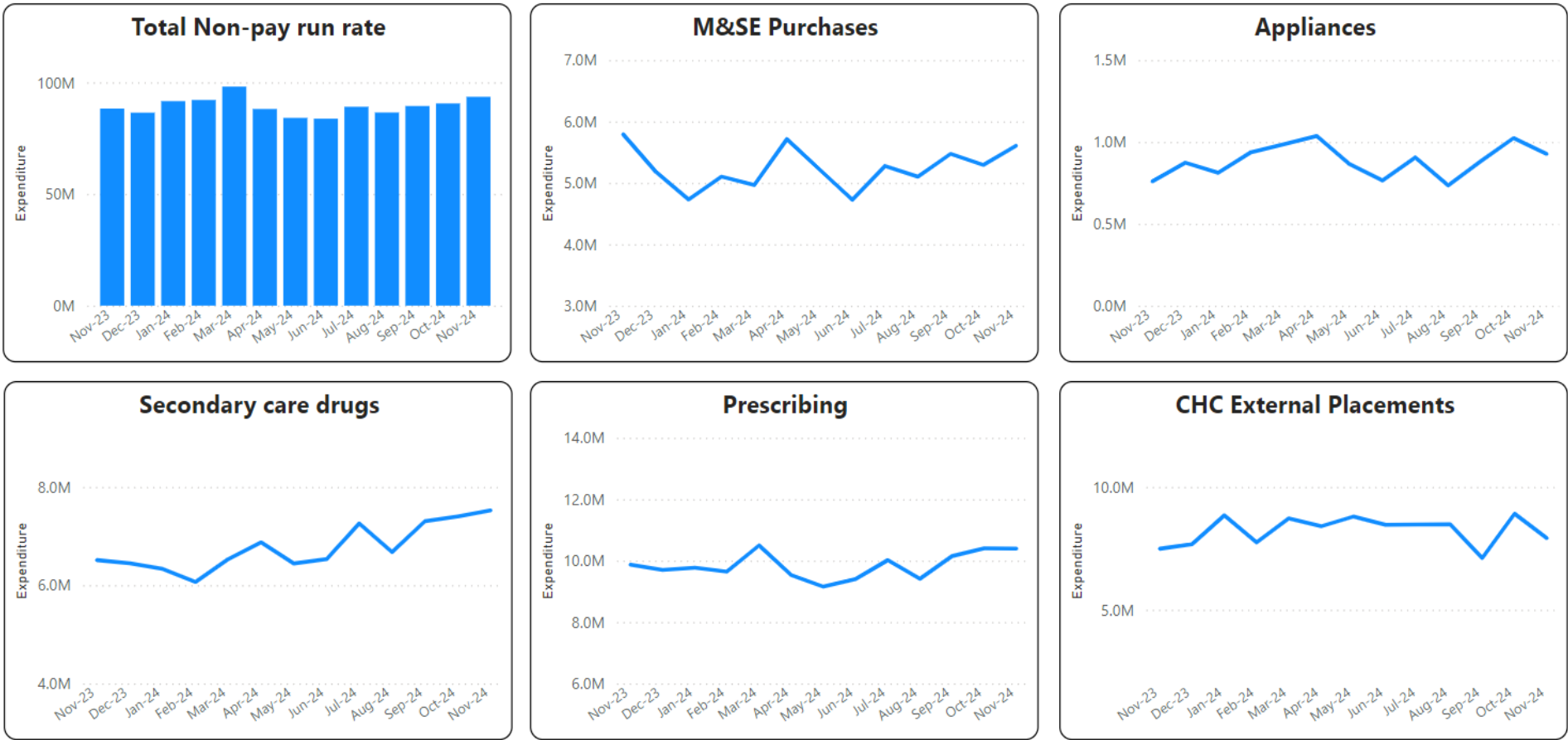


Pay Summary (3): Variable Pay (£'k)

Pay category	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Change	%	Avg 23/24
Agency																
Admin & Clerical Agency	38	29	67	82	59	28	8	19	-4	6	12	-6	-47	-41	737.0%	59
Allied Health Prof Agency	165	135	120	86	82	102	105	162	132	128	105	132	148	16	12.3%	153
Estates & Ancilliary Agency	246	281	239	184	232	205	139	78	188	176	-446	78	36	-42	-53.3%	401
Medical Agency	1,187	1,166	690	1,274	938	1,124	869	902	1,201	1,227	792	876	962	86	9.8%	1,222
Nurse HCA/HCSW Agency	79	89	65	88	59	26	39	38	57	37	39	58	43	-15	-25.4%	157
Other Agency	47	21	99	39	109	53	94	77	109	82	63	76	51	-25	-33.3%	60
Registered Nurse Agency	1,369	1,371	1,388	1,286	1,469	1,034	1,064	1,011	1,169	1,150	1,064	1,056	927	-130	-12.3%	1,475
Total	3,132	3,093	2,668	3,040	2,948	2,571	2,318	2,286	2,852	2,805	1,627	2,271	2,121	-151	-6.6%	3,527
Bank																
Admin & Clerical Bank	89	87	95	84	119	68	79	75	93	82	76	70	83	12	17.6%	95
Estates & Ancilliary Bank	224	243	254	235	263	218	257	249	263	260	256	252	287	35	13.9%	210
Nurse HCA/HCSW Bank	1,572	1,473	1,711	1,523	1,784	1,428	1,680	1,548	1,614	1,656	1,649	1,589	1,749	160	10.1%	1,614
Other Bank	-2	0	0	0	0	1	0	1	0	-1	0	0	5	5	-3303.3%	0
Registered Nurse Bank	1,808	1,589	1,620	1,949	2,093	1,345	1,711	1,555	1,721	1,598	1,608	1,625	1,816	190	11.7%	2,001
Total	3,692	3,392	3,681	3,790	4,259	3,060	3,727	3,427	3,690	3,595	3,590	3,537	3,939	403	11.4%	3,919
Locum																
Medical Locum	299	332	330	332	330	333	360	337	285	330	315	332	317	-15	-4.7%	299
Total	299	332	330	332	330	333	360	337	285	330	315	332	317	-15	-4.7%	299
Total	7,122	6,817	6,678	7,162	7,537	5,964	6,404	6,051	6,828	6,730	5,532	6,140	6,377	237	3.9%	7,746



Non-Pay Summary:



Referral to Treatment (RTT):

- Elective Treatments for Nov '24 was 2,151 (Oct '24: 2,470. 2023/24 total: 24,688, 22/23 total: 22,327, 19/20 total: 28,004)

Planned Treatments (M08)						Actual Treatments (M08)						Treatment Variance (M08)				
Treatment	Core	Backfill	WLI	Other	Total	Treatment	Core	Backfill	WLI	Other	Total	Treatment	Core	Backfill	WLI	Total
N107-Dermatology	181	0	0	0	233	N107-Dermatology	225	16	0		241	Derm	44	16	0	8
N147-ENT	122	0	0	0	136	N147-ENT	153	10	16		179	ENT	31	10	16	43
N105-General Surgery	284	0	0	0	328	N105-General Surgery	355	17	0		372	GS	71	17	0	44
N146-Oral Surgery	218	0	0	0	163	N146-Oral Surgery	245	0	0		245	Max Fax	27	0	0	82
N148-Ophthalmology	281	0	0	0	402	N148-Ophthalmology	341	0	0		341	Ophth	60	0	0	(61)
N108-Rheumatology	0	0	0	0	0	N108-Rheumatology	0	0	0		0	Rheum	0	0	0	0
N115-Trauma & Orthopaedics	503	0	0	0	660	N115-Trauma & Orthop	539	3	11		553	T&O	36	3	11	(107)
N106-Urology	390	0	0	0	436	N106-Urology	216	4	0		220	Urology	(174)	4	0	(216)
Total	2,153	206	0	0	2,359		2,074	50	27	0	2,151		(79)	(156)	27	(208)

- Outpatient activity for Nov '24 was 6,475 (Oct '24: 7,646. 2023/24 total: 71,165, 22/23 total: 65,873, 19/20 total: 75,707)

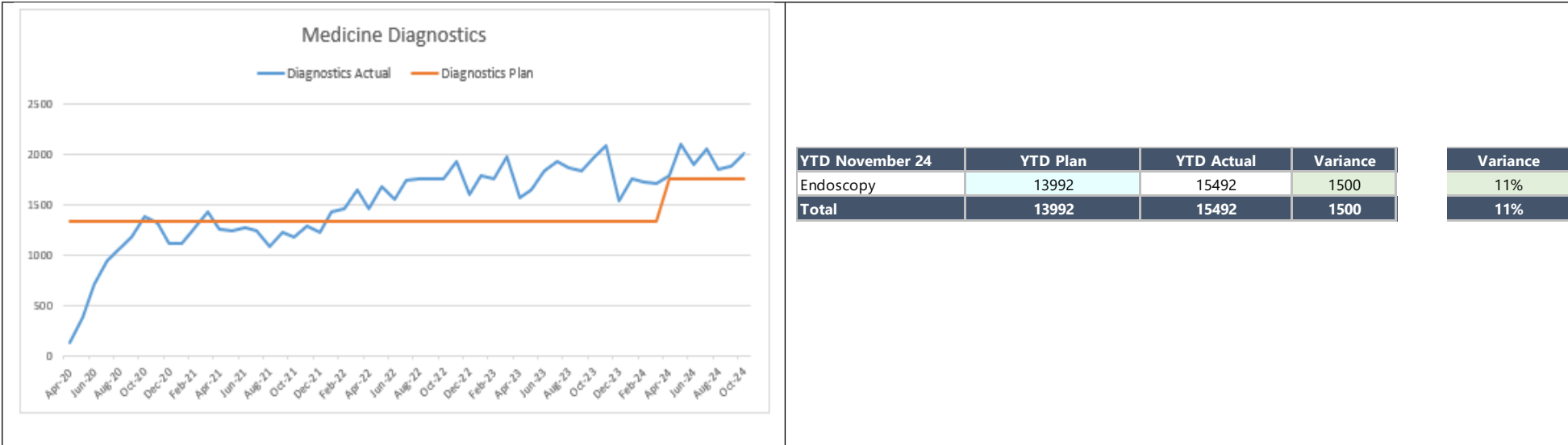
Planned Outpatients (M08)						Actual Outpatients (M08)						Outpatient Variance (M08)					
Outpatient	Core	Backfill	WLI	Other	Total	Outpatient	Core	Backfill	WLI	Other	Total	Outpatient	Core	Backfill	WLI	Other	Total
N107-Dermatology	1,361	0	0	0	1,339	N107-Dermatology	1,194	0	0	339	1,533	Derm	(167)	0	0	339	194
N147-ENT	449	0	0	0	645	N147-ENT	634	0	71	0	705	ENT	185	0	71	0	60
N105-General Surgery	1,651	0	0	0	1,703	N105-General Surgery	1,322	109	0	0	1,431	GS	(329)	109	0	0	(272)
N146-Oral Surgery	275	0	0	0	363	N146-Oral Surgery	281	0	30	0	311	Max Fax	6	0	30	0	(52)
N148-Ophthalmology	674	0	0	0	812	N148-Ophthalmology	684	0	0	0	684	Ophth	10	0	0	0	(128)
N108-Rheumatology	187	0	0	0	164	N108-Rheumatology	184	0	0	0	184	Rheum	(3)	0	0	0	20
N115-Trauma & Orthopa	871	0	0	0	1,663	N115-Trauma & Orthopa	810	0	218	0	1,028	T&O	(61)	0	218	0	(635)
N106-Urology	404	0	0	0	431	N106-Urology	595	0	4	0	599	Urology	191	0	4	0	168
Total	6,775	345	0	0	7,120		5,704	109	323	339	6,475		(1,071)	(236)	323	339	(645)

Medicine Outpatients activity for November '24 was 1,974 (Oct '24: 2,169, 2023/24: 22,708 2022/23: 19,258):

Nov-24			
	Assumed monthly activity	Actual activity	Variance
Gastroenterology	475	361	-114
Cardiology	430	385	-45
Respiratory (inc Sleep)	455	467	12
Neurology	257	312	55
Endocrinology	186	199	13
Geriatric Medicine	313	250	-63
Total	2116	1974	-142

Nov-24				
YTD	YTD Plan	YTD Actual	Variance	Variance
Gastroenterology	3800	3109	-691	-18%
Cardiology	3440	3005	-435	-13%
Respiratory (inc Sleep)	3640	3470	-170	-5%
Neurology	2056	2386	330	16%
Endocrinology	1488	1259	-229	-15%
Geriatric Medicine	2504	1977	-527	-21%
Total	16928	15206	-1722	-10%

Medicine Diagnostics activity for November '24 was 1,944 (Oct '24: 1,999, 2023/24: 21,466, 2022/23: 20,748):



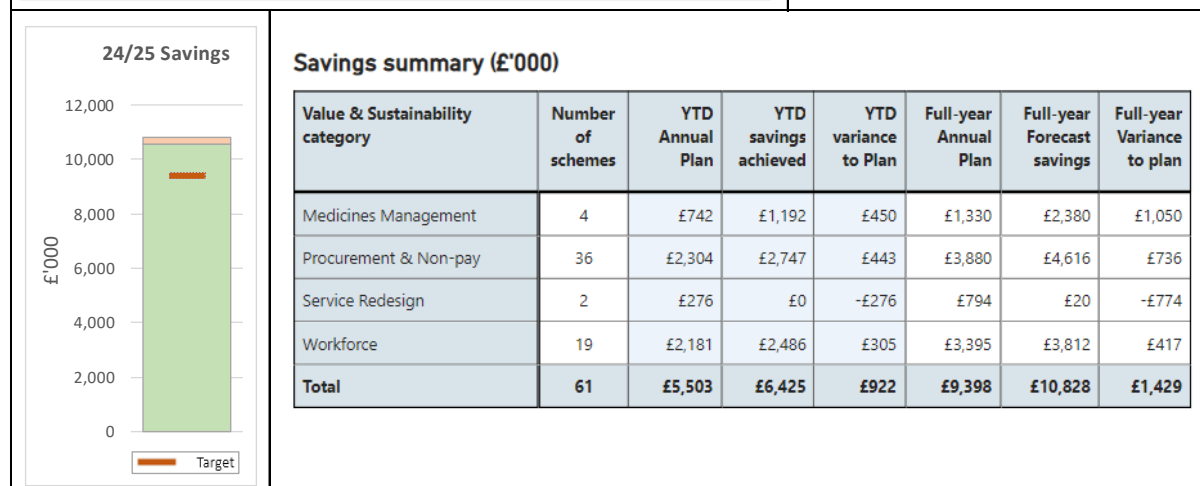
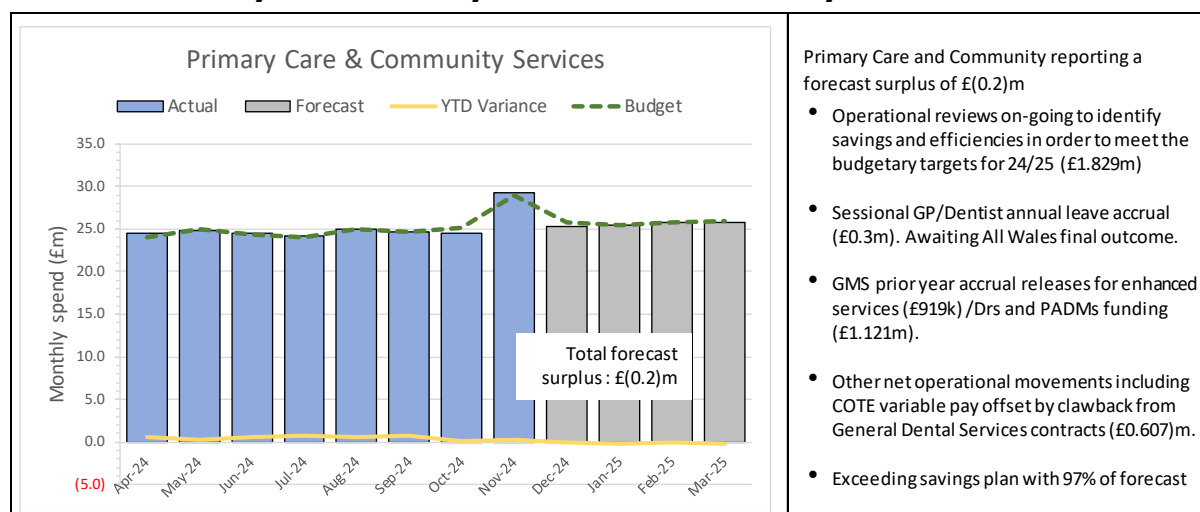
RAG rating category definitions

Savings schemes are categorised as *Red*, *Amber* or *Green* according to the certainty of the forecast achievement. Definitions for each rating are as follows:

- **Green scheme:** Started delivering in the current month or prior month and is expected to continue delivering for the remaining period.
- **Amber scheme:** Agreed plan in place and expected to deliver starting in a future month. Not yet started, therefore Amber due to the time factor risk.
- **Red scheme:** No plan in place and not expected to achieve.

The definitions are consistent with Welsh Government guidance and have been communicated to Divisions.

Divisional analysis – Primary Care and Community



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-02	Managed practices to independant status from 01/04/24	R	Month 1	Green	1,285	1,928	1,928	0
PCC-03	Revise Academy Offer	NR	Month 1	Green	284	426	426	0
PCC-04	Stoma Team Phase 2	NR	Month 1	Green	99	149	149	0
PCC-05	NHS wales reduction in enhanced mileage rate	R	Month 1	Green	40	60	60	0
PCC-06	Reduction in Medication/NonPay stock - Reduction in Drugs moving STW to RGH by using omniceII cabinets and bed side lockers, opportunity to introduce across other sites for bigger savings if found beneficial	R	Month 1	Green	20	30	30	0
PCC-07	Pharmacy Closures - Benefits within various fees & services (mainly establishment fee). Four community pharmacies due to close by April 24 along with one additional pharmacy following this. Saving of £35k each in the year though this would be a one-off saving	NR	Month 1	Green	117	175	175	0
PCC-08	Staffing - Current B5 post holder reduction in hours	R	Month 1	Green	5	10	10	(0)
PCC-09	Staffing - Review of nursing rota and opportunities to decrease specialist nurse rate	R	Month 1	Green	3	5	5	0
PCC-10	Staffing - Currently have one agency GP, bring this peron on substantive contract so cost of fees removed	R	Month 1	Green	5	10	10	(1)

Primary Care & Community savings schemes continued...

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-11	Reduction in Chepstow beds - 2 - Reducing 2 beds within Cas Gwent ward	R	Month 1	Green	113	204	204	(0)
PCC-12	E-rostering scrutiny and efficiency. Adopting additional scrutiny, process transparency and further/refresh training	R	Month 1	Green	2	10	10	0
PCC-13	Staffing structure review -Remove 8a role from structure	R	Month 1	Green	41	65	65	1
PCC-14	Redeployment of Business Administrator - Redeployment of B3 administrator following end of secondment. Role not required due to apprentice in post.	R	Month 1	Green	19	28	28	0
PCC-15	Business Intelligence / Data Analyst - If Data Analyst / Business Partner model continues to be provided by Information Services (current agreed via ACD/SPPC) there will be less requirement to backfill vacancy for a dedicated band 6 performance manager. Workplan/commitment needed from Corporate Information to reassess that work will be progressed on Division's behalf. May necessitate permanent recruitment of B6 business manager from within current structure, thereby releasing a band 5 role.	R	Month 1	Green	29	44	44	(0)
PCC-16	Review Management structure	R	Month 1	Green	51	76	66	(10)
PCC-17	Review Admin Structure	R	Month 1	Green	9	32	27	(5)
PCC-18	Review Professional structure	R	Month 1	Green	38	76	76	0
PCC-19	Removal of vacant part time physio post	R	Month 1	Green	12	18	18	0
PCC-20	111 funding redistribution	NR	Month 1	Amber	0	215	215	0
PCC-21	Non pay other - Look at opportunities including prescribing, Opex and Wireless Logic	R	Month 1	Green	6	10	10	0
PCC-22	Non pay premises rent - Explore accommodation opportunities. Currently UPC/GP OOH pick up costs for all P&CC care space within VPH which also includes SPA	R	Month 1	Red	0	30	0	(30)
PCC-23	Non-Pay reduction	R	Month 1	Green	26	22	34	12
PCC-24	Non-Pay reduction	R	Month 1	Green	(1)	10	(1)	(11)
PCC-25	Non-Pay reduction	R	Month 1	Green	8	10	10	0
PCC-26	Non-Pay reduction	R	Month 1	Green	5	10	10	0
PCC-27	Stock - Bring stock values in to balance sheet	NR	Month 1	Amber	0	66	66	0
PCC-28	Non pay review - Review stock, supplier usage, waste levels and training with a view to securing better prices / using less . Target 15% reduction.	R	Month 1	Green	70	109	109	0
PCC-29	Income opportunities - Increase charges to Llanarth Court to ensure costs are covered. Explore any other income generating opportunities	R	Month 1	Green	71	7	73	66
PCC-30	GDS contracts - Review service / number of sessions provided within the GDS contracts for OOHs, Blaenavon and Abertillery	R	Month 1	Green	40	60	60	0
PCC-31	Cessation of Hygiene Waste collection - Cessation of PHS contract and adoption of HB service supplier at saving of £2,000 per annum	R	Month 1	Green	1	2	2	0
PCC-32	Non Pay - Non Pay spend review to bring into line with budget for 24-25	R	Month 1	Green	5	5	5	0
PCC-33	Chase Project - Removal of this project	R	Month 1	Green	10	10	10	0
PCC-34	License Fees - No Longer needed	R	Month 1	Green	6	6	6	0
PCC-35	Reconfiguration of beds PCCS	R	Month 1	Red	0	750	0	(750)

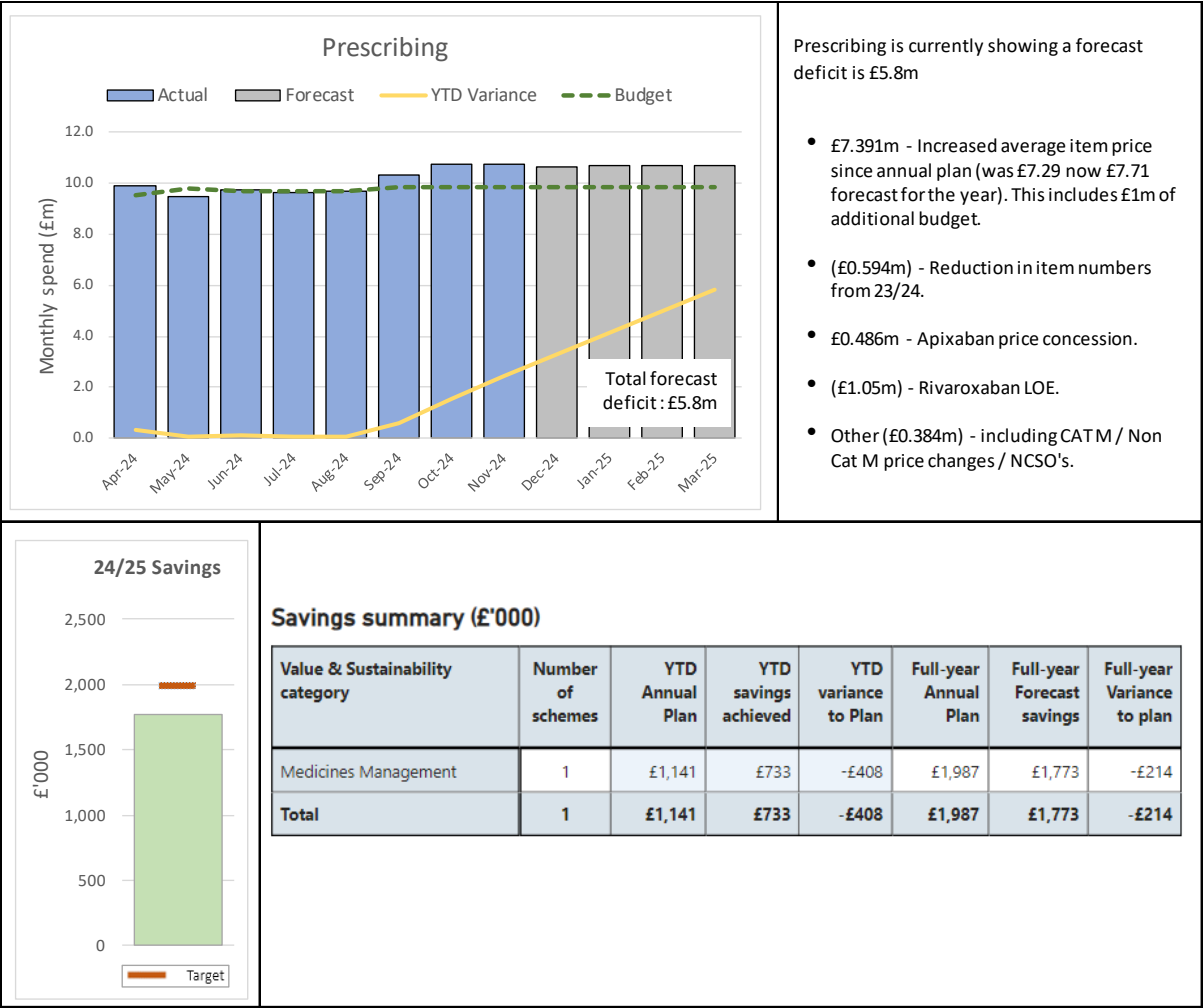
Primary Care & Community savings schemes continued...

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-36	Glyn Ebbw Closure	R	Month 1	Green	0	44	20	(24)
PCC-37	Staffing Structures in Community Dental Services	R	Month 1	Green	89	100	106	6
PCC-38	Additional clinical sessions LES	R	Month 1	Red	0	673	0	(673)
PCC-38a	Additional clinical sessions LES	NR	In Year	Green	449	0	673	673
PCC-39	Reduction in NCN areas	R	Month 1	Green	10	30	30	0
PCC-40	Relinquish Comms and Engagement agreement	R	Month 1	Red	0	30	0	(30)
PCC-41	GDS clawback savings - Corporate assessment	R	Month 1	Green	133	200	200	0
PCC-42	Dental patient charges	R	Month 1	Green	1,007	1,600	1,600	0
PCC-43	Administration & Clerical review savings (2%)	R	Month 1	Red	0	254	0	(254)
PCC-43a	Administration & Clerical review savings (2%)	NR	In Year	Green	259	0	289	289
PCC-44	Anti-viral cost mitigation / GP stock	R	Month 1	Red	0	1,300	0	(1,300)
PCC-44a	Anti-viral cost mitigation / GP stock	NR	In Year	Green	722	0	1,300	1,300
PCC-45	Optometry contract reduction	R	Month 1	Green	278	500	500	0
PCC-46	Nurse led Imms Team - under GMS Contract	R	In Year	Green	101	0	202	202
PCC-47	SLAs-Carers Collective Torfaen	NR	In Year	Green	30	0	45	45
PCC-48	SLAs-Carers Collective Monmouth	NR	In Year	Green	19	0	27	27
PCC-49	SLAs-British Red Cross Pan Gwent – Newport Hub	NR	In Year	Green	7	0	14	14
PCC-50	SLAs-Age Cymru Caerphilly	NR	In Year	Green	22	0	34	34
PCC-51	Llanarth House rates rebate	NR	In Year	Green	44	0	44	44
PCC-52	Ruperra - RTG Ward - Bed reduction and revised model	R	In Year	Green	191	0	398	398
PCC-53	GMS-HB Improvement Grant funding	NR	In Year	Green	133	0	200	200
PCC-55	SLAs - National Exercise Referral Scheme	NR	In Year	Green	8	0	12	12
PCC-56	ODTC & WET AMD - Activity cap	NR	In Year	Green	28	0	50	50
PCC-57	Rivaroxaban LOE - Price reduction	R	In Year	Green	450	0	1,050	1,050
PCC-58	Procurement saving for IV Giving Sets Switch	R	In Year	Amber	0	0	0	0
PCC-59	Hospital Pharmacy - Temperature Monitoring	R	In Year	Green	1	0	4	4
PCC-60	ODTC & WET AMD Implementation of WGOS4	R	In Year	Green	24	0	92	92
					6,425	9,398	10,828	1,429

Red savings schemes (listed above) over £200k

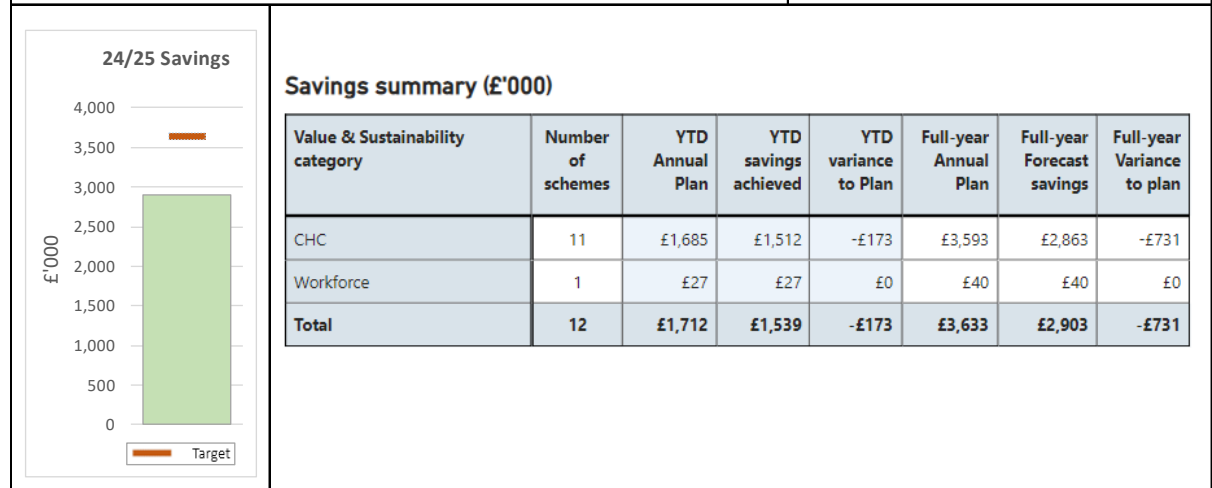
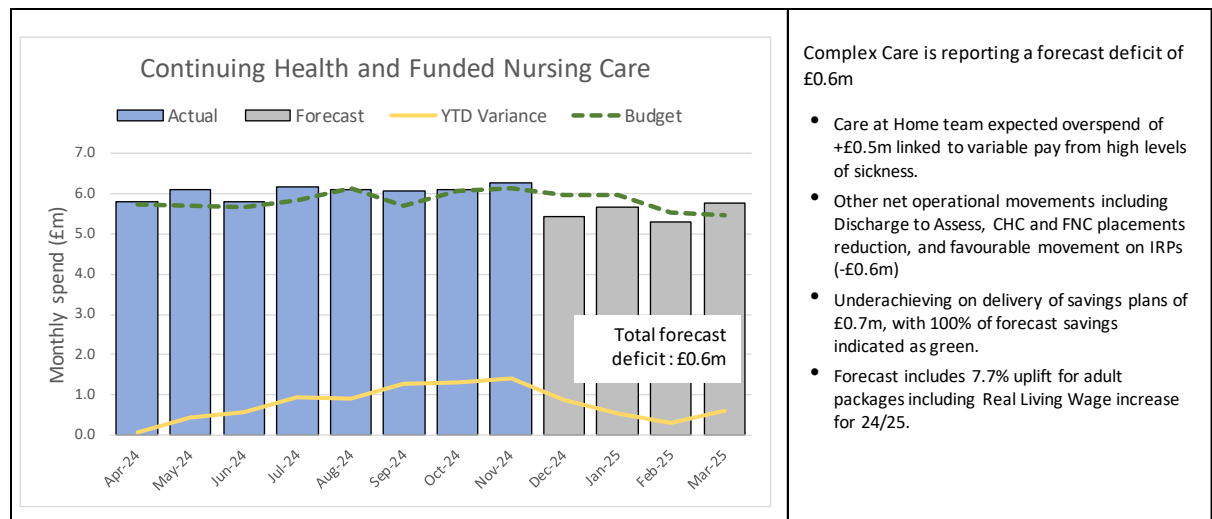
Business Unit	Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
Primary Care and Communi	PCC-44	Anti-viral cost mitigation / GP stock	1,300	Savings are achieving in full for 24/25, however will not achieve on a recurrent basis. The 2024/25 achievement is reflected in scheme PCC-44a
Primary Care and Communi	PCC-38	Additional clinical sessions LES	673	Savings are achieving in full for 24/25, however will not achieve on a recurrent basis. The 2024/25 achievement is reflected in scheme PCC-38a
Primary Care and Communi	PCC-43	Administration & Clerical review savings (2%)	254	Savings are achieving for 24/25, however will not achieve on a recurrent basis. The 2024/25 achievement is reflected in scheme PCC-43a
Primary Care and Communi	PCC-35	Reconfiguration of beds PCCS	750	Assumption regarding bed savings for Feb and March has been removed based on requirement to open additional beds

Divisional analysis – Prescribing



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-01	Prescribing savings options / opportunities	R	Month 1	Green	733	1,987	1,773	(214)
					733	1,987	1,773	(214)

Divisional analysis – Complex Care

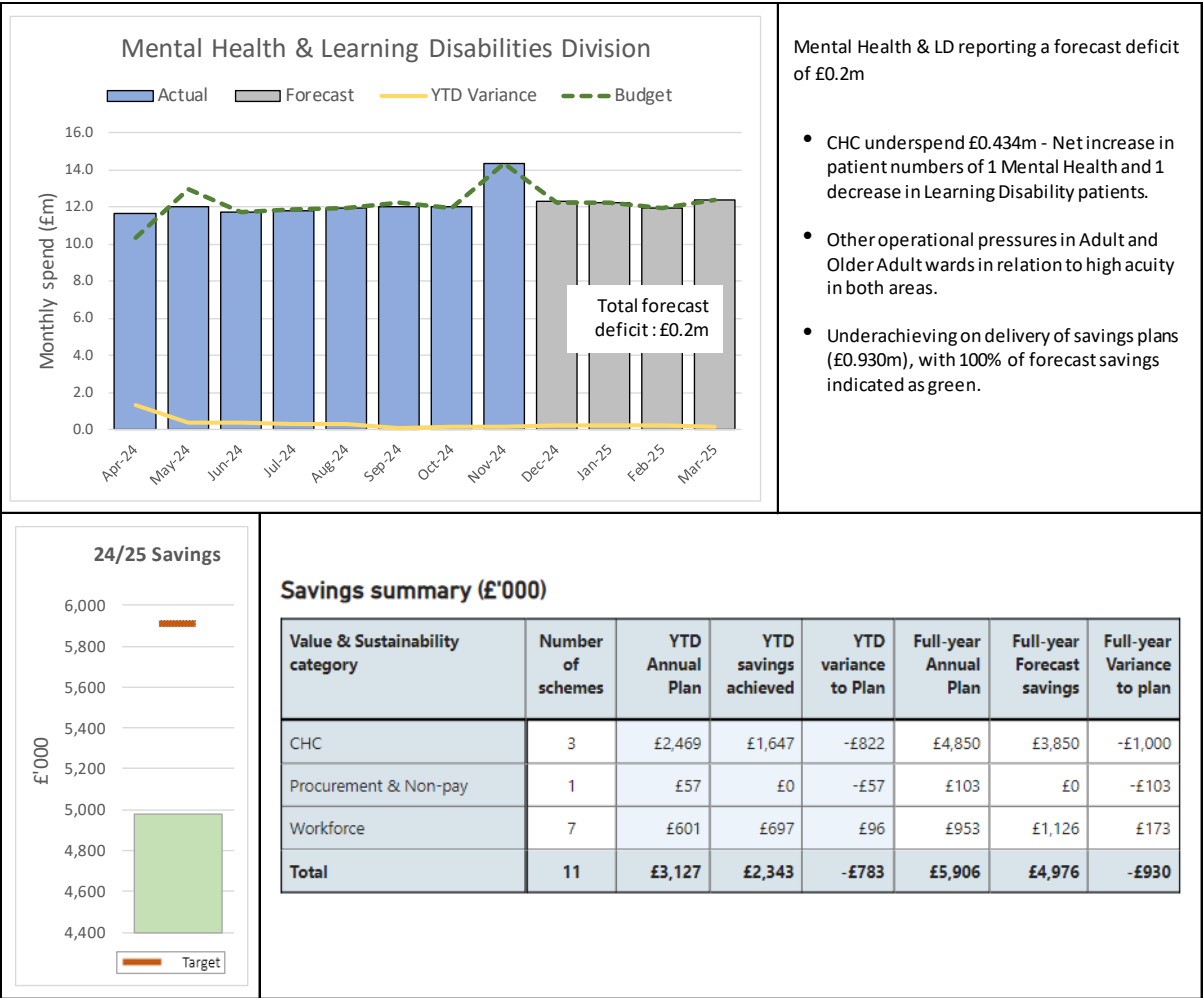


Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CHC-01	Contract Adjustments - hospital admissions and days after death	R	Month 1	Red	0	314	0	(314)
CHC-02	Removal of CHC Premium for Gwent Care Homes with one to one placements	R	Month 1	Red	0	179	0	(179)
CHC-03	23/24 staff vacancies - no further recruitment	R	Month 1	Green	27	40	40	0
CHC-04	Deputyship SLA	R	Month 1	Red	0	35	0	(35)
CHC-05	Cwmgelli Enhanced Care contract	R	Month 1	Green	22	33	28	(6)
CHC-06	Travel (Mileage rate reduction of 5p)	R	Month 1	Green	8	12	12	0
CHC-07	CHC - Adult reviews	NR	Month 1	Green	480	1,440	1,440	0
CHC-08	Reduction in hospital payments for independent providers for CHC & FNC patients	R	Month 1	Red	0	203	0	(203)
CHC-09	New Direction Retainer	R	Month 1	Green	41	62	62	0
CHC-10	Administration & Clerical review	R	Month 1	Green	14	15	21	6
CHC-11	FNC activity reduction schemes	R	Month 1	Green	528	700	700	0
CHC-12	CHC Care at Home and other vacancies	R	Month 1	Green	419	600	600	0
					1,539	3,633	2,903	(731)

Red savings schemes (listed above) over £200k

Business Unit	Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
CHC	CHC-08	Reduction in hospital payments for independent providers for CHC & FNC patients	203	The savings target for Scheme CHC-08 is incorporated within scheme CHC-01 currently shown as Amber
CHC	CHC-01	Contract Adjustments - hospital admissions and days after death	314	Following receipt of legal advice on provider feedback, savings target removed for 24/25
CHC	CHC-02	Removal of CHC Premium for Gwent Care Homes with one to one placements	179	Following receipt of legal advice for CHC-01, savings target removed for 24/25

Divisional analysis – Mental Health and Learning Disabilities



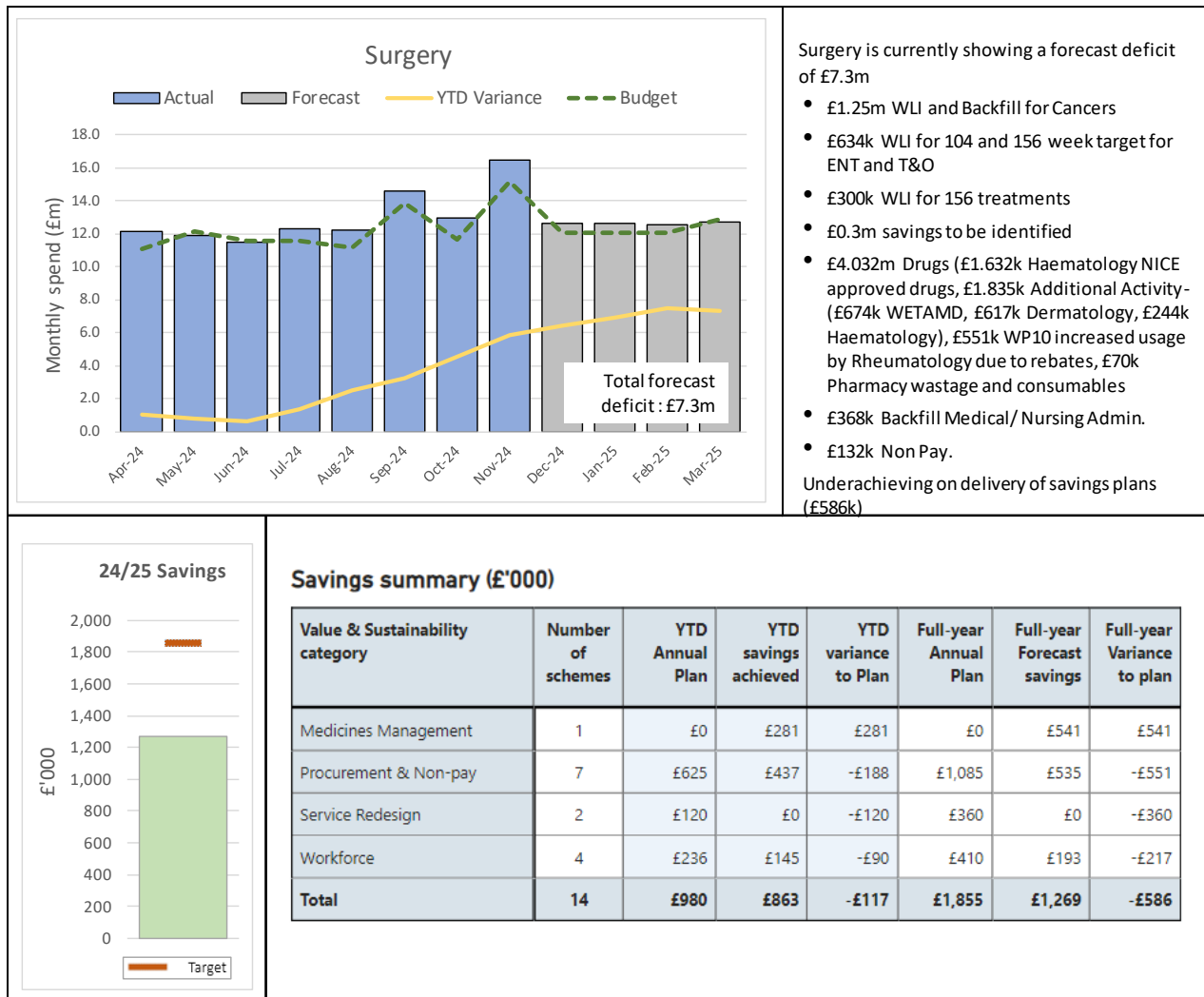
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
MH-01	Reduction in variable pay agency premium B2 HCSW	R	Month 1	Green	141	192	192	0
MH-02	Ty Lafant ward LD reduction to VP	R	Month 1	Green	142	199	199	0
MH-03	Mitchell Close	R	Month 1	Red	0	103	0	(103)
MH-04	Medical Agency Reduction	R	Month 1	Green	85	169	169	0
MH-05	Reduction in PHP Leadership PHPs	R	Month 1	Green	36	54	54	0
MH-06	MH&LD CHC reduction	R	Month 1	Green	1,313	3,250	3,250	(0)
MH-07	Administration & Clerical review	R	Month 1	Green	7	140	33	(107)
MH-07a	Administration & Clerical review	NR	In Year	Green	74	0	107	107
MH-08	MH&LD CHC further reductions	R	Month 1	Green	333	600	600	0
MH-09	MH&LD variable pay schemes	R	Month 1	Green	212	200	373	173
OPPS2-10	West Sussex	NR	Month 1	Red	0	1,000	0	(1,000)
					2,343	5,906	4,976	(930)

Mental Health and Learning Disabilities continued...

Red savings schemes (listed above) over £200k

Business Unit	Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
Mental Health and Learning Disabilities	OPPS2-10	West Sussex	1,000	Currently with West Sussex Legal team for a response. If wish to progress likely with lead into a legal dispute which could be costly. Working towards full recovery of costs however current assumption that saving will not be achieved in the near future.

Divisional analysis – Surgery

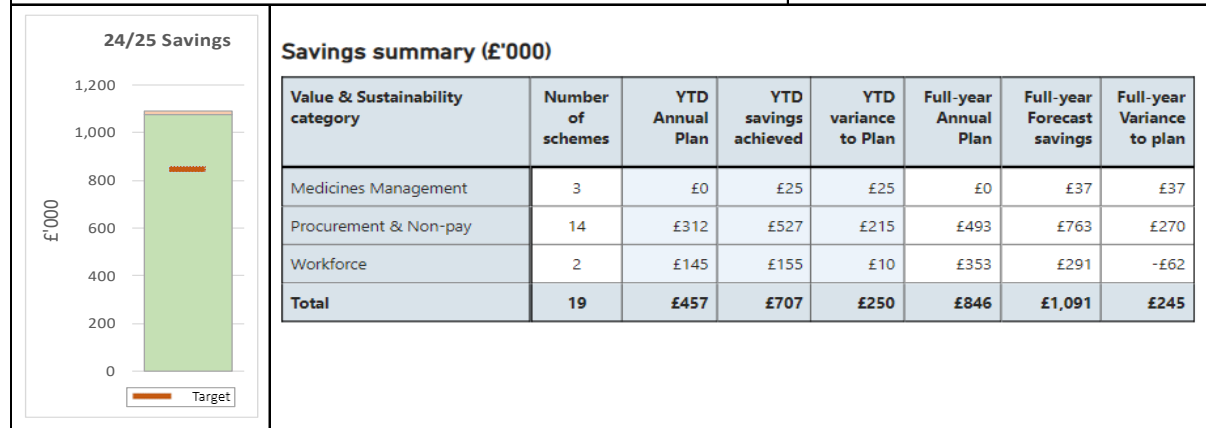
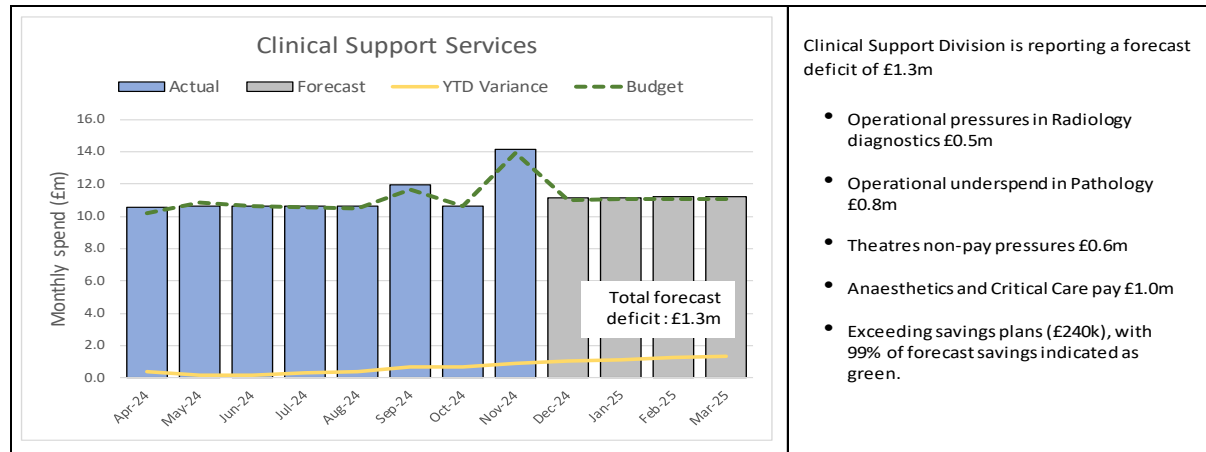


Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
SUR-01	Ophthalmology Phaco Lenses and Procedure packs	R	Month 1	Green	53	79	79	0
SUR-02	Intensity Banding for On-call	R	Month 1	Red	0	44	0	(44)
SUR-03	Orthopaedics: Femoral Heads	R	Month 1	Green	40	45	55	10
SUR-04	Orthopaedics: rationalisation of suppliers for hips and knees	R	Month 1	Green	33	50	50	0
SUR-05	Trauma Contract	R	Month 1	Green	60	60	100	40
SUR-06	Bed Day Efficiencies	R	Month 1	Red	0	205	0	(205)
SUR-07	Theatre Efficiencies	R	Month 1	Red	0	155	0	(155)
SUR-08	Reduce Machen Ward Sat - Mon	R	Month 1	Red	0	179	0	(179)
SUR-10	Administration & Clerical Review	R	Month 1	Green	95	187	103	(84)
SUR-11	National priorities/best value biosimiliars & Haematology	R	In Year	Green	281	0	541	541
SUR-12	Agency reduction with all junior clinical fellow posts now filled	NR	In Year	Green	50	0	90	90
OPPS2-11	WRP	R	Month 1	Red	0	251	0	(251)
OPPS2-11a	WRP	NR	In Year	Green	251	0	251	251
OPPS2-12	Consignment / other M&SE disposables	R	Month 1	Red	0	600	0	(600)
					863	1,855	1,269	(586)

Red savings schemes (listed above) over £200k

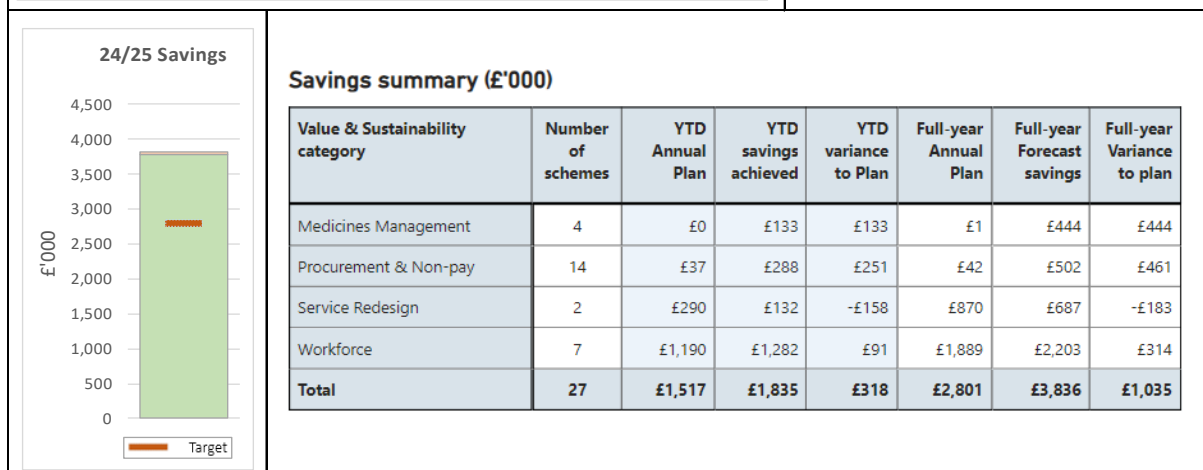
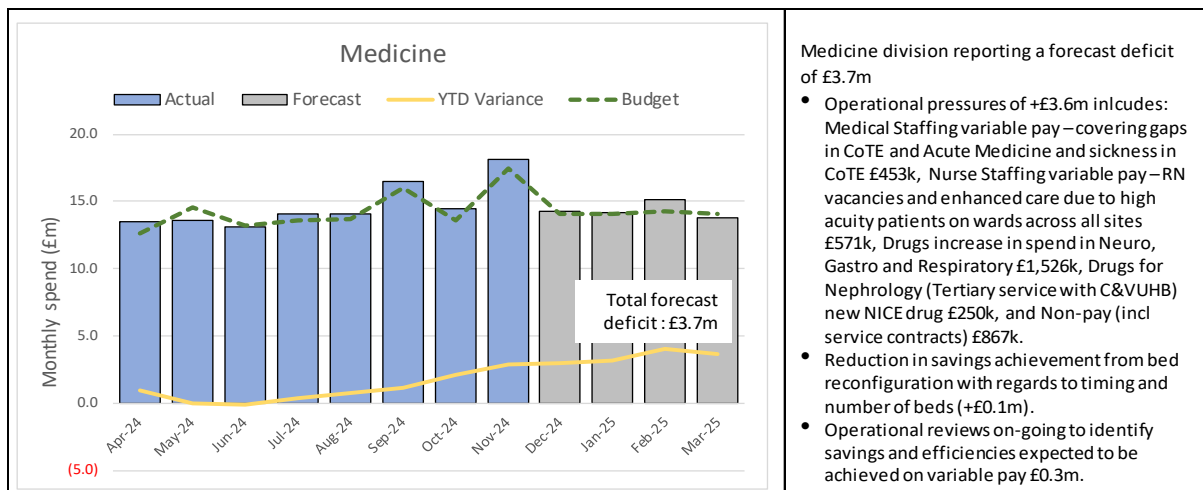
Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
OPPS2-12	Consignment / other M&SE disposables	600	Original plan for Consignment Stock saving determined unachievable following technical advice
OPPS2-11	WRP	251	Savings are achieving in full for 24/25, however will not achieve on a recurrent basis. The 2024/25 achievement is reflected in scheme OPPS2-11a
SUR-08	Reduce Machen Ward Sat - Mon	179	Machen ward unable to close on weekends so far due to shortages of beds in GUH.
SUR-06	Bed Day Efficiencies	205	As part of the annual plan savings schemes 300k was set as a target for bed and theatre day efficiencies through BADs. Although there is evidence some work has been done we have now lost the 5 bedded Machen ward to medicine and ministerial priority targets for the rest of the year has lead the Divisional Director to decide we should remove these initiatives and they won't be achieved this Financial Year.
SUR-07	Theatre Efficiencies	154	

Divisional analysis – Clinical Support Services



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CSS-01	Administration & Clerical review	R	Month 1	Green	93	123	158	35
CSS-02	Pathology - repatriation of tests	R	Month 1	Green	9	43	21	(22)
CSS-03	PFI saving (Llanwenarth suite)	R	Month 1	Green	200	300	300	0
CSS-04	Theatre Efficiencies	R	Month 1	Green	62	230	133	(97)
CSS-05	FIT Testing (Novation into Siemen's Managed Service contract	R	In Year	Green	17	0	29	29
CSS-06	Decommissioning NovaView Service & Maintenance	R	In Year	Green	13	0	19	19
CSS-07	Quantiliser Maintenance	NR	In Year	Green	4	0	5	5
CSS-08	Urine Collection Tubes	R	In Year	Green	7	0	10	10
CSS-10	Fuji - Equipment Inventory Review	R	In Year	Amber	0	0	7	7
CSS-11	MIU General Room - RGH - Decommissioned	R	In Year	Amber	0	0	3	3
CSS-12	MIU General Room - RGH - Replacement	NR	In Year	Amber	0	0	4	4
CSS-13	Drugs - Sevoflourane	R	In Year	Green	5	0	8	8
CSS-14	Maintenance Contracts (Theatres, Radiology, Pathology)	NR	In Year	Green	166	0	166	166
CSS-15	Price Reduction in Ethicon suturing materials (Theatres)	NR	In Year	Green	30	0	50	50
CSS-16	Radiology - Contrast Media	R	In Year	Green	20	0	29	29
CSS-17	Paracetamol IV to Oral Omnicell Implementation	R	In Year	Green	0	0	0	0
OPPS2-01	WHSSC Liver	R	Month 1	Green	64	116	116	0
OPPS2-02	Additional Savings Targets - Pathology NR maintenance saving	R	Month 1	Green	18	34	28	(7)
CSS-18	YYF General Room - capital replacement - maintenance contract	NR	In Year	Green	0	0	5	5
					707	846	1,091	245

Divisional analysis – Medicine

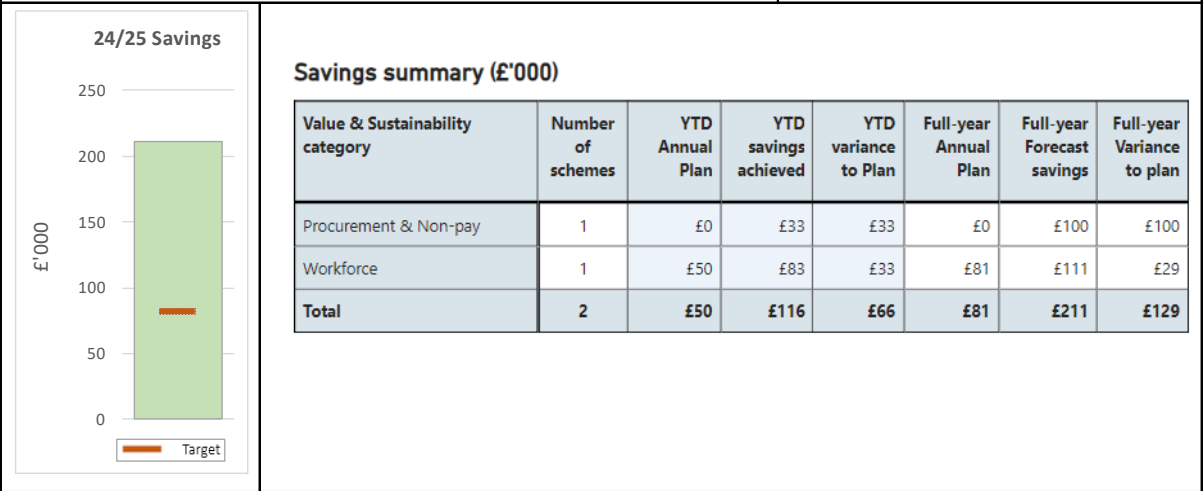
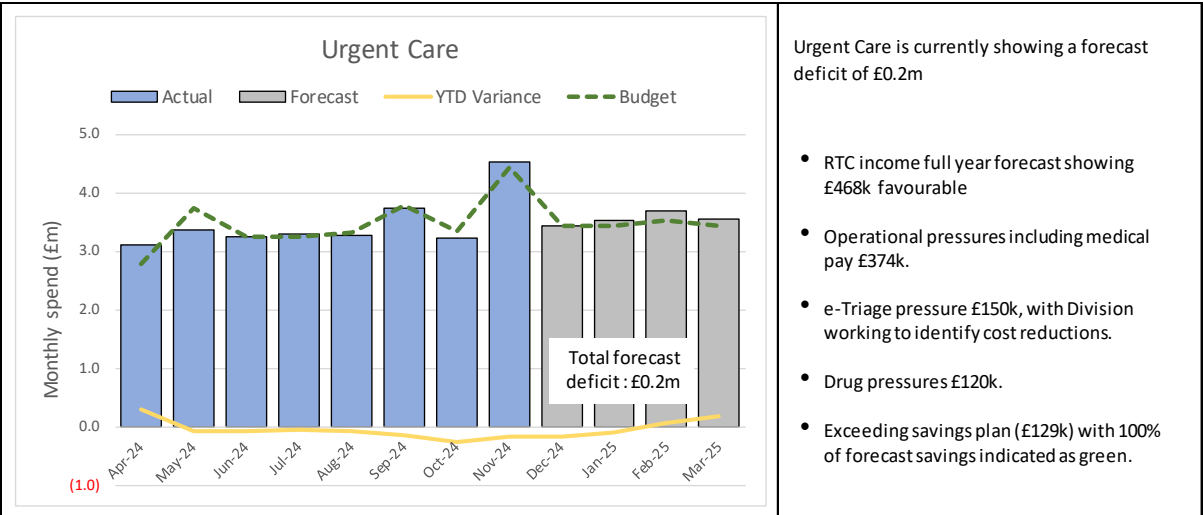


Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Med-01	Medicines Management review across Directorates. Horizon Scanning	NR	Month 1	Green	59	1	93	93
Med-02	Reconfiguration of beds across 3 wards with the net reduction of 14 beds for Medicine	R	Month 1	Green	1,112	1,558	1,674	116
Med-03	No backfill for 0.40 band 7 sleep nurse wef	R	Month 1	Green	16	24	24	0
Med-04	Procurement of Medtronic pumps at reduced rate for a set period of time	NR	Month 1	Green	17	27	17	(10)
Med-05	Reduced catalogue price for Medtronic sensors	NR	Month 1	Green	49	15	74	59
Med-06	Reconfiguration of beds Medicine	R	Month 1	Green	132	750	687	(63)
Med-07	Administration & Clerical review	R	Month 1	Red	0	158	0	(158)
Med-08	Cardiology backfill sessions	R	Month 1	Red	0	120	0	(120)
Med-09	Cardiology insourcing below plan	R	Month 1	Green	83	150	150	0
Med-10	Reduced catalogue price for Dexcom pumps and consumables	NR	In Year	Green	62	0	97	97
Med-15	Natalizumab - contract change	NR	In Year	Green	67	0	133	133
Med-17	Medical Rota - IMT Doctors (1 in 16 to 1 in 22 on call rota)	R	In Year	Green	35	0	70	70
Med-18	Respiratory CPAP purchase	NR	In Year	Green	44	0	80	80

Medicine savings schemes continued...

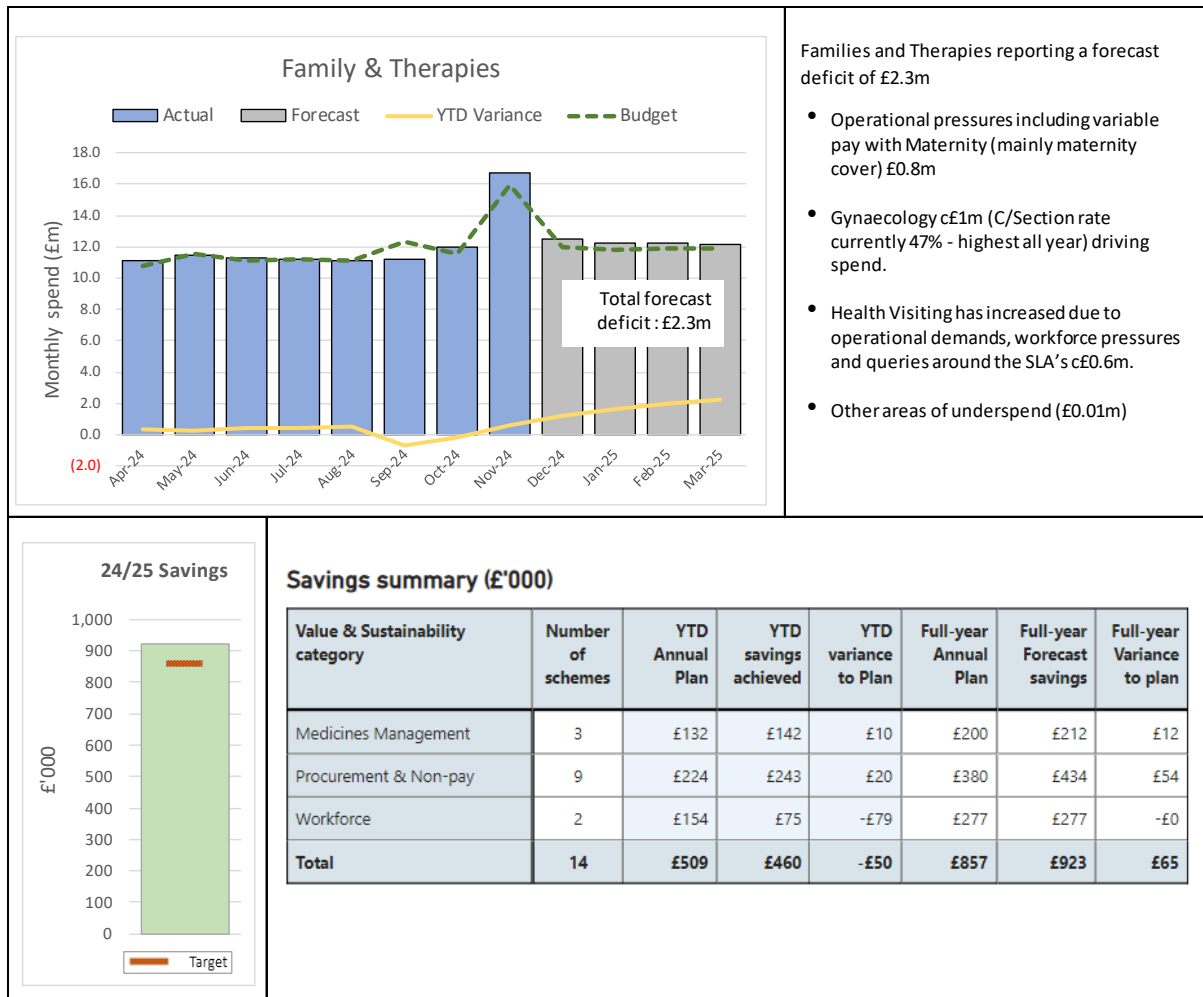
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Med-19	Gastroenterology Switch in product type Polyp Trap	R	In Year	Green	0	0	1	1
Med-20	Cardiology Reduction in Echo Insourcing reliance	R	In Year	Green	15	0	30	30
Med-21	Cardiology Recruitment Slippage CR/HF Hub	NR	In Year	Amber	0	0	45	45
Med-22	Gastroenterology Consent forms - Cessation of leaflet	R	In Year	Green	7	0	11	11
Med-23	Respiratory CPAP Mask Renewals	R	In Year	Green	40	0	60	60
Med-24	Respiratory CPAP Mask new set ups	R	In Year	Green	13	0	20	20
Med-25	Cardiology Mini comp tender Stents (Cath Lab)	R	In Year	Green	3	0	9	9
Med-27	Gastroenterology Out of Area drug cost recovery for Ward Attenders	NR	In Year	Green	17	0	50	50
Med-28	Neurology Out of Area drug cost recovery for Ward Attenders	NR	In Year	Green	17	0	50	50
Med-29	Acute Medicine Substantiate RNs in Line with Rosters	R	In Year	Green	35	0	240	240
Med-30	Diabetes Insulet Rebate	NR	In Year	Green	4	0	4	4
Med-31	GACU Giving Sets - Alternative Product with reduced Port	R	In Year	Green	0	0	0	0
Med-32	Paracetamol IV to Oral Omnicell Implementation	R	In Year	Green	0	0	1	1
Med-33	Drug switch Ustekinumab	R	In Year	Green	7	0	217	217
					1,835	2,801	3,836	1,035

Divisional analysis – Urgent Care



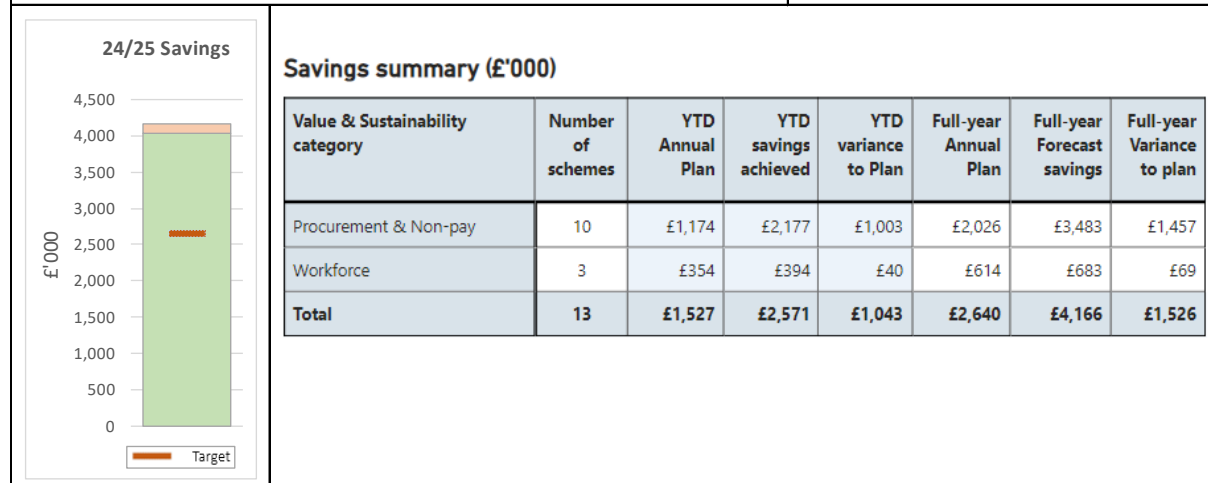
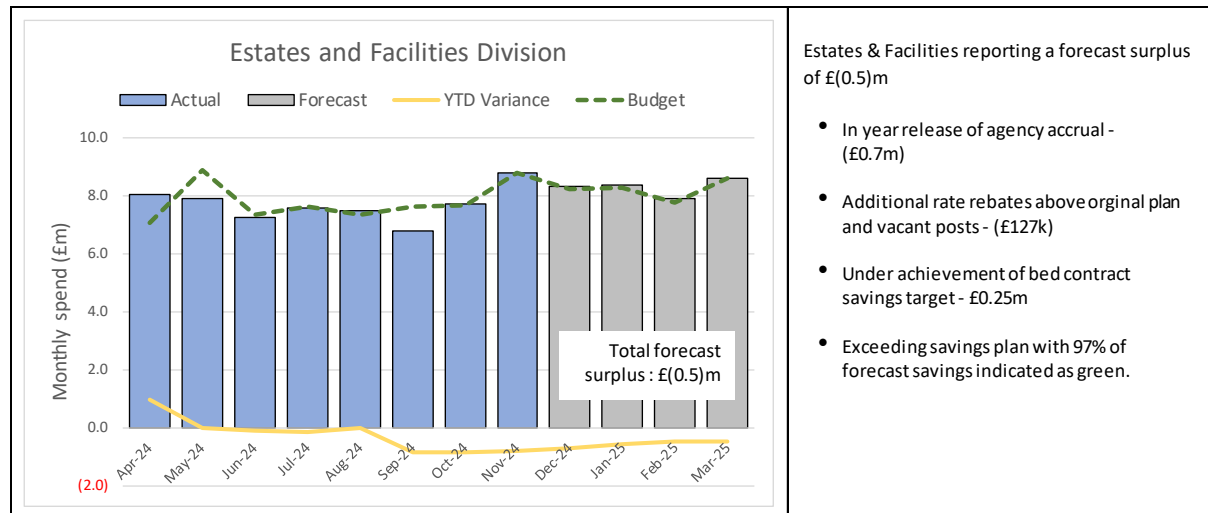
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
URG-01	Administration & Clerical review	R	Month 1	Green	83	81	111	29
URG-02	RTC Income	NR	In Year	Green	33	0	100	100
					116	81	211	129

Divisional analysis – Family & Therapies



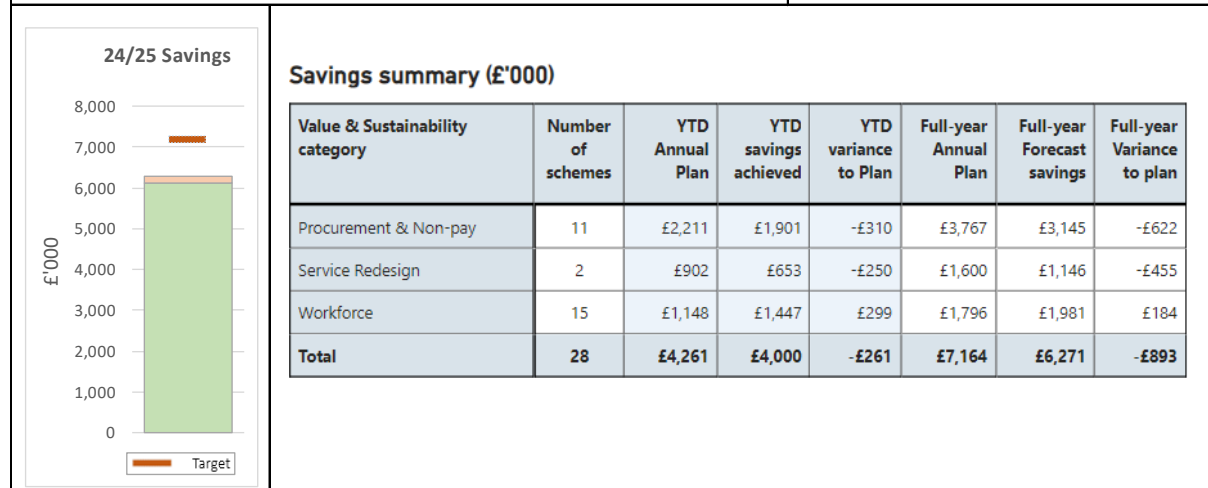
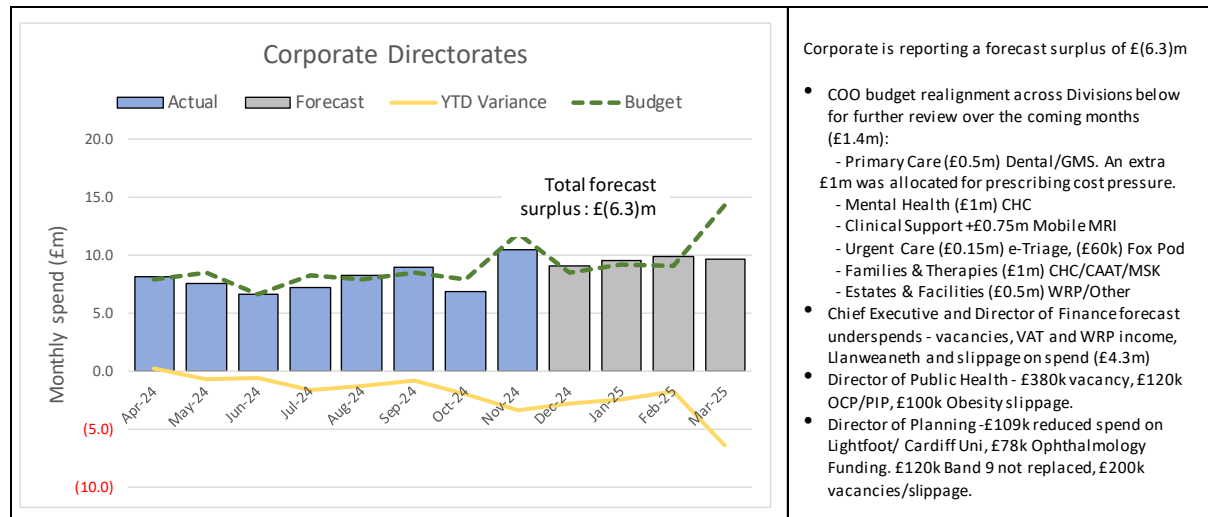
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
F&T-01	Maternity - Easy Pay Kiosk Additional Income (Ultrasound)	R	Month 1	Green	13	50	35	(15)
F&T-02	TRUCLEAR - Replacing Myosure consumables	R	Month 1	Green	98	177	177	0
F&T-03	Konica Photocopier / Printer Review	R	Month 1	Green	22	40	40	0
F&T-04	Reduction in Mileage by 5p per mile	R	Month 1	Green	35	53	53	0
F&T-05	Reduction in Variable pay	R	Month 1	Green	19	34	34	0
F&T-06	SRH - Billing C&V for MIV drug costs for C&V patients treated in ABUHB	R	Month 1	Green	136	200	203	3
F&T-07	Medtronic pump & Sensor All Wales procurement savings	R	Month 1	Green	40	60	60	0
F&T-08	Administration & Clerical review	R	Month 1	Green	56	243	243	(0)
F&T-09	HIV - Dovato Switches	R	In Year	Green	5	0	9	9
F&T-10	Switching to SOL Gases	R	In Year	Green	3	0	8	8
F&T-11	Enteral Feeding tubes	R	In Year	Green	3	0	8	8
F&T-12	CTG Wallets	R	In Year	Green	1	0	2	2
F&T-13	Paracetamol IV to Oral Omnicell Implementation	R	In Year	Green	0	0	0	0
F&T-14	Further price reduction of Dexacom Diabetes products	R	In Year	Green	28	0	51	51
					460	857	923	65

Divisional analysis – Estates & Facilities



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
EF-01	Window Cleaning Capped at 1 clean per year per site	R	Month 1	Green	13	19	19	0
EF-02	Cease Liftshare software	R	Month 1	Green	9	14	14	0
EF-03	COVID A&E Portacabin	R	Month 1	Green	211	316	316	0
EF-04	Administration & Clerical review	R	Month 1	Green	76	114	114	0
EF-05	Discharge Lounge Portacabin	R	Month 1	Green	41	62	62	0
EF-06	NWSSP Energy Saving	NR	In Year	Green	921	0	1,657	1,657
EF-07	NHH Ward Closure 4:3	R	In Year	Amber	0	0	69	69
OPPS2-06a	Rates Rebates - Newport Sites	NR	Month 1	Green	784	930	980	50
OPPS2-06b	Rates Rebates - NHH	NR	Month 1	Amber	0	70	70	0
OPPS2-07	Enhanced Cleaning	R	Month 1	Green	318	500	500	0
OPPS2-08	Bed contract	R	Month 1	Green	83	500	250	(250)
OPPS2-09	WRP	R	Month 1	Red	0	115	0	(115)
OPPS2-09a	WRP	NR	In Year	Green	115	0	115	115
					2,571	2,640	4,166	1,526

Divisional analysis – Corporate



Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CEO-01	Administration & Clerical review	R	Month 1	Green	29	53	52	(1)
COO-01	Administration & Clerical review	R	Month 1	Green	10	20	17	(3)
CORP-01	Generic CIP - Pay	R	Month 1	Green	27	53	44	(9)
CORP-02	Generic - Non-pay	NR	Month 1	Green	9	15	14	(1)
CORP-03	Hybrid mail	R	Month 1	Green	120	300	180	(120)
CORP-04	Intersite transport	R	Month 1	Green	533	1,300	966	(334)
CORP-05	Healthcare Pathways	R	Month 1	Red	0	120	0	(120)
CORP-06	Health Protection - Caerleon House	R	Month 1	Amber	0	273	150	(123)
CORP-07	Health Protection - Newport	R	Month 1	Green	147	220	220	0
CORP-08	Health Protection - LA / TTP	R	Month 1	Green	356	534	534	0
CORP-09	Health Protection - Microbiology	R	Month 1	Green	194	291	291	0
CORP-10	VAT income / over-recovery	NR	Month 1	Green	245	300	345	45

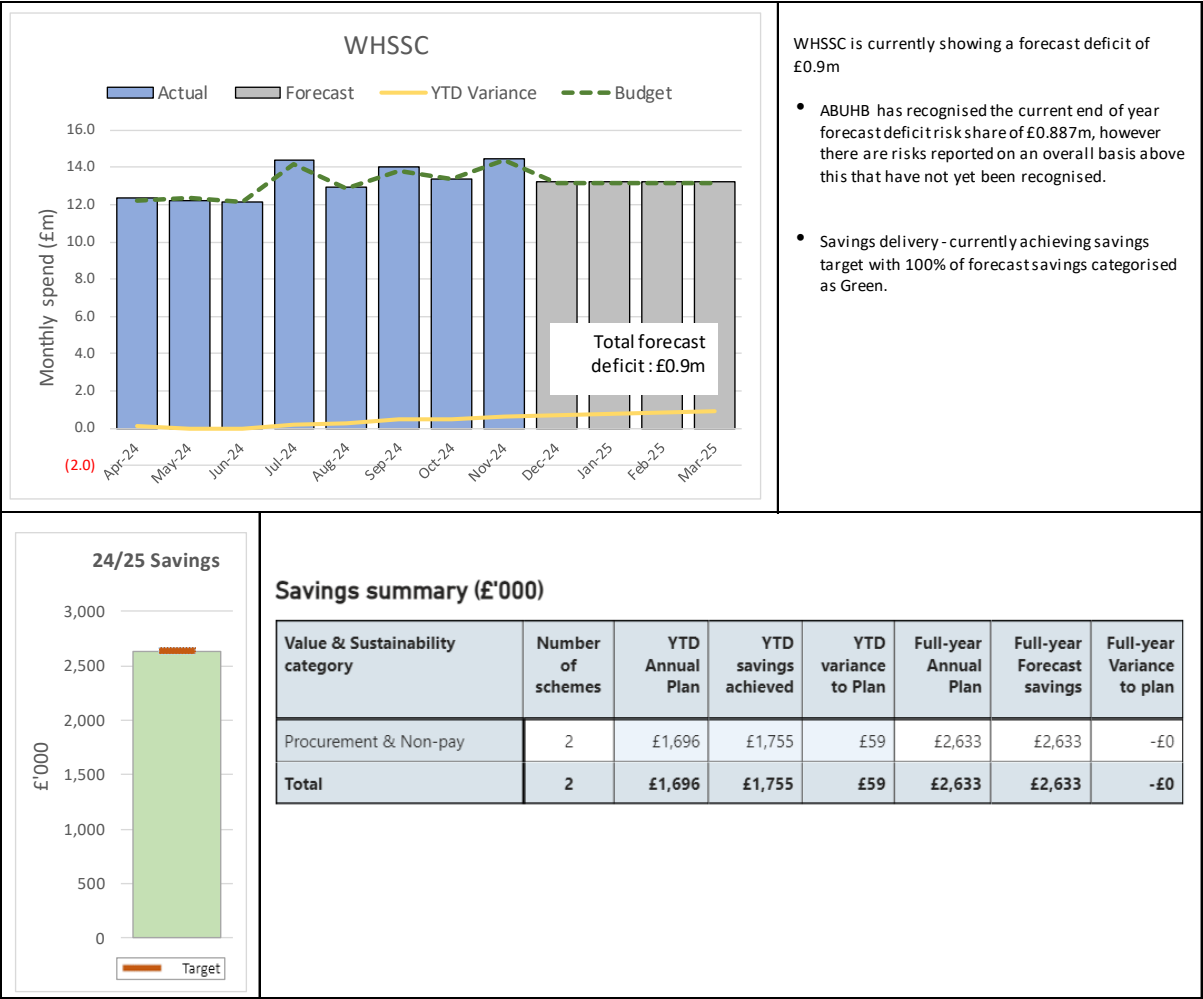
Corporate savings schemes continued...

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CORP-11	Finance administration savings	R	Month 1	Green	107	161	161	0
DIG-02	Administration & Clerical review	R	Month 1	Green	545	319	596	277
FIN-03	Administration & Clerical review	R	Month 1	Green	93	139	139	0
GOV-01	Administration & Clerical review	R	Month 1	Green	11	19	20	1
MEDR-01	Administration & Clerical review	R	Month 1	Green	30	59	49	(10)
NUR-01	Administration & Clerical review	R	Month 1	Green	27	53	44	(9)
PLA-01	Administration & Clerical review	R	Month 1	Green	62	68	81	13
THE-01	Administration & Clerical review	R	Month 1	Green	10	19	16	(3)
WOD-01	Administration & Clerical review	R	Month 1	Green	137	122	171	49
CORP-13	Litigation cost reductions	R	Month 1	Green	214	385	385	0
CORP-14	Other specific funding benefits	NR	Month 1	Green	167	300	300	0
CORP-15	Recovery of agency fees	NR	Month 1	Green	401	700	812	112
OPPS2-03	WRP	R	Month 1	Red	0	335	0	(335)
OPPS2-03a	WRP	NR	In Year	Green	335	0	335	335
OPPS2-04	Further litigation schemes	R	Month 1	Green	194	350	350	0
OPPS2-05	Further Corporate schemes / opportunities inc. Public Health	R	Month 1	Red	0	655	0	(655)
					4,000	7,164	6,271	(893)

Red savings schemes (listed above) over £200k

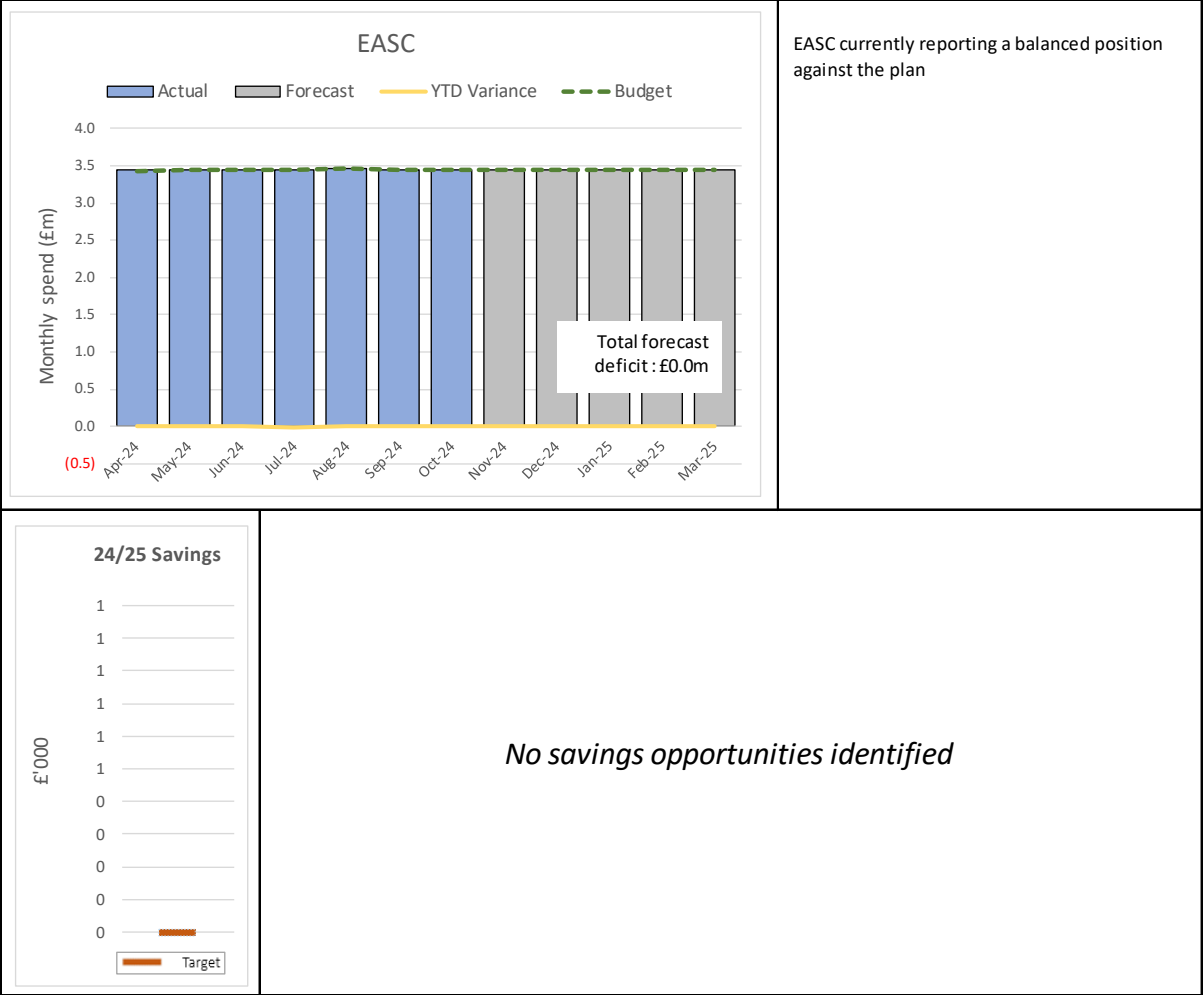
Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
OPPS2-05	Further Corporate schemes / opportunities inc. Public Health	655	Unachievement due to no specific plan. Mitigated by overachievement in other areas
OPPS2-03	WRP	335	Savings are achieving in full for 24/25, however will not achieve on a recurrent basis. The 2024/25 achievement is reflected in scheme OPPs-03a

Divisional analysis – WHSSC

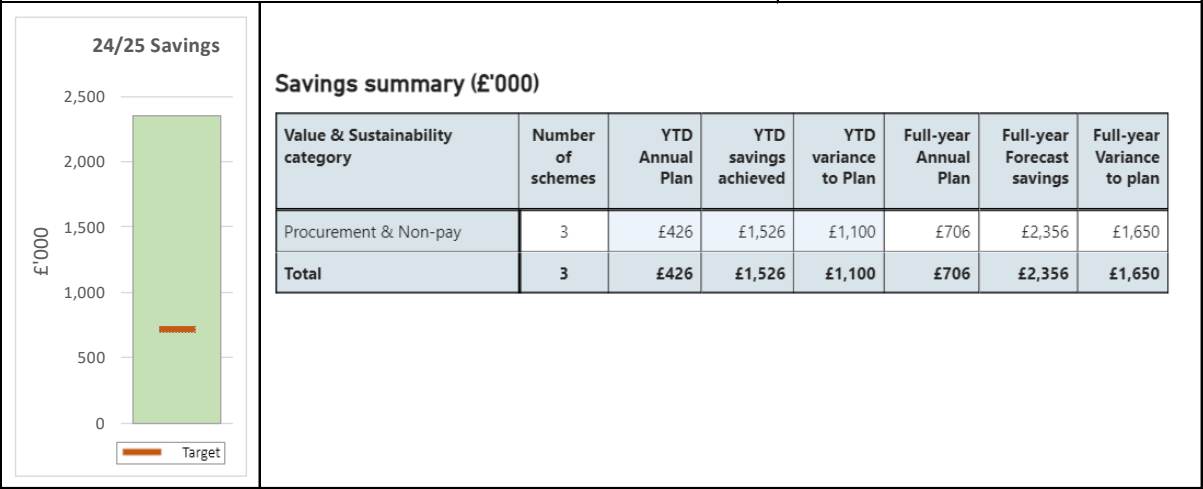
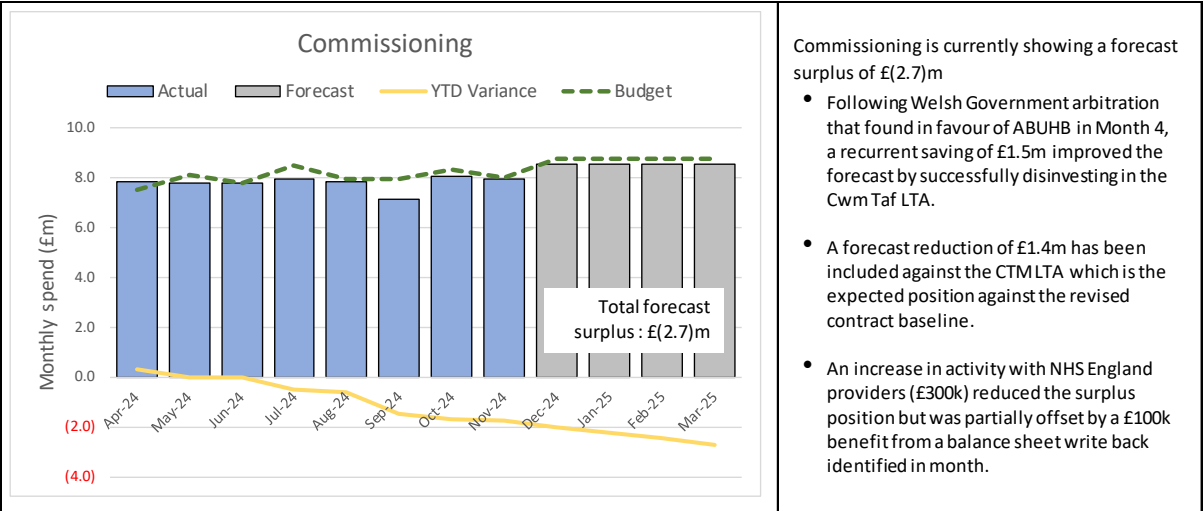


Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
WHSSC-01	WHSSC Savings Schemes	R	Month 1	Green	1,399	2,099	2,099	(0)
WHSSC-02	WHSSC Savings Schemes	R	Month 1	Green	356	534	534	0
					1,755	2,633	2,633	(0)

Divisional analysis – EASC



Divisional analysis – External Commissioning



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
COMM-01	Reduction in expenditure for robotic surgery (repat)	R	Month 1	Green	226	406	406	0
COMM-02	LTA reviews	R	Month 1	Green	1,200	300	1,800	1,500
COMM-03	Refugee scheme income	NR	In Year	Green	100	0	150	150
					1,526	706	2,356	1,650

Reserves

Reserves Delegation:

Following Board budget delegation undertaken in month 2 the reserves position at 30th of November 24 is £13.077m. This consists of the revised recurrent deficit for 24/25 of £8.359m (following additional £40.5m Welsh Government funding), specific commitment reserves of £7.764m, allocations to be delegated of £11.419m and items retained to support the deficit position of £2.253m.

The specific commitment reserves include targeted funding to support additional expenditure relating to RTT. An Innovation and Development reserve of £1.426m remains within reserves for new pressures and investments. From the original £2.0m held for Innovation and Development, a number of Executive approved funding decisions have been made including expansion of the Multiple Sclerosis service (£0.257m), ED business case (£247k), and Creo Endoscopy (£0.148m).

Funding will continue to be reviewed with further anticipated allocations being retained within reserves pending delegation.

7769-ALLOCATIONS TO BE DELEGATED

Description	24/25
Mental Health 111 Press 2 service funding 24-25 (tranche 1)	142,857
Mental Health 111 Press 2 service funding 24-25 (tranche 2)	141,659
Real Living Wage (RLW) - 24/25	1,228,074
International Nurses 24-25	894,000
PCC Optometry funding 24-25	1,135,000
RIF PMO income	245,000
Planned Care - 104 week wait gap for Orthopaedics	3,776,000
Planned Care - Diagnostic Schemes	1,307,000
Planned Care - ENT	1,600,000
Planned Care -RTT Infrastructure	40,000
EPMA Funding	754,414
Planned care Transformation Fund Q3 and Q4	48,017
Non Consolidated Consultant Payments 2024-25	12,600
Improving Waiting times for Childrens Neurodevelopment Services	94,000
Confirmed / Anticipated Allocations to be apportioned	11,418,621

7788-COMMITMENTS TO BE DELEGATED

Description	24/25
Innovation and Development Fund	1,425,824
Approved Business Case: ED Staff	57,579
Approved Business Case: Discharge/Transfer lounge	189,000
Innovation and Development Fund - RTT	866,000
Inflationary pressures reserve	1,220,000
Newport East HWBC (GDS contract increase)	48,000
Newport East HWBC (E&F costs)	66,000
GUH ED Extension	161,000
Prescribing price & volume growth 2024/25	1,800,000
Energy underspend at M4	1,657,000
Pay Matrix: Income via: PHW (core)	(118,000)
Junior Doctors income adjustment	379,080
Pay award element relating to individuals charged to capital	12,296
Total Commitments	7,763,779

7501-SUPPORTING FINANCIAL POSITION

Description	24/25
Balance at month 7	2,235,937
IT Revenue to capital M8	17,514
Total Supporting financial position reserve	2,253,451

7515-IMTP 23/24 DEFICIT

Description	24/25
24/25 recurrent deficit	(48,858,587)
Additional in-year funding re: Cost pressures	9,500,000
Additional in-year funding re: Target control total adjustment	31,000,000
Total IMTP 23/24 recurrent deficit	(8,358,587)

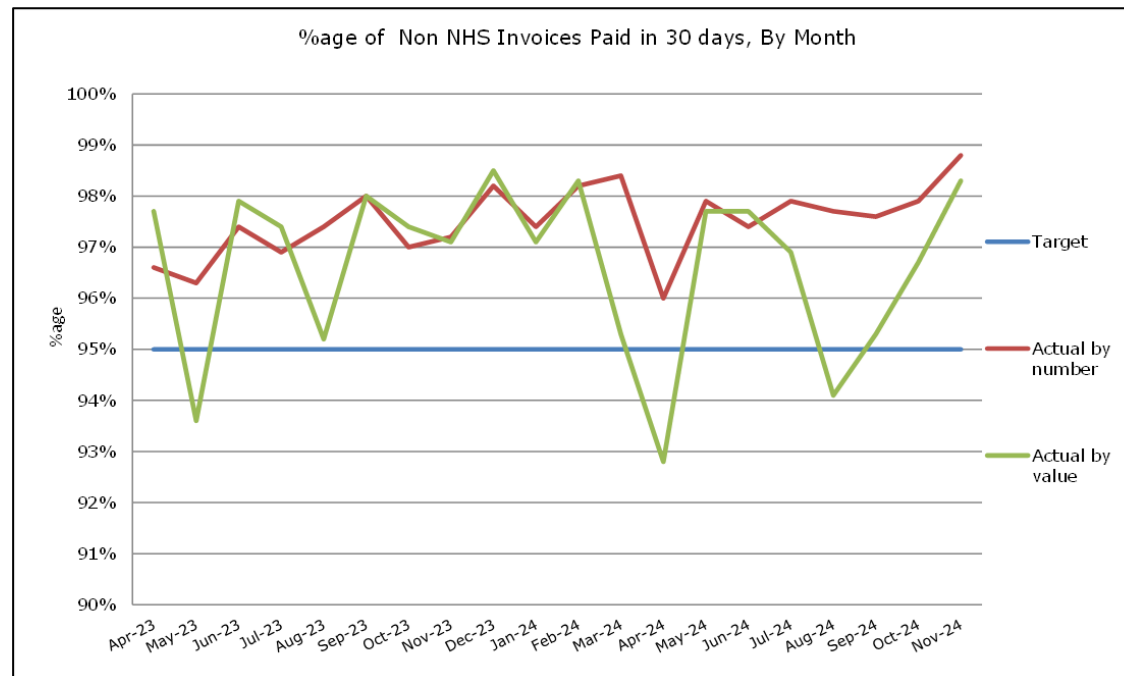
Total **13,077,264**

Cash Position

The cash balance at the 30th November is £3.275m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSP)

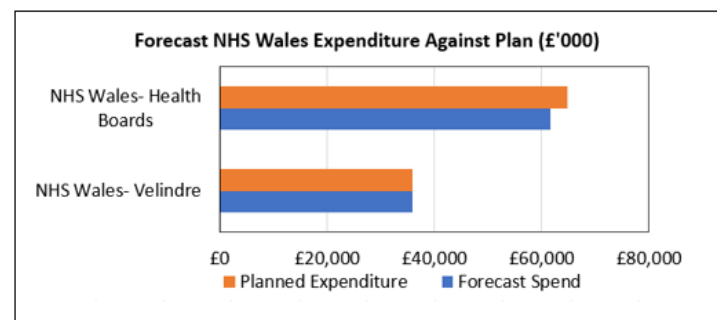
The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in October and cumulatively. There has been an increase in the number of NHS invoices paid within 30 days this month.



Contracting & Commissioning – LTA Spend & Income

At Month 8 the year to date financial performance for Contracting and Commissioning is £1,760k underspend against the delegated budget, with a forecast outturn of £2.7m underspend.

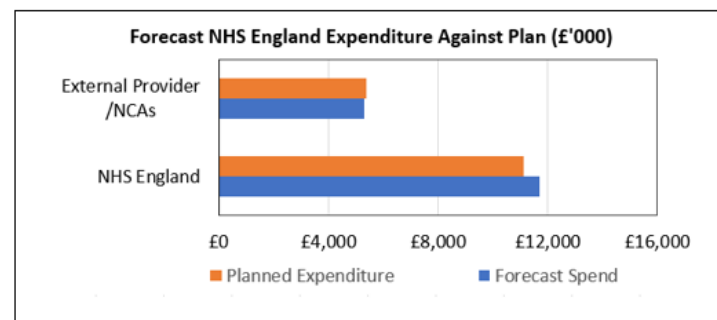
The key elements contributing to this position at Month 8 are as follows:



NHS Wales Expenditure

Expenditure in NHS Wales contracts is forecast to be £3.2m less than plan after the disinvestment from Cwm Taf was supported by Welsh Government.

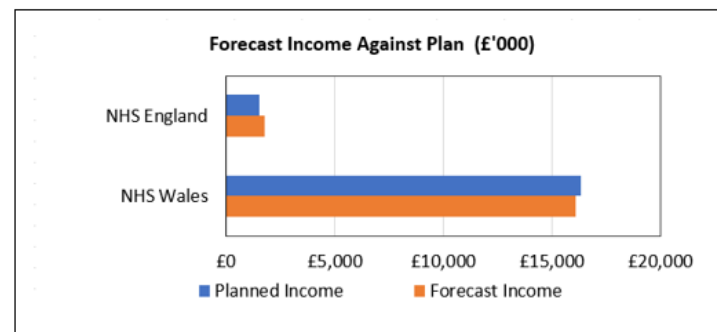
An uplift of 3.67% as per WG guidance was applied to contracts in 2024/25.



NHS England Expenditure

Contract Expenditure with NHS England organisations is expected to be c£13m in 2024/25

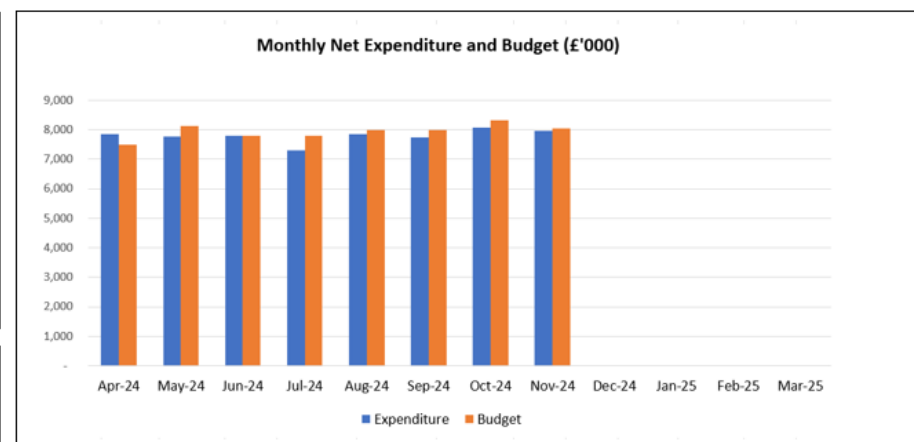
Month 7 monitoring that has been received is forecasting a pressure above planned levels as more activity is being delivered in NHS England



Provider Income

Provider income of c£17.9m is being planned and forecast in 2024/25 and will continue to be monitored and managed regularly

Month 7 activity provided by ABUHB has been in line with previous years performance and is monitored monthly

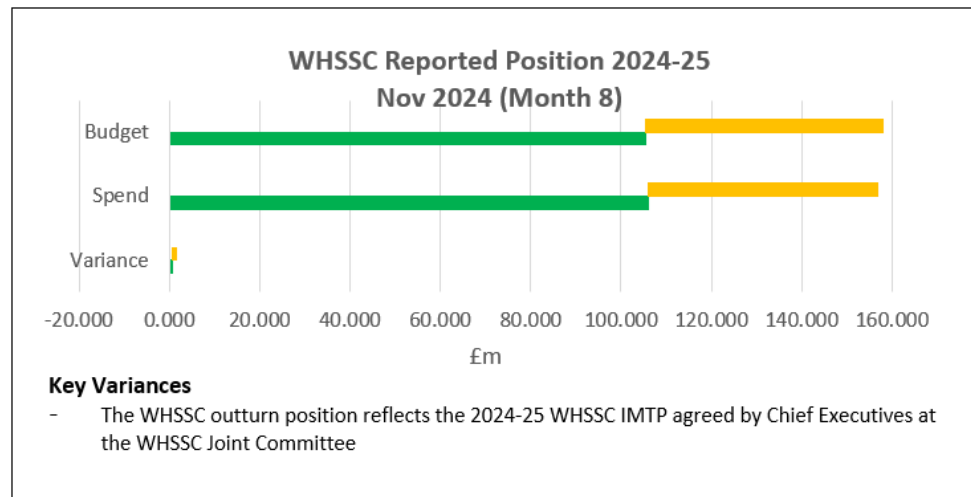
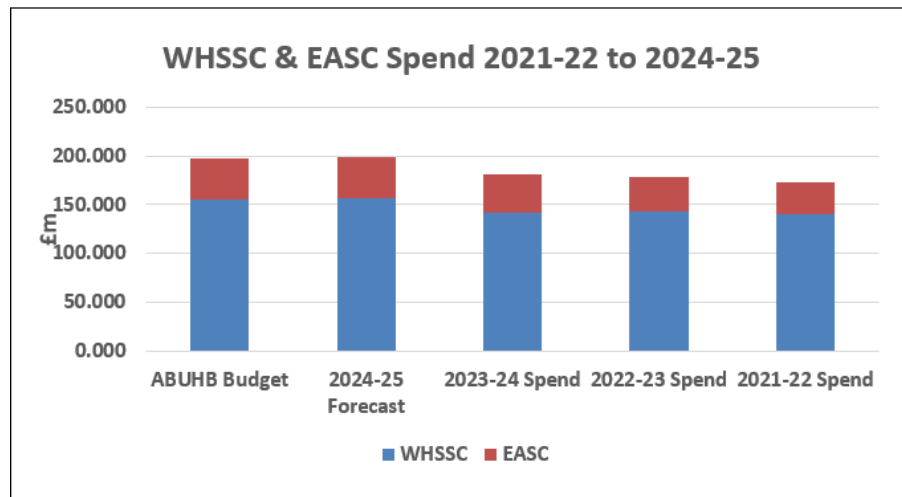


Key Issues 2024-25

- All LTAs have been signed in line with the WG deadline of the end of June 2024 apart from the Cwm Taf LTA which has been signed by ABUHB following WG arbitration decision but currently awaiting the Cwm Taf signed copy back
- The nationally agreed core uplift of 3.67% has been funded and is reflected in the above position
- Infectious diseases support has been formally commissioned from Cardiff from 2024/25 ensuring that ABUHB patients and clinicians have access to specialist advice and treatment pathways for this service going forwards
- A saving of £406k for robotic surgery repatriation is being forecast to be achieved in 2024-25
- A recurrent annual saving of £1.8m from LTA negotiations with Cwm Taf has been achieved against a target of £300k which results in a £1.5m benefit.
- **An additional c£1.4m underspend as a result of reduced activity is being forecast against the revised CTM LTA baseline however CTM are not in agreement with this assumption and so this represents a risk to the forecast outturn position**
- The expenditure being forecast for cancer services at Velindre is in line with provider expectations and ABUHB IMTP planning assumptions.
- ABUHB are working through a potential rebasing of the Velindre contract to ensure allocation matches the actual activity share but this is not yet agreed

JOINT COMMISSIONING COMMITTEE (formerly WHSSC & EASC) Financial Position 2024-25

The Month 8 financial performance for the Joint Commissioning Committee is a forecast overspend of £0.887m. The Month 8 position reflects the agreed IMTP and budget delegation for the Specialised Services (formerly WHSSC) and EASC elements.



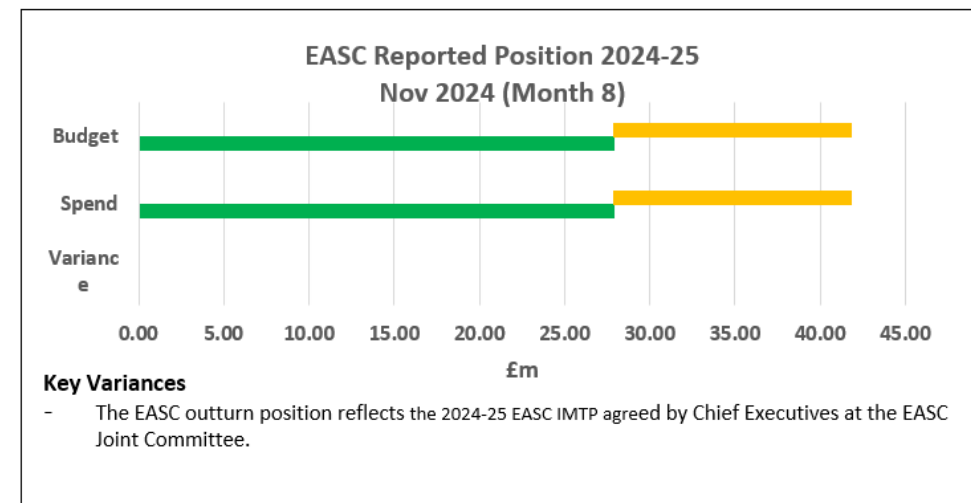
Key Issues 2024-25

Specialised Services

- Forecasts based on M7 of Activity and NICE drugs data where available
- Key issues driving overspend
 - Overperformance in C&VUHB (Specialised Cardiology, ALAS, NICE drugs)
 - Individual patient treatments
 - Offset by underspends on Mental Health Placements and Slippage on Developments
 - Key risk around delivery of savings plans

EASC

- Confirmation of final WG Allocations
- Slippage against Plan
- Activity Reporting



Balance Sheet

Balance sheet as at 30th November 2024			
	2024/25 Opening balance £000s	30th November 2024 £000s	Movement £000s
Fixed Assets	910,187	927,477	17,290
Other Non current assets	149,418	135,233	(14,185)
Current Assets			
Inventories	9,844	10,648	804
Trade and other receivables	136,632	143,258	6,626
Cash	4,145	3,275	(870)
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	150,621	157,181	6,560
Liabilities			
Trade and other payables	218,038	210,003	(8,035)
Provisions	221,474	193,799	(27,675)
	439,512	403,802	(35,710)
	770,714	816,089	45,375
Financed by:-			
General Fund	581,390	621,088	39,698
Revaluation Reserve	189,324	195,001	5,677
	770,714	816,089	45,375

Fixed Assets

- An increase in net additions of £32.762m in relation to new 2024/25 capital expenditure incurred.
- A reduction of £28.15m for depreciation charges. A decrease of £0.9m for IFRS16 related charges.
- An increase in indexation costs of £13.59m

Other Non-Current Assets: This relates to a decrease in Welsh Risk Pool claims due in more than one year £14.7m, an increase in intangible assets of £0.2m and an increase in ICR income due in more than one year of £0.3m since the end of 2023/24.

Inventories: The increase in year relates to changes in stock held within the divisions

Current Assets, Trade & Other Receivables: The main movements since the end of 2023/24 relate to:

- A decrease in the value of debts outstanding on the Accounts Receivable system since 2023/24 to the end of November £0.3m
- An increase in the value of both NHS & Non-NHS accruals of £2.1m, of which £3.8m relates to a decrease of Welsh Risk Pool claims due in less than one year, £0.2m relates to a decrease in NHS & Non NHS accruals and £6.1m relates to an increase in VAT and other debtors since the end of 2023/24.
- An increase in the value of prepayments held £4.8m

Cash: The cash balance held at the end of November was £3.275m.

Liabilities, Trade & other Payables:

The movement since the end of 2023/24 relates to a number of issues the most significant of which were:-

- A decrease in Capital accruals (£1.5m), an increase in NHS Creditor accruals (£2.0m), a decrease in the level of invoices held for payment from the year end (£10.8m), an increase in non NHS accruals (£7.5m), an increase in Tax & Superannuation (£11.3m), a decrease in other creditors (£14.1m), a decrease in the liability for lease payments (£0.6m), an increase in payments on account £1.8m)

Provisions:

- This is due to a decrease in the provision for clinical negligence and personal injury cases of £24.7m, which is based on information provided by the Welsh Risk Pool. There has also been a decrease in other provisions of £3.0m.

General Fund: This represents the difference in the year to date resource allocation budget and actual cash draw down including capital.

Health Board Income WG Funding Allocations: £1.8bn

Confirmed Allocations as at November 2024 (M8 2024/25)

	£'000
HCHS	1,534,876
GMS	113,886
Pharmacy	36,808
Dental	34,643
Total Confirmed Allocations - November 2024	1,720,212
Plus Anticipated Allocation - November 2024	108,028
Total Allocations - November 2024	1,828,240

Other Income:

The HB receives income from a number of sources other than WG, based on the year-to-date income, this is forecast to be approximately £117.6m. (£114m for 23/24). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Estimated funding (allocations & income) for the UHB totals £1.95bn (£1.88bn for 23/24).

WG anticipated allocations: £108.03m

WG Revenue Resource Limit : Anticipated Allocations (November)			
Funding Type	Description	Value £'000	Recurrent / Non Recurrent
GMS	GMS Refresh	1,603	R
HCHS	Capital - DEL Depreciation - Baseline Surplus/Shortfall	(2,202)	NR
HCHS	Capital - DEL Depreciation - Strategic	1,904	NR
HCHS	Capital - DEL Depreciation - Accelerated	190	NR
HCHS	Capital - DEL Depreciation - IFRS 16 Leases	3,721	NR
HCHS	Capital - AME Depreciation - IFRS 16 Leases (Peppercorn)	109	NR
HCHS	Capital - AME Depreciation - Donated Assets	325	NR
HCHS	Capital - AME Depreciation - Impairments	16,832	NR
HCHS	Capital - AME Depreciation - Impairment reversals	(14,445)	NR
HCHS	Capital - Removal of Donated assets / Gvnt grant receipts	(50)	NR
HCHS	Revenue Interest Expense (IFRS16) Equipment	204	NR
HCHS	Revenue Interest Expense (IFRS16) Property	129	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Equip)	(2,505)	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Prop)	(1,469)	NR
HCHS	Real Living Wage 24/25	4,001	R
HCHS	Clinical Excellence Awards (CDA's)	152	R
HCHS	WHSSC - National Specialist CAMHS improvements (Tier 4)	234	R
HCHS	Same Day Emergency Care (SDEC)	725	R
HCHS	Urgent Primary Care	647	R
HCHS	VBH: Heart Failure and Rehab in the Community	506	R
HCHS	New Medical Training Posts 2017-2022 cohorts	1,400	R
HCHS	MCA and DoLS	189	NR
HCHS	MCA - IMCA service	217	NR
HCHS	International recruitment funding 24-25	404	NR
HCHS	Primary Care - Optometry funding 24-25	1,135	NR
HCHS	RIF-National Dementia Advocacy scheme (Age Cymru)	384	NR
HCHS	Medical and Dental Pay Award 24/25	12,331	R
HCHS	Planned Care - Diagnostic Schemes	1,307	NR
HCHS	EPMA Funding	226	NR
HCHS	Mental Health 111 Press 2 service funding	142	R
HCHS	One Wales Hospice at Home Funding (£1m across Wales)	187	NR
HCHS	Planned Care - ENT	1,600	NR
HCHS	Improving Waiting times for Children's Neurodevelopment Services	94	NR
HCHS	Pay award-Substantive	28,784	R
HCHS	Pay award-Substantive Consultant	4,996	R
HCHS	Pay award-SLE	2,774	R
HCHS	Pay award-Bank	503	R
HCHS	WG additional funding 24/25 (pressures and control total adjustment)	40,500	R
HCHS	RIF PMO funding	245	NR
Total Anticipated: Per Ledger		108,028	

Capital Planning & Performance

Summary Capital Plan Month 8 2024/25	2024/25				
	Original Plan £000	Revised Plan £000	Spend to M8 £000	Forecast Outturn £000	Variance £000
Source:					
Discretionary Capital:					
Approved Discretionary Capital Funding Allocation	10,814	10,814		10,814	0
Less EFAB Contribution	-725	-725		-725	0
Less AWCP Brokerage 23/24	-230	-1,669		-1,669	0
Less DCP Brokerage 23/24	0	350		350	0
NBV of Assets Disposed	0	35		35	0
Total Approved Discretionary Funding	9,859	8,805		8,805	0
All Wales Capital Programme Funding:					
AWCP Approved Funding	42,399	54,811		54,811	0
Total Approved and Anticipated AWCP Funding	42,399	54,811		54,811	0
IFRS16 Lease Funding:					
Approved IFRS16 Lease Funding	0	1,642		1,642	0
Total Approved IFRS16 Lease funding	0	1,642		1,642	0
Total Capital Funding / Capital Resource Limit (CRL)	52,258	65,258		65,258	0
Applications:					
Discretionary Capital:					
Commitments B/f From 2023/24	284	356	264	255	-101
Statutory Allocations	1,076	1,026	423	1,057	31
Divisional Priorities	3,414	3,435	1,362	3,423	-11
Corporate Priorities	1,267	462	115	462	0
Informatics National Priority & Sustainability	2,257	2,645	1,852	2,645	0
Release of DCP Provision re: Tredegar H&WBC	0	-1,727	-1,727	-1,727	0
Remaining DCP Contingency	1,562	2,608	0	3,547	939
Total Discretionary Capital	9,859	8,805	2,289	9,662	856
All Wales Capital Programme:					
Grange University Hospital (VAT Recovery)	-3,517	-6,481	-6,496	-6,481	0
Tredegar Health & Wellbeing Centre Development	0	2,558	2,126	2,458	-100
NHH Satellite Radiotherapy Centre	15,755	13,980	11,087	13,980	0
YYF Breast Centralisation Unit	0	111	5	111	0
Newport East Health & Wellbeing Centre Development	12,754	12,119	11,445	12,392	273
RGH Endoscopy Unit	0	4	5	5	1
RGH – Block 1 and 2 Demolition and Car Park	230	279	-2	279	0
EFAB Schemes	2,612	2,889	1,356	2,889	0
ED Waiting Area Funding	0	55	54	54	-1
CAMHS Sanctuary Hub	1,202	1,226	1,064	1,226	0
GUH ED Extension	10,879	9,474	3,710	9,474	0
IRCF - Abervalley H&WBC	742	150	148	150	0
IRCF - Dixton H&WBC	742	742	317	742	0
Housing with Care Fund - 2023/24 & 2024/25 Schemes	0	363	211	360	-3
Digital Year End Funding 2023/24	0	73	54	73	0
Diagnostics Funding 2023/24	0	35	37	47	12
Ty Gwent	1,000	1,219	710	1,219	0
End Of Year Funding 2023/24	0	49	27	50	1
Head Lease for Chepstow Community Hospital	0	5,490	5,441	5,490	0
Diagnostic Equipment Funding 2024/25	0	606	144	605	-1
Digital Priorities Investment Funding - RISP & EPMA	0	862	134	862	0
Backlog Maintenance 2024-25	0	4,231	416	3,330	-901
End of Year Funding 2024/25	0	4,000	0	4,000	0
Prior Year AWCP IT VAT provision release	0	-41	-41	-41	0
Centralised Decontamination Unit RGH	0	818	0	679	-139
Total AWCP Capital	42,399	54,811	31,952	53,954	-856
Total IFRS16 Lease Expenditure	0	1,642	1,641	1,642	0
Total Programme Allocation and Expenditure	52,258	65,258	35,883	65,258	0
Forecast Break Even against Overall Capital Resource Limit					0

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	2025/26 Allocation letter briefing
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rob Holcombe - Director of Finance, Procurement & VBHC
SWYDDOG ADRODD: REPORTING OFFICER:	Suzanne Jones – Interim Assistant Director of Finance

Pwrpas yr Adroddiad Purpose of the Report

Er Sicrwydd/For Assurance

This report summarises the baseline recurrent allocation letter for 2025/26 received by the Chair of the Health Board on 20th December 2024. The report shows the total increase in baseline recurrent funding from 2024/25, and the amount of 'new' funding to the Health Board to support unavoidable demand growth and inflationary pressures forecast for 2025/26.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This briefing summarises the funding headlines announced in the revenue Allocation letter (WHC (2024) 051 – dated 20th December 24) and highlights the financial implications for Aneurin Bevan University Health Board's (ABUHB) 2025/26 Financial Plan.

Baseline funding for 2025/26 has increased by **£126.8m** compared with 2024/25 (baseline December 23), a significant element of which relates to 2024/25 in-year recurrent funding. A detailed breakdown of the increase is shown in the Appendix.

Total additional 'new' funding to the Health Board i.e. excluding committed and directed funding is £27.7m. However an estimated £7.7m (1.77% uplift) of this funding will be passed onto NHS provider organisations to cover relevant cost increases in healthcare agreements as directed by WG, leaving approximately **£19.9m** as new funding to the Health Board upon which funding decisions can be made.

Net funding uplift	Committed / Directed (£'000)	LTA / Specialist Services pass- through funding (estimate) (£'000)	New funding available for decision (£'000)	Total 2025/26 funding (£'000)
Baseline funding 2024/25	1,636,590			1,636,590
2024/25 funding received shown in 2025/26 baseline	99,168			99,168
Total funding before uplifts and additional funding	1,735,758	0	0	1,735,758
Core uplift 25/26		7,740	17,372	25,113
Mental Health core uplift 25/26			2,532	2,532
Other funding movements			21	21
Uplifts and additional funding 2025/26	0	7,740	19,925	27,666
Total baseline funding 2025/26	1,735,758	7,740	19,925	1,763,424
Anticipated funding for year-on-year non-recurrent spend				59,424
Central income (estimate)				12,572
Total confirmed and anticipated funding & other anticipated income 2025/26 "Total Budget"				1,835,420

Key points to note:

- Funding for NHS pay awards in 2025/26 is being held centrally and will be allocated to Health Boards once awards are made. Pay award funding for 2024/25 will be allocated in-year once the pay mapping exercise has been completed.
- A total of £2.1m has been top sliced from recurrent baseline funding for the agreed central procurement of Flu vaccines, resulting in a reduction in both discretionary and GMS funding (£0.284m and £1.8m respectively). This procurement will be centrally managed by NWSSP.
- GMS and GDS contractor allocations are issued at this stage at 2024/25 recurrent levels excluding any 2024/25 pay agreement funding.
- Baseline recurrent funding for 2024/25 to support the 2024/25 financial position (£64.5m), and part of the further additional recurrent funding notified by Welsh Government in November 24 (£31m) remains as recurrent in principle only and is conditional on the Health Boards progress towards delivering the target control total.
- Other allocations of £59.4m have been anticipated on top of the baseline allocations where Welsh Government correspondence has been received (see Appendix).
- When comparing the total HCHS & Prescribing allocations (excluding Primary Care contracts) ABUHB's proportionate share of the All Wales allocation for 2025/26 is 18.65%, this represents an increase of 1.12% (£17.5m) from 2024/25 (18.45%) share and *improves* the ABUHB position in terms of formula fair shares.

Cefndir / Background

This briefing summarises the funding headlines announced in the revenue Allocation letter and highlights the financial implications for Aneurin Bevan University Health Board's (ABUHB's) 2025/26 Financial Plan.

The Ministerial letter to Chairs formally issued the 2025/26 revenue allocations to Health Boards, and was received by the Health Board on the 20th December 2024. The allocation reflects the Minister for Health and Social Services decisions about the distribution of resources to Health Boards for the forthcoming year.

Health Boards are expected to achieve and deliver the statutory duties and ministerial priorities in line with the Welsh Government annual priorities for 2025/26, with consideration to the following actions and expectations:

- New funding provided should support unavoidable demand growth and inflationary pressures forecast for 2025/26. There is no discretionary investment funding reflected within the 2025/26 uplift outside of those specified in the funding letter.
- Organisations will need to make significant savings to deliver and implement financially sustainable plans for 2025-26, with a minimum expectation of at least 2% of total baseline expenditure (£35m), and consistent with achievement in the current financial year (2024/25 savings forecast: £43m).
- Savings in the current financial year, actions being taken to deliver target control totals on a recurrent basis, and new savings required in 2025/26, should enable organisations to deliver a sustainable financial position.

The following points relate to other Welsh Government centrally held funding:

- **Pay awards:** Agreed recurrent pay allocations for 2023/24 have been added to the recurrent baseline funding. Due to timing issues, 2024/25 pay allocations for nationally agreed A4C/DDRB/VSM have not been included in the allocation letter and will be a supplementary allocation once the pay mapping exercise has been undertaken. Funding for NHS pay awards in 2025/26 will be held centrally (in full) and allocated to the Health Board once awards are made.
- **Primary Care contract uplifts:** Contract negotiations for General Medical Services (GMS) and the General Dental Services (GDS) have not been finalised for 2024/25, therefore baseline allocations have been issued on the same basis as 2024/25 i.e. excluding any contract uplift for 2024/25. Community Pharmacy contract allocations have been issued at 2024/25 recurrent levels which includes the 2024/25 agreed uplift as per the contract negotiations. A supplementary allocation will be issued when contract agreements have been confirmed.
- **SIFT:** Revenue funding for SIFT and Research and Development will be issued as direct funding to Health Boards.

- **Capital charges:** Allocations for accelerated depreciation, AME depreciation for donated assets, relevant IFRS 16, and DEL and AME impairments will be issued as direct funding in-year to the relevant Health Boards and NHS Trusts. This also applies to any increases in depreciation related to approved schemes with confirmed strategic support.
- **NICE ATMPs:** Funding will be held centrally to recognise the impact of NICE mandated Advanced Therapeutic Medicinal Products (ATMPs). This will be issued in-year aligned with the spend forecast through the Joint Commissioning Committee (JCC).
- **Genomics:** Genomics spend will be monitored centrally and any additional impact for 2025/26 (over and above 2024/25 baseline allocations) will be dealt with as an in-year matter. This will be issued in-year aligned with the spend forecast through JCC.
- **Real Living Wage / National Living Wage:** Funding for the in-year difference between Real Living Wage and the National Living Wage in line with Welsh Government policy (the impact of the policy on Social Care) will be dealt with outside of this allocation.
- **Cystic Fibrosis medicines:** Funding will continue to be retained centrally by WG to fund the costs of purchasing cystic fibrosis medicines Orkambi and Symkevi and to maintain access to Kalydeco (note, costs will also be incurred centrally within WG).
- **HEIW Education and Training:** Funding for education and training investments in 2025/26 will continue to be provided to Health Education and Improvement Wales (HEIW) from the Welsh Government NHS budget, rather than directly to Health Boards.
- **Hospice funding:** Hospice funding will be retained centrally until its allocation to Health Boards, once the Hospice Commissioning Framework is finalised.
- **CHC information:** Funding to support a system for standardising CHC information and intelligence on all Wales basis will be centrally held. Further advice will follow on this.
- **Pension costs:** As in 2024/25, funding to cover the increased employer's contribution for the NHS Pension Scheme will be held centrally in 2025/26.

Revenue Allocation categories

Hospital and Community Health Services (HCHS) allocations are derived from the 2024/25 baseline funding, adjusted for recurrent and new funding issued. The HCHS Revenue allocation is divided into *Discretionary*, *Ringfenced* and *Directed* expenditure funding. It is the total funding available to the Health Board to fund HCHS and Primary Care prescribing costs.

- **Discretionary allocations** – represents the funding available to the Health Board to fund HCHS and Primary Care prescribing costs without restrictions/conditions imposed by Welsh Government.
- **Ring fenced allocations** – represents the minimum the Health Board must invest in specific areas. Ring fencing restraints continue for Learning Disabilities, Mental Health, Planned and Unscheduled Care Sustainability funding, Regional Integration Fund and Depreciation costs.
- **Directed Expenditure** – allocated for specific purposes where the Health Board acts on an Agency basis i.e. pass through for Welsh Government or lead organisation for other Health Boards. This is not part of the population-based funding.

Other significant areas of funding within the Health Board’s total revenue allocations relate to Primary Care Contracts; General Medical Services (GMS), General Dental Services (GDS), and Community Pharmacy. Allocations for GMS, and GDS (including the *Designed to Smile* and *Gwên am Byth* oral health improvement programmes within the GDS contract), are ringfenced in terms of the definition above, therefore the funding within these areas indicates the minimum required spend. The Health Board may, however, invest additional discretionary funding in these services.

Summary of Allocations

Initial baseline funding allocations for the Health Board total £1,763.4m (£1,636.6m, 2024/25). The increase in the baseline from 2024/25 of **£126.8m** includes the recurrent impact of funding issued during 2024/25, new committed funding for 2025/26, and inflationary uplifts. A summary of the increase in baseline funding across funding categories is shown in the table below, with a detailed breakdown contained within the Appendix:

Category	2024/25 Baseline £M	2025/26 Allocation letter £M	Change in baseline allocation £M	% change
HCHS and Prescribing				
Discretionary	1,211.4	1,329.2	117.8	9.7%
Protected and Ringfenced	245.5	254.4	8.9	3.6%
Directed Expenditure	1.5	1.5	0.0	2.4%
Total HCHS and Prescribing	1,458.3	1,585.1	126.7	8.7%
General Medical Services	108.7	106.9	(1.8)	-1.7%
Community Pharmacy	34.9	36.8	1.9	5.4%
General Dental Services	34.6	34.6	0.0	0.0%
Total baseline allocations	1,636.6	1,763.4	126.8	7.7%

Table 1 - Summary Revenue Allocations 2025/26

A summary of the main movements within each category are:

- **HCHS Discretionary:** funding increase of £117.8m predominantly due to:
 - recurrent pay award funding for 2023/24 (£49.4m of which £6.4m is pass through to JCC)
 - additional recurrent funding issued in 2024/25 £40.5m, comprising £9.5m recurrent funding for evidenced inflationary pressures, and £31m recurrent funding conditional on specified conditions being met.
 - funding for Optometry contract reform (£3.0m) comprising £2.2m which was held centrally by Welsh Government in 2024/25, and a negotiated agreed increase of £0.8m relating to 2024/25.
 - **2025/26 core uplift (£25.1m) based on 1.77% increase on the recurrent discretionary allocation, the ring-fenced allocation (excluding mental health and depreciation) and directed expenditure.**
 - Other baseline funding adjustments (net reduction of £0.2m) including a top slice (to NWSSP) of £284k for the central procurement of flu vaccines, and recurrent funding of £72k for the Cost Uplift Factor (CUF) England previously issued in-year.
- **Ringfenced:** total ringfenced funding of £254.4m representing 14% of the Health Boards total funding for 2025/26. Increase in funding of £8.9m due to:
 - Mental Health Service Improvement funding (SIF) for 2022/23 (£4.2m) and 2023/24 (£1m) has been transferred from WG central budgets into the Health Board's baseline ringfenced funding.
 - additional funding for Genomics (£1m) to be directed through JCC
 - Hospice funding of £0.2m to be provided directly to Hospices delivering core NHS services.
 - core uplift for Mental Health Services (£2.5m).
- **Directed expenditure:** Directed funding total £1.5m, a net increase of £0.036m compared to 2024/25 due to Specialist Registrar (SpR) funding being included as part of baseline recurrent allocations (£0.125m - previously allocated non-recurrently each year), a reduction in funding for Medical Emergency Response Incident Team (MERIT) of £0.025m due to work no longer undertaken by the Health Board, and a further reduction due to realignment of National Lymphedema funding (£0.064m) between Aneurin Bevan and Swansea Bay.
- **Primary Care contracts:** Contract negotiations for GMS and the General Dental Services (GDS) contract have not been finalised for 2024/25, therefore baseline allocations have been issued on the same basis as 2024/25 i.e. excluding any contract uplift for 2024/25. A supplementary allocation will be issued when the 2024/25 contract agreement is confirmed. Uplifts for 2025/26 for GMS, GDS and Community Pharmacy will be agreed in due course.

- **GMS:** Funding adjustments have been made to the baseline position in relation to a Global Sum uplift for 24/25 due to list size increases (+£0.028m), and a top-slice of funding from GMS to reflect the Central Procurement of Flu Vaccination costs (-£1.8m).
- **Community Pharmacy:** Recurrent funding of £1.9m included in the baseline to reflect the 2024/25 agreed uplift as per the contract negotiations.
- **General Dental Services:** Dental patient charges were increased 1st of April 2024. No changes were made to 2024/25 dental contract patient charge targets as a result of the increase, and any increased patient charge revenue have been utilised by Health Boards to offset the current shortfall against the targets set in baseline dental contract allocations. No funding adjustments have been actioned for 2025/26.

Total additional 'new' funding to the Health Board i.e. excluding committed and directed funding is £27.7m, however an estimated £7.7m of this funding will be passed onto provider organisations to cover relevant cost increases in healthcare agreements, leaving approximately **£19.9m** as new funding to the Health Board upon which funding decisions can be made as shown in the following table:

Net funding uplift	2025/26 funding (£'000)
Core uplift 25/26 (1.77%)	25,113
Mental Health core uplift 25/26 (1.77%)	2,532
Other funding movements	21
Gross uplifts	27,666
LTAs and Specialist Services pass-through (estimated based on 1.77%)	(7,740)
Net available new funding 25/26	19,925

Table 2- Net uplift summary

Notes to Table 2:

- **Core uplift for 2025/26 - £25.1m (£46.9m, 2024/25) –**
 - The Welsh Government draft budget provides £131m of funding across Welsh Health Boards to meet core cost inflation and unavoidable demand pressures for 2025/26. The Health Board's element of £25.1m equates approximately to a 1.77% increase (3.64% increase, 2024/25) on the total of recurrent Discretionary allocation, Ring Fenced (excluding mental health and depreciation) and Directed Expenditure.
 - In relation to Healthcare agreements with other Health Boards and NHS Trusts, Welsh Government have stipulated that 1.77% core uplift for demand and inflation is expected to 'unequivocally' pass through from commissioners to providers. For ABUHB, this pass through element is estimated to be £7.74m as shown in Table 2.

- In addition to the expected efficiencies detailed in the allocation letter (i.e. minimum of 2% of total baseline expenditure, and consistency with achievement in the current financial year), the core uplift provides support for new non-pay inflationary growth in particular for areas such as medicines.
- **Mental Health core uplift £2.5m (£4.9m, 2024/25)** - additional funding for Mental Health equivalent to 1.77% of the 2023/24 baseline for Mental Health Services, to fund unavoidable cost and demand growth.
- **Other funding movements £0.021m** – Additional £45k with regards to the expected inflationary pressures funding announced in November 24, less reduction of £25k for the Medical Emergency Response Incident Teams (MERIT) as the service is no longer provided by the Health Board.

Application of the uplifts will be determined via the Annual Plan & Budget setting process.

Further Notes on other allocations.

- **Cost Uplift Factor (CUF) England £0.072m** - Funding has been included for the impact of the 2024-25 CUF England (£0.041m JCC), which were issued as in year allocations in previous years, over and above the core cost inflation (3.67%) in the 2024-25 allocation letter
- **Depreciation** - The DEL depreciation budget remains ring-fenced and is a non-cash allocation. The depreciation ring-fence includes the allocation made here as well as for any non-recurrent funding that is issued in-year to cover accelerated depreciation, DEL impairments and further support for strategic schemes and baseline pressures.
- **Substance Misuse** - this remains ring-fenced in 2025/26 and will be withheld from Health Boards until confirmation is received from the Chair of the relevant Area Planning Board (APB) that the use of these resources complements the delivery of the Welsh Government Substance Misuse Delivery Plan (£3.5m for the Health Board following an uplift of £78k).
- **Infrastructure SIFT** - Funding for infrastructure SIFT (£0.7m) has been included as a Directed Expenditure Allocation. This funding must be used to support medical undergraduate education, and recipients of this funding will still be required to account for its use as part of the annual SIFT accountability agreements.
- **Dental Patient Charges** - Increases to dental patient charges have recently been agreed from the 1st of April 2024. No changes have been made to dental contract patient charge targets as a result of the increase, and any increased patient charge revenue should be utilised by health boards to offset the current shortfall against the targets set in baseline dental contract allocations.
- **Discretionary Capital** – The capital discretionary baseline funding has been confirmed as £12.875m, an increase of £2m compared to 2024/25.

Anticipated Allocations

The funding included in the baseline position for the Health Board (detailed within this document) is recurrent in nature and will form part of the rolled-forward baseline position for future years. The Health Board also assumes further funding within its financial plan which can be recurring or non-recurring and will be indicated by way of individual WG funding letters during the financial year.

These additional allocations can be anticipated within the financial position in situations where official confirmation from Welsh Government has been received by the Health Board that funding will be issued for a specified period of time (e.g. successful bids for projects), or funding is recurring in nature however is not included within the baseline allocations for the Health Board (e.g. due to uncertainty of the period of the activity or if the funding values can vary based on actual spend from one year to the next). A full list of anticipated allocations is reported to the Board and to Welsh Government as part of the monthly reporting timetable.

A list of anticipated allocations assumed for 2025/26 as of December 24, can be reviewed in the Appendix.

The Minister for health and Social Services reiterates in the allocation letter the challenging financial position for Welsh Government and NHS Wales, and that significant uplifts have been issued to support the NHS and protect front line services. The letter also states that the focus remains on delivering Welsh Government and Health Board priorities efficiently and effectively, along with ensuring strong and effective financial management arrangements that support strong cost control, in support of financial delivery in 2025/26

Argymhelliad / Recommendation

The Board is asked to NOTE the contents of this report, including:

- The new 25/26 allocations, specifically the uplift,
- The allocations that are held centrally,
- The 2024/25 allocations made recurrent, and
- Allocations that have conditions attached.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	SRR001
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources Governance, Leadership & Accountability All Health & Care Standards Apply Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	WG allocation letter 2025/26
Rhestr Termau: Glossary of Terms:	A&C – Administration & Clerical A&E – Accident & Emergency A4C - Agenda for Change AME – (WG) Annually Managed Expenditure AQF – Annual Quality Framework AWCP – All Wales Capital Programme AP – Accounts Payable

	AOF – Annual Operating Framework ATMP – Advanced Therapeutic Medicinal Products B/F – Brought Forward BH – Bank Holiday C&V – Cardiff and Vale CAMHS – Child & Adolescent Mental Health Services C/F – Carried Forward CHC – Continuing Health Care Commissioned Services – Services purchased external to ABUHB both within and outside Wales COTE – Care of the Elderly CRL – Capital Resource Limit Category M – category of drugs CEO – Chief Executive Officer CEAU – Children’s Emergency Assessment Unit CTM – Cwm Taf Morgannwg D&C – Demand & Capacity DCP – Discretionary Capital Programme DHR – Digital Health Record DNA – Did Not Attend DOSA – Day of Surgery Admission D2A – Discharge to Assess DoLS - Deprivation of Liberty Safeguards DoF – Director(s) of Finance DTOC – Delayed Transfer of Care EASC – Emergency Ambulance Services Committee ED – Emergency Department EDCIMS – Emergency Department Clinical Information Management System eLGH – Enhanced Local general Hospital EFAB – Estates Funding Advisory Board ENT – Ear, Nose and Throat specialty EoY – End of Year ETTF – Enabling Through Technology Fund F&T – Family & Therapies (Division) FBC – Full Business Case FNC – Funded Nursing Care GDS – General Dental Services GMS – General Medical Services GP – General Practitioner GWICES – Gwent Wide Integrated Community Equipment Service GUH – Grange University Hospital GIRFT – Getting it Right First Time HCHS – Health Care & Hospital Services

HCSW – Health Care Support Worker
 HIV – Human Immunodeficiency Virus
 HSDU – Hospital Sterilisation and Disinfection Unit
 H&WBC – Health and Well-Being Centre
 IMTP – Integrated Medium Term Plan
 INNU – Interventions not normally undertaken
 IPTR – Individual Patient Treatment Referral
 I&E – Income & Expenditure
 ICF – Integrated Care Fund
 LoS – Length of Stay
 LTA – Long Term Agreement
 LD – Learning Disabilities
 MH – Mental Health
 MSK – Musculoskeletal
 Med – Medicine (Division)
 MCA – Mental Capacity Act
 MDT – Multi-disciplinary Team
 MMR – Welsh Government Monthly Monitoring Return
 NCA – Non-contractual agreements
 NCN – Neighbourhood Care Network
 NCSO – No Cheaper Stock Obtainable
 NI – National Insurance
 NICE – National Institute for Clinical Excellence
 NHH – Neville Hall Hospital
 NWSSP – NHS Wales Shared Services Partnership
 ODTC – Optometric Diagnostic and Treatment Centre
 OD – Organisation Development
 PAR – Prescribing Audit Report
 PCN – Primary Care Networks (Primary Care Division)
 PER – Prescribing Incentive Scheme
 PICU – Psychiatric Intensive Care Unit
 PrEP – Pre-exposure prophylaxis
 PSNC – Pharmaceutical Services Negotiating Committee
 PSPP – Public Sector Payment Policy
 PCR – Patient Charges Revenue
 PPE – Personal Protective Equipment
 PFI – Private Finance Initiative
 RGH – Royal Gwent Hospital
 RN – Registered Nursing
 RRL – Revenue Resource Limit
 RTT – Referral to Treatment
 RPB – Regional Partnership Board
 RIF – Regional Integration Fund

	SCCC – Specialist Critical Care Centre SCH – Scheduled Care Division SCP – Service Change Plan (reference IMTP) SLF – Straight Line Forecast SpR – Specialist Registrar STW – St.Woolos Hospital TCS – Transforming Cancer Services (Velindre programme) T&O – Trauma & Orthopaedics TAG – Technical Accounting Group UHB / HB – University Health Board / Health Board USC – Unscheduled Care (Division) UC – Urgent Care (Division) ULP – Underlying Financial Position VCCC – Velindre Cancer Care Centre VERS – Voluntary Early Release Scheme WET AMD – Wet age-related macular degeneration WG – Welsh Government WHC – Welsh Health Circular WHSSC – Welsh Health Specialised Services Committee WLI – Waiting List Initiative WLIMS – Welsh Laboratory Information Management System WRP – Welsh Risk Pool YAB – Ysbyty Aneurin Bevan YTD – Year to date YYF – Ysbyty Ystrad Fawr
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Finance & Performance Committee

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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

2025/26 Baseline movements	24/25 funding, now confirmed in baseline £'000	Committed programme £'000	Pass through to other Health Boards / Trusts (estimate) £'000	Net additional Discretionary funding £'000	Total 2025/26 £'000
Baseline funding 2024/25	1,636,590				
<u>HCHS Discretionary</u>					
Optometry contract reform (additional activity)		2,223			2,223
Optometry contract reform (2024-25 pay agreement)		767			767
Topslice for Central Procurement of Flu Vaccines		(284)			(284)
Pay Mapping 2023-24	42,972				42,972
Pay Mapping JCC 2023-24	6,378				6,378
Revised 24-25 Cost Uplift Factor (CUF) England		31			31
Revised 24-25 Cost Uplift Factor (CUF) England JCC		41			41
24/25: Evidenced inflationary pressures	9,500			45	9,545
24/25: Conditional funding	31,000				31,000
Core Cost and Demand Uplift for 2025-26 (1.77%)			7,740	17,372	25,113
<u>Ringfenced</u>					
Palliative care / Bereavement / Hospice funding		187			187
Genomics for Precision Medicine Strategy		1,026			1,026
<u>Mental Health Services</u>					
MH: Service improvement funding 22-23	4,199				4,199
MH: Service improvement funding 23-24	976				976
MH: Core Cost and Demand Uplift (1.77%) 2025-26				2,532	2,532
<u>Directed Expenditure</u>					
Medical Emergency Response Incident Teams (MERIT)				(25)	(25)
National Lymphedema funding		(64)			(64)
SpR allocation	125				125
<u>GMS Contract</u>					
Topslice: Central procurement of Flu Vaccine costs		(1,828)			(1,828)
GMS: Global Sum / PSP List Size Increase 2024-25	28				28
<u>Pharmacy Contract</u>					
Pharmacy contract: 24-25 agreed uplift CPCF	1,891				1,891
Net movement in baseline funding 25/26	97,069	2,099	7,740	19,925	126,834
Baseline funding 2025/26	1,763,424				
Anticipated funding for year-on-year non-recurrent spend	59,424				
Central income (estimate)	12,572				
Total confirmed and anticipated funding 2025/26	1,835,420				

Anticipated funding - December 2024

HCHS	£'000
Pay award-Substantive	28,784
Medical and Dental Pay Award 24/25	8,042
Pay award-Substantive Consultant	4,996
Real Living Wage 24/25	4,001
Substance Misuse & increase	3,402
Capital - DEL Depreciation - IFRS 16 Leases	3,166
Pay award-SLE	2,774
RIF Dementia	1,611
New Medical Training Posts 2017-2022 cohorts	1,400
AHW:Prevention & Early Years allocation	1,114
CAMHS In Reach Funding	817
Memory Assessment Services - Gwent RPB	565
VBH: Heart Failure and Rehab in the Community	506
Pay award-Bank	503
Clinical Excellence Awards (CDA's)	298
Mental Health 111 Press 2 service funding	285
WHSSC - National Specialist CAMHS improvements (Tier 4)	234
RSV funding 24/25 - HCHS element	197
Learning Disabilities-Improving Lives	64
Capital - AME Depreciation - IFRS 16 Leases (Peppercorn)	62
Neighbourhood District Nursing (incl. B3 and B4 staff developmen	21
Invest to Save Omnicell	(80)
Revenue Lease Payment Budget Reduction (IFRS16 Prop)	(944)
Revenue Lease Payment Budget Reduction (IFRS16 Equip)	(2,173)
Welsh Risk Pool Risk Share agreement (24/25)	(5,776)
Total HCHS anticipated allocations	53,869
GMS	
GP Pay/expenses uplift	3,801
GMS Refresh	1,603
RSV funding - GMS element	152
Total GMS anticipated allocations	5,556
Total Anticipated funding at January 24	59,424

Anticipated Allocations have been delegated to Divisions as part of the 2024/25 budget setting process. There is a risk to the HB position if the anticipated allocations are not received.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategic Risk Report, January 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Chief Executive Officer
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

This report provides the Board with an assessment of strategic risks associated with its key priorities and provides assurance that these risks are being managed effectively.

Cefndir / Background

The Strategic Risk Report, presented to the Board on 26 November 2024, led to the approval of a reduction in the risk score for SRR 001I, from 16 (Extreme) to 12 (High). This adjustment reflects the improvements in mitigation strategies and the increased effectiveness of current control measures.

Additionally, the Board approved the separation of SRR 004 into two distinct risks, as the combined structure had failed to assess accurately the differing risks of Major Incident and Business Continuity preparedness. While Major Incident readiness is robust, Critical Incident preparedness remains underdeveloped due to inconsistent business continuity arrangements. This separation intends to improve accuracy, transparency, and risk management.

The Strategic Risk Register status as presented in Table 1, reflects the position up to the end of November 2024. It is important to note that **SRR 001H**, **SRR 003**, and **SRR 009** have been de-escalated previously to corporate or divisional risk levels and

are therefore excluded from the table. Furthermore, **SRR 001E**, **SRR 004A**, **SRR 007A**, and **SRR 008** hold a risk score of 8 (Moderate risk), so they are not represented within the risk level columns.

The table delineates risks categorised as either 'High' or 'Extreme' only.

Table 1

Overarching Strategic Risk Description	Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (9 – 12)	Extreme (15 – 25)		
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.	A, B, C & D	3	1	People	People and Culture Committee
	*E & F	-	1	Service Delivery	Partnerships, Public Health & Planning Committee
	G	-	1	Financial Sustainability	Finance and Performance Committee
	I	1	-	Compliance and Safety	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	A & B	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	*A & B	1	-	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	A	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	A, B & C	3	-	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	*A & B	1	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	*A	-	-	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee

SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	A	1	-	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
TOTAL	20	12	4		

*- represents the moderate risks not accounted for in the risk level totals.

Asesiad / Assessment

Strategic Risk Register

In line with best practice, all strategic risks have been thoroughly reviewed to confirm that the control environment remains robust and adequate for managing the identified risks. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Where it has been determined that the existing controls are insufficient, the necessary additional controls have been documented, and actions are currently being taken to address these gaps. Similarly, assurances are evaluated across all three lines of defence to ascertain the effectiveness and reliability of the controls in place. If gaps in assurance are identified, the control environment is reassessed, and appropriate measures are implemented to close these gaps.

Developments in Risk Profiles

Since the Board's last report in November and the subsequent review of strategic risks, the overall risk environment has remained stable. Of the 20 identified sub-risks, only one has had movement in terms of change to its risk score and the exposure levels. Additionally, horizon scanning, has identified a potential new risk.

Change to Risk score and Exposure

SRR 001A: 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; due to an inability to recruit and retain staff across all disciplines and specialties.

This paper seeks the Board’s approval of the revised workforce risk assessment, contained in **Appendix A** reflecting improvements achieved through ongoing recruitment, retention, and governance measures.

While workforce challenges remain a strategic priority, evidence suggests that the likelihood of responding to sustained challenges is improving. Therefore, it is proposed that the likelihood score be reduced from 4 (Likely) to 3 (Possible), while retaining the impact score at 4 (Major) to account for ongoing vulnerabilities in patient care and compliance. The revised risk score would therefore be 12 (High).

Key developments support this reassessment are as follows:

- Recruitment efforts, including national and international campaigns such as BAPIO and Kerala initiatives, have reduced vacancies, with 51 WTE positions filled by September 2024.
- Retention-focused initiatives, such as career pathways, flexible working policies, and pension reforms, are showing early signs of success, supported by dashboards that track and address turnover trends.
- Plans to reduce reliance on agency staff have begun to control costs and stabilise resources.
- Monitoring and governance improvements have further strengthened workforce management.
 - Enhanced reporting mechanisms, including weekly shift reports and monthly sickness monitoring, ensure proactive oversight, while e-rostering and medical staffing systems improve deployment and planning.

These measures have contributed to reduced reliance on temporary staff, better resource utilisation, and the development of training opportunities to address long-term workforce gaps.

The Board is therefore asked to approve the revised risk assessment, reflecting these positive trends while maintaining appropriate caution regarding remaining challenges.

Identified New Risk

The proposed new risk, presented for the Board's approval, highlights the increasing challenges of achieving the Welsh Government’s decarbonisation targets. This addition ensures that appropriate governance and oversight mechanisms are in place to address these emerging risks effectively. A high-level summary of the proposed risk is provided in the table below, with a detailed risk assessment included in **Appendix B**.

Proposed NEW Overarching Strategic Risk Description		
Risk Theme – Service Delivery Risk Appetite – OPEN (Score of 17 or below)		Risk Rating and Score
SRR 011: The Health Board is at risk of failing to meet the Welsh Government's Public Sector emissions reduction targets of 16% by 2025 and 34% by 2030.		
Sub-risk	Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected	Extreme 15 (L5 x I3)

In 2024, Internal Audit assessed the Health Board’s progress against the NHS Wales Decarbonisation Strategic Delivery Plan and issued a limited assurance opinion. The audit concluded that the Health Board is unlikely to meet the Welsh Government’s carbon reduction targets for 2025 and 2030.

Despite this finding, the Health Board has established a robust governance framework to oversee its decarbonisation programme, led by the Director of Finance and

Procurement. The Decarbonisation Programme Board (DPB), coordinated by the Clinical Futures Team, provides a structured approach for planning, implementing, and monitoring progress against the initiatives outlined in the NHS Wales Decarbonisation Strategic Delivery Plan. This framework includes the development of a Decarbonisation Action Plan (DAP), supported by the establishment of sub-groups and performance metrics that are regularly reviewed by the DPB. Progress against the DAP is reported to key forums, including the Executive Committee, the Finance and Performance Committee, and the Board.

To address identified risks, Internal Audit has recommended strengthening governance and oversight by integrating decarbonisation efforts into the Board’s Strategic Risk Register (SRR). The introduction of SRR 011 will ensure that decarbonisation is given appropriate focus, enabling the mitigation of significant risks and support the delivery of the Decarbonisation Action Plan.

The Board is therefore asked to approve the inclusion of the newly identified strategic risk in the Strategic Risk Register.

Risk Exposure

The infographic below offers a comprehensive overview of the Health Board's current risk exposure across the 20 strategic sub-risks. Additionally, SRR 011, though pending Board approval, is included to enhance transparency and provide a complete view of the Health Board’s strategic risk profile.

The majority of these risks are positioned along the central-right quadrant of the risk matrix, reflecting a high level of risk exposure. Notably, six of these risks exceed the Board's established risk appetite.

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)				1 x (Extreme)	
4. Likely (61-90%)				1 x (Extreme)	
3. Possible (41-60%)			1 x (High)	↓ 12 x (High)	1 x (*1) (Extreme)
2. Unlikely (11-40%)				4 x (Moderate)	
1. Rare (1-10%)					

(*1) SRR 011 - Board approval required
↓
The move in risk score and exposure

Risks outside of Appetite

If the Board approves the proposed changes to the Strategic Risk Register, there will be **nine** principal risks with a total of **21** sub-risks. Of these **21** sub-risks, **seven (SRR 001G & I, SRR 002A & B, SRR 004B, SRR 010 and SRR 011)** currently exceed the acceptable risk thresholds for their respective domains.

In line with best practice, ongoing discussions with executive leads and responsible officers continue to focus on identifying additional mitigation measures to reduce the likelihood or impact of these risks.

Furthermore, the revised approach to risk reporting to Committees remains in place to enhance focused scrutiny. At each Committee meeting, reports now highlight one to two priority risks, selected based on their exposure relative to the Board’s agreed risk thresholds. This targeted approach enables Committees to conduct more in-depth reviews of high-exposure risks, providing stronger assurance on the management and mitigation measures in place as well as supports more robust oversight and better-informed decision-making.

Argymhelliad / Recommendation

- The Board is requested to:
- **APPROVE** the inclusion of **SRR 011** onto the Strategic Risk Register;
 - **APPROVE** the reduction in risk score and exposure for **SRR 001A**;
 - **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report;
 - **NOTE** the risks that remain outside of the agreed-upon appetite for their respective risk domains, recognising the ongoing efforts to mitigate these risks and bring them within acceptable levels.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
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 Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
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:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

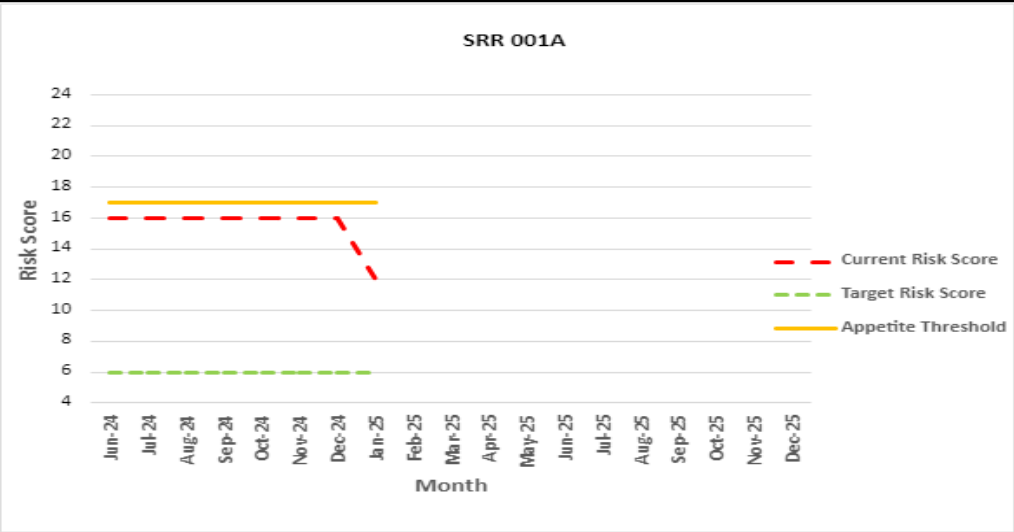
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service 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	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

https://futuregenerations.wales/about-us/future-generations-act/	

				Risk Score Matrix												
Risk Description				2	4	5	6	8	9	10	12	15	16	20	25	
SRR 001	Director of workforce and OD	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	a)Due to an inability to recruit and retain staff across all disciplines and specialities.				X←	---	---	---	●		◇			
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff						X←	---	---	●		◇		
			c) Due to insufficient and ineffective leadership levels throughout the organisation.				X←	---	---	---	---	●		◇		
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level					X←	---	---	---	---	●		◇	
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs				X←	●						◇		
			f) Due to unsustainable service models				X←	---	---	---	---	---	●		◇	
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan					X←	---	---	---	---	---	---	◇	●
	Director of Strategy, Planning and 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.					◇X←	---	---	---	---	●			
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	X←	---	---	---	---	◇	---	---	---	---	---	●	
			b) Due to significant levels of backlog maintenance				X←	◇	---	---	---	---	---	---	---	---
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident				X←	●◇								
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.				X←	◇	---	---	---	---	---	---	---	---
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow						X←	---	---	---	---	◇		
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					X←	---	---	---	---	---	◇		
			b) Due to an adverse impact on service delivery in the implementation of new digital systems				X←	---	---	---	---	---	---	---	◇	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future					X←	---	---	---	---	---	---	---	◇
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.		X←	---	---	---	---				◇			
			b) Due to the impact of fragile services across the regional and supra regional geography		X←	---	---	---	---	---	●		◇			
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement		X←	---	---	---	---				◇			
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				X←	◇	---	---	---	---	---	---	---	

Key	Current Score	●
	Target Score	×
	Appetite Threshold	◇
	Current to target	←

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 effectively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficient in telling us that the controls in place are working effectively with substantial gaps identified which need to be addressed.

RISK THEME	PEOPLE				
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	a. Due to an inability to recruit and retain staff across all disciplines and specialties.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Non-compliance with safe staffing principles and standards - Reliance on agency and bank staff - Litigation & Financial Penalties				Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
					Expected Date Target Score will be Achieved –
					
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)	
Last Reviewed	01 January 2025	Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (quarterly based on risk score)	01 April 2025				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Monitoring Framework to support roll-out of the People Plan. - Workforce Dashboard to track activity – recruitment, turnover, sickness absence. - Supply and demand tracker (Nursing and HCSW). - People Plan tracker to support delivery of actions within the People Plan 2022-25. - Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. - Management of attendance through All Wales Management Attendance at Work Policy. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. - Nurse Staffing Levels (Wales) Act 201625b/25c. - Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. - Workforce planning supported by Compendium of new roles to support innovative workforce models. - Recruitment KPI's. - IMTP (Integrated Medium-Term Plan) Educational Commissioning. - Workforce Establishment controls national working group has been instigated. - Value and Sustainability Board. - Collective Agreement (Non-Pay Deal) 2022/24 Recruitment - Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor.	Retention - Development of career pathways (e.g., non-clinical to clinical). - NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 - Short project in progress with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis is underway with a 5 year past dataset shared. Variable Pay Reduction - Development of action plan based on WHC to support the reduction in bank and agency usage. E- Systems - Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. - Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill. - Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. - Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles. Development of alternative and new roles

- Annual programme of Apprentice recruitment - Overseas Nursing (All Wales Recruitment programme) - Nursing Workforce Strategy agreed. - Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) - Partnerships with employability schemes and FE/HE to widen access. - Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. - Working with partners to improve visibility and attraction - DBS Policy in place with DBS risk assessment form Retention - Retention lead appointed with programme action plan in place for the next two years. - Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. - Week of events planned to support retention agenda in June 2024. This will include a mixed method of online webinars, videos and retention materials. - Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. - Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return. - Development of HCSW skills matrix and career framework has commenced. - Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee. - Career conversations and succession planning resources designed; workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked. - All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline. Variable pay reduction - Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. E- Systems - Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all ‘live’ and rolled out within the Health Board. - E-Rostering is planned to go live shortly following ESR interface testing, provisionally scheduled for the end of January 2025. - Development of alternative and new roles - A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent, and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care - The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management. Training - The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2025 and beyond which are required to support turnover and existing vacancies in addition to external recruitment and internal training developmental programmes. - The 2024/25 education training plan demonstrated very few increases on previous years for students graduating in 2027 and beyond. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice. - HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience. - RCN Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (12 supported so far this year, with 3 more to interview) - Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - K102 bridging model now being offered to support HCSW pathways into registered nursing.	- Continued implementation of new roles such as Physician Associates, CAAPs, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. - Establishment of Mental Health Workforce Planning through HEIW leadership of Mental Strategic Workforce Plan and allocation of workforce planning resources and training programme currently being delivered to Health Boards. - Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. - Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology - Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. - Increasing consultant therapy and nurse practitioners. - RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027. - Development of new roles and career pathways to support hard to fill roles in Health Visiting. - Re-design of the Health Board’s work experience programme with 246 applicants since March 2024 and 75 placements confirmed Training - HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy - Workforce planning training prospectus of local and online training launched September 2024 - Development opportunity being scoped for Business support staff. - Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. 236 attendees in July 2024. - Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire. - Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies. - A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention. 31 staff enrolled on workforce planning on line training modules level 1. 15 managers enrolled on level 2 training delivered locally March 25.

- Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) is in its second year. Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024. Nursing and Midwifery Academy for senior level nurses and midwives, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff. - Delivery of workforce planning training Vacancy Numbers and establishment control - Quarterly reporting of vacancy numbers for each staff to the WG as of 30th September 2024 were 585 WTE a reduction of 51 WTE since March 2024. - Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan has been developed and project workstream established and work commenced. National work programme proposal is also in development to assess digital solutions Staff attendance - Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. “Hot spot” areas identified and plans in place to support	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Workforce reports to the Nurse Strategic Workforce Group. - Monthly sickness monitoring reports. - Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. - Medical Staffing Co-ordinator review of medical rotas. - Cross site operational calls. - Occupational Health and Wellbeing dashboards report KPIs. - Recruitment KPIs - Medical & Dental and Student Streamlining fill rate reports		
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 - Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. - Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. - Measurements of Wellbeing through the ABUHB (Aneurin Bevan University Health Board) Staff Survey - Routine Reporting against nurse staffing levels. - Variable Pay Programme Board reporting to Value and Sustainability Board		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
- Internal Audit Reviews 2023 -24 - Long Term Sickness Absence Management (Q4) - Flexible Working (Q4) - External quarterly vacancy reporting to WG - External reporting on Nursing Staffing Levels - National Acuity Audits (Nursing) - National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative. - Workforce planning external audit action plan 2024	Latest local survey saw a reduction in staff wellbeing	Internal Audit Staff Culture Q3 2024/25
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		

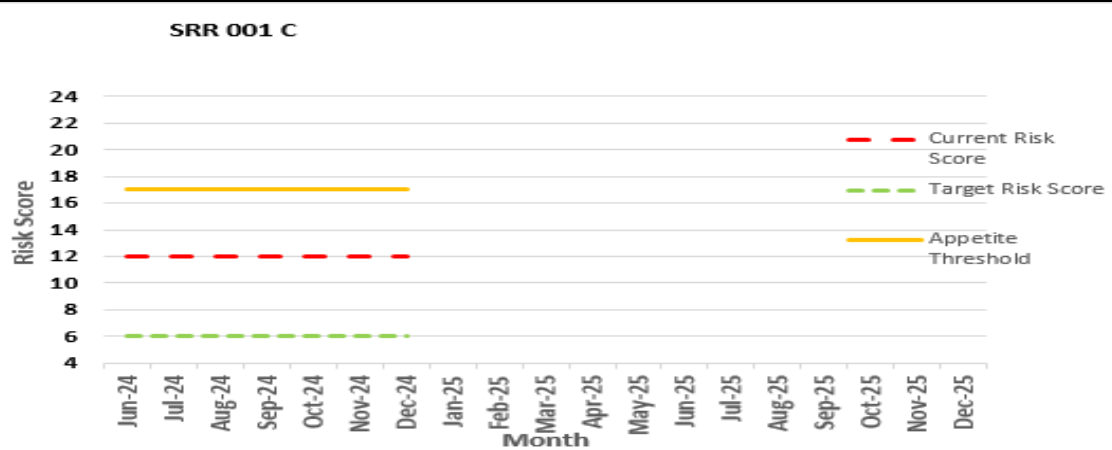
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Positive Assurance

RISK THEME	PEOPLE					
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status	Public
Strategic Threat	b. Due to a deterioration in, and a failure to improve, the well-being of staff.				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- High absence levels, with some sustained long periods - Adverse impacts on delivery of care to patients across acute and non-acute settings - Non-compliance with safe staffing principles and standards - Reputational damage to the health board as an employer - Work-related claims - Financial Implications				Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
					SRR 001 B </	

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
General - Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. - Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. - Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. - Strategic Equality plan - Rest and Facilities charter – monitoring and compliance. - Staff related policies. - National Staff Survey and Health Board Employee Experience Survey - External Employee Assistance Programme - Speaking up Safely action plan - Race/LGBT groups. - Wellbeing resources - Staff diversity networks - Regular Schwartz rounds arranged across the Health Board	General - Increase wellbeing initiatives. - Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders). - Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. - Trained mediators so there is team and organisational resilience and network. - Scope, design and deliver a programme of research ‘Healthy Working Day’. - Enhanced our financial well-being offer. - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales. Occupational Health. - Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted.

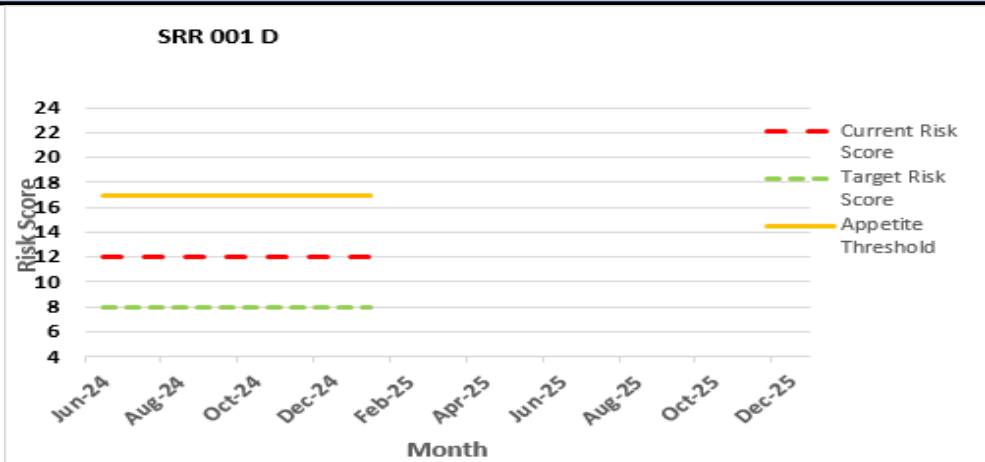
• Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Chaplaincy service for staff • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits • The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. • an externally commissioned SUS hotline will be piloted in September 2024. • An external Employee Assistance Programme (Vivup) has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. Waiting times have now reduced on average by 30%. Occupational Health • Additional occupational health resources secured to reduce waiting times. • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. • Support equality and diversity of workforce. • A part time Disability Inclusion Officer has been seconded to the EDI Team (December 2023 – December 2024). • Band 5 EDI Officer appointed and commence in post at the end of March 2024. • Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. • Reverse Mentorship Programme launched February 2024. Other • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC • Reducing fatigue poster developed.	• Submission of response to All Wales KPI delivery and ongoing data analysis review in place. • Recently appointed 8a role to provide further clinical leadership and key priority for M1-3 is to undertake training needs analysis to develop OH team. • Support equality and diversity of workforce. • Review of staff diversity networks. • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
• Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services	• Understand if support is reaching all staff	• Meetings with Divisions ongoing to ensure all areas are aware of what’s available.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
• People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and Facilities		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
• National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter • Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively. Positive Assurance

RISK THEME	PEOPLE			
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Strategic Threat	c. Due to insufficient and ineffective leadership levels throughout the organisation			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	- 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; - Poor levels of accountability and delivery; - Reputational damage to the health board as an employer; - Adverse impacts on staff recruitment and retention			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 December 2024	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 March 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>
- Talent and Succession Planning - Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. - Monitoring Frameworks with HEIW - Lead appointed July 2023 on secondment funded by HEIW to create organisational talent management framework to enable to organisation to be deliberate and consistently attract, identify and develop talent for critical roles across ABUHB. - HEIW schemes 1 x HEIW funded graduate managements trainee successfully appointed August 2023 following additional recruitment process. - Develop Leadership Capabilities - Leadership journey and programmes mapped and 1 pager flyer designed and on intranet. Leadership development offer now available for entry level leaders and mangers, clinical directors, directorate manager development programme DMx to launch Q1 2024/25, senior nurses and multi-disciplinary teams. - Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations. - Leading people programme (starting cohort 8 may 2024) 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire council; our graduate joined the health board in March 2023 and is supporting the decarbonisation agenda.	Talent and Succession Planning - Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. Development leadership capabilities - Currently exploring leadership funding options with USW in order to maximise Governmental Grants and utilisation of the apprentice levy. - Continued commitment to NHS graduate schemes.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- WOD Divisional reporting - Evaluation of internal leadership programmes and regular review of our internal offer		
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
Reporting to People and Culture Committee - progress against People Plan 22-25		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
- Internal Audit Review - Talent and Succession Board		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Positive Assurance		

RISK THEME	PEOPLE					
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status	Public
Strategic Threat	d. Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Non-compliance with safe staffing principles and standards - Litigation & Financial Penalties - Reputational damage to the health board and loss of public confidence				Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
					SRR 001 D 	
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level		
Monitoring Committee	People & Culture Committee	Likelihood	3 <i>(Possible)</i> x	3 <i>(Possible)</i> x		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>		
Last Reviewed	01 December 2024	Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>		
Next Review (Quarterly based on risk score)	01 March 2025					

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- All Wales Industrial Action Planning Group - Local Health Board planning arrangements - Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and - CODE OF PRACTICE Industrial Action Ballots and Notice to Employers - Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture - Effective derogation processes including Christmas Day cover definition. - Local Negotiating Committee (LNC) - Services Business continuity plans in place. - Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. - Command and control structure and leads established. - Derogation test completed. - Executive and Senior Manager leads established links with national planning cells. - All Wales training sessions provide by legal and risk to support industrial action. - Reducing impact on patients - Support for early supported discharge prior to industrial action. - Picketing guidance supported and agreed	- Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. - Issue of WHC AFC non pay elements of collective agreement 2022-24. Response to WG on immediate assurance by end May 2024 - Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). - Communication plans- public, stakeholders and partners - Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. - Consideration of further additional national legal advice

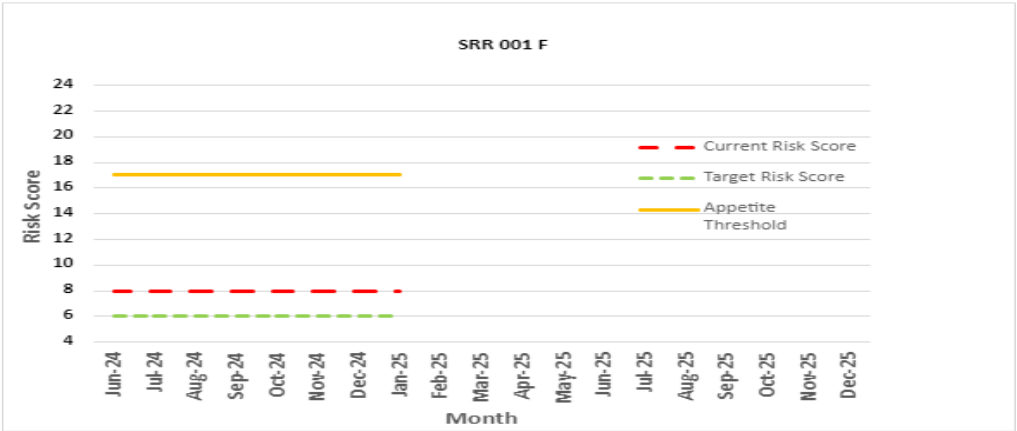
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Local Staff re-deployments assessment - Divisional engagement and service planning arrangements in place - Local Negotiating Committee (LNC) - Trade Union Partnership meetings		Further industrial action
• Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Reporting to Executive team - Business Continuity groups - Command and control structure in place to be implemented as required.		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
- All Wales IA group and Welsh Government planning group. - Debriefing session planned to reflect and capture learning for any potential future action		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively. Reasonable Assurance

RISK THEME	SERVICE DELIVERY			
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Strategic Threat	E. Due to inadequate strategic plans which respond to population health and socio-economic needs.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	- Increased demand - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 September 2024	Risk rating	= 8 (Moderate)	= 6 (Moderate)
Next Review (Six-monthly based on risk score)	01 March 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Health Board IMTP and associated KPIs - Public Health Wales surveillance data - QlikSense – performance dashboard - Population Needs Assessment and Area Plan - Marmot Region Programme	- Area plan is being refreshed through the RPB - Marmot Region Implementation Plan - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Refresh organisational strategy with a central focus on population health and wellbeing. - Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.

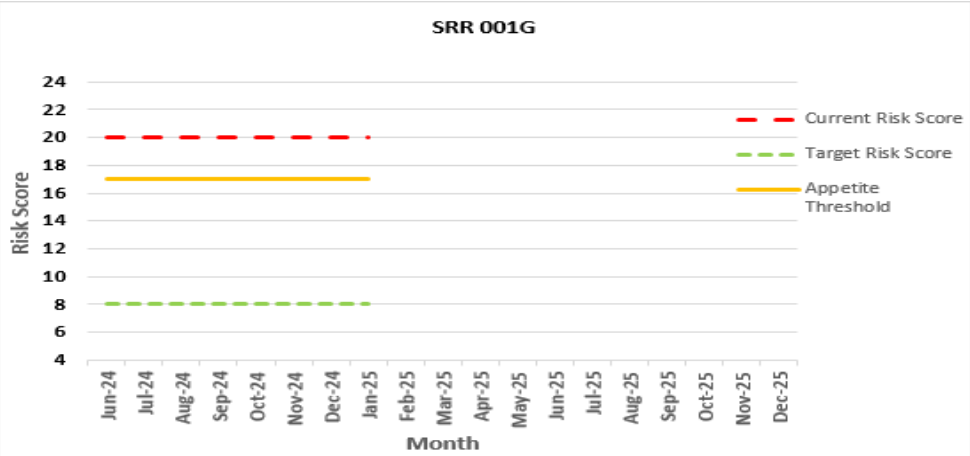
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- QlikSense – performance information - SFN – performance information			Effectiveness of the plans in delivering improvements
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- IMTP Delivery and Outcomes Reporting to Board - Marmot Region Programme - RPB reporting to Board and Population Health, Planning and Partnerships Committee - Regional Planning reporting to Population Health, Planning and Partnerships Committee - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee			Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit Reviews 2023-24 - IMTP Planning (Q1) Outcome – Reasonable Assurance			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	SERVICE DELIVERY			
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Strategic Threat	F. Due to unsustainable service models			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	- Increased demand - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence			Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold. Expected Date Target Score will be Achieved –
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 September 2024	Risk rating	= 8 (Moderate)	= 6 (Moderate)
Next Review (Six Monthly based on risk score)	01 March 2025			



Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- The Health Board IMPT and associated KPIs - Clinical Futures Transformation programmes. - Public Health Wales surveillance data – Covid, flu and other communicable diseases. - QlikSense – performance information. - Population needs assessment and area plan development by the RPB. - Southeast Wales Plan for fragile services.	- Area plan is being refreshed through the RPB. - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Review of enhanced local general hospital service models to ensure sustainable quality services. - Development of SEW plan for fragile. - Review of organisational strategy – to launch Summer 2024.

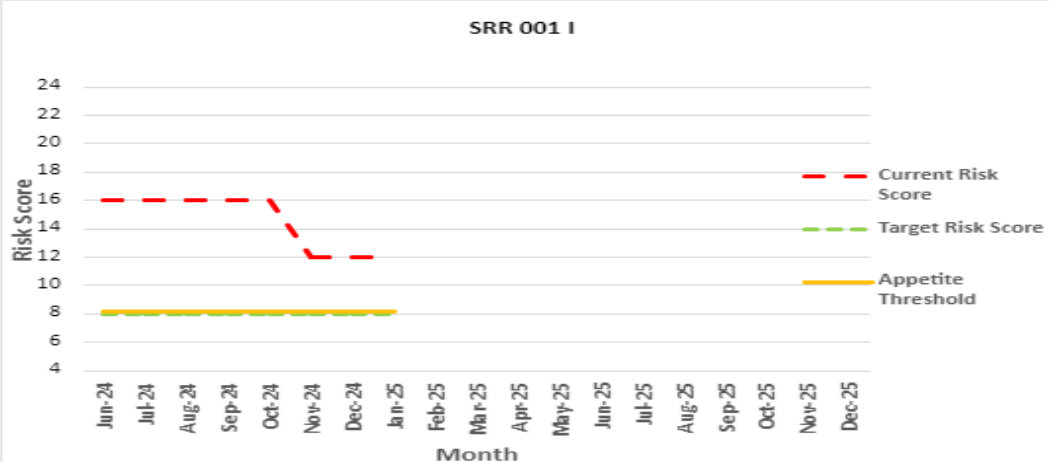
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Public Health Wales surveillance data – COVID, flu and other communicable diseases. - QlikSense – performance information.		Evidence of individual arrangements in place to deliver service plans.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- IMTP delivery and outcomes reporting to Board. - RPB reporting to Board and Population Health, Planning and Partnerships Committee. - Regional Planning reporting to Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.		Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews 2023-24 - IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 - IMTP – Service Plans (Q2)		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	FINANCIAL SUSTAINABILITY				
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Strategic Threat	G. Due to the failure to deliver a sustainable financial position and longer-term financial plan.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
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 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
				Expected Date Target Score will be Achieved –	
					
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level	
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 December 2024	Risk rating	= 20 (Extreme)	= 8 (Moderate)	
Next Review (Monthly based on risk score)	01 January 2025				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- IMTP 2023/24-25/26 - IMTP Delivery Framework - Accountability Framework - Performance Framework - Scheme of Delegation - Standing Financial Instructions (SFIs) - Standing Orders (SOs) - Final budget delegation - Financial Control Procedure (FCP) Budgetary control - Financial Budget Intelligence (FBI) - Appropriately trained Finance Team (capacity & capability) - 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 - Value & Sustainability Board established.	- Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny. - Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

- Revised accountability arrangements part of Executive governance. 3-year route map to sustainable recovery developed and approved by Board July 24.	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- 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.		- Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. - Development of detailed 3-year recovery plan.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- 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. .		2024/25 IMTP plans focussed on ‘living within’ budget levels. 2024/25 savings plan to be delivered. - Detailed delivery plans will be a constant development over next 2 years.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews 2023-24 - IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 - IMTP – Service Plans (Q2)	Internal Audit Reviews 2023 – 24 - Savings Programmes – Reported to ARAC - Reasonable Assurance - Financial Controls – Reported to ARAC July 2024 – Substantial Assurance - Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance External Audit Reports 2023 -24 - Efficiency Review 23/24 Q3/Q4 – Not yet reported. - Structured Assessment - Received at ARAC November 2023. - Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. - Financial assessment and review reports to Welsh Government – monthly - Enhanced monitoring T.I. meetings with Welsh Government – monthly	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	COMPLIANCE AND SAFETY				
SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
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.			Risk Appetite Level - MINIMAL 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.	
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 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 the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
					Expected Date Target Score will be Achieved –
					
Lead Director	Director of Strategy, Planning & Partnerships	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Finance & Performance Committee	Likelihood	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	19 April 2024	Impact	4 (Major)	4 (Major)	
Last Reviewed	01 December 2024	Risk rating	= 12 (High)	= 8 (Moderate)	
Next Review (Quarterly based on risk score)	01 March 2025				

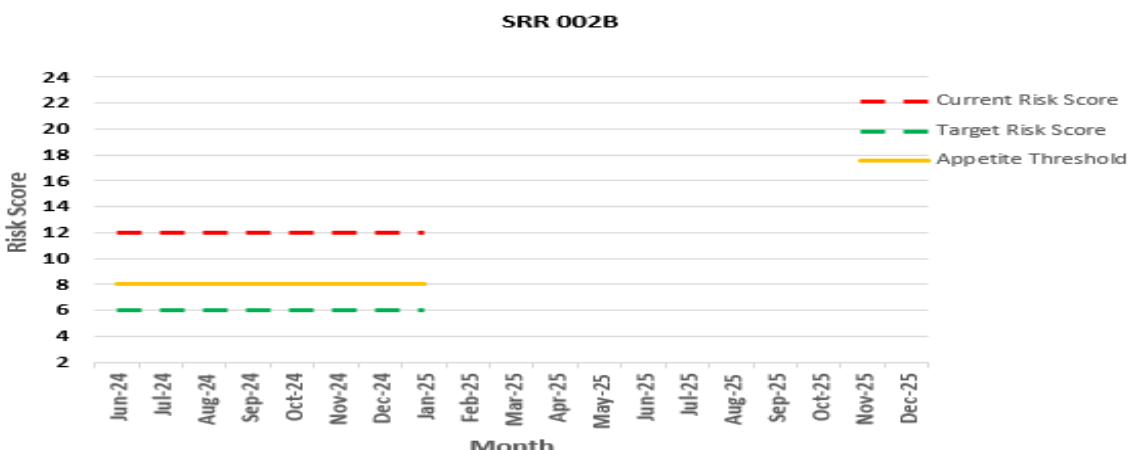
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Performance Management and Assurance Framework - Executive Accountability letters - Divisional Directors Accountability letters - Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place - Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off - Reporting through to Finance and Performance Committee via Executives - Specific areas of focus are discussed at Value and Sustainability Board - System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. - External scrutiny via Welsh Government and NHS Executive	6-month review of Performance Management and Assurance - Alignment of internal mechanisms to national escalation - 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. - Appropriate Business Partnering Support and analytical support - Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- 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 - Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support		12-month Performance Management Framework review in the Autumn	Internal Audit 2024/25 Plan - Findings and recommendations from the Divisional Governance Arrangements (Q2) - Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)
• Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- 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 <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit 2024/25 Plan - Directorate Review - Mental Health and Learning Disabilities (Q2) - Divisional Governance Arrangements (Q2) - HIW Inspections - Llais for feedback			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	COMPLIANCE AND SAFETY										
SRR 002	There is a risk that there will be significant failure of the Health Boards Estates.								Publication Status		Public
Strategic Threat	a. Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.					Risk Appetite Level - MINIMAL 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.					
Impact	- Harm or injury to patients and/or staff. - Adverse impacts on the delivery of care to patients across acute and non-acute settings. - Non-compliance with health and safety legislation. - Loss of estate - Litigation and financial penalties					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 the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold					
						Expected Date Target Score will be Achieved –					
						SRR 002A <					

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (most recent June/July2024 with report detailing recommendations received in October 2024). Next round of surveys will be December 2024 to January 2025 - Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance - Remediation work to areas of high-risk areas undertaken - Controlled access to roof areas - Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. - Ongoing engagement with expert surveyor - Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management - Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. <i>Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations</i> - Links with NHS England and other Health Boards in Wales for shared learning. Regular dialogue with Welsh Government and Shared Services Estates.	- Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues - Review of existing arrangements to monitor, manage and mitigate issues associated with RAAC is underway with external support and advice from the surveying contractor based on their experiences in NHS England and education bodies. This will inform any additional steps to monitor manage and mitigate led by the RAAC Working Group (chaired by the Director of Estates and Facilities Division)

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Fortnightly checks in place for the props in place - Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) - Review of existing arrangements in place supported by external body		Ongoing management of the issues.	- Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements Internal Audit 2024/25 Plan - Review of existing governance arrangements– undertaken with external advisors and final version of review will be received alongside the Management Strategy in December 2024
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. - Outcome of H&S risk assessment - Formal reporting to the Board/Committees in place - Formal update to the PPHPC in July with full SOC end of Q3.			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. - Management Action Plan agreed following Internal Audit including the development of a Management Strategy. This is in draft and will be concluded December 2024 for discussion with the RAAC Group in January 2025. - Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME		COMPLIANCE AND SAFETY		
SRR 002	There is a risk that there will be significant failure of the Health Boards Estates.			Publication Status Public
Strategic Threat	b. Due to significant levels of backlog maintenance and structural impairment.			Risk Appetite Level – MINIMAL 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.
Impact	- Harm or injury to patients and/or staff. - Adverse impacts on the delivery of care to patients across acute and non-acute settings. - Non-compliance with health and safety legislation. - Litigation and financial penalties. - Loss of estate			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 the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Health Protection & Planning Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 December 2024	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 March 2025			

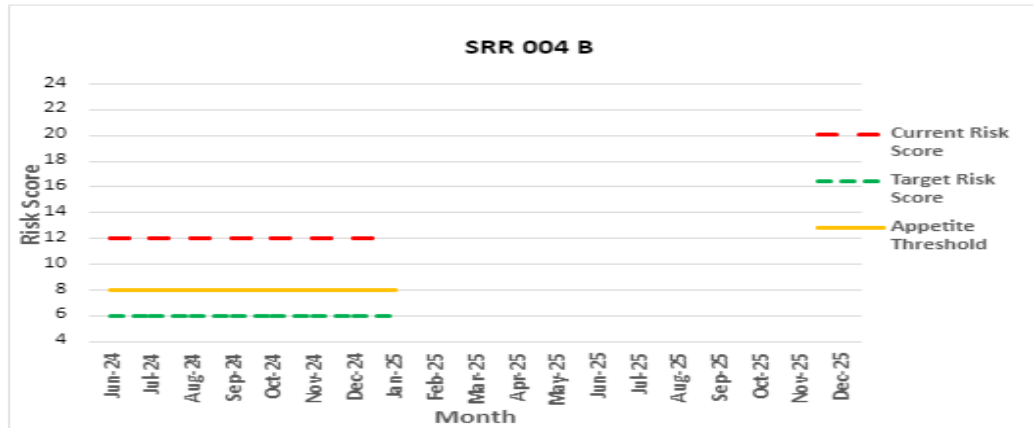
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Health Board Estates Rationalisation Strategy - Health Board Estates Strategy - Health Board policies and procedures related to the maintenance of Health Board estate. 6 Facet survey completed in 2019. - Divisional Risk Register - Multiple policies and SOPs published and communicated to staff. - A robust internal training programme in place covering all aspects of estate management including food hygiene. - Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) - Asbestos reinspection programme (over the next 3 years) - Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation - HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants - A clear approach to compliance monitoring and escalation of AE reports has been implemented.	- Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. - A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. - Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. - Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. - Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. - Drive clinical service engagement in compliance meetings where engagement is low. - Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Divisional reporting of Statutory and Mandatory training of staff - Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. - Outcome of the Asbestos reinspection programme	If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	Performance reporting
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group - Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews 2023- 24 Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and Finance and Performance Committee Internal Audit Plan 2024-25 Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the November ARAC. - Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. - Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	COMPLIANCE AND SAFETY			
SRR 004	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a business continuity incident or critical incident.			Publication Status Public
Strategic Threat	A. Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.
Impact	- Adverse impacts on delivery of care to patients across acute and non-acute settings - Inability to respond to a major incident to meet needs of those affected - Harm or injury to patients and/or staff; - Health Board breaches statutory duties under the Civil Contingencies Act 2004; - Litigation & Financial Penalties; - Reputational damage and loss of public confidence			Risk Appetite Threshold – SCORE 8 AND BELOW. Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 November 2024	Risk rating	= 8 (Moderate)	= 6 (Moderate)
Next Review (Six Monthly based on risk score)	01 May 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
Major Incident Plan and procedures - Local/Divisional action cards are in place. - Training undertaken service-specific relating to local response. - Major incident exercise ‘Euclid’ undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident - As a result of the exercise action cards refreshed and renewed with teams to incorporate learning - Internal strategic on call training - Executive Team attending 2-day strategic training. - Loggist training is provided and accessed regularly - New all Wales log books are in place for use - Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) - Joint Planning and Training with LRF and across Wales. - Ongoing Participation in exercises UK, Wales, LRF and HB. - Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP) - Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner	- Continue to deliver training programmes to support staff preparedness to response to an incident. - Additional ‘local’ team and intra team exercises to take place for areas to practice and embed their response to a major incident together - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Departmental debrief following an incident to inform learning and enhance controls. • Training records • Plans and action cards in place and up to date • Debrief with key stakeholders following an incident to inform learning and enhance controls.			
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness		•	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Review(s) • Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance • Outcome and feedback from national exercises		Internal Audit Reviews 2023 – 24 • Savings Programmes – Reported to ARAC - Reasonable Assurance • Financial Controls – Reported to ARAC July 2024 – Substantial Assurance • Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance External Audit Reports 2023 -24 • Efficiency Review 23/24 Q3/Q4 – Not yet reported. • Structured Assessment - Received at ARAC November 2023. • Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. • Financial assessment and review reports to Welsh Government – monthly • Enhanced monitoring T.I. meetings with Welsh Government – monthly	•
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	COMPLIANCE AND SAFETY					
SRR 004	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident.				Publication Status	Public
Strategic Threat	b. Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.				Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.	
Impact	Adverse impacts on delivery of care to patients across acute and non-acute settings; • impact to operational flow if services fail to BC plan against the 5 key themes • Harm or injury to patients and/or staff; • Staff absence (injury, wellbeing) • Financial implications due to staff absence • Loss of infrastructure; • Health Board breaches statutory duties under the Civil Contingencies Act 2004; • Litigation & Financial Penalties; • Reputational damage and loss of public confidence				Risk Appetite Threshold – SCORE 8 AND BELOW. Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					Expected Date Target Score will be Achieved –	
					SRR 004 B 	
Lead Director	Director of Strategy, Planning and Partnerships	Risk Exposure	Current Level	Target Level		
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	3 (likely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023	Impact	4 (major)	3 (Moderate)		
Last Reviewed	01 November 2024	Risk rating	= 12 (High)	= 6 (Moderate)		
Next Review (Quarterly based on risk score)	01 February 2025					

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
Business Continuity (BC) /Critical Incident • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. • 3C (Command/Control, Communication) structure in place to respond to incidents. • 1-2-1 graining with Divisional BC leads and BC plan workshops for services • EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. • Awareness raising of the requirement for BC across the Health Board through various training programmes • Infectious Diseases • Joint plan with PH in response to infectious diseases and public health incidence response overall • Internal strategic on call training • Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	• Ongoing support to develop business continuity plans. • Developing a Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans in place • Continued engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Develop further training programmes to support staff preparedness to response to an incident. • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. (as this is not fully implemented, it is still being worked through thus would make it additional control until in place) • Each Division to identify on their risk register outstanding business continuity planning for their areas.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Departmental debrief following an incident to inform learning and enhance controls. - Training records - Plans and action cards in place and up to date - Debrief with key stakeholders following an incident to inform learning and enhance controls.		
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Report to the EPRR Group from debrief of incidents - Reports to the PPHP Committee on Emergency Planning Preparedness		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Review(s) - Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance - Outcome and feedback from national exercises	Internal Audit Reviews 2023 – 24 - Savings Programmes – Reported to ARAC - Reasonable Assurance - Financial Controls – Reported to ARAC July 2024 – Substantial Assurance - Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance External Audit Reports 2023 -24 - Efficiency Review 23/24 Q3/Q4 – Not yet reported. - Structured Assessment - Received at ARAC November 2023. - Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. - Financial assessment and review reports to Welsh Government – monthly - Enhanced monitoring T.I. meetings with Welsh Government – monthly	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	SERVICE DELIVERY				
SRR 005	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.			Publication Status	Public
Strategic Threat	A. Due to inadequate arrangements to support system-wide patient flow			Risk Appetite Level - Open Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	- Avoidable deaths or significant harm - Delays in releasing ambulances from hospital sites back into the community - Delayed discharges from acute and non-acute settings resulting in deteriorating patients; - Litigation & Financial Penalties - Reputational damage and loss of public confidence			Risk Appetite Threshold – Open 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.	
				Expected Date Target Score will be Achieved –	
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level	SRR 005 A
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	Likelihood	3 (Possible) X	3 (Possible) X	
Initial Date of Assessment	01 June 2023	Impact	4 (Catastrophic)	3 (Minor)	
Last Reviewed	01 November 2024	Risk rating	= 12 (High)	= 9 (High)	
Next Review (Quarterly based on risk score)	01 February 2025				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Escalation Policy. - Performance and Accountability Framework - Major incident Procedures - Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. - Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. - fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. - Enhanced monitoring in place for U&EC - Range of performance measures/metrics in place - Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. - Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. - Planned care recovery meetings with the NHS execs. - Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. - WG – IQPD meetings to review areas of focus.	- Operational framework – Being revamped through operational framework ahead of next winter. - Improve regional acceptance of flow processes with neighbouring Health Boards. - Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. - Performance report against measures/metrics	- Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. - The impact of the Performance and Accountability framework in improving patient flow	Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Divisional Assurance reviews. - Performance against measures/metrics reported to the Executive Committee		Operational framework coming into place in November / December 2024 and will be tested as part of a deep dive exercise.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews - Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. - External inspections/visits.		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	SERVICE DELIVERY			
SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.		Publication Status	Public
Strategic Threat	a. Due to the full or partial failure of existing digital infrastructure and systems.		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. Expected Date Target Score will be Achieved –	
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 December 2024	Risk rating	= 12 (High)	= 8 (Moderate)
Next Review (Quarterly based on risk score)	01 March 2025			

SRR 006 A

Month	Current Risk Score	Target Risk Score	Appetite Threshold
Jun-24	15	8	17
Jul-24	15	8	17
Aug-24	15	8	17
Sep-24	12	8	17
Oct-24	12	8	17
Nov-24	12	8	17
Dec-24	12	8	17
Jan-25	12	8	17
Feb-25	12	8	17
Mar-25	12	8	17
Apr-25	12	8	17
May-25	12	8	17
Jun-25	12	8	17
Jul-25	12	8	17
Aug-25	12	8	17
Sep-25	12	8	17
Oct-25	12	8	17
Nov-25	12	8	17
Dec-25	12	8	17

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. 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. - 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 - 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. - Working 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, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. - Implement the recommendations from Templar report: - Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. - Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. - Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · - Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · - Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. ·	- Implement the recommendations from Templar report: - Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. - A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan.

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.	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.	Oversight from NHS Wales Cyber Resilience Unit.	An assessment against CAF was undertaken by CRU in January ‘24 and the report along with its recommendations has been circulated to key stakeholders.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan.		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	Latest local survey saw a reduction in staff wellbeing	
Internal Audit 2024/25 Technical Continuity – planned for Q3		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	SERVICE DELIVERY					
SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.				Publication Status	Public
Strategic Threat	b. Due to an adverse impact on service delivery in the implementation of the new digital systems.				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	
					Expected Date Target Score will be Achieved –	
					SRR 006 B	

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- 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. - 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 - Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee

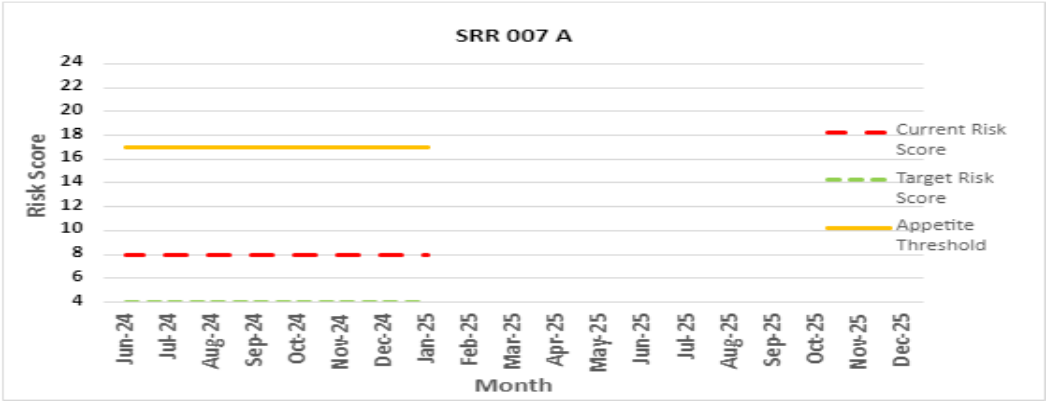
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Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) - Digital Directorate meetings being held monthly 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		Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
Regular Reporting to the Finance & Performance Committee			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2023/24 - Benefits Management review – Outcome Substantial Assurance - Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance Internal Audit 2024/25 - Implementation of the Welsh Intensive Care System – planned for Q1			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

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SRR 006	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.				Publication Status	Public																																																																											
Strategic Threat	c. Due to failure to develop digital solutions that are sustainable and fit for the future.				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.																																																																												
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Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- New Digital Service Request process in place which provides governance in several key areas: - Automation of request process via ‘Seren’ the ICT Portal - Information Governance – ensuring new services have appropriate controls to keep patient information safe. - Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. - Patient Safety – ensuring services do not introduce any patient safety risks. - 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. - Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process - New Digital Request processes include fortnightly senior leadership scrutiny of requests, - New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards - Annual operational plan completed and aligned with IMTP - Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place - Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints	- Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, - Portfolio optimisation to ensure the resources of the service are aligned to key priorities - New Digital Request quarterly reporting to DDAT sub-committee - New governance structures to be put in place further to directorate restructuring - Development of product management approach to delivery of core software applications and extending use of agile processes to ICT

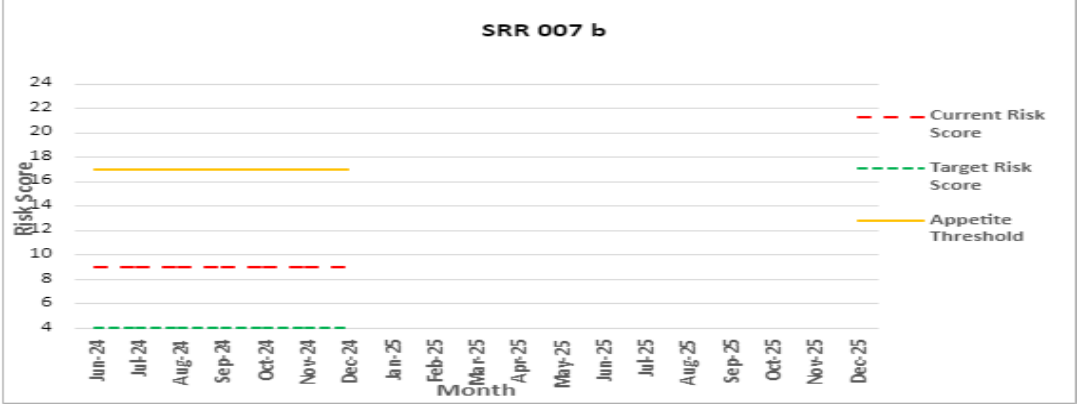
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>		Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>					
Quarterly reporting to DDAT sub-committee		- If the NDSR process delivers anticipated improvements - The outcome of the EDRMS audit		- Monitor the performance of the NDSR process - Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>					
Regular Reporting to the Finance & Performance Committee					
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>					
- Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2023/24 - LINC Programme– Outcome Reasonable assurance - Network Infrastructure (VPN) - Outcome Reasonable assurance Internal Audit 2024/25 - Electronic document and records management solution -planned for Q4					
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>					
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 007	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status Public
Strategic Threat	A. Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.			Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	- Unmet patient need resulting in harm - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence			Risk Appetite Threshold - SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. 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. Expected Date Target Score will be Achieved –
Lead Director	Director of Strategy, Planning, and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 September 2024	Risk rating	= 8 (Moderate)	= 4 (Moderate)
Next Review (Six monthly based on risk score)	01 March 2025			



Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	- Governance review of Regional Partnership Board undertaken in August 2023. - Renewed Strategy for strategic partnership Capital in place and revised governance processes. - New Long-Term Strategy for Health Board to focus on Partnership approach.

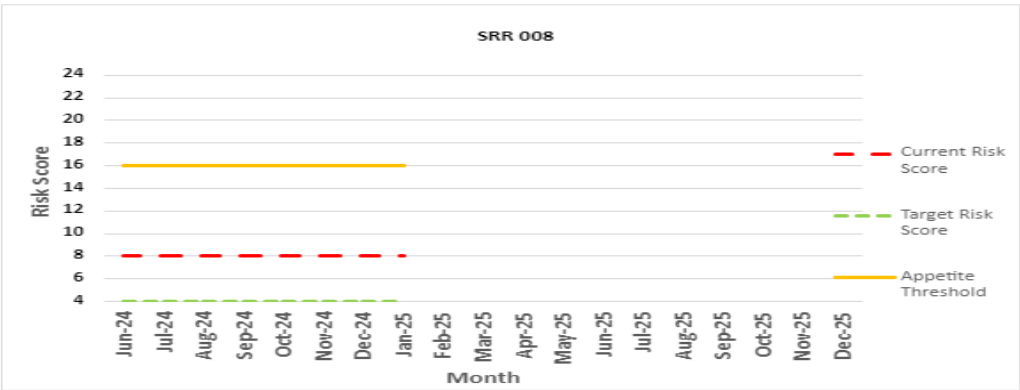
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>			Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>				
- PMO reporting to the Director of Strategy, Planning and Partnerships. - Regional Leadership Group Reporting			- Systematic reporting of outcomes - Systematic evaluation of schemes - Governance of financial control arrangements	- Implementation plan to be developed following RPB governance review. - Health Board strategy development approach to focus on partnership approach.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>				
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board.				
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>				
Internal Audit Plan 2024/25 - RPB Governance Review (Q4) – Outcome = Limited Assurance. Reported to ARAC September 2024 - Partnership Arrangements Review (Q1) Not yet undertaken				
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>				
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance	

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 007	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status Public
Strategic Threat	B. Due to the impact of fragile services across the regional and supra regional geography			Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	- Unmet patient need resulting in harm - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence			Risk Appetite Threshold - SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
				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.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Strategy Planning and Partnerships	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	04 January 2024	Impact	3 (Moderate)	2 (Minor)
Last Reviewed	01 December 2024	Risk rating	= 9 (High)	= 4 (Low)
Next Review (Quarterly based on risk score)	01 March 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>
- A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. - The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. - Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. - Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. - When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these formal arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - - An absolute commitment to delivering on the existing regional programmes of work but with these ‘re-baselined’ for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. - The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. - The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. - The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions (collaborative work has been undertaken in March with a parallel WG review of fragile services across south Wales, to ensure alignment of assumptions and priorities) - A further workshop (to include Chairs, Executives and clinicians) has been arranged for June Discussion ongoing at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work

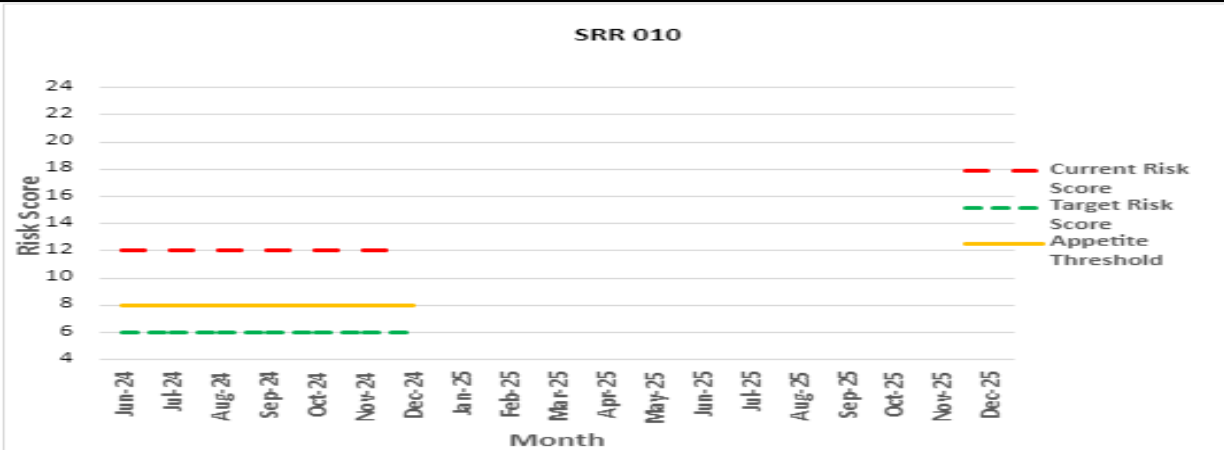
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
Service Divisions reporting to the Chief Operational Officer	Alignment and effectiveness of partners to deliver integrated services	Internal Audit 2024/25 Recommendations from the Partnership Arrangements Review (Q1)
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board. - Regular touchpoint meetings of all key players to review progress and issues arising		
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Plan 2024/25 Partnership Arrangements Review (Q1) - Not yet undertaken		
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>		
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.			Publication Status Public
Strategic Threat	A. Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement			Risk Appetite Level – Open Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	- Unmet patient need resulting in harm - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence			Risk Appetite Threshold – Open SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold. Expected Date Target Score will be Achieved –
Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 July 2024	Risk rating	= 8 (Moderate)	= 4 (Moderate)
Next Review (Six monthly based on risk score)	01 January 2025			



Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Corporate Engagement Team - Patient Experience and Involvement Strategy- organisational ownership - Person Centred Care (PCC) Surveys via CIVICA - PCC KPI's (support PCC Quality pillar) 'You said..... we did' public facing information for service areas. - PLO service at GUH - Introduction of PALS Service (Oct 23) - Volunteer Patient Experience Feedback - Collaboration to recruit community listeners to support Dementia Awareness - Digital patient stories to support listening and learning. - Patient Experience and Involvement Strategy - DATIX - Oversight of Medical Examiner reports to determine patient experience actions - Public Engagement- Big Conversation Bereavement held 20th March 2024 - People Participation Panel ED in Progress	- Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. - PCCT staff training to support Civica data entry and retrieval. - Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. - Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG - Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. - Discussions with VBHC to pilot SMS in ED through DrDoctor - National directives around new national surveys that need to be managed additional to internal roll out programme. - Volunteer feedback to be reviewed to identify themes.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>			Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>				
• Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation • Immediate feedback and escalation to clinical teams following PALS queries and concerns			• No SMS provision to increase the number of PCC surveys. • No single point of contact or ‘drop in’ provision for patients/families/staff to raise initial patient experience concerns. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.	• Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing ‘drop in’ clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms. • Patient experience KPI’s and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>				
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module				
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>				
• LLais Reports • HIW inspections • Advocacy reports				
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>				
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance	

RISK THEME	COMPLIANCE AND SAFETY			
SRR 010	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974			Publication Status Public
Strategic Threat	B. Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.			Risk Appetite Level - MINIMAL. Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.
Impact	- Unintended physical harm; - Punitive actions from the Health and Safety Executive (HSE); - Increased levels of staff sickness; - Loss of estate due to unsafe environments; - Financial implications; - Adverse publicity; and, - Reputational damage			Risk Appetite Threshold - 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.
				SUMMARY The current risk level is OUTSIDE of target level and OUTSIDE appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
				Expected Date Target Score will be Achieved –
				
Lead Director	Director of Allied Health Professions and Health Science	Risk Exposure	Current Level	Target Level
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 December 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 November 2024	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 February 2025			

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. - Health and Safety Policies and Procedures - Dedicated Health and Safety site on ABPULSE - Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 ‘Health and Safety Assistance’. - Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) - Partial Programme of Health and Safety Monitoring (Active & Reactive) - Corporate and Directorate Health and Safety Risk Register established. - Board Training /development (Completed 24 April 2024) - Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. - Health and Safety Governance and reporting arrangements (Health and Safety Committee)	- Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System - Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) - Consultation and communication with the workforce regarding compliance with the Act - New ways of working with Divisions to ensure accountability for health and safety is recognised. - Implement key performance indicators to monitor health and safety compliance. - Review the governance arrangements for the Health & Safety Committee - Health and Safety Policies and Procedures to be reviewed. - Onboard further Manual Handling trainers across the organisation to improve compliance. - Scope for training non-Health Board staff - Learning from events to be documented and communicated to the organisation.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>		Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>	
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>					
Health and Safety compliance data extracted from ESR and Datix and reported		- Implementation of a health and safety performance report - Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. - Compliance on completion of risk assessments and mitigating actions		- Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. - Review the membership and ToRs of the Health and Safety Committee - Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>					
- Established monitoring of H&S at the Executive Committee - Corporate H&S report risk and assurance to the Health and Safety Committee - Established monitoring of H&S at the PQSO Committee					
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>					
Internal Audit 2024/25 Plan - H&S processes - Performance reviews at All Wales Health and Safety Management Steering Group - South Wales Fire & Rescue Service fire safety audit programme. - Health and Safety Executive reviews/inspections.					
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>					
	Negative – Insufficient evidence that the controls in place are working effectively.		Reasonable - adequate evidence that the controls in place are working effectively.		Positive - robust evidence that the controls in place are working effectively.
Reasonable Assurance					

RISK THEME	SERVICE DELIVERY				
Strategic Risk SRR 011	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030). This is common to all Health Bodies across the country.				Publication Status Public
Strategic Threat (Due To)	The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected.				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure
Impact	➤ Failure to meet the target set on Welsh Health bodies for reducing carbon output ➤ Non–delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. ➤ Reputational damage and loss of public confidence ➤ Opportunity cost of reduced energy costs				Risk Appetite Threshold – SCORE 17 AND BELOW. Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small.
					SUMMARY The current risk level is OUTSIDE of target level and WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
					Expected Date Target Score will be Achieved – Can Not Be Determined
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Decarbonisation Programme Board	Likelihood	5 (Almost certain) x	4 (Likely) X	
Initial Date of Assessment	30 October 2024	Impact	3 (Moderate)	3 (Moderate)	
Last Reviewed	02 January 2025	Risk rating	= 15 (Extreme)	= 12 (High)	
Next Review (Quarterly based on risk score)	01 February 2025				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Quarterly review of projects and workstreams at the Decarbonisation Programme Board - The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, waste and facilities and estates - Regular reporting of financial data available - Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. - Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. - Annual net zero return submitted to Welsh Government - Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) - Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website - SUS Qi training - Met office training - Carbon literacy training HEIW 4 modules on carbon reduction and net zero ESR - Spread & Scale academy training sessions	- Project structure regularly reviewed should action be needed. - Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Regular meetings of the sub groups to discuss position, monitor and new ideas - Bi-annual ISO14001 audit to be undertaken in October 2024. - Estates operational meetings	Detailed level metrics and measures are limited due to data capture equipment.	- All opportunities for funding will be optimised - Training opportunities will be maximised.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Six monthly updates to the Board - Executive Committee (Clinical Futures Board) updates – Quarterly - Six monthly updates to the Finance & Performance Committee - Decarbonisation Programme Board – Quarterly reporting		- The annual reporting to Welsh Government via the net zero return is the main source of information for carbon output by the Health Board. However, it provides a relatively simplistic picture of output of total tonnes per carbon and so its value is limited. - Funding is the greatest limitation on achieving targets. All opportunities for funding will be optimised - Training opportunities will be maximised.	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Report in July 24. - Received “limited assurance” but not because of controls – the issues were largely around funding limitations. External Audit Reports 2023 -24 - Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	Funding for a comprehensive ABUHB decarbonisation strategy is not available.	As above - REFIT invest to Save capital opportunities being progressed.	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i>			
Negative – Insufficient evidence that the controls in place are working effectively.	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Presentation of Nurse Staffing Levels
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Kelly Downes, Deputy Director of Nursing

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 report is to assure the Board that it is meeting its statutory requirements in calculating and maintaining the nurse staffing levels for all wards included under Section 25B of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA) within the review period October 2023 to November 2024.

Cefndir / Background

The attached annual presentation report (**Appendix 1**) details the method, output, conclusions, and actions arising from the (Spring & Autumn 2024) nurse staffing recalculation cycles. In line with the requirements of the NSLWA, the triangulated methodology for calculating the nurse staffing levels for adult medical, surgical, and paediatric in-patient wards has been carefully applied to determine the required nursing establishments for all 25B wards and have been presented to the designated person (Executive Director of Nursing) in the challenge and support meetings.

Asesiad / Assessment

Spring recalculations (March / April)

On completion of the Spring recalculations during March and April 2024, 7 Wards in total were identified as requiring amendments to previously agreed rosters, 5 in the Division of Medicine and 2 in the Division of Surgery.

These recalculations were presented to the Executive Committee in September 2024.

Summary of amendments required to establishments post Spring 2024 recalculations						
Ward	Pre-Calculation			Post-Calculation		
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE
C0 GUH	26.85	25.2	52	30.3	28.55	58.85
D7E RGH	12.64	11.22	23.86	15.48	14.02	29.5
3.2 NHH	15.48	22.42	37.9	15.48	25.2	40.68
3.4 NHH	15.48	22.42	37.9	15.48	25.2	40.68
Bargoed YYF	15.48	25.2	40.68	15.48	27.99	43.78
EFU YYF	18.32	22.36	40.68	15.48	25.2	40.68 Cost neutral
Oakdale Ward YYF	18.32	22.36	40.68	15.48	25.2	40.68 Cost neutral

Details of all proposed changes are set out in **Appendix 1**.

The decision to convert the 2 wards in YYF to Core Care Model was reversed in the subsequent Autumn calculations because the wards have been able to recruit into Registered Nursing vacancies.

No changes were required to the paediatric ward establishment.

Autumn Calculations (August / September)

On completion of the Autumn recalculations during August and September 2024, the planned rosters to most wards were deemed appropriate to meet the needs of patients. As a result, no alterations were required to rosters on the medical wards. Two wards in the division of surgery requested an increase in Health Care Support Worker (HCSW) establishment to be funded from the Royal Gwent Hospital (RGH) Surgery HCSW Pooled budget.

Medicine

There were no changes required to planned rosters during the August and September 2024 recalculations. However, it was noted that this was likely to change in line with the reconfiguration of respiratory services planned for November 2024. The wards involved in the reconfiguration across GUH and NHH underwent further recalculations during November to ensure the repurposed wards would have appropriate planned rosters to suit the needs of the patients.

Surgery

The wards requiring changes include the 2 Orthogeriatric stepdown wards, C7E at RGH and Ward 4.2 Nevill Hall Hospital (NHH).

Ward C7E RGH

25 bedded Orthogeriatric stepdown ward in constant surge to 28 beds. An extra HCSW by night required to support constant use of surge beds, high acuity and the enhanced care needs of this frail and vulnerable cohort of patients.

Total Cost per annum: £120,734

Ward 4.2 NHH

25 bedded Ward with the capacity to surge to 28 beds. An extra HCSW by night required to support, high acuity and the enhanced care needs of this frail and vulnerable cohort of patients. There is a frequent need to utilize two (4 bedded bays) to cohort patients with enhanced care needs. This group of patients are often high risk of falls and require constant supervision.

Total Cost per annum: £120,734

Financial Impact

The RGH surgical HCSW pool has an annual budget of £380,491 to fund 12.11 WTE HCSWs. Currently there are 4.72 WTE in post. The HCSW pool is used to support surgical HCSW deficits across RGH either for short term sickness or enhanced care needs. Recruitment and retention of the HCSW pool has been challenging and therefore the division has decided to reallocate part of this budget to support the need to increase the HCSW establishment on the 2 wards noted.

Surgical Wards:										
Ward	Pre-Calculation			Post-Calculation			Difference		Cost	
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	RN	HCSW
C7E	15.48	22.34	39.90 including WM	15.48	25.2	40.68 including WM	Nil	2.8	Nil	£120,734 Cost neutral re-deployed from Surgery RGH pool.
4.2	15.48	22.34	39.90 including WM	15.48	25.2	40.68 including WM	Nil	2.8	Nil	£120,734 Cost neutral re-deployed from Surgery RGH pool.

Ward Reconfiguration (November)

Following the reconfiguration of respiratory services during November, recalculations of the nurse staffing levels were undertaken for the repurposed wards to ensure planned rosters were appropriate to suit the needs of patients. Following the recalculations and recommendations from the Executive Director of Nursing, a report outlining the new establishments was approved by the Executive Committee.

The wards affected included:

Ward C.4 GUH (Respiratory and General Internal Medicine - 45 Beds)

A deep dive was undertaken of Ward C.4, which following the reconfiguration will comprise of 45 beds (6 Respiratory High Care beds, 15 General Medical beds and 24 Respiratory beds). The changes to the planned roster and funded establishment will be supported by:

- 5.69 WTE Band 5 RN to transfer from Ward B4.
- 5.69 WTE Band 2 HCSW to transfer from Ward B4.
- Paper submitted to Executive Committee in September agreed extra funding of:
 - 0.60 WTE Band 6 RN - £32,644
 - 5.84 WTE Band 2 HCSW - £215,844

Ward B.4 GUH (Stroke 15 Beds)

Following the reconfiguration, the B.4 footprint and funded establishment will reduce and comprise of 15 stroke beds, 8 of which will be hyperacute beds. The recalculated establishment allows for a reduction of 5.69 WTE Band 5 and 5.69 WTE Band 2 HCSW – this staffing resource will transfer directly from the B.4 to the C.4 roster.

Ward 4.4 NHH (26 Beds – Surges to 30 Beds)

Ward 4.4 has been repurposed as a care of the elderly ward and the planned roster has been recalculated to reflect these changes. This includes a reduction of 1 RN by night (2.85 WTE) and an increase of 2 HCSW by night (5.69 WTE).

The financial impact of this change is £90,665. It is anticipated that this cost will be offset by a significant reduction in variable pay.

Site / Ward	Pre-Calculation			Post-Calculation			Difference		Cost	
	RN WTE	HCS W WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	RN	HCSW
GUH C4	39.86	27.97	68.83 inc WM	46.3	39.65	86.95 inc WM	+6.29	+11.53	£283,871 from B4 cost neutral Additional £32,644 Approved	£215,844 from B4 cost neutral Additional £215,844 Approved Total additional £248,488 funded
GUH B4	23.01	22.37	46.37 inc WM	17.17	16.53	34.7 inc WM	-5.69	-5.69	- £283,871	-£215,844
NHH 4.4	20.17	13.98	35.15 inc WM	17.32	19.58	37.99 inc WM	-2.85	+5.69	- £156,225	+£246,488 Total additional 90,665 unfunded

Argymhelliad / Recommendation

The Health Board has a duty to implement the statutory guidance and ensure compliance with the requirement of the Nurse Staffing Levels (Wales) Act.

The Board is asked to: -

- NOTE the changes outlined within the report.
- Receive ASSURANCE that the Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA.
- NOTE that the Health Board is meeting its statutory duty to provide an annual presentation to the Board of the nurse staffing levels on 25B wards.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 5. Timely Care 7.1 Workforce 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
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 prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	As set out within the paper
Rhestr Termiau: Glossary of Terms:	As set out within the paper
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	Not Applicable
• 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/	Not Applicable Choose an item.

Annual Presentation of Nurse Staffing Levels to the Board			
Health Board	ABUHB		
Date of annual presentation of Nurse Staffing Levels to Board	29 January 2025		
Period Covered	This report details amendments to ward nursing establishments to all wards included in 25B of the Nurse Staffing Levels (Wales) Act 2016 from 1 October 2023 to 30 September 2024. This report further includes an amendment to the Autumn recalculation completed in January 2025.		
Number and identity of section 25B wards during the reporting period. • Adult acute <u>medical</u> inpatient wards • Adult acute <u>surgical</u> inpatient wards (inclusive of Women's Gynaecological inpatient wards) • <u>Paediatric</u> inpatient wards	The board is required to consider and have due regard to the duty on them under Section 25A of the Act to have sufficient nurses to allow time to care for patients sensitively wherever they are receiving nursing services. There is a requirement to constantly review and carry out comprehensive and systematic reviews of all nurse staffing levels. The Act requires Health Boards and Trusts to report on the calculation process and outcomes for all wards that fall under 25B of the Act, these include all acute medical, surgical and paediatric wards.		
	Adult acute <u>medical</u> inpatient wards	Adult acute <u>surgical</u> inpatient wards	Paediatric inpatient wards
	21 /19	13	1

Required establishment (WTE) calculated (October 2023)	RN	HCSW	RN	HCSW	RN	HCSW
	372.29	486.96	227.21	236.03	70.22	17.06
WTE of required establishment funded (October 2023)	372.29	478.56 Changes on hold	227.21	236.03	70.22	17.06
Staffing requirements following Spring Cycle (May 2024)	Adult acute medical inpatient wards		Adult acute surgical inpatient wards		Paediatric inpatient wards	
Required establishment (WTE) calculated (May 2024)	RN	HCSW	RN	HCSW	RN	HCSW
	352.13	475.87	233.5	242.18	70.22	17.06
WTE of required establishment funded (May 2024)	352.13	475.87	233.5	242.18	70.22	17.06
Staffing requirements at end of reporting period (September 2024)	Adult acute medical inpatient wards		Adult acute surgical inpatient wards		Paediatric inpatient wards	
Required establishment (WTE) calculated (September 2024)	RN	HCSW	RN	HCSW	RN	HCSW
	337.64	439.99	233.5	247.78	70.22	17.06

WTE of required establishment funded (September 2024)	337.64	439.99	233.5	247.78	70.22	17.06
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	19	13	1			
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards	Evidence of Triangulated Approach In accordance with the NSLWA- a systematic and well embedded triangulated approach to review and recalculate the nurse staffing levels on all 25B wards (Adult and Paediatric) has been applied as stipulated in legislation. The Spring and Autumn recalculations include in-depth discussions with the Divisional/Deputy Nurse, Senior Nurse, Ward Manager, Nurse Staffing Act Programme Lead as well as representation from the e-rostering and finance teams. The Professional judgement of the teams is paramount and informs the recalculation decisions, to ensure sufficient staffing levels and resources are deployed for each individual ward. Discussions include: • Ward speciality, bed base, planned roster. • Funded establishment and aligned budget. • E-roster housekeeping and Safecare compliance.					

- Patient acuity levels from the January and June audits are scrutinised alongside patient flow and activity data.
- Staffing levels deployed, including bank and agency usage and variable pay figures.
- Additional roles to support the ward but not included in the template, such as ward clerk, ward assistant, activities coordinator, discharge coordinator and rehab assistants.
- Care quality indicators-which include incidences of hospital acquired pressure ulcers, patient falls with harm, medication errors, SI's, infection rates, complaints, and incidences of infiltration/extravasation on the paediatric ward.
- Staff related data including PADR and mandatory training compliance and sickness percentage/management.
- Ward managers are given the opportunity to discuss any ward initiatives and improvement projects.

An agreed All-Wales template for each 25B ward is subsequently completed and presented to the Designated Person, (Executive Director of Nursing), Deputy Director of Nursing and Nurse Staffing Act Programme Lead by way of challenge and support meetings which were held in April, July and October.

In line with the requirements of the Act assurance is sought that:

- All Section 25B wards have a 26.9% uplift applied to the Registered Nurse workforce within their calculated establishments to allow for annual, sick and
- Ward Managers are supernumerary to the planned rosters. The 26.9% uplift has also been applied to the Ward Manager establishment to cover sick leave, study leave and to enable the continuing provision of the supervisory role in the ward manager's absence.

Finance and workforce implications	Spring Recalculations (March / April 2024) Themes The activity's coordinator role has been trialled and well received on some of the Care of the Elderly (COTE) wards in Medicine. Despite anecdotal benefits, further work to review and evaluate the role is being undertaken. High numbers of patients requiring Enhanced Care remains a theme on the COTE wards, with acuity and dependency increasing year on year. To seek clarity on this phenomenon, the Nursing Directorate established a working group to review the enhanced care documentation and to assess accuracy of completing the documentation on COTE wards across the health board. The findings revealed inconsistent and inaccurate completion of assessments, with the level of care often overestimated resulting in increased variable pay to support perceived enhanced care needs. Consequently, the Enhanced Care documentation has been revised and ward staff are in the process of receiving training to undertake accurate daily assessments of patients requiring enhanced care. Moving forward ward managers and senior nurses will be required to undertake consistent review of the documentation to ensure accuracy of assessments. Medicine On completion of the Spring recalculations, 5 Wards in total were identified as requiring amendments to previously agreed rosters. Two wards in YYF (Oakdale and EFU) proposed converting to the cost neutral Core Care Model, however, this decision was reversed in the Autumn calculations as the wards have been able to recruit into Registered Nurse vacancies.

The recalculations were presented to the Executive Committee in September 2024.

Proposed changes to establishments

Ward 3.2 NHH: 28 bedded Ward in constant surge to 32 beds.

A review of the acuity, dependency and variable pay usage over the past 12 months supported the need for an extra HCSW by night to increase from 3 to 4. This equates to 2.8 WTE band 2 HCSW.

Total cost per annum: £120.734

Ward 3.4 NHH: 28 bedded CTE ward with the capacity to surge to 32 beds.

This ward had recently been repurposed from a stroke rehab ward to a COTE ward. Professional discussions around acuity, dependency and high enhanced care needs of this cohort of patients supported the need for an extra HCSW by night from. This equates to 2.8 WTE band 2 HCSW.

Total cost per annum: £120.734

Bargoed Ward YYF: 28 bedded Stroke Rehabilitation Ward.

This ward has been repurposed from a 28 bedded shared COTE/Stroke Rehabilitation ward to a 28 bedded Stroke Rehabilitation ward.

Review of the acuity data and staff feedback over the past 6 months supported the need to increase the nursing establishment by 1 band 2 HCSW 12hrs per day 7 days a week this equates to an additional 2.8 WTE HCSW.

The rationale for the additional HCSW is based on the increased dependency of patients who are transferred from GUH at an earlier stage of the pathway. This impacts on the acuity of the patients, many have a percutaneous endoscopic gastrostomy (PEG) in place which leads to increased time

spent administering medicines. This can delay or prevent the Registered Nurse from being available to assist the Health Care Support Worker with the delivery of the fundamentals of care needs.

Total cost per annum: £95,847.

Surgery

On completion of the Spring recalculations, most wards were considered to have the correct staffing levels to provide safe care to patients. Two Wards in total required amendments to previously agreed rosters.

Proposed changes to establishments

Ward C0 GUH: 31 bedded Head & Neck Surgical Ward and 5 Machen beds.

The Divisional Management Team agreed to fund the necessary increase in staffing template for this ward to support the 5 Machen beds (elective Head & Neck, ENT, and Maxillofacial urgent suspected cancer procedures). These beds are situated on ICU but staffed by Ward C0. The necessary establishment increase include:

1 RN Tuesday - Saturday Day

1 RN Tuesday - Friday Night

1 HCSW Tuesday – Friday Day

1 HCSW Tuesday – Friday Night

Total Cost per annum £284,665 (RN £173,371 HCSW £111,294) Funded by Directorate.

Ward D7E RGH: 20 bedded T&O stepdown ward

This ward has been repurposed from an elective T&O ward to a trauma stepdown ward

The planned roster and funded establishment for this ward was previously calculated for a 20 bedded elective orthopaedic ward. Due to bed pressures following the opening of GUH, the ward has mainly operated as a step-down orthopaedic ward. The Spring recalculation review and professional discussions recognised the increased acuity and dependency of this cohort of patients. The stepdown trauma patients are more complex and have higher acuity than elective orthopaedic surgery patients, involving complex care pathways, spinal injuries, cognitive impairment, increase length of stay and complex discharge planning.

Following the spring calculations an SBAR was taken to the Divisional Management team in April, and D7E was redefined as a step-down orthopaedic ward.

The new template is to increase by:

- 1 RN 7 days per week
- 1 HCSW 7 nights per week.

Total Cost per annum: £240,896 per annum. (RN £124,351, HCSW £116,545)

Appendix 2- summary of amendments required to establishments post Spring 2024 recalculations						
Ward	Pre-Calculation			Post-Calculation		
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE

C0 GUH	26.85	25.2	52	30.3	28.55	58.85
D7E RGH	12.64	11.22	23.86	15.48	14.02	29.5
3.2 NHH	15.48	22.42	37.9	15.48	25.2	40.68
3.4 NHH	15.48	22.42	37.9	15.48	25.2	40.68
Bargoed YYF	15.48	25.2	40.68	15.48	27.99	43.78
EFU YYF	18.32	22.36	40.68	15.48	25.2	40.68 Cost neutral
Oakdale Ward YYF	18.32	22.36	40.68	15.48	25.2	40.68 Cost neutral

The staffing level recalculations result in an overall cost pressure of £70,000 taking into consideration the cost of investment and variable pay saving.

Paediatrics

Despite challenges with recruiting into Registered Nurse vacancies on the 50 bedded paediatric ward, patient safety is maintained through variable pay which is largely covered with substantive staff through the Nurse Bank.

No changes were required to the planned rosters and establishments to the paediatric ward.

Autumn Recalculations 2024 (August / September 2024)

Medicine

Following the Autumn recalculations, no changes are required to the planned rosters on the medical wards.

There was a reconfiguration of Respiratory services within November 2024. The wards involved in the reconfiguration across GUH and NHH undertook additional recalculations in early November. This will ensure repurposed wards have appropriate planned rosters to suit the needs of the patients and the agreed budgets are aligned.

Following the recalculations, and recommendations from the Executive Director of Nursing, a report outlining the new establishments has been presented and approved at the Executive Committee.

Surgery

On completion of the Autumn 2024 recalculations, 2 wards in the division of surgery require a change to the planned rosters and subsequent funded establishments.

The wards requiring changes include the 2 Orthogeriatric stepdown wards, C7E Royal Gwent Hospital (RGH) and Ward 4.2 Nevill Hall Hospital (NHH).

Professional discussions included the review of quality indicators, scrutiny of acuity and dependency alongside variable pay figures. Discussions supported the need for an extra HCSW by night on both wards.

Ward C7E RGH: 25 bedded Orthogeriatric stepdown ward in constant surge to 28 beds

	An extra HCSW by night is needed to support constant use of surge beds, high acuity and the enhanced care needs of this frail and vulnerable cohort of patients. Total Cost per annum: £120, 734 Ward 4.2 NHH: 25 bedded Ward with the capacity to surge to 28 beds An extra HCSW by night is needed to support, high acuity and the enhanced care needs of this frail and vulnerable cohort of patients. There is a frequent need to utilize two (4 bedded bays) to cohort patients with enhanced care needs. This group of patients are often high risk of falls and require constant supervision. The divisional lead intends to fund these posts by transferring the budget and staff from the RGH HCSW Pool Roster. Following the challenge and support meeting with the Executive Director of Nursing the Divisional lead will present an SBAR to DMT, outlining the necessary changes and outline how the roles will be funded. The remaining wards in surgery were deemed to have the correct establishment to care for patients.

Surgical Wards:

Site	Ward	Pre-Calculation			Post-Calculation			Difference		Cost	
		RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	RN	HCSW
RGH	C7E	15.48	22.24	37.90 including WM	15.48	25.2	40.68 including WM	Nil	2.8	Nil	£120.734 Cost neutral re-deployed from SC pool.
NHH	4.2	15.48	22.24	37.90 including WM	15.48	25.2	40.68 including WM	Nil	2.8	Nil	£120.74 Cost neutral re-deployed from SC pool.

Respiratory GIM Reconfiguration (Additional Recalculations, October/November 2024)

Ward C.4 GUH (Respiratory & Gen med) 45 beds

A deep dive was undertaken of Ward C4 GUH regarding the proposed respiratory reconfiguration which will comprise of 45 beds. The breakdown being 6 Respiratory High Care beds, 15 General Medical beds and 24 Respiratory beds.

The patients under the care of the respiratory team will be split across 3 wards over 2 floors:

C4: 32 beds, 26 Respiratory beds and 8 Gen Med beds

B4: 8 Gen Med beds

C2: 6 beds Respiratory High Care (Machen wing)

The new roster will provide leadership consistency in the form of a Band 6 on every shift plus a coordinator Monday to Friday. The additional HCSW will support with the flow through the unit as the geography of the unit will cover 2 floors.

Ward C4 footprint will increase and take over the management of 8 beds on Ward B4. Some of the funding to accommodate this increase in footprint will be transferred from Ward B4 budget to Ward C4 budget.

The extra funding for the additional staffing required to support the increase in Ward C4 footprint (additional to the WTEs being transferred from Ward B4 budget) was approved following the submission of the reconfiguration paper to the Executive Committee in September 2024.

Total WTE 86.95 plus 1WTE Supernumerary Ward Manager

The changes to the planned roster and funded establishment will be supported by:

5.69 WTE Band 5 RN to transfer from Ward B4.

5.69 WTE Band 2 HCSW to transfer from Ward B4.

Paper submitted to Executive Committee in September agreed extra funding of:

0.60 WTE Band 6 RN - £32,644

5.84 WTE Band 2 HCSW - £215,844

Total additional staff for C4 Template: **18.12 WTE**

Ward B.4 GUH (Hyperacute Stroke) 15 beds

Ward B4 has historically been difficult to calculate, the ward has 31 beds and comprises of 15 hyperacute stroke and 8 general medical beds. Additionally, there are 8 haematology beds managed by scheduled care.

Following the reconfiguration, the B4 footprint and funded establishment will reduce and comprise of 15 stroke beds, 8 of which will be hyperacute (HASU) beds.

The haematology beds will remain the same, however, haematology will be required to move to a different wing on B4 to accommodate the extension of C4 on to B4 to accommodate 8 Gen Med beds overseen by the Respiratory team.

Total WTE 34.70

To support the changes with the increase to the respiratory footprint on C4, 8 beds on B4 will become part of the C4 footprint. The budget for 5.69 WTE Band 5 and 5.69 WTE Band 2 HCSW will transfer directly from B4 to C4 roster.

Costings: RN 5.69 WTE & HCSW 5.69 WTE (**£215,844**) to be transferred from B4 budget to C4 Budget.

Ward 4.4 NHH 26 beds with capacity to surge to 30 beds

On completion of the respiratory reconfiguration ward 4.4 will no longer be a respiratory stepdown ward. The staff will no longer be providing NIV therapy to stepdown patients from the GUH and therefore, will not require 3 RNs by night. The ward has been repurposed as care of the elderly ward and the planned roster has been recalculated to reflect these changes. The triangulation of professional judgement, acuity data and quality indicators support the need for 4 HCSWs by night for the delivery of safe care.

The financial impact of this change is £90,665. However, this will support reduction in variable pay.

The new roster template will require a reduction of 2.85WTE RN's and an increase of 5.69 WTE HCSW's with an expectation that variable pay will reduce significantly.

This establishment change is supported by the Divisional Leadership Team and robust monitoring arrangements are in place to monitor roster efficiencies.

Total WTE: 37.9

Respiratory GIM Reconfiguration:

Site	Ward	Pre-Calculation			Post-Calculation			Difference		Cost	
		RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	RN	HCSW
GUH	C4	39.86	27.97	68.83 including WM	46.3	39.65	86.95 including WM	+6.29	+11.53	£283,871 from B4 (cost neutral) Additional £32,644 (Approved)	£215,844 from B4 (cost neutral) Additional £215,844 (Approved) Total additional £248,488 funded

GUH	B4	23.01	22.37	46.37 including WM	17.17	16.53	34.7 including WM	-5.69	-5.69	-£283,871	-£215,844
NHH	4.4	20.17	13.98	35.15 including WM	17.32	19.58	37.99 including WM	-2.85	+5.69	-£156,225	+£246,488
											Total additional 90,665 unfunded

Conclusions and Recommendations

The Board is asked to:

- NOTE the changes outlined within the report
- Receive ASSURANCE that the Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA.
- NOTE that the Health Board is meeting its statutory duty to provide an annual presentation to the Board of the nurse staffing levels on 25B wards.

**CYFARFOD BWRDD IECHYD PRIFYSGOL
ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING**

MINUTES OF MEETING HELD

Date and Time	Tuesday 26th November 2024 at 09:30am	
Venue	Conference Centre, St Cadoc's Hospital and Microsoft Teams	
PRESENT	Ann Lloyd Pippa Britton Richard Clark Paul Deneen Dafydd Vaughan Iwan Jones Helen Sweetland Neil Patrick Penny Jones Louise Wright Phil Robson Nicola Prygodzicz James Calvert Sarah Simmonds Jennifer Winslade Rob Holcombe Paul Solloway Leanne Watkins Peter Carr Hannah Evans	Chair Vice Chair Independent Member (Local Authority) Independent Member (Community) Independent Member (Digital) Independent Member (Finance) Independent Member (University) Independent Member (Community) Independent Member (Community) Independent Member (Trade Union) Special Advisor to the Board Chief Executive Medical Director Director of Workforce and OD Director of Nursing Director of Finance & Procurement Director of Digital Chief Operating Officer Director of Therapies and Health Science Director of Strategy, Planning and Partnerships
IN ATTENDANCE	Rani Dash Lisa Charles	Director of Corporate Governance Regional Director, Llais Cymru
APOLOGIES	Tracy Daszkiewicz	Director of Public Health

	PRELIMINARY MATTERS
ABUHB 2611/01	Welcome and Introductions The Chair welcomed everyone to the meeting, in particular members of the public who had joined the meeting to observe. It was noted that the meeting would be recorded and published on the Health Board's website following the meeting.
ABUHB 2611/02	Declarations of Interest for Noting There were no declarations of interest raised.
ABUHB 2611/03	Consent Agenda The Chair introduced the Consent Agenda and asked if there were any items to be brought forward for discussion. There were no requests made.
ABUHB 2611/04	Report from the Chair Ann Lloyd, Chair, provided her verbal report, with a focus on the following areas for which she was involved: • The Care Action Committee, a forum for health and social care leaders to meet with ministers to improve the performance of the health and social care systems, had continued to meet. A 50-day challenge had been launched with the purpose of bringing a collective and consistent approach across Wales to improving hospital discharge procedures and to building community capacity in order to ease winter pressures on the NHS and social care systems. The role of the Regional Partnership Board was therefore key in responding from a Gwent perspective and an action plan had been developed. • RPB leaders had continued to meet and focused on the health and social care challenges. • The Gwent RPB had met with considerable discussion on the development of the Winter Plan for 2024/25 held. • An initial meeting with the Chair of the Ministerial Advisory Group (MAG) on NHS Performance and Productivity, which will provide an independent review of the existing arrangements in place to support improvements in NHS Wales had been held. The MAG would be looking to meet with Health Boards in due course. • A meeting of NHS Chairs and the Cabinet Secretary had been held to focus on opportunities for innovation and improvement in performance. • The Cabinet Secretary had recently visited Ysbyty Ystrad Mynach and Nevill Hall Hospital which had been an opportunity to show the Breast Unit and how improvements in planned care performance were being made across sites.

- Plaid Cymru had held a launch event to promote its report on strengthening governance and accountability in the Welsh NHS, much of which reflected the recommendations in the Task & Finish Ministerial Advisory Group Report into NHS Wales Accountability which had been published in November 2024.

The Board **NOTED** the Chair's updates.

**ABUHB
2611/05**

Report from the Chief Executive

Nicola Prygodzicz (NP), Chief Executive, provided her verbal report, with a focus on the following areas:

- It remained a hugely busy and challenging time for the teams across the organisation and so there was an ongoing focus on the key priorities over the next few months at an organisational level. This included preparation and planning for winter, delivery of ministerial targets including planned care, cancer and mental health services, and delivering the 2024/25 financial plan. NP noted that all three areas were covered by papers on the meeting's agenda.
- Additional funding to support planned care improvements had been announced by Welsh Government and this was welcomed, particularly to support improvement in 104 week waits and diagnostics, with further detail set out in the paper provided with the agenda. The organisation was working hard to deliver this by 31st March 2025.
- The Southeast Wales Health Boards had been successful in securing funding for the region for ophthalmology, with particular focus on improving waits for cataracts surgery, and so work was ongoing at pace to set up teams and explore other opportunities for securing capacity to deliver improvements.
- Urgent and Emergency Care remained a significant priority and an integral part of the Winter Plan for 2024, as well as working with Local Authorities to support improvement in Pathways of Care Delays and promoting vaccination uptake across staff groups and communities.
- The Health Board had been successful in securing additional capital funding towards the second MRI Scanner and Discharge Lounge at the Grange University Hospital. Additional discretionary capital funding had also been secured which would help address risks within the capital portfolio.
- The Health Board had experienced some significant challenges related to IT outages and thanks were extended to the Director of Digital his team and operational and clinical teams for the work in resolving and managing the issues to ensure business was continued and fully restored as swiftly as possible.
- The Health Board had experienced challenges at the weekend due to extreme weather with flooding across the Health Board

area. NP noted the huge efforts of teams and communities to respond to the challenges and thanked all those involved.

- NP had attended the Health Board's Nursing and Healthcare Support Workers Conferences which had been outstanding events bringing together professions to celebrate learning and achievements.
- NP had attended the NHS Wales Awards Ceremony and the RCN Awards Ceremony, both of which included a number of our staff and teams as finalists which was a recognition of their outstanding achievements.

The Board **NOTED** the Chief Executive's updates.

ABUHB
2611/06

Experience Story – Children's Rights and Participation in Action

The Board welcomed the following guests to support delivery of a presentation that provided an insight into work to embed children's rights and the work of the Child and Adolescent Psychology Service.

- Dr Jennifer McElwee (JE), Consultant Child Psychologist
- Mike Charles (MC), Assistant Psychologist
- Lucy Bennett Downes (LBD), Parent Carer Peer Mentor
- Emma Alm (EA), Parent Carer

The Board was informed that embedding a children's rights approach meant that organisations will prioritise children's rights in their work with children and families to improve children's lives and was provided with an overview of its components including equality, non-discrimination, empowerment and accountability.

The presentation provided examples of how children's rights were being embedded into the care provided to children and families, including the introduction of peer mentor support. The Board heard of the significant benefits that peer mentors brought to children and families in sharing lived experiences and the positive impact this had on outcomes.

The Board heard of some of the challenges associated with further developing a children's rights approach which included the need for additional funding to support roll-out across Gwent in developing the service to receive automatic referrals and challenges in transition to adulthood. The Board, via the Director of Finance and Procurement, gave a commitment to explore funding opportunities to support further development of the service given the excellent benefits shared with the Board during the presentation.

The Board **RECEIVED** the presentation and extended thanks to all those involved in the positive work underway to improve the experience and outcomes of children and families. Particular thanks

	were extended to those present who had shared their personal experiences in delivering the presentation.
ABUHB 2611/07	Llais Report Lisa Charles (LC), Regional Director, presented Llais’ report which set out current issues of concern and positive observations, and public feedback being addressed by Llais Gwent Region. The Chair queried the reference within Llais’ report to concerns in relation to sexual safety encountered by patients accessing health services and asked if these concerns were specific to Aneurin Bevan University Health Board patients. LC confirmed that these concerns had arisen from an all-Wales piece of work and discussions were being held with the Health Board to understand if these extended to Aneurin Bevan University Health Board patients; however there were no validated concerns at this stage. There was a request from the Board for Llais to provide granular detail within its report for the Board when referring to concerns, so that the Board could understand the volume of concerns and the detail of concerns to enable the Board to take informed decisions. LC acknowledged this request. The Board thanked Llais for the ongoing support to communities and the insights brought back to the Board to inform ongoing planning and delivery of services. The Board RECEIVED the Report from Llais.
ABUHB 2611/08	Winter Plan 2024/25 – Responding to Seasonal Pressures Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the Winter Plan 2024/24 (the plan) which set out how the Health Board, with partners, would respond to the challenges faced by the health and care system over the winter months. HE confirmed that respiratory illness would again pose a threat this year with further anticipated waves of COVID-19, influenza and Respiratory Syncytial Virus (RSV) peaking in December and early January 2025. This together with increasing demand driven by an ageing population and staffing challenges, services across the region would be required to meet the health and well-being needs of both staff and the population in evermore complex and pressured circumstances. HE noted that, within this context, the plan set out the actions that would provide focus, step flow and consider best utilisation of capacity. In addition, it set out work in partnership between health

and social care through the Regional Partnership Board, to support the system and deliver preventative activity and built upon local urgent and emergency care plans, delivered through the Health Board's Six Goals for Urgent Care programme, which focuses upon enhancing capacity within the community and providing alternatives to admission.

HE outlined the detail of the plan which focused around:

1. Health Board actions – primary and community services and hospital system
2. Partnership Actions - the 50-day challenge and Regional Partnership Board actions
3. Prevention actions – vaccination and communication
4. Resources – the focus of workforce & OD and financial implications

HE acknowledged the financial situation of the Health Board and outlined that the plan highlighted the risks and opportunities in delivering winter actions to the financial plan.

HE concluded that, through undertaking the actions set out in the plan, the organisation will endeavour to meet the challenges of the winter and target the areas of greatest challenge and provide the best opportunity to ensure people access care and support in the right place, first time, whilst optimising effective flow through the system.

The Board discussed the detail of the plan, the modelling available and the actions to be taken to prevent admissions and build capacity to respond to the anticipated pressures. The Board emphasised the need to build capacity across the community and the importance of partnership working to achieve this. The Board also focussed on the need to maintain support for staff wellbeing through sustained periods of challenge.

The Board **APPROVED** the Winter Plan 2024/25, acknowledging the need to closely monitor the situation with supporting data.

**ABUHB
2611/09**

Improving Waiting Times for Planned Care and Diagnostics 2024/25

Leanne Watkins (LW), Chief Operating Officer, presented an update on planned care performance along with an overview of the allocation of additional funding received from Welsh Government to support additional improvements.

LW confirmed that as a result of additional focus and an internal prioritisation of funding since May 2023, in line with ministerial expectations, there had been positive improvements in the trajectory of the Health Board's planned care waiting lists for those patients

waiting over 104 weeks as well as those waiting for a routine diagnostic over 8 weeks.

LW informed the Board that in August 2024 the Health Board submitted potential costed options to increase activity to reduce both surgical and diagnostic waiting lists. This was completed using detailed modelling looking at all options to deliver required activity and considering the waiting list cohort sizes to the end of the year.

The Board was advised that in October 2024 Welsh Government had confirmed the following funding for Aneurin Bevan University Health Board:

- £3.816m to address the outstanding 104 week wait gap for Orthopaedics;
- £1.3m for the diagnostic schemes, to include Endoscopy, Neurophysiology and Cardiology to get to 95%+ under 8 weeks.

LW outlined, as set out within the paper, how the allocation of this funding would be utilised within respective specialities and associated risks to achieving the expected targets.

It was noted that ENT schemes had not yet been supported for additional funding; however further information had been requested, and the Health Board was liaising with Welsh Government in this regard.

The Board was also advised that Welsh Government had additionally confirmed that the Southeast Region would also receive £3m for Ophthalmology, in a first phase of a further £7.4m potentially available, to meet the cataract treatment plan developed for the region. It was noted that the first phase would deliver c.2100 treatments with a potential to increase if the additional capacity to do so is available.

It was noted that the Health Board was working with Welsh Government to understand the potential recurring planned care funding opportunities going into the next financial year to enable more substantive decisions to achieve service sustainability and ensure value for money. This would also support submitting more ambitious planned care trajectories for the 2025/2026 annual plan.

The Board welcomed the additional funding received and the opportunities this would bring to improve patient waiting times and outcomes. The progress already made by the organisation in reducing waiting times was acknowledged. The ongoing and increasing ask of staff was of concern to the Board and the importance of the organisation having robust staff wellbeing support was emphasised.

	The Board NOTED the update on planned care performance and ENDORSED the deployment of additional funding received from Welsh Government to make further improvements.
ABUHB 2611/10	ReFIT Funding Opportunities Rob Holcombe (RH), Director of Finance and Procurement, presented the Board with an overview of work to develop proposals under the ReFit framework (a Welsh Government promoted scheme that aims to accelerate the energy efficiency of public sector buildings) for invest to save capital funding to enhance the Health Board’s estate, reduce carbon emissions and reduce costs associated with energy. RH advised that, following a tender process and award of contract partner, the Health Board had worked with the appointed partner and developed a high-level assessment of the potential for investment and the next stages including an Investment Grade Proposal (IGP) and formal submission for investment. RH outlined that, upon the advice of Welsh Government’s Energy Service, the Health Board had submitted an Expression of Interest to the Wales Funding Programme (Salix Funding) for £7.44m, phased over 2 financial years of investment as Phase One progresses (to be delivered in 2025/26 and 2026/27). RH noted that the IGP will form the business case upon which the Health Board will form its bid to the Invest-2-Save Wales Funding Programme. The appointed partner would undertake further site visits to clarify specifications and quantities, so more accurate capital costs could be drawn up. It was noted that a final proposal would then be developed by mid-January 2025 for formal consideration within the Health Board as well as Local Partnerships and Welsh Government’s Energy Service. The timeline for internal review and approval of the case was outlined within the paper, which would culminate in the Executive Committee’s final approval, subject to Board approval. The Board held detailed discussion regarding the need to ensure the alignment of any investment in estates work undertaken with the future strategic direction of the Health Board. There was assurance provided that the approach set out within the paper would align with the future estates model and would ensure an appropriate allocation of spend. Discussion raised concern from some board members regarding the need for the Board to refresh its long-term Estates Strategy. The capacity required to undertake this work was noted as significant and could not be prioritised at this time, given all other priorities agreed through the Annual Plan 2024/25, including winter response, planned

	care, a number of prioritised capital programmes and strategic planning for 2025/26 and the longer-term strategy. Nicola Prygodzicz (NP), Chief Executive, reinforced that the Board did have an extant Estates Strategy which was being implemented and the importance of refreshing all enabling strategies in the context of the Long-Term Strategy (10 years) when agreed by the Board. It was noted that the Board's Partnerships, Population Health and Planning Committee had received routine updates on the Capital and Estates Programme being delivered. NP committed to bringing to the Board in March 2025 a timeline which would set a line of sight to a refreshed Estates Strategy being brought forward to the Board for consideration. Action: Chief Executive and Director of Strategy, Planning and Partnerships The Board NOTED the programme of work planned for the year leading to IGP submission and the associated funding request and AGREED that the Executive Committee have delegated authority to approve the final proposal to be submitted.
ABUHB 2611/11	Quality Improvement Strategy Jennifer Winslade (JW), Director of Nursing, presented to the Board a 3-year Quality Improvement Capability Strategy (QICS), which would underpin the Board's approved Quality Strategy. JW noted that the QICS set out a vision and approach where Quality is embedded in the culture of the Health Board, with a commitment to continuously improving the care provided. The queried the need for further detail to be provided to support approval of the QICS, including an impact assessment of resources and a capacity assessment as to whether the ambitions of the QICS could be realistically delivered, recognising the impacts on staff already discussed throughout the meeting. The Board fully supported the importance of quality improvement and acknowledged the Board's role in driving a culture of quality improvement and safety. The quality improvement work already underway in the organisation was also acknowledged. The Board ENDORSED the approach to Quality Improvement as set out within the paper, however, did NOT APPROVE the document as a Strategy in the absence of the further detailed assessments.
ABUHB 2611/12	Compassionate Leadership Pledge Sarah Simmonds (SS), Director of Workforce & OD, presented a proposed Compassionate Leadership Pledge for the Health Board, which was tailored from Healthcare Education and Improvement

	Wales' pledge, to commit to develop, model and maintain compassionate leadership type behaviours at all levels to enable compassionate and inclusive cultures within the organisation. The Board reinforced the position that the Health Board is committed to creating and maintaining a compassionate and inclusive environment for staff, patients and service users and demonstrate a commitment to living the values of the Health Board and regarded as an employer of choice. The Board APPROVED and ADOPTED the compassionate leadership pledge for its use across the Health Board.
ABUHB 2611/13	Establishment of a Mental Health and Learning Disabilities Committee Rani Dash (RD), Director of Corporate Governance, set out a proposal with supporting Terms of Reference for the Board's Mental Health Act Monitoring Committee be reviewed and revised to a Mental Health and Learning Disabilities Committee to incorporate a broader focus on all aspects of the Health Board's activities in relation to mental health, learning disabilities and child and adolescent mental health services. The proposed Terms of Reference would also delegate responsibility to a Mental Health and Learning Disabilities Committee to review and seek assurance regarding the Mental Capacity Act and National Dementia Standards. The Board APPROVED the establishment of a Mental Health and Learning Disabilities Committee to replace the Mental Health Act Monitoring Committee and its associated Terms of Reference.
ABUHB 2611/14	Stroke Reconfiguration Update Leanne Watkins (LW), Chief Operating Officer, provided the Board with an update on the outcome of the temporary Stroke reconfiguration and the consolidation of services across the Hyper Acute Stroke Unit (HASU) at the Grange University Hospital and one stroke rehabilitation site at Ysbyty Ystrad Fawr (YYF) in November 2023, following board approval in 2023. LW highlighted improvements in stroke audit performance, reduced length of stay, and increased access to the hyper-acute stroke unit since temporary changes were implemented. It was also noted that the reconfiguration had improved financial sustainability, contributing to around £1.6 million in savings. LW noted ongoing discussions with local authority partners and staff engagement to further enhance and improve the stroke rehabilitation service.

LW requested the Board's approval for the extension of the current service provision for an additional 12 months, aligned to the Health Boards wider long-term strategy development and public engagement and consultation process, to support further assessment alongside a thorough review of patient outcomes.

Louise Wright (LW), Independent Member, acknowledged the positive work undertaken in engaging and listening to staff.

The Board welcomed the positive improvements reported to-date as a result of the temporary change and **APPROVED** the request to extend these arrangements for an additional 12 months pending the further work set out.

**ABUHB
2611/15**

Management of General Medicine Patients at the Grange University Hospital

Leanne Watkins (LW), Chief Operating Officer, presented to the Board an update report on the implementation of a General Internal Medical (GIM) model of care at the Grange University Hospital (GUH) and the Respiratory Medicine reconfiguration which included:

- Realignment of medical staff from Nevil Hall Hospital (NHH) to GUH to further support the Respiratory team; and
- Clear clinical accountability for 16 General Internal Medicine beds at GUH.

LW emphasized that the new model aimed to improve patient care by having a bespoke team looking after general medicine patients, which is expected to reduce length of stay and improve quality of care, as well as supporting financial savings.

LW outlined the complex jigsaw of bed configuration changes to support the new model, including the relocation of the high care respiratory unit to an ITU pod. The reconfiguration of respiratory medicine and the implementation of a General Internal Medical model of care at GUH, consistent with the Health Board's Clinical Futures model, took place over the week commencing 11th November 2024, with a phased decommissioning of beds at NHH to support the change prior to this date.

LW noted that quality improvement was already seeing results since changes were implemented and a clear set of metrics would be tracked to demonstrate the improvement resulting from the new model, with a report on the mitigation and impact expected after six months. The Chair requested that this report be brought forward to Board in due course.

Action: Chief Operating Officer

	The Board NOTED the realignment of medical staff from NHH to GUH to further support the Respiratory team and the clear clinical accountability for 16 General Internal Medicine (GIM) beds at GUH; the improved model of care at GUH for elderly and frail patients; and the system wider mitigating actions aligned to the overall bed reduction as set out within the paper.
ABUHB 2611/16	Review of Children and Young People's Services Jennifer Winslade (JW), Director of Nursing, presented to the Board a report on children and young people's services, covering areas such as maternity and early years, school age, transition, safeguarding, and CAMS. The report highlighted improvements and ongoing challenges, with a focus on ensuring equity and addressing waiting times. Updates included a focus on health and well-being during pregnancy, the rise in C-section rates, and a maternity services improvement program with around 150 actions and a focus on the Healthy Child Wales program, child weight management services, and improvements in childhood vaccination rates. JW emphasized the need to refresh the transition programme, particularly for complex children, and to address transition to employment and transition for children up to their early 20s. JW outlined the increasing referrals for criminal exploitation of children and the multi-agency response in Gwent, as well as the enhancement of safeguarding through specialist posts. JW also noted the improvements in CAMHS collaboration and outcomes, although she highlighted ongoing challenges in primary CAMHS and neurodevelopmental services, with there being a focus on reducing waiting times. The Board welcomed the comprehensive report and NOTED the progress in relation to the improvements within children and young people's services and the next steps.
ABUHB 2611/17	The Grange University Hospital System Report Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided an update on the Grange University Hospital (GUH) and the hospital network model, highlighting improvements in access times, diagnostic capacity, quality outcomes, and financial performance. HE highlighted improvements including: access times and the management of flow, with MIUs responding to 51% of urgent care demand and only 13% of calls being redirected to ED; the significant increase in diagnostic capacity, with nearly doubled CT and MRI

	activity through the new system; and improved quality outcomes, including reduced RAMI, lower infection rates and better mortality performance in key areas such as the emergency department and stroke services. HE referred to the financial performance assessment made against the original financial assumptions, including the challenges and opportunities addressed, and the impact of the new model on the underlying cost base. HE confirmed that the report had been shared as a draft with Welsh Government for review as part of the escalation requirements, with a focus on demonstrating the benefits and outcomes of the new model. The Board welcomed the positive benefits of the new model, as set out, and RECEIVED the report.
ABUHB 2611/18	Integrated Performance Report, Quarter 2, 2024/25 Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented the quarter 2 performance report, highlighting progress in areas such as urgent and emergency care, cancer, planned care, diagnostics, and mental health. The report noted improvements and ongoing challenges, with a focus on achieving performance targets, including: • progress in urgent and emergency care, with ambulance waits over an hour tracking the trajectory and 12-hour ED waits showing improvement, though challenges remained in October; • the reduction in the total waiting list for cancer patients and significant improvements in the backlog of patients waiting over 104 days and 62 days; • the reduction in 156-week waits to one patient and the improvement in 104-week waits, as well as the significant progress in diagnostic waits, particularly in radiology; and • in respect of in adult mental health and CAMHS, improvements in 1A performance but challenges in 1B and neurodevelopmental services, with plans for further review and additional funding being progressed. The Board NOTED the performance as reported at Quarter 2, acknowledged the significant improvements made and passed thanks to all staff involved in achieving these.
ABUHB 2611/19	Quality Performance and Outcomes Report, Quarter 2, 2024/25 Jennifer Winslade (JW), Director of Nursing, presented the quality outcomes and performance report, highlighting areas of improvement such as patient satisfaction, ward accreditation, and theatre safety.

	The report also addressed ongoing challenges in infection rates, complaints resolution, falls, and safeguarding training. The Board NOTED the performance as reported at Quarter 2.
ABUHB 2611/20	Financial Performance, Month 6, 2024/25 Rob Holcombe (RH), Director of Finance and Procurement, presented the finance report for September 2024, highlighting a year-to-date deficit of £26.1 million and a forecast deficit of £47.8 million. The report noted progress in savings plans and ongoing risks related to prescribing costs and winter planning. RH noted that early indications for month 07 (October) performance was of a similar position to month 06 with the same level of risk as being reported at month 06. The Board NOTED the financial performance position and the ongoing risks to achieving the 2024/25 as set out within the paper.
ABUHB 2611/21	Strategic Risk Report, November 2024 Nicola Prygodzicz, Chief Executive, presented Board with an assessment of strategic risks at September 2024 and outlined proposed changes in respect of: • a reduction in score and exposure or SRR 001I regarding risks associated with divisional performance; • a separation of risk SRR 004 into two separate sub-risks regarding emergency planning. The Board NOTED the strategic risks as set out within the paper and APPROVED amendments to the two risks as proposed.
	CONSENT AGENDA
ABUHB 2611 /22	The Board APPROVED the Draft Minutes of the Health Board Meeting, held on 25th September 2024. The Board APPROVED the Report on Sealed Documents and Chair's Actions. The Board NOTED the Board Action Log with Updates. The Board NOTED the Strategic Partnership Updates of the Regional Partnership Board and Public Service Board. The Board NOTED the Executive Committee Chair's report. The Board NOTED Key Matters from Committees of the Board.

	The Board NOTED the overview of Joint and Partnership Committee Activity of the Joint Commissioning Committee and NHS Wales Shared Services Partnership Committee.
	OTHER MATERS
ABUHB 2611/23	Any Other Business The Chair acknowledged that this would be the last meeting attended by Pippa Britton, Vice Chair, as she ended her term of office with Aneurin Bevan University Health Board and would shortly assume the role of Chair with Public Health Wales. The Chair expressed huge thanks to Pippa on behalf of the Board, acknowledging the significant contribution she had made during her tenure and she wished her every success in her new role. There was no other business raised for discussion.
ABUHB 2611/24	Date of the Next Meeting: 22 nd January 2024

DRAFT

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Governance Matters: Report on Sealed Documents and Chair's Actions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

This report is presented for compliance and assurance purposes to ensure the Health Board fulfils the requirements of its Standing Orders in respect of documents agreed under seal and situations where Chair's Action has been used for decisions.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between 13th November 2024 and 15th January 2025.

The Board is asked to note that there have been three (3) documents that required the use of the Health Board's seal during the above period.

Chair's Action in Standing Orders requires approval by the Chair, Chief Executive and two Independent Members, with advice from the Board Secretary (the Director of Corporate Governance). All Chair's Actions require ratification by the Board at its next meeting.

During the period 13th November 2024 and 15th January 2025 there were three (3) Chairs Actions agreed.

Cefndir / Background

1. Sealed Documents

The common seal of the Health Board is primarily used to seal legal documents such as transfers of land, lease agreements and other contracts. The seal may only be affixed to a document if the Board or Committee of the Board has

determined it should be sealed, or if the transaction has been approved by the Board, a Committee of the Board or under delegated authority.

2. Chair’s Action

Chair’s Action is defined by the Health Board’s Standing Orders as: Chair’s action on urgent matters: There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practical to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

3. Key Issues

3.1 Sealed Documents

Under the provisions of Standing Orders, the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. Three documents were sealed between the 13th November 2024 and 15th January 2025, as outlined below.

Date	Title
14/11/2024	Agreement between Newport City Council and ABUHB in regard to the demolition of Ringland Health Centre and the construction of Newport East Health Centre.
20/11/2024	Engrossed Lease between ABUHB and Rupert Alistair Smith, Martin James Guilford, Lauren Kaye Grigg and Jonathan Antony Currie in regard to the lease of Ringland Practice, 19 Hills Health and Well Being Centre, Newport
10/12/2024	Licence to assign relating to a lease of dental suites at the Integrated Health and Social Care Centre, Resource Centre, Caerphilly between MXF Properties V Ltd, ABUHB, Dr Daniel John Srivastava, Lawn Practice Ltd, Oday Hammond and Mohammed Hafeez Sharief.

3.2 Chair’s Action

The Chair’s Actions approved between 13th November 2024 and 15th January 2025 are summarised below:

Date	Title
20/11/2024	Regional Outsourcing – Ophthalmology: To provide a 4-month solution for additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise use of the Health Board’s assets.

	The additional capacity will provide a service for health board patients from Aneurin Bevan, Cwm Taff Morgannwg and Cardiff and Vale University Health Boards. There is a contract currently in place for regional cataracts outsourcing which ends in March 2025. However, Welsh Government has provided additional funding (£7,500,000) for another 5000 cases to be delivered by 31st March 2025. Total value of new contract: £7,500,000: Provider 1 -2400 cases Provider 2 – 825 cases Provider 3 – 2500 cases For the period 1st December 2024 to 31st March 2025.
13/01/2025	Percutaneous Coronary Intervention (PCI) – Stents and associated Consumable Items, Cardiology Department: PCI is carried out at the Grange University Hospital Catheterisation Laboratory. Following re-tender, an award was made under the All-Wales Framework. Contract period: 1st December 2024-30th November 2025 with option to extend for one year to 30th November 2026. Value of expired contract: Annual: £441,678.00 (ex VAT) Total £883,356.00 (ex VAT) Value of New Contract: Annual: £448,535.00 (ex VAT) Total: £897,070.00 (ex VAT)
08/01/2025	ENT Treatment Insourcing: Provision of a 3-month insourcing solution to fulfil a quota of 750 ENT patient treatments during January to March 2025, primarily at the Royal Gwent Hospital and Grange University Hospital. Total Value of new contract: £1,600,000.00 Funding assigned to the Health Board from Welsh Government in December 2024.
<u>Asesiad / Assessment</u> In endorsing this report the Health Board will comply with its own Standing Orders.	
<u>Argymhelliad / Recommendation</u> The Board is asked to NOTE the documents that have been sealed and to RATIFY the action taken by the Chair on behalf of the Board.	

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
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. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb	No does not meet requirements

Equality Impact Assessment (EIA) completed	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. Not applicable to this report

Joint Commissioning Committee

Joint Commissioning Committee Governance Framework

Dyddiad y Cyfarfod / Date of Meeting	29/01/2025
Statws Cyhoeddi / Publication Status	Open/ Public
Awdur yr Adroddiad / Report Author	Jacqui Maunder, Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Jacqui Maunder, Committee Secretary
Noddwr yr Adroddiad / Report Sponsor	Ian Green, Chair of the JCC

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)		
Committee/Group/Individuals	Date	Outcome
Joint Commissioning Committee	21 January 2025	The JCC endorsed the updated ToR.
Joint Commissioning Committee	12 November 2024	Agreed to amend ToR to reflect CEO members as members of sub- committees.
JCC Strategy Workshop	10 December 2024	CEOs discussed nominations for CEO members on sub- committees.
Sub Committee Structure NHS Wales Joint Commissioning Committee (JCC)	17 September 2024	Endorsed
Health Board Meeting	September 2024	Approved
Engagement Chair of the JCC Chief Commissioner	August 2024	Feedback assisted in developing the drafts.

JCC SLT Working Group of NHS Wales DoCG / Board Secretaries SLT Development Day JCC Development Day NHS Wales Directors of Corporate Governance (DoCG) peer group		

Acronyms / Glossary of Terms	
HBs	Health Boards
JCC	NHS Wales Joint Commissioning Committee
MoA	Memorandum of Agreement
PP&F	Planning, Performance and Finance Sub-committee
QS&O	Quality, Safety and Outcomes Sub-committee
SoD	Scheme of Delegation
SOs	Standing Orders
ToR	Terms of Reference

1. SITUATION/BACKGROUND

Further to the 7 x Health Boards (HBs) approving the final elements of the NHS Wales Joint Commissioning Committee’s (JCC) (*“Joint Committee”*) governance framework at their September 2024 Board meetings, the purpose of this report is present updated Terms of reference (ToR) for the JCC’s sub committees which have been updated to reflect that CEO’s are designated as members of sub-committees.

In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework is reserved to HBs. On the 17 September 2024 the Joint Committee reviewed and endorsed the proposed sub-committee structure, the accompanying terms of reference, the hosting agreement (HA) and the memorandum of agreement (MoA) for submission to individual HB Board meetings in September 2024 for final approval.

Since then following discussions with the JCC members at the JCC meeting on 12 November and at the JCC Strategy workshop on 10 December 2024 it was agreed to include CEOs as members of the sub committees.

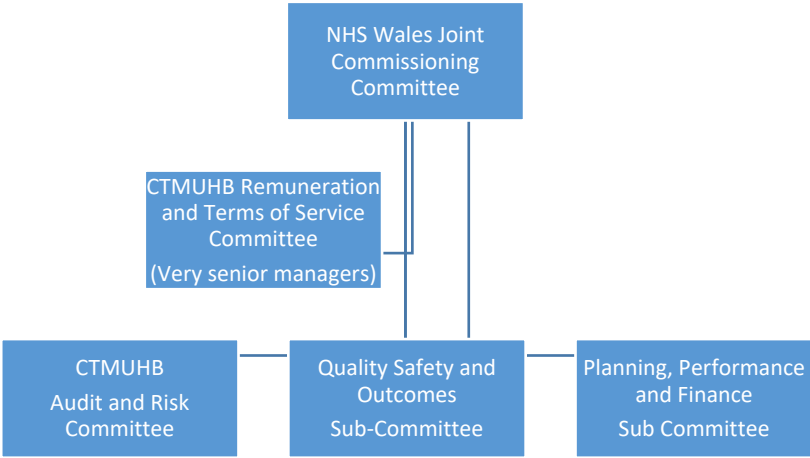
The NHS Wales Directors of Corporate Governance (DoCG) peer group have been consulted on this change and are aware of the JCCs decision to include CEOS as members and not attendees.

2. SUB COMMITTEE TERMS OF REFERENCE (TOR) AND MEMBERSHIP

In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework is reserved to HBs.

On the 17 September 2024 the Joint Committee endorsed the proposed sub-committee structure for the JCC – see **Figure 1** and the 7 x individual HB Board meetings formally approved the structure and the documents at their Board meetings in September 2024.

Figure 1 – Approved JCC Sub-Committee Structure



Following a request from the JCC to update the Terms of Reference (ToR) for the Quality, Safety and outcomes (QS&O) Sub-Committee and the Planning, Performance and Finance (PP&F) Sub-Committee to reflect the designation of a CEO representative as a member and not attendee, the ToR have been updated and are presented **Appendices 1** and **2** for approval, following endorsement at the JCC meeting on 21 January 2025.

The first meetings of each Sub-Committee will be held in February 2025 and Sub-Committee highlight reports will be provided to the JCC meeting by way of assurance and escalation in March 2025. Sub-Committee cycles of business will also be presented to ensure JCC oversight.

The membership and attendance for the sub committees is outlined in **Tables 1 & 2** below:

Table 1 – Membership/Attendance Quality and Safety and Outcomes Sub-Committee

Quality and Safety and Outcomes Sub-Committee	
Designation	Lay Member/Attendee
Chair	Susan Elsmore
Vice Chair	Mandy Rayani
Member	Shameem Nawaz
One representative Chief Executive or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)	Phil Kloer, CEO HDdUHB
Llais Representative	Angela Mutlow

Table 2 –Membership/Attendance Planning, Performance and Finance Sub Committee

Planning, Performance and Finance Sub Committee	
Designation	Lay Member/Attendee
Chair	Paul Worthington
Vice Chair	Nia Roberts
Member	Ian Green
One representative Chief Executive or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)	Abigail Harris, CEO, SBUHB Deputy - Hayley Thomas, CEO PtHB

Now that the sub-committees have been established each sub-committee will report formally into the JCC via highlight reports from the sub-committee chairs. In addition, discussions are ongoing with the NHS Wales Directors of Nursing peer group and the NHS Wales Directors of Corporate Governance peer group to consider the most appropriate assurance reporting to HB sub committees and Boards to ensure effective governance.

Objectives / Strategy	
Dolen i Nod(au) Strategol BIP CTM /Link to JCC Strategic Goal(s)	Not Applicable
	The JCC was established on 1 April 2024. Draft Strategic Objectives are being presented for approval at the September Joint Committee Meeting.
Dolen i Feysydd Strategol BIP CTM /Link to JCC Strategic Areas	Not Applicable
	The JCC was established on 1 April 2024. Draft Strategic Objectives are being presented for approval at the September Joint Committee Meeting.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	If more than one applies, please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	If more than one applies, please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies, please list below:

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	Consideration has been given to the Duty of Quality as set out in section 1A of the NHS (Wales) Act 2006 ("the

		2006 Act”) as it applies to the Welsh Ministers. The Duty of Quality places Ministers under an additional duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health services. The establishment of the new JCC arrangements will support the delivery of the Duty of Quality requirements.
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	A Regulatory Impact Assessment is contained with the Explanatory Memorandum to The National Health Service Joint Commissioning Committee (Wales) Regulations 2024 .
Cyfreithiol / Legal	In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework terms of reference is reserved to HBs. National Health Service Joint Commissioning Committee (Wales) Directions 2024 National Health Service Joint Commissioning Committee (Wales) Regulations 2024	
Enw da / Reputational	There is no direct impact on the reputation of the Local Health Boards or the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

3. RECOMMENDATIONS

The Board is asked to **Approve:**

- the updated terms of reference (ToR) for the JCC Quality, Safety and Outcomes Sub-Committee; and
- the updated terms of reference (ToR) for the JCC Planning, Performance & Finance Sub-Committee.

4. NEXT STEPS

4.1 Review

A formal review of the governance framework for the JCC will be undertaken in April 2025 in collaboration with the HB DoCGs following a full year of operation as the new JCC.



PLANNING, PERFORMANCE AND FINANCE SUB- COMMITTEE (PPFSC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

Document Author:	Committee Secretary
Lead Directors	Director of Finance and Information Director of Planning and Performance
Endorsed By	Joint Commissioning Committee 17 September 2024
Approved By	Health Boards – 25 and 26 September 2024 Board Meetings
Issue Date	1 December 2024
Review Date	~~1 June 2025~~ 12 January 2025
Version	~~1~~ 2

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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1	Health Boards	17 September 2024	Approved at HB September Board meetings	1 June 2025

Sub-Committee Arrangements:

This schedule forms part of, and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

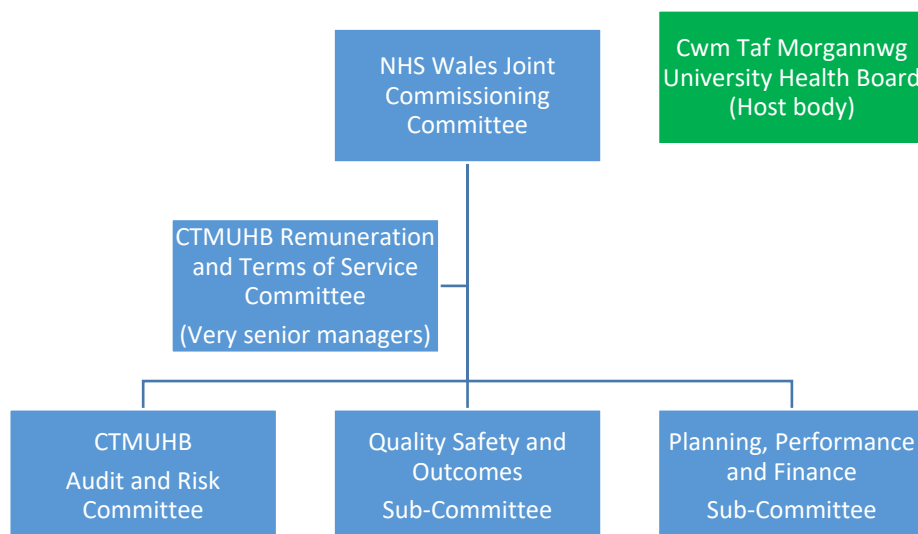
1. Introduction & Constitution

- 1.1 In accordance with JCC Standing Order 5.5, the NHS Wales Joint Commissioning Committee (JCC – the Joint Committee) may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-committees of the JCC either to undertake specific functions on the JCC's behalf or to provide advice and assurance to others (whether directly to the JCC or on behalf of the JCC to each LHB Board and/or its other sub-committees). The JCC shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.
- 1.2 In accordance with Standing Orders (SOs) (and the JCC Scheme of Delegation), the Joint Committee shall nominate annually a sub- committee to be known as the **Planning, Performance and Finance Sub-Committee**. The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this sub-committee are set out below.

2. Purpose

- 2.1 The purpose of the Planning, Performance and Finance Sub-Committee is to be assured that the Joint Committee is effectively managing the strategic planning, performance and financial duties outlined in the Joint Committees SOs and Standing Financial Instructions (SFIs) relating to planning, securing and commissioning the services delegated to the JCC.

Figure 1 – JCC Sub Committee Structure



3. Scope and Duties

The Sub-Committee will provide scrutiny and assurance in relation to the duties below:

3.1 Planning

- Monitor the process for the development of the Integrated Medium Term Plan (IMTP) in line with the relevant SOs, SFIs and the NHS Wales Planning Framework
- Receive assurance on the delivery of the IMTP
- Scrutinise the alignment of service, workforce, digital and financial commissioning plans in the IMTP (as appropriate to the business of the JCC)
- Scrutinise the development and delivery of strategic or major service plans through the agreed Service Transformation Programme in the IMTP.

3.2 Performance

- Advise on and assure the development and implementation of the JCC's Performance Management Framework
- Monitor in-year performance against the financial plan and activity targets that support the relevant metrics agreed by the Joint Committee
- Monitor overall performance of commissioned services against the JCC's IMTP and the national targets for NHS Wales (Ministerial Priorities).

3.3 Organisational Risk Register

- Regularly review the planning, performance and finance risks included on the JCC Risk Register and assigned to the Sub-Committee by the JCC.

3.4 Finance

- Monitor delivery of financial plans and savings programmes
- Monitor risk to financial delivery including mitigating actions to appropriately manage the risks
- Robustly challenge and support progress against delivery of savings plans including consideration of impact on services
- Scrutinise investments in line with the Standing Financial Instructions (SFIs) and the Scheme of Delegation prior to submission to the Joint Committee for approval
- Monitor activity and productivity including operational efficiency and effectiveness
- Report on significant financial variances and issues, including potential mitigation decisions.

3.5 Sub-Committee Programme of work

Each year the Joint Committee will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's IMTP and Corporate Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that

these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the Joint Committee throughout the year.

- 3.6 The Sub-Committee, in monitoring and scrutinising the above areas, will discuss and recommend corrective action where necessary. This will include the transformation, recommissioning and value in health care approach.
- 3.7 The Sub-Committee will monitor the development of appropriate Key Performance Indicators (KPIs) across all parts of the organisation.
- 3.8 Where necessary, the Sub-Committee will undertake detailed "deep dives" of specific areas. These reviews will be supported by appropriate benchmarking information to ensure all of the JCCs commissioned services are striving to achieve "best in class" in relation to planning, performance and finance.

4. Membership

Members

- 4.1 The Membership of the PPFSC Sub-Committee is as follows:

Chair	Lay (Independent) Member of the JCC
Vice Chair	Lay (Independent) Member of the JCC
Member	One further Lay (Independent) Member of the JCC
Member	One representative Chief Executive or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)

- 4.2 The membership of the Sub-Committee shall be determined by the Joint Committee, based on the recommendation of the Chair of the Joint Committee and lay members, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.
- 4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, will receive a nomination from the CEOs of Local Health Boards as outlined below.
- 4.4 The Membership will be reviewed annually.

Support to Sub-Committee Members

- 4.5 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:
 - Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and

- Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

4.6 **In Attendance**

JCC Director of Planning and Performance (co-lead JCC Director)
JCC Director of Finance & Information (co-lead JCC Director)
Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Sub-Committee Chair
Staff side representative.

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

- 4.7 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk or matters that are the responsibility of that Director / member of staff.
- 4.8 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Member Appointments

- 4.9 The membership of the Sub-Committee shall be determined by the Chair of the Joint Committee, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5 Quorum & Attendance

- 5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.
- 5.2 For effective governance, the Director of Finance and Information and the Director of Planning and Performance are required to attend all meetings.

6 Meeting Secretariat

- 6.1 The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

7 Frequency of Meetings

- 7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.

- 7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.
- 7.3 Additional meetings may be held with the chairs of the LHBs Planning, Performance and Finance Committees where there is requirement.
- 7.4 Members will be required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.
- 7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Business.

8 Withdrawal of Individuals in Attendance

- 8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9 Circulation of Papers

- 9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.
- 9.2 The Committee Secretariat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.
- 9.3 The JCC Committee Secretariat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.
- 9.4 The Sub-Committee highlight report will also be shared with members and HB Directors of Corporate Governance / Board Secretaries.

10 Access

- 10.1 The Chair of the Planning, Performance and Finance Sub-Committee shall work closely with the Director of Finance and Information and the Director of Planning and Performance and have reasonable access to the Directors and other relevant senior staff within the JCC Team.

11 Accountability, Responsibility & Authority

- 11.1 Although health boards have delegated authority to the Joint Committee and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each health board

retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.

- 11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the JCC that Planning, Performance and Finance are being managed appropriately within the commissioning cycles.

Authority

- 11.3 The Sub-Committee is authorised by the Joint Committee to investigate, or have investigated, any activity within its terms of reference. The Sub-Committee is authorised by the Joint Committee to obtain outside legal or other independent professional and clinical advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with procurement, budgetary and other policy requirements.

Sub Groups

- 11.4 The Sub-Committee may, subject to the approval of the JCC establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

Delegated Powers

- 11.5 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

Dealing with Members interests during meetings

- 11.6 Declarations of interest will be a standing agenda item for all meetings.
- 11.7 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.
- 11.8 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the JCC Standing Orders.

12 Reporting

- 12.1 The Sub-Committee Chair shall:
- Report formally, regularly and on a timely basis to the Joint Committee on the Sub-Committee's activities. This includes:
 - Assurance that Planning, Performance and Finance are being managed appropriately
 - oral updates on recent activity
 - submission of written Sub-Committee highlight reports throughout the year

- to receive annual reports, which will incorporate key information on planning, performance and finance
 - Bring to the Joint Committee’s specific attention any significant matters under consideration by the Sub-Committee; and
 - Ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, Chief Commissioner, HB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the JCC and HBs.
- 12.2 The Sub-Committee shall provide a written, annual report to the Joint Committee on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.
- 12.3 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Planning, Performance and Finance are being managed appropriately, for inclusion on suitable HB Sub-Committee agendas.
- 12.4 The Joint Committee may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee’s assurance role relates to a joint or shared responsibility.
- 12.5 The JCC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee’s performance and operation.

Relationship with the Joint Committee and its Sub-Committees / Groups

- 12.6 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the effective planning, performance and financial management of healthcare for commissioned services through the effective governance of its organisation.
- 12.7 The Sub-Committee is directly accountable to the Joint Committee for its performance in exercising the functions set out in these Terms of Reference.
- 12.8 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the Joint Committees other Sub-Committees to provide advice and assurance to the JCC through the:
- joint planning and co-ordination of JCC and Committee business; and
 - sharing of information.
- 12.9 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the JCCs overall risk and assurance arrangements.

12.10 The Sub-Committee, through its Chair and members, shall work closely with LHB Planning, Performance and Finance Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the JCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the JCC's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

12.11 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

13 Applicability of Standing Orders to Sub-Committee Business

13.1 The requirements for the conduct of business as set out in the JCC Standing Orders are equally applicable to the operation of the Sub-Committee, except in the area relating to the quorum.

13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the JCC Team or Joint Committee, as appropriate.

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Committee Secretary as appropriate, may deal with the matter on behalf of the Sub-Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the sub-committee Chair has a personal or business interest in the urgent matter requiring decision.

15 In Committee (Private Meeting)

15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ratified by the Joint Committee.



GIG
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Joint Commissioning
Committee

QUALITY SAFETY AND OUTCOMES SUB- COMMITTEE (QSOSC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

Document Author:	Committee Secretary
Lead Director	Director of Nursing and Quality
Endorsed By	Joint Commissioning Committee 17 September 2024
Approved By	Health Boards – 25 and 26 September 2024 Board Meetings
Issue Date	1 December 2024
Review Date	~~1 June 2025~~ 12 January 2025
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Sub-Committee Arrangements:

This schedule forms part of and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

1. Introduction & Constitution

- 1.1 In accordance with JCC Standing Order 5.5, the NHS Wales Joint Commissioning Committee (JCC – the Joint Committee) may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee or on behalf of the Joint Committee to each LHB Board and/or its other committees). The Joint Committee shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.
- 1.2 In accordance with Standing Orders (SOs) (and the JCC Scheme of Delegation), the Joint Committee shall nominate annually a sub- committee to be known as the **Quality, Safety and Outcomes Sub-Committee**. The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this sub-committee are set out below.

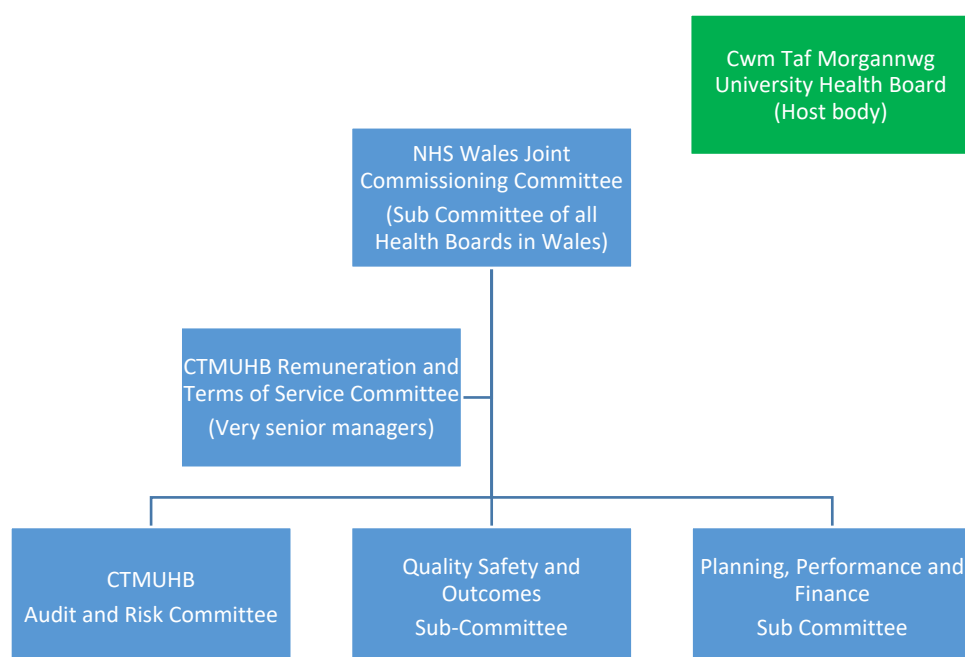
2. Purpose

- 2.1 The purpose of the Quality, Safety and Outcomes Sub-Committee "the Sub-Committee" is to be assured that the Joint Committee is commissioning appropriate, high quality and safe services from providers (Health boards, Trusts and private sector providers) on behalf of health boards in Wales.

This will be achieved by:

- Providing scrutiny and assurance to the Joint Committee for the Quality Safety and Outcomes of services commissioned from providers including health boards, NHS Trusts and private providers who are accountable for the provision of safe, quality services)
- Reporting to and providing advice to the Joint Committee, including escalation of issues that require urgent consideration and action by the JCC
- Addressing concerns delegated by the Joint Committee ensuring that individual LHB Quality and Patient Safety Committees are informed of any issues relating to their population recognising that concerns of the services commissioned may impact on primary and secondary and vice versa (whole pathway) and contribute to the achievement of the Duty of Candour; and
- Providing assurance to the Joint Committee in relation to improving the experience of patients, carers, citizens and those that come into contact with the services commissioned by the JCC.

Figure 1 – JCC Sub-Committee Structure



3. Scope and Duties

- 3.1 The Sub-Committee will provide scrutiny and assurance in and will, in respect of its provision of advice to the Joint Committee:
- Monitor and support the development and implementation of the Commissioning Assurance Framework ensuring that there is continuous improvement in the commissioning of safe, effective and sustainable services for the people of Wales
 - Consider the quality, patient safety and outcome implications arising from the development of commissioning strategies, including developments outlined in the agreed JCC Integrated Medium Term Plan (IMTP)
 - Ensure that all aspects of commissioning activity, through regular reporting to the sub-committee consider quality, safety and outcomes as part of the commissioning of services
 - Receive, when required, items for urgent consideration and escalation
 - Ensure a robust process is in place for the development and approval of evidence-based service specifications, focussed on quality and safety of service provision, for all services commissioned by the JCC
 - Have responsibility for the commissioning risks designated to the Sub-Committee for monitoring ensuring that quality, safety and outcomes of services commissioned are a priority for the organisation

- Monitor and scrutinise risk management and assurance arrangements for the risks designated to the Sub-Committee for monitoring from the perspective of clinical and patient safety risks
- receive assurance from provider organisations that concerns management arrangements are robust and reported through the appropriate governance routes; and
- Receive assurance that patient safety incidents, complaints and claims (relating to the services commissioned by the JCC) are routinely monitored and are considered a critical part of the evaluation of services in the JCC commissioning cycle.

Sub-Committee Programme of work

- 3.2 Each year the Joint Committee will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's Commissioning Assurance Framework and Corporate Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the Joint Committee throughout the year.

4. Membership

Members

- 4.1 The Membership of the QS&O Sub-Committee is as follows:

Chair	Lay (Independent) Member of the Joint Committee
Vice Chair	Lay (Independent) Member of the Joint Committee
Member	One further Lay (Independent) Member of the Joint Committee
Member	One representative Chief Executive or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)

- 4.2 The membership of the Sub-Committee shall be determined by the Joint Committee, based on the recommendation of the Chair of the Joint Committee and lay members, taking account of the balance of skills and expertise necessary to deliver the subcommittee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.
- 4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, receive from nominations from the CEOs of Local Health Boards

4.4 The Membership will be reviewed annually.

Support to Sub-Committee Members

- 4.5 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:
- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
 - Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

4.6 In Attendance

JCC Director of Nursing and Quality (Lead Director for the Committee)
JCC Medical Director
JCC Director of Commissioning for Specialised Services
JCC Director of Commissioning for Ambulance and 111
JCC Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MH, LD & VG)
Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Committee Chair
Llais Representative
Staff side representative.

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

- 4.7 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk or matters that are the responsibility of that Director / member of staff.
- 4.8 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Member Appointments

- 4.9 The membership of the Sub-Committee shall be determined by the Chair of the Joint Committee, taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5 Quorum & Attendance

- 5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.
- 5.2 For effective governance, at least two JCC Team directors, one of which must be a Clinical Director should be in attendance at the meeting.

6 Meeting Secretariat

- 6.1 The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

7 Frequency of Meetings

- 7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.
- 7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.
- 7.3 Additional meetings may be held with the chairs of the LHBs Quality and Safety Committees where there is requirement.
- 7.4 Members will be required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.
- 7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Committee Business.

8 Withdrawal of Individuals in Attendance

- 8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9 Circulation of Papers

- 9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.
- 9.2 The Committee Secretariat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.
- 9.3 The JCC Committee Secretariat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.
- 9.4 The Sub-Committee highlight report will also be shared with members and HB Directors of Corporate Governance / Board Secretaries.

10 Access

- 10.1 The Chair of the Quality, Safety and Outcomes Sub-Committee shall work closely with the Director of Nursing and Quality and have reasonable access to the JCC Directors and other relevant senior staff within the JCC Team.

11 Accountability, Responsibility & Authority

- 11.1 Although health boards have delegated authority to the Joint Committee and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each health board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.
- 11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the Joint Committee that Quality, Safety and Outcomes are being managed appropriately within the commissioning cycles.

Authority

- 11.3 The Sub-Committee is authorised by the Joint Committee to investigate, or have investigated, any activity within its terms of reference.
- 11.4 The Sub-Committee is authorised by the Joint Committee to obtain outside legal or other independent professional and clinical advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the JCCs procurement, budgetary and other requirements.
- 11.5 The Sub-Committee will ensure that it is aware of and receives relevant reports on the activities and reports of external independent regulators and agencies, such as Healthcare Inspectorate Wales, Care Quality Commission, National Audit Office and Audit Wales, that relate to the commissioning of services.

Sub Groups

- 11.6 The Sub-Committee may, subject to the approval of the Joint Committee establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

Strategy

- 11.7 Oversee and monitor the development and implementation of the JCCs Strategies for patient quality, safety and outcomes:

- **Patient Quality, Safety and Outcomes**

- Provide assurance to Joint Committee on implementation of the Quality aspects within the Integrated Medium Term Plan (IMTP) for the Joint Committee
- Provide assurance to the Joint Committee in relation to the Commissioning Assurance Framework.
- Contribute to and oversee the development of effectiveness of the Joint Committee's Annual Quality Statement and the Annual Governance Statement
- Monitor quality via the Quality Dashboard.
- Monitor and receive reports on the organisation's progress with embedding and implementing the Health & Care Quality Standards
- Ensure arrangements are in place to review and act on clinical audit activity which responds to national and local priorities applicable to the business and services commissioned by the JCC as part of the commissioning cycle.
- Receive recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response.

Organisational Risk

- 11.8 Regularly review and provide assurance to the Joint Committee on the risks included on the organisational Risk Register and assigned to the Sub-Committee by the Joint Committee.

Quality Improvement activities

- 11.9 The Commissioning Assurance Framework provides the framework for quality improvement projects supporting compliance with the Duty of Quality. The Quality, Safety and Outcomes Sub-Committee will:
- Provide scrutiny and assurance to the Joint Committee that priorities relating to quality, safety and outcomes are progressing.

11.10 Patient Experience

- Receive and review progress reports relating to Patient Experience and the requirements identified in the Commissioning Assurance Framework
- Ensure that the JCC engages with and co-operates with representatives of Llais as appropriate on ongoing patient engagement or major service change. (S.O. 7.7)

11.11 Concerns

- Receive as presented within the quarterly quality report, reports on Concerns relating to the services commissioned by the JCC (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with emphasis on ensuring that lessons are learnt and are built into the evaluation of services as part of the JCC commissioning cycle.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) relating to commissioned

services from across NHS Wales, in accordance with the legislation under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) contributing to HB approaches providing information related to the services commissioned to support them in complying with their have legal and contractual requirements.

Delegated Powers

11.12 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

11.13 This Sub-Committee is responsible for providing scrutiny and assurance to the Joint Committee that Quality, Safety and Outcomes are being managed appropriately within the evaluation of services as part of the JCC commissioning cycle.

The Sub-Committee will:

- Seek assurance that the JCC's **Commissioning Assurance Framework** remains appropriate, is aligned to the Duty of Quality and is embedded in practice.
- Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:
 - Seek assurance on the delivery of the Patient Experience Plan within the Commissioning Assurance Framework; and
 - Contribute information from the commissioning perspective to HBs in their implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned through the commissioned service lens.
- Seek assurance that arrangements for the **provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
 - the Commissioning Assurance Framework arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services
 - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities
 - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response
 - the development of the Joint Committee's Annual Quality Statement including annual quality priorities; and

- performance against key quality focussed performance indicators and metrics.
- Seek assurance on the arrangements in place to support **improvement and innovation**, including:
 - an overview of the research and development activity for commissioning within the organisation
 - alignment of the commissioning of services with the national objectives published by Health and Care Research Wales (HCRW);
 - an overview of the quality improvement activity for commissioned services within the organisation.
- Seek assurance that arrangements for commissioned services are **compliant with mental health legislation** are sufficient, effective and robust, including:
 - the Mental Health Act 1983
 - Mental Health Act Code of Practice for Wales and associated regulations (2016);
 - the Mental Capacity Act 2005 Code of Practice and associated regulations;
 - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
 - the Mental Health Measure (Wales) 2010.

11.14 The Sub-Committee will seek assurances on the management of strategic risks delegated to the Sub-Committee by the Joint Committee, from the JCC Risk Register.

Dealing with Members interests during meetings

11.15 Declarations of interest will be a standing agenda item for all meetings.

11.16 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

11.17 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the JCC Standing Orders.

12 Reporting

12.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the Joint Committee on the Committee's activities. This includes:
 - Assurance that Quality, Safety and Outcomes are being managed appropriately
 - oral updates on recent activity
 - submission of written Sub-Committee highlight reports throughout the year

- to receive annual reports, which will incorporate key information on quality, safety and outcomes.
 - Bring to the Joint Committee’s specific attention any significant matters under consideration by the Committee; and
 - Ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, Chief Commissioner, HB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the JCC and HBs.
- 12.2 The Sub-Committee shall provide a written, annual report to the Joint Committee on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.
- 12.3 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Quality, Safety and Outcomes are being managed appropriately, for inclusion on suitable HB Committee agendas.
- 12.4 The Joint Committee may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee’s assurance role relates to a joint or shared responsibility.
- 12.5 The JCC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee’s performance and operation.

Relationship with the Joint Committee and its Sub-Committees / Groups

- 12.6 Although the Joint Committee has delegated authority to the sub-committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and outcomes of healthcare for its commissioned services through the effective governance of its organisation.
- 12.7 The Sub-Committee is directly accountable to the Joint Committee for its performance in exercising the functions set out in these Terms of Reference.
- 12.8 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the Joint Committees other Sub- Committees to provide advice and assurance to the JCC through the:
- joint planning and co-ordination of Joint Committee business; and
 - sharing of information.
- 12.9 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the JCCs overall risk and assurance arrangements.

12.10 The Sub-Committee, through its Chair and members, shall work closely with LHB Quality and Safety Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the JCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the JCC's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

12.11 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

13 Applicability of Standing Orders to Sub-Committee Business

13.1 The requirements for the conduct of business as set out in the JCC Standing Orders are equally applicable to the operation of the Sub-Committee, except in the area relating to the quorum.

13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the JCC Team or Joint Committee, as appropriate.

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Committee Secretary as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

15 In Committee (Private Meeting)

15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

- 16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ratified by the Joint Committee.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD ACTION LOG

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
17 July 2024	ABUHB 1707/14	Community Therapy MSK Transformation Update An update report to be scheduled for 9 – 12 months' time (May 2025)	Secretariat	May 2025	Not Yet Due
25 September 2024	ABUHB 2509/07a	Urgent and Emergency Care Business Cases: The Grange University Hospital (GUH) Transfer Lounge and Increase in Emergency Department (ED) Consultant Establishment Following implementation of the models a six-month review to be scheduled to provide assurance to the Board that the models have delivered improvements in patient outcomes and experience.	Secretariat / Chief Operating Officer	March / May 2025	Not Yet Due

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
26 November 2024	ABUHB 2611/10	ReFIT Funding Opportunities: A timeline which sets out a line of sight to a refreshed Estates Strategy being brought forward to the Board for consideration.	Chief Executive and Director of Strategy, Planning and Partnerships	March 2025	Not Yet Due
26 November 2024	ABUHB 2611/15	Management of General Medicine Patients at the Grange University Hospital A Six-month review of the respiratory Medicine reconfiguration to be presented to the Board.	Action: Chief Operating Officer	May 2025	Not Yet Due

All actions in this log are currently active and are either part of the Board'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 Board meeting will be ready.

Once the Board is assured that an action is complete, it will be removed. This will be agreed at each Board meeting.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Partnership Board Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Executive Director for Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Chris Dawson Morris, Deputy Director Strategy, Planning and Partnerships

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

Er Gwybodaeth/For Information

This report is to provide the Board with information in relation to the Regional Partnership Board activities and progress made during the last reporting period.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Social Services and Wellbeing Act 2014 sets out the requirement for Local Authorities and Local Health Boards to establish Regional Partnership Boards (RPB), to manage and develop services to secure strategic planning and partnership working. RPBs need to work with wider partners such as the third sector and providers to ensure care and support services are in place to meet the needs of their respective populations.

This report provides an update on the activities of the RPB.

Cefndir / Background

This report is being provided to the Board for information, to ensure consistent messaging and updates are communicated between the Regional Partnership Board and the Health Board.

Assessment

50 Day Challenge and Winter

On the 11th November the Welsh Government launched a *50 Integrated Care Winter Challenge*. The Care Action Committee of the Welsh Government launched the Challenge to facilitate improvement in outcomes for patients who can be safely managed in the community or are 'clinically optimised' and can be discharged from hospital, cared for in more appropriate settings, and to release much-needed acute and community hospital bed capacity. The 50 days were from 11th November to Christmas Day.

Ten best practice interventions were identified and agreed nationally through gathering learning from across Wales as well as other parts of the UK. The 50 day challenge asked Regional Partnership Boards to review and take action in these 10 areas.

The below table summaries the intervention and actions set out for the Gwent Region:

50 Day Challenge Actions		
	High Impact Intervention	Summary of key actions
1	Optimal Hospital Flow Framework	• Optimal ward focus on 3 wards at RGH to embed flow framework • Operational framework pre-launch end of November multi-site approach • Senior nurse allocation to sites leading framework • Embedding of D2RA principles, deconditioning leads
2	7 day working for Health & Social care	• Additional 10 HCSW to increase weekend CRT capacity • Frailty weekend pilot • Discharge lounge & hub 7 day model • 7 day acute frailty response from Jan 25 • Urgent primary care HCSW weekend coverage
3	Undertake Decision Support Tool in the Community	• Additional hospital to home capacity • Fortnightly integrated discharge board to oversee goals 5, 6 and 50 day plan, • Develop covid-19 pandemic initiative for care home support for patients with complex needs
4	Integrated Navigation Hubs	• Develop plan for a single integrated navigation hub encompassing Urgent Care, Urgent Primary Care • Frailty and health protection • Expand discharge hub model
5	Regional Health & Social care weekly review of long LOS Patients	• Action orientated weekly Pathway of care delay reviews with local authorities • Agreed joint weekly action plans

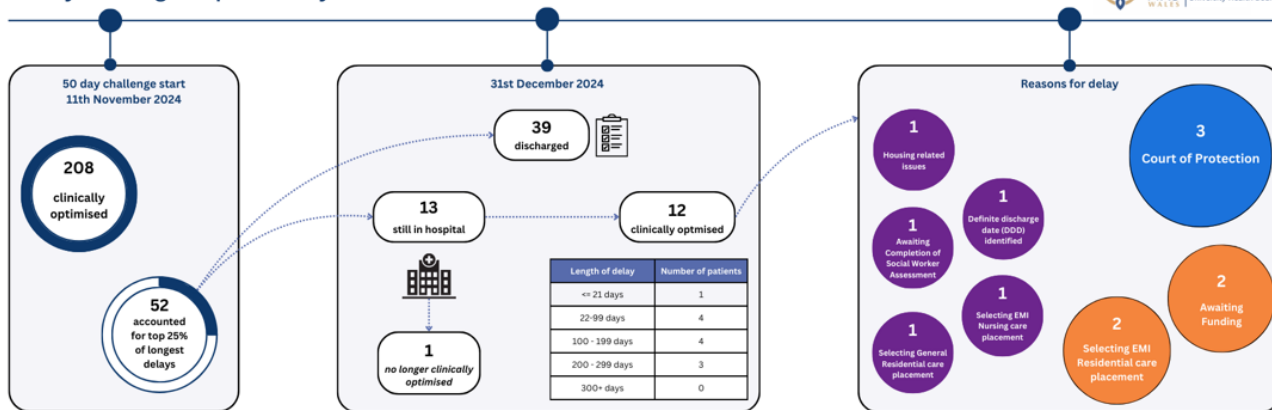


		• CWS2 roll-out to improve data accuracy, routine monitoring aligned to integrated discharge board
6	Proactive management of 0.5% population at Risk	• MDT approaches in three NCN areas • Risk stratification exercise to align EFI and SFN generated risk scoring • Future care plans approach to care homes • Winter support for respirator • Fracture liaison service
7	GP enhanced Service rollout for care homes and HRAC	• Increasing the proportion of care home patients with active future care plans • Care home direct access to urgent primary care professional line
8	Trusted Assessor Model for all care Settings	• Review of best practice models for leveraging such as YYF stroke ward trusted assessor model on behalf of 5 local authorities
9	Home First default for all clinically optimised patients	• Balancing right and responsibilities training/education roll-out • GUH front door services review underway encompassing home first, Acute frailty and therapies teams for improved 'one team' working • Re-enforcing 'what matters' communication and practice
10	7 day community falls response	• Workshop held on 11th Nov, involving ABUHB and WAST colleagues to explore opportunities for reducing conveyance to hospital • Agreement to review current support to care homes, with a view to improving our offer, referencing past schemes such as I-stumble • Agreement to map all current falls response services and associated funded streams,

In order to monitor the Challenge, the Cabinet Secretary for Health and Social Care in the Care Action Committee, asked each regional partnership to identify a cohort of those currently delayed (25% of the total, per region) to focus on developing and delivering a discharge plan for those with the longest stays in hospital.

The below infographic sets out the regions progress on this target:





On 6th December Welsh Government wrote to Regional Partnership Boards to provide non-recurrent additional funding for Winter to support the 50 day Challenge. A spend plan was agreed by the Integrated Discharge Board as delegated by the RPB.

- High Risk Patient Cohort, £955,000: The funding will be utilised to enable GPs or appropriate member from a Multidisciplinary Team (MDT) to undertake care reviews of individuals identified as 'High Risk' in line with national service specification
- Community transition and assessment beds, £764,000: The funding is being utilised to open an additional 23 Beds in line with the Care of the Elderly/Rehabilitation model at the Royal Gwent Hospital.
- Reablement and Domiciliary Care, £1,799,819: An allocation was made to each local authority to Increase Integrated Reablement Teams capacity – via Reablement Practitioners, Planner, Assessment Staff, OT and Enablement support workers.

It has been agreed via Regional Partnership Board that the Integrated Discharge Board, a group that contains operational leadership across health and social care will provide the tactical coordination of activity through the winter period including the 50 day Challenge activity. It was also agreed at RPB that any slippage in partnership funding would be allocated for winter resilience and provided to the integrated discharge board to support this endeavour.

Governance Review

Progress is being made against the actions set out in the Governance review. The role of the Leadership Group has been strengthened therefore there is already greater ownership, clarity and scrutiny of items going to the RPB. A revised Governance Framework following on from the legislative changes introduced by Welsh Government was presented to the January meeting of the RPB: [Draft Partnership Arrangements \(Miscellaneous Amendments\) \(Wales\) Regulations 2024 | GOV.WALES](#).

Amended regulations cover:

- **Objectives of RPBs:** New objectives covering market stability reports, working with Llais, and promoting the development of integrated health and social services arrangements
- **Membership of RPBs:** Adding Welsh Ambulance Service Trust, County Voluntary Councils, primary care providers and worker voice as members; Llais as an independent member
- **Responsible persons:** Requiring the partnership bodies to nominate a responsible person to facilitate the partnership arrangements.
- **Administrative functions of RPBs:** New arrangements around recruitment and support for members
- **Self-assessment:** Biennial RPB self-assessments
- **Annual reports:** Definition of what is required in annual reports.
- **Annual delivery plans and annual reviews:** Requirement for annual RPB delivery plan.
- **Market stability report:** Date of submission of future market stability reports.

A draft Scheme of Delegation has also been developed which seeks to delegate responsibilities into the RPB subgroups (Strategic Partnerships) in this way if should accelerate decision making and ensure decisions are taken at appropriate levels.

Argymhelliad / Recommendation

The Board is asked to NOTE the update provided.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	SRR009 – Transformation and Partnership Working
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live healthily and age well Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions



Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

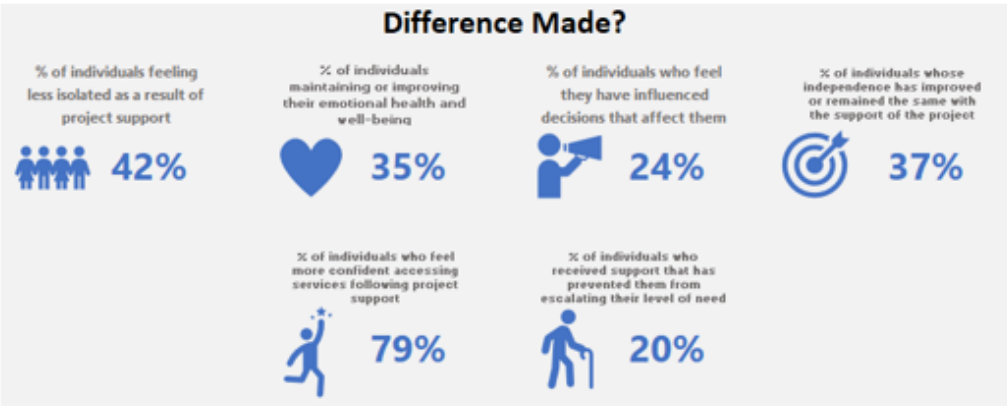
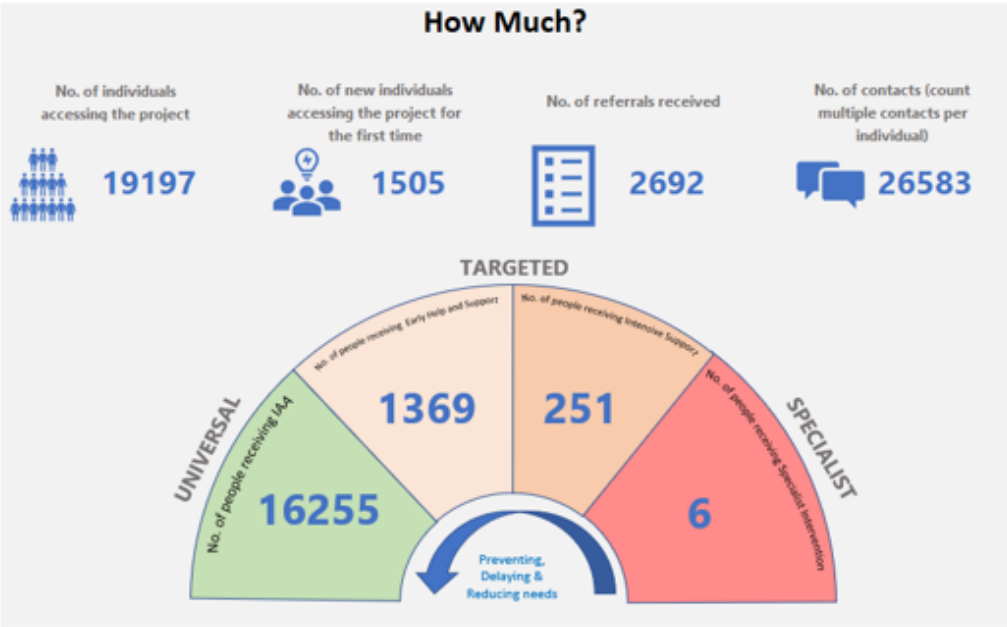
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Explained within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Planning, Partnerships and Population Health Committee.

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/	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 Choose an item.

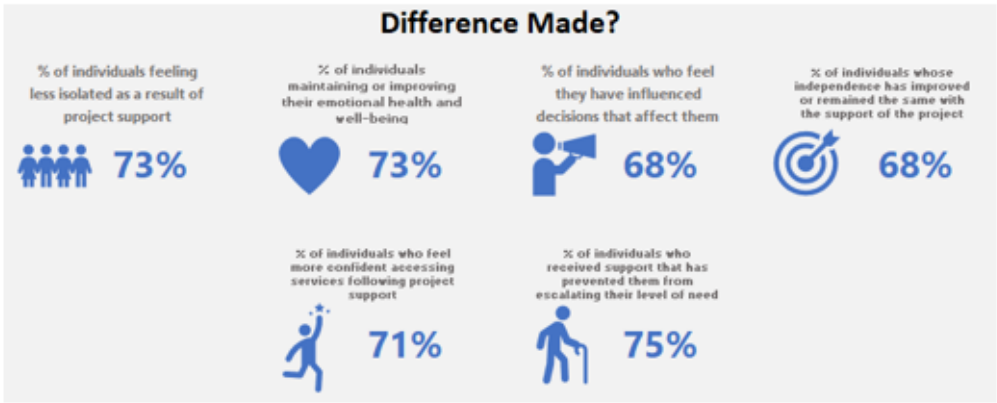
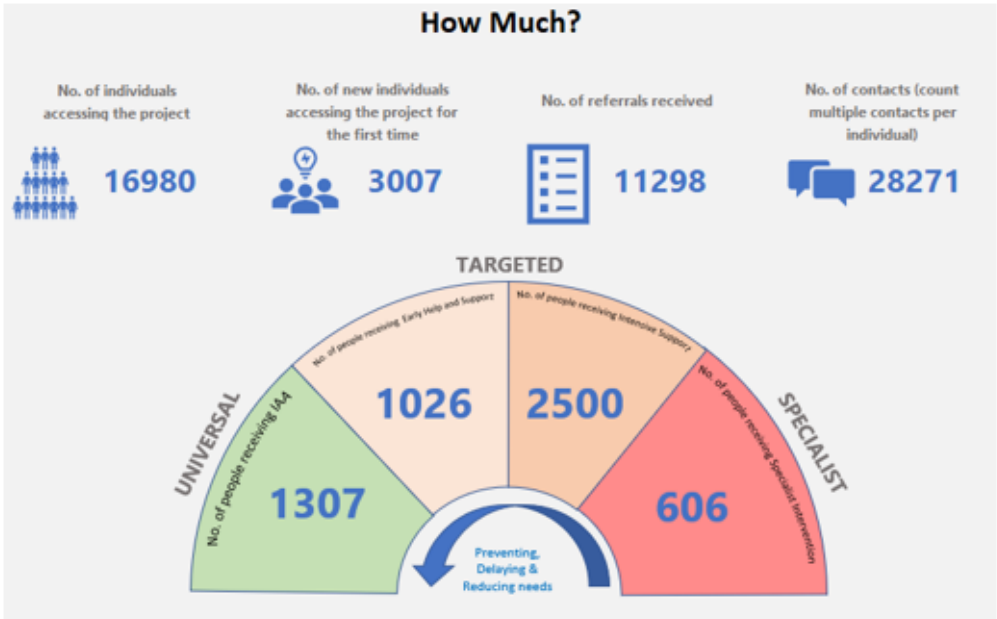


Appendix A: Strategic Partnership Portfolio Visuals

Carers Strategic Partnership

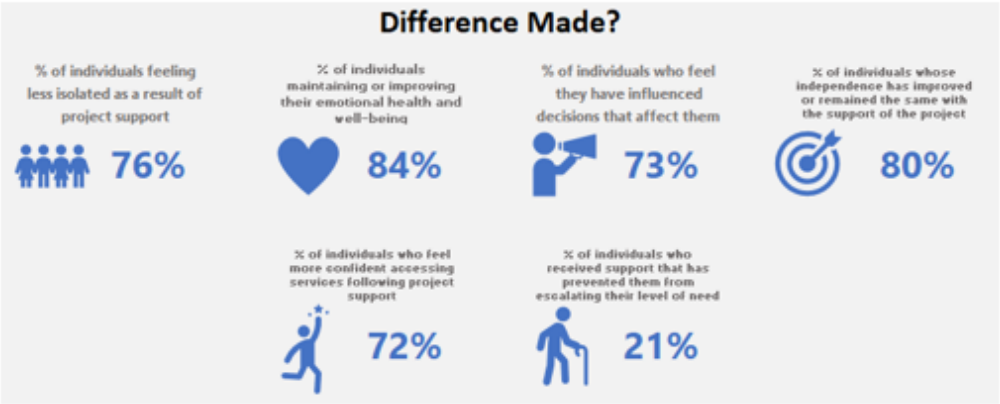
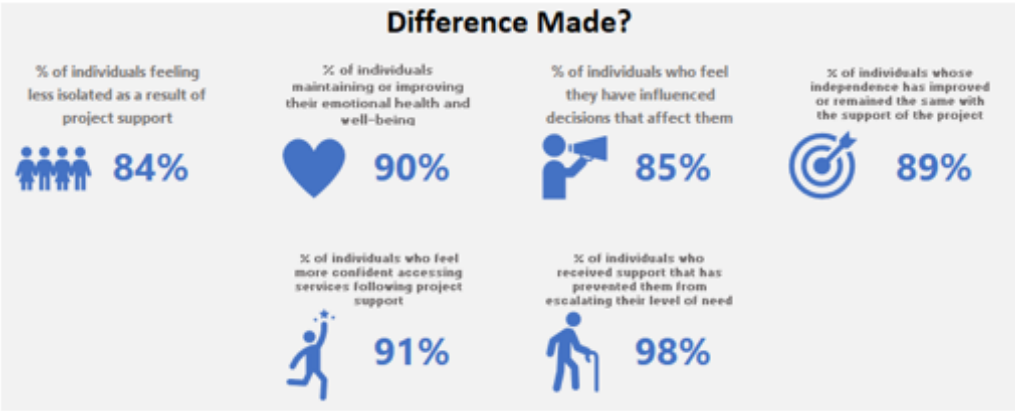
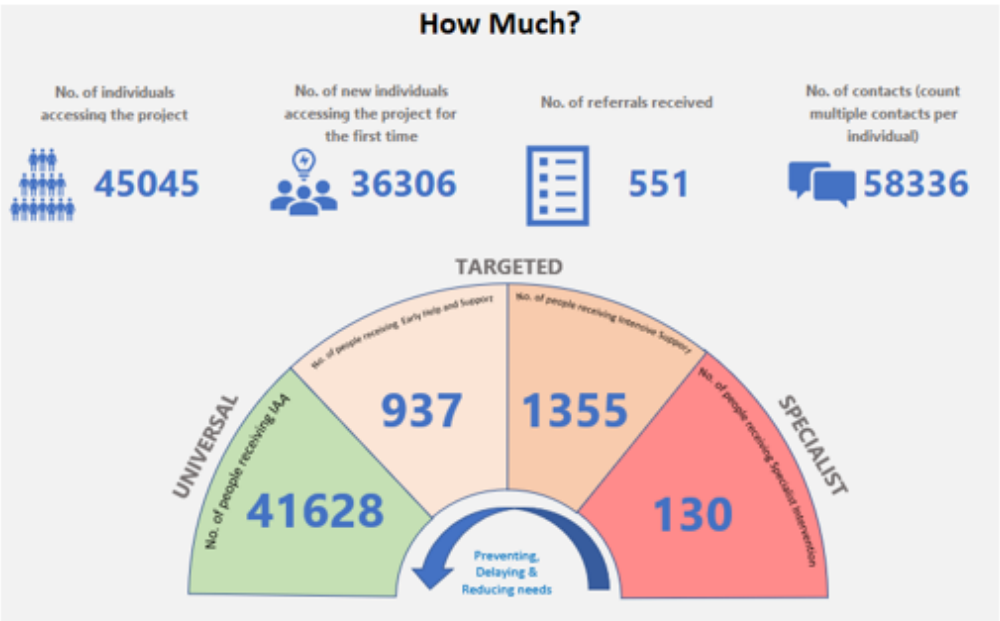
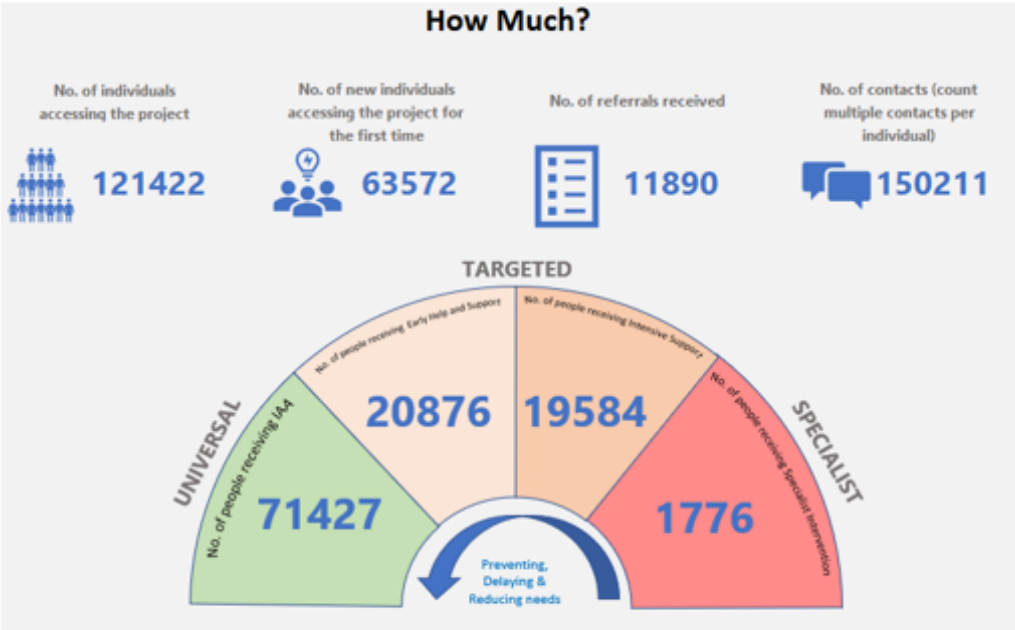


Children & Families Strategic Partnership

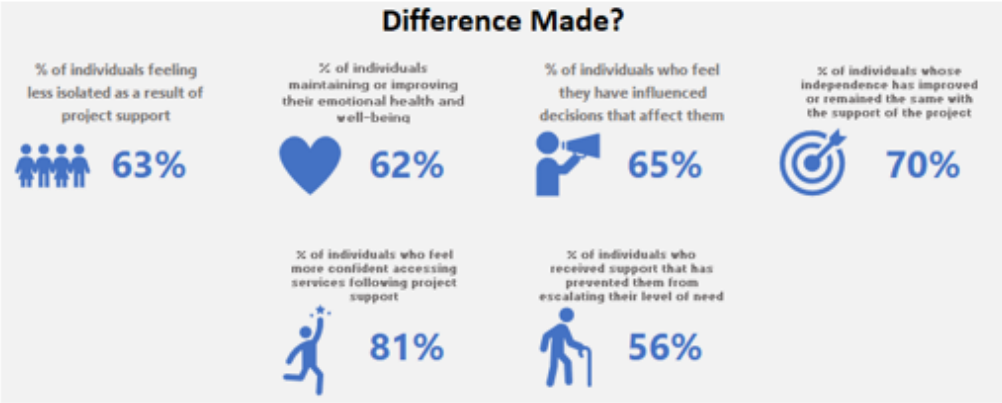
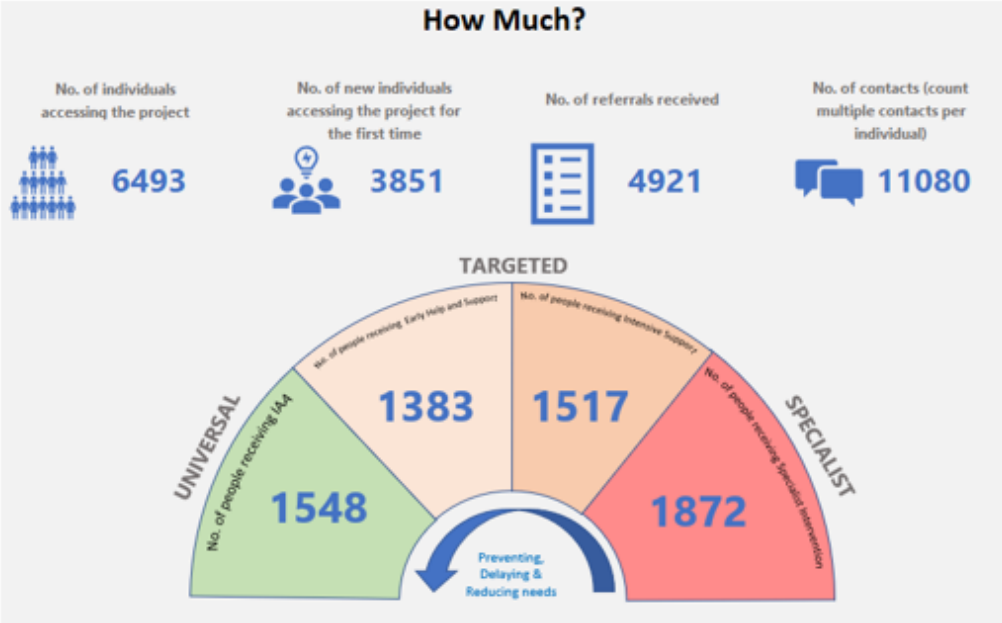


Gwent Adults Strategic Partnership

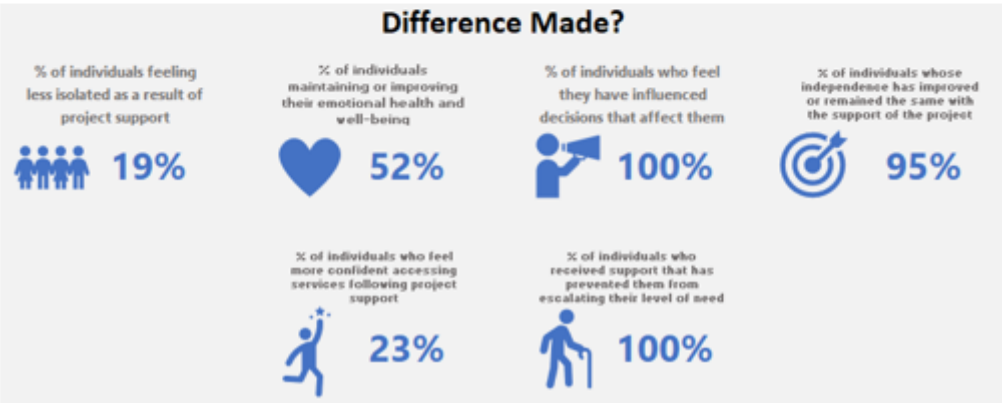
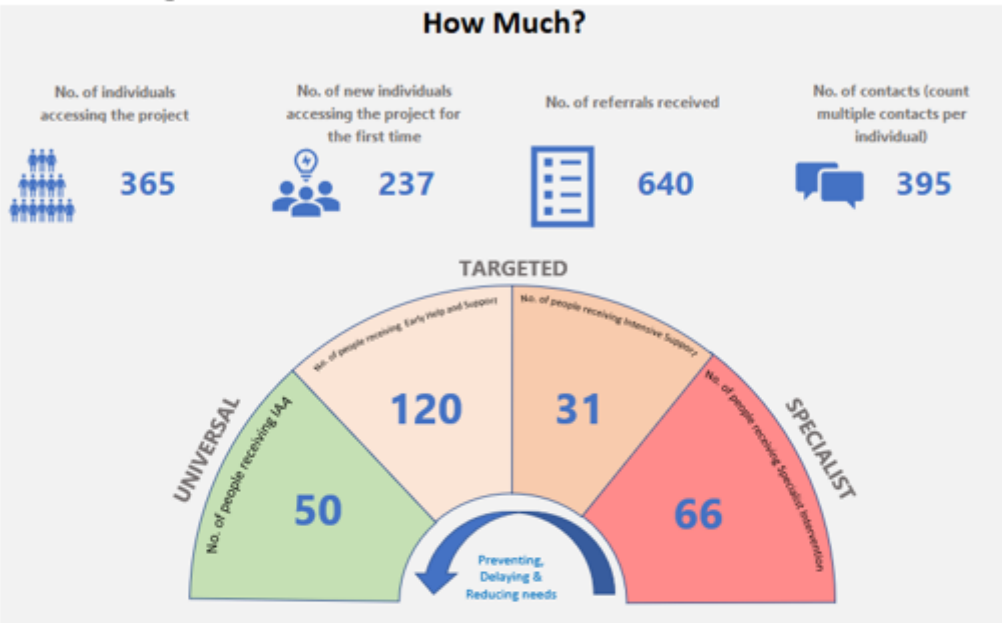
MH & LD Strategic Partnership



Regional Dementia Board



Housing Strategic Partnership (AT Programme)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Gwent Public Services Board Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Professor Tracy Daszkiewicz, Executive Director for Public Health & Strategic Partnerships.

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

This paper is to provide Board members with an update on the current work of Gwent Public Services Board (PSB).

Cefndir / Background

The Gwent Public Services Board last met on 12th December 2024. This meeting was Chaired by the Vice Chair Tracy Daszkiewicz, Director of Public Health, ABUHB. A significant agenda item for this meeting was the electing of a new Chair following Cllr Sean Morgan fulfilling his term of Office. The PSB expressed their gratitude to Cllr Morgan for establishing the combined PSB and leading the Board through its time of transition and development. The new Chair is Councillor Anthony Hunt, Torfaen County Borough Council.

Gwent Public Services Board brings public bodies together to work to improve the economic, social, environmental and cultural well-being of Gwent. The PSB is responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of a local (five year) well-being plan. The statutory member organisations are:

- Blaenau Gwent County Borough Council
- Caerphilly County Borough Council
- Newport City Council
- Monmouthshire County Council

- Torfaen County Borough Council
- Aneurin Bevan University Health Board
- South Wales Fire and Rescue Service
- Natural Resources Wales

Gwent Public Services Board approved its first five year well-being plan in July 2023. The plan contains two strategic objectives and five delivery steps. These are:

Strategic objectives:

1. We want to create a fairer, more equitable and inclusive Gwent for all
2. We want a climate-ready Gwent, where our environment is valued and protected, benefitting our well-being now and for future generations

Delivery steps:

1. Take action to reduce the cost of living crisis in the longer term.
2. Provide and enable the supply of good quality, affordable, appropriate homes
3. Take action to reduce our carbon emissions, help Gwent adapt to climate change, and protect and restore our natural environment
4. Take action to address inequities, particularly in relation to health, through the framework of the Marmot Principles.
5. Enable and support people, neighbourhoods, and communities to be resilient, connected, thriving and safe.

A copy of the Gwent well-being plan is available at:

<https://www.gwentpsb.org/en/well-being-plan/gwent-well-being-plan/>

Asesiad / Assessment

The PSB is progressing the development at scale of four areas of focus to improve well-being in Gwent. The four areas of focus are:

1. That every child has the best start in life;
2. That everyone lives in a place they feel safe;
3. That everyone has the same economic chances;
4. That everyone lives in a climate-ready community where their environment is valued and protected.

During the most recent meeting there was an extended discussion on priority 4 – “that everyone lives in a climate ready community where their environment is valued and protected”. This group will be Chaired by Steve Morgan from Natural Resources Wales. This session was formed of a presentation setting out the ambitions for this agenda as a request that all organisations nominated representation to this new group to develop the strategic objectives and deliver on this agenda.

The next of these four groups to be established will be Priority 3: That everyone has the same economic chances.

The PSB was asked to identify Board level leads for the remaining priorities.

These four leadership groups will drive forward the work and consideration. It was agreed that changes will be made to the Terms of Reference to include a Leads

Group where the four Chairs of the Priority area groups will work to consider cross cutting actions and also be accountable for delivery against the Wellbeing of Future Generations Act.

A forward view has been established with an intention to look more broadly at an agenda which aligns to the priority areas. The March meeting will receive an action plan against the recommendations set out in the Fairer Gwent report; and this will set the direction for delivery.

A refresh of PSB responsibilities on harm reduction - the first two areas to be reviewed will be the work of the Area Planning Board and its role in preventing harm associated with substance use, early warning around high risk substance circulation such as drugs contaminated with Nitazenes, a synthetic opioid.

In line with the presentation given by the Police and Crime Commissioner at the September meeting on the review of the Community Safety Partnership, a closer look at the impacts of crime and public and on private space violence on health and wellbeing. A particular focus will be on gender-based violence and the Violence Against Women and Girls, Domestic Abuse and Sexual Violence (VAWDASV) agenda.

Becoming a HIV Fast Track Region

The March Meeting will be held face to face to enable all members to physically sign the agreement to become a Fast Track area. This is the PSBs commitment to supporting the UK wide ambition to stop all new transmissions of HIV by 2030. Ahead of signing the agreement we have invited a member of community to share their experience of living with HIV.

There is still no cure for HIV; however, knowing you have the virus means you can receive treatment which can reduce your viral load to zero. In these circumstances, the virus is not detectable and therefore cannot be passed on to others. Therefore Fast Track will support our work to get people tested and treated as well as sharing information on how to avoid contracting HIV.

- In 2023, there were 119 new HIV diagnoses in Wales, a 16% increase from the previous year.
- The majority of new HIV diagnoses were among heterosexuals (62%).
- 31% of people with HIV were diagnosed late. Gwent has the highest late diagnosis rate in Wales.
- The number of people tested for HIV in Wales increased in 2023, the highest number since 2019.

The Fast Track approach will support the cessation of new transmissions of HIV, whilst raising awareness and ensuring the right treatment and care for those living with HIV.

Argymhelliad / Recommendation

Board is asked to note the update of this paper.

Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Strategic Risk Register
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Partnership First
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Gwent well-being plan https://www.gwentpsb.org/en/well-being-plan/gwent-well-being-plan/ Gwent Joint Strategic Assessment https://abuhb.nhs.wales/health-advice/gwent-joint-strategic-assessment/
Rhestr Termiau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Is EIA Required and included with this paper 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 Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Executive Committee Activity: 18th November 2024 – 10th January 2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad Purpose of the Report

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides the Board with an overview of a range of issues discussed by the Executive Committee during the period

Due to the nature of the Executive Committee's business, not all issues will be suitable for disclosure into the public domain.

Cefndir / Background

The Chief Executive Officer is responsible for the overall organisation, management and staffing of the Health Board and its arrangements related to quality and safety of care as well as matters of finance, together with any other aspect relevant to the conduct of the Health Board's business in pursuance of the strategic directions set by the Health Board's Board, and in accordance with its statutory responsibilities.

The Executive Committee is the executive decision-making committee of the organisation, which is chaired by the Chief Executive as Accountable Officer.

The Executive Committee is responsible for ensuring the effective and efficient co-ordination of all functions within the organisation, and thus supports the Chief Executive/Accountable Officer to discharge her responsibilities.

Asesiad / Assessment

The Executive Committee meets on a weekly basis and focusses on the breadth of the organisation's business. These formal meetings are supplemented by:

- Informal Executive Team Sessions, which are used to focus on strategic developments, information sharing and Executive Team engagement.
- A quarterly Clinical Futures Board, which enables the Executive Team to oversee implementation of the Board's strategic priorities, take decisions and resolve issues which may be impacting delivery.
- A monthly Executive Committee Performance Meeting, which enables the Executive Team to monitor the Health Board's integrated performance to enable a focus on quality, workforce, activity and financial performance.
- Regular Executive Team development sessions focussing on the effectiveness of the Executive Team and its way of working.

Much of the business of the Executive Committee informs onward reporting to the Board's assurance committees, providing assurance to the Board on the effective management of the organisation and achievement of the Board's strategic objectives. The Executive Committee's business also informs much of the Board's formal meeting agendas, given the Executive Team's responsibility for strategy development and its implementation.

The Workplan of the Executive Committee is based on five key areas to ensure appropriate focus, oversight of the organisation's business, and enable the Chief Executive Officer and Executive Team members to discharge their responsibilities effectively:

- Quality, Safety and Culture
- Delivery, Performance and Efficiencies
- Strategic Planning and Service Development
- Strategic Partnership Arrangements
- Transformational programmes (IMTP/Clinical Futures).

During the period 18th November 2024 - 10th January 2025 the following matters were some of the issues considered by the Executive Committee:

QUALITY, SAFETY & CULTURE

At each weekly meeting, the Executive Committee receives a Safety Briefing which includes a summary of recent Patient Safety Incidents, Complaints, Never Events, and Injurious Falls. The Executive Committee also continues to maintain a focus on the performance of the urgent and emergency care system, including ambulance handover delays and red release requests to ensure that the level of risk in the community is balanced across the entire system.

Other matters discussed included:

Welsh Government AMR & HCAI Improvement Goals for 2024/2025: The Executive Committee received a report on the Health Board's position with the Antimicrobial Resistance & Healthcare Associated Infections Improvement Goals for 2024/2025. The Committee was informed of the improvement goals for infection prevention and control and received an action plan for improvement via the

Antimicrobial Stewardship Plan. The Committee approved a multi-disciplinary approach for improvement via the Strategic Infection Prevention Improvement Group and will receive a monthly infection rates dashboard.

Management of Higher Risk Surgical Patients in RGH Surgical High Care (SCH) Unit: The Executive Committee received assurance from the Medical Director that the Surgical High Care Unit in the Royal Gwent Hospital was effective without impacting upon patient quality of care. The Committee noted that during the period from 01 January 2024 to 31 August 2024 there were 729 admissions to the SCH Unit at the Royal Gwent Hospital (RGH). The Committee was informed that the overall in-hospital mortality rate for patients admitted to the SCH unit for this period was 0.4% which was a reduction of the 0.5% rate for the period 01 April 2023 to 31 March 2024.

Winter Respiratory Vaccination Plan: The Executive Committee was updated on the Winter Respiratory Vaccination Plan to improve influenza vaccination uptake in primary care which included GP practices. This included additional capacity being provided from the ABUHB Vaccination Service to district nursing teams to complete influenza vaccinations for housebound patients by the start of December 2024 and pop-up clinics to be provided in areas with low uptake – particularly Blaenau Gwent East, Newport West and Caerphilly North – offering walk-in vaccinations for all cohorts with targeted community engagement. The Committee requested communications be used to optimise access to these clinics across communities.

DELIVERY, PERFORMANCE & EFFICIENCIES

The Executive Committee has monitored and discussed the Health Board's financial position continuously and implemented mitigating actions to improve the forecasted financial position. To ensure a consistent sufficient focus on delivery and to explore further opportunities across the Health Board, an Executive Value and Sustainability Board meets fortnightly, with progress reported through the Financial Performance Report presented to the Board.

Other matters discussed include:

Medical and Dental Workforce Solution: USW Proposal: The Executive Committee approved a proposal to commence work to explore opportunities to create a medical school in partnership with the University of South Wales.

Estates Compliance Update: The Executive Committee was updated on the current state of the Health Board's estate. The Committee noted compliance issues were mainly within the older structures within the Health Board, as the newer buildings were compliant with new building regulations. The Committee noted that compared with other Welsh Health Boards, ABUHB receives less funding from Welsh Government for this area and was assured that the Estates Division was working to maximise resource without additional funding being available. The Committee discussed areas of improvement and the current risk profile being managed. Assurance on this was also provided to the Finance and Performance Committee.

STRATEGIC PLANNING & DEVELOPMENT

Decarbonisation Programme: The Executive Committee received a report on a mid-point review of the Decarbonisation Programme and was provided with an overview of all activities carried out to date. The Committee was assured that progress had been made on compliance with decarbonisation for the Health Board's Estate.

Digital Cellular Pathology Business Case: The Executive Committee received a draft business case for a new digital system for cellular pathology to address challenges of the current system which included: challenges recruiting / retaining highly skilled staff; impact of the pandemic and the development of a backlog; demand growth and increase capacity gap. The Committee was informed the business case would utilise the benefits of using AI/computational pathology to enable delivery of a robust, sustainable and equitable diagnostic cellular pathology service fit for the future and to scale up digital cellular pathology reporting which includes scanners, management systems, AI, hardware, software, cloud storage, IT infrastructure/bandwidth and staff resource delivered via a fully-revenue managed service contract. The Committee discussed and agreed a timeline for submission to Board in March 2025.

Service Impacting Network Changes: The Executive Committee was updated on the project of moving the data centre from Mamhilad to the Grange University Hospital and delays caused in November 2024 by BT outages. The Committee noted the delay would impact the decommissioning of the data centre at Mamhilad and agreed to extend the lease until the end of January 2025 to allow time for decommissioning and to ensure the wellbeing of staff involved.

Mental Health In-Patient Re-configuration: The Executive Committee approved the commencement of a feasibility study into opportunities for the re-configuration of Older Adult Mental Health in-patient services across the Health Board area.

Long Term Strategy Update: The Executive Committee has continued to spend time contributing to the ongoing development of the Long-Term Strategy and considering the views of communities gathered through supporting engagement events.

STRATEGIC PARTNERSHIP ARRANGEMENTS

Regional Planning: The Executive Committee continues to receive updates on progress in respect of several ongoing regional and south Wales service planning programmes with assurance on these being presented to the Partnerships, Population Health and Planning Committee.

OTHER FORMAL BUSINESS

In this reporting period, the Executive Committee has also considered papers ahead of Board and Committee consideration, including:

- Quality and Safety Performance Report
- Workforce Performance Dashboard
- Strategic Risk Report
- Financial Performance Report

- Activity & Performance Report, including Ministerial Priorities
- Nurse Staffing Levels (Wales) Act: Annual Report
- Executive Director Portfolios and Strategic Lead Responsibilities
- Pharmacy & Medicines Management Annual Report 2023-24
- Learning from Deaths Report
- Progress on Hepatitis B and C Elimination
- Hypertension – A Case Finding Approach

WINTER PLANNING AND RESPONSE

The Executive Committee has held regular meetings to focus on winter preparedness and response, with a focus on modelling data to inform plans and delivery of the Board's agreed Winter Plan 2024/25.

The Health Board has been under significant operational pressure with impacts on staff and activity and a detailed update is provided to the Board via the Winter Plan 2024/25 update.

EXECUTIVE TEAM DEVELOPMENT

The Executive Team continues to hold monthly sessions to focus on team development, informal discussion on the development of cultural and strategic aspects as well as enable dedicated attention to key risks and issues. In the last reporting period, the Executive Team has dedicated informal time to focus on team key risks, challenges and opportunities allowing space to explore matters in an informal and collective way.

Argymhelliad / Recommendation

The Board was asked to **NOTE** the update of the Executive Committee and the overview of some of its activities.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Linked to all IMTP priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
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 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 Termiau: Glossary of Terms:	IMTP- Integrated Medium-Term Plan RAAC- Reinforced Autoclaved Aerated Concrete NICU- Neonatal Intensive Care Unit CMO- Chief Midwifery Officer MHLD- Mental health and Learning Disabilities SHC- Surgical High Care HEIW- Health Education and Improvement Wales OCP- Organisational Change Process FNC- Funded Nursing Care WHC- Welsh health Circulars RGH- Royal Gwent Hospital GUH- Grange University Hospital ToR- Terms of Reference EHCR- Electronic Health & Care Record

Partion / 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)	
	Is EIA Required and included with this paper
Asesiad 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 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 Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Key Matters from Committees of the Board
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In line with the Health Board's Standing Orders, a number of Board Committees and Advisory Groups have been established. This report provides, for assurance, an overview of the business undertaken by these committees during the reporting period, and highlights key matters for Board consideration, where required.

Cefndir / Background

The Health Board's Standing Orders, approved in line with Welsh Assembly Government guidance, require that a number of Board Committees and advisory groups be established. The following Committees and advisory groups have been established:

- Audit, Risk and Assurance Committee
- Charitable Funds Committee
- Patient Quality, Safety and Outcomes Committee
- Mental Health Act Monitoring Committee
- People and Culture Committee
- Remuneration and Terms of Service Committee
- Partnerships, Population Health and Planning Committee
- Finance and Performance Committee

Assurance Reporting

The following Committee assurance reports for the period are included at Appendix 1:

- Audit, Risk and Assurance Committee – 12th November 2024
- Patient Quality Safety and Outcomes Committee - 12th November
- Finance and Performance Committee – 16th December 2024
- Charitable Funds Committee – 13th January 2025

Asesiad / Assessment

In receiving this report, the Board is contributing to the good governance practice of the organisation in ensuring that Committee business is reported to the Board and any key matters escalated, where appropriate.

Argymhelliad / Recommendation

The Board is asked to NOTE for assurance this report, and the updates provided from Health Board Committees.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
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. There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Committee Chairs

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. Not applicable to this specific report, however WBFGA considerations are included within committee's considerations

Name of Committee:	Audit, Risk and Assurance Committee
Chair of Committee:	Iwan Jones
Reporting Period:	12 th November 2024
Key Decisions and Matters Considered by the Committee:	
Audit Recommendations Tracker The Committee reviewed the closing position for Q3 2024/25 audit recommendations, with 42 recommendations considered. Of those, 22 requested revised deadlines, 17 were completed, and 3 remained overdue. Concerns were raised regarding the repeated delays in completing recommendations from the 2022 Internal Discharge Planning Audit, leading to an agreement that a review against all recommendations from the audit would be brought back to the next scheduled meeting.	
Use of Single Tender Action (STA) The committee reviewed the Single Tender Actions approved between 30 th August and 18 th October 2024. During this period one request was made in relation to Reagent Rental which was approved, with an annual value of £335,227.13 Excluding VAT.	
Financial Governance Report and Changes to Financial Capital Procedures (FCP) The Committee approved the two financial control procedures listed below. • Recovery of overpayments to employees • Accounts payable	
Report of Losses and Special Payments The committee received an update on the status of Losses and Special Payments made between the 1 st April and 30 th September 2024, which outlined an actual loss of £1.1million for the Health Board.	
Assurance Note on the Implementation of the Actions from the Audit Wales Community Pharmacy Data Matching Report The Committee received an update on the implementation of actioned raised within the Audit Wales Community Pharmacy data matching report.	
Update Report on Consultant Job Planning The Committee received an update on the implementation of Consultant Job Planning processes and systems. Concerns were raised regarding the current level of compliance leading to an agreement that a further report focusing on a timeline for completion would be brought to the next scheduled meeting.	
Receive the Private Practice Policy The committee received and noted the newly implemented Private Practice Policy.	
Receive a Mid-Year update in respect of Post-Payment Verification Activity PPV The committee received and noted the mid-year status of PPV activity.	

- 62 visits scheduled for General Medical Services (GMS), of which 16 have finalised or in progress.
- 20 scheduled visits for General Ophthalmic Services (GOS) of which 12 have been completed or in progress.
- 42 visits scheduled for General Pharmacy Services (GPS) of which 14 are in progress.

Committee Risk and Assurance Report and Update on implementation of the Risk Management Framework

The Committee received an overview of the Risk and Assurance Report, where the effectiveness of actions in reducing strategic risks was questioned. It was acknowledged that ongoing work was being completed to effectively mitigate these risks by incorporating risk deep dives into committee agendas to allow more focused scrutiny.

Internal Audit Progress Report

The committee received an update on the ongoing internal audit plan for 2024-25, with no concerns raised.

To Receive Internal Audit Reports

The committee were presented with an overview of five internal audit reports finalised within this reporting period.

Energy Management

The review focused on rising costs of energy, effective management and control of energy costs has been risk assessed as an area of potential benefit for audit and received reasonable assurance.

NHH Reinforced Autoclaved Aerated Concrete

The review sought to evaluate the arrangements in place to manage/mitigate the risks associated with the presence of Reinforced Autoclaved Aerated Concrete (RAAC) a lightweight concrete used in construction in many buildings between the 1950s and 1990s which has recently been identified as posing a significant risk to the structural integrity of building found within Nevil Hall Hospital (NHH) and received reasonable assurance.

Providing Care to Asylum seekers and Refugees

The review focused on the arrangements in place within the Health Board for providing care to asylum seekers and refugees, including that applicable guidance is being adhered to and received reasonable assurance.

Newport East Health & Wellbeing centre

The review focused on the delivery and management arrangements in place to progress the Newport East Health & Wellbeing Centre project, and the performance to date against its key delivery objectives and received reasonable assurance.

Facilities Stock

Follow up review with a focus on the implementation progress of the Facilities stock recommendations raised within the 2023/24 audit and received reasonable assurance.

External Audit Progress Report 2024/25 The committee received an overview of the External Audit progress report noting that one of two scheduled finance audits (Charitable Fund Accounts 2023-23) were underway. It was also reported that in relation to Performance audit work it was reported that two audits remain in clearance, two remain in draft, one in progress and two at the scoping stage. Final Annual Accounts Memorandum The committee were presented with an overview of the Final Annual Accounts Memorandum noting that four recommendations were made; treatment of pooled budget transactions, Existence of fixed assets, senior officer remuneration and ProLease user reviews, three of which were entirely accepted by the Health Board with one being partially accepted. Committee Programme of Business An overview of the Forward Work Programme was provided, confirming that the Committee was on track in receiving updates on its delegated responsibilities. The Committee Noted the report for assurance. Matters Requiring Board Level Consideration or Approval: - No Items. Key Risks and Issues/Matters of Concern: - No Items. Planned Committee Business for the Next Reporting Period: - Review of the Committee Programme of Business - Annual review of Committee Effectiveness 2023/24 to include a review of terms of reference - Receive assurance on the implementation of the Governance Priorities set out within the IMTP 2022-25 - Review and report upon the adequacy of arrangements for declaring, registering and handling interests - Receive full report of all officers of gifts and hospitality as declared - Compliance and ministerial directions - Compliance with Welsh Health Circulars WHCs - Review of Standing Orders, Standing financial instructions, and scheme of delegation. - Compliance with regulatory requirements - Audit recommendations tracking report - Annual Review of Risk Management Framework - Committee risk and assurance report - Report of the use of single tender action - To consider the approach and timelines for the Annual Report and Accounts - Receive the Counter Fraud Annual Report - Receive a quarterly Report on Counter Fraud Activity - Receive Internal Audit Reports - Receive the 2024 Structured Assessment - Receive the External Audit Progress Report 2024-25 Date of Next Meeting: Tuesday 18th February 2025 at 09:30

Name of Committee:	Patient Quality, Safety and Outcomes Committee
Chair of Committee:	Pippa Britton
Reporting Period:	12th November 2024
Key Decisions and Matters Considered by the Committee:	
Committee Risk Report The Committee received an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. The Committee noted since September, the risk environment had remained relatively stable, with no changes in the risk score or exposure to the three strategic risks that the Committee monitors. Primary Care Quality Report The Committee received the 2023/24 Annual Quality Report, which provided an overview of the areas of focus during the reporting period, including:- • General Dental Services • Urgent Access and Wait Times • Orthodontic Services • General Ophthalmic Services • General Medical Services • Enhanced and Supplementary Services • Community Pharmacy Services The Committee noted the importance of the primary care academy in ensuring safeguarding quality for the future delivery of the primary care services. Quality Strategy – Quality Outcomes Framework The Committee received the Quality Outcomes Framework, which had been developed to support the implementation of the Quality Strategy and Patient Experience Strategy. The Committee noted that the quality outcomes framework focused on the 7 key objectives that would drive continuous improvement across health care services. There was a 2year implementation plan which would be used from the next quarter to embed the framework. Quality Performance and Outcomes Report The Committee received the Quality Performance and Outcomes report for the period of quarter 2. The key areas arising from this report were: - • Mental Health and Learning Disabilities division and urgent and emergency care remained in the escalation status of enhanced monitoring, with the Health Board working to improve the position of both areas. • Maternity services and the patient experience team had won 2 silver awards for the Diverse Cymru Cultural Competency Accreditation scheme.	

- Hip and knee survey report had been completed in July 2024 by Llais, Gwent Region, with 3 recommendations and the Health Board submitted an improvement plan in September 2024.
- Update on Antimicrobial prescribing, noting the primary care Welsh Government targets which aimed to reduce prescribing within the next 5 years.
- Sepsis awareness campaign had targeted ED and the children's assessment unit with posters displayed on how to spot sepsis if a child was unwell.
- Sepsis education campaign launched to allow recognition of early sepsis within primary care to try to prevent patients needing to come into hospital.
- General Practice and Child Protection Register programme had been working along side Monmouthshire council and the GP practices to ensure they were receiving up to date lists of the register and aim to use the approach across all 5 local authority areas.
- Overview of the actions and learning taken from the death of a 9year old boy in December 2022 who had presented at the children's emergency unit in the Grange University Hospital.
- The Ward and Team Accreditation phase 1 had been completed with 55 adult wards, 2 paediatric wards and all inpatient mental health and learning disability wards and 10 independent reviews across 4 sites with 7 of these reviewed wards met the criteria for bronze level status.

Falls and Bone Health Management Annual Report

The Committee received the Falls and Bone Health Management Annual report, which outlined the data analysis, key activities, challenges and next steps in support of reducing falls incidents alongside improving bone health as an ongoing commitment in further enhancing the quality of patient care.

The Committee noted the Health Board was represented nationally across a number of fora and were ensuring the Health Board were following the national guidelines when lifting a patient following a fall.

A pilot was underway for patients within the hospital setting to be allocated yellow wrist bands to identify which patients were at a high risk of falls and the aim was to roll out across all Health Board sites.

It was highlighted to the Committee that training of all staff members in relation to falls remained a challenge for the Health Board. To address this, a Falls Training Strategy was to be completed by March 2025.

Health and Safety Compliance Annual Report

The Committee received the Health and Safety Compliance Annual report, which identified the opportunities and challenges for the Health Board in ensuring and sustaining compliance within Health and Safety legislation, including specific compliance improvement action delivered in 2023/24.

The Committee noted the Health, Safety and Fire plan was created to focus on the following 5 areas:-

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Committee noted that a fire alarms system programme within the Health Board had commenced with work ongoing to replace all alarms on the sites. Fire barriers across the Health Board sites had been assessed and had identified that improvement was needed at Nevil Hall Hospital and Royal Gwent Hospital with work in progress to improve these areas.

It was highlighted to the Committee that there were challenges around the compliance of the Health and Safety policies, to address this, a plan was in place for 2024/25 to review the policies which were out of date.

Matters Requiring Board Level Consideration or Approval:

None Noted

Key Risks and Issues/Matters of Concern:

None Noted

Planned Committee Business for the Next Reporting Period:

- Review of Committee Programme of Business 2024/25
- Committee Risk Report
- Mental Health Act Monitoring Report
- Quality Performance Report
- Maternity Services Organisational and Improvement Plan
- Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes (Macken Ward).
- NHS Wales Joint Commissioning Quality Committee Report
- Learning from Death Report
- Listening & Learning Forum Minutes
- Clinical Advisory Committee Minutes
- Radiation Protection Committee Report
- Pharmacy and Medicines Management Annual Report
- Children and Young Peoples Board Minutes
- SOP on Deep Dives report

Date of Next Meeting: Monday 20th January 2025

Name of Committee:	Finance and Performance Committee
Chair of Committee:	Richard Clark
Reporting Period:	16th December 2024
Key Decisions and Matters Considered by the Committee:	
Performance Management:	
ABUHB's Performance Management Framework Update	
The Committee received an update on the Performance Management Framework. The purpose of the report was to launch the conversation and provide opportunities to engage.	
The Committee noted key elements and changes made to the performance management framework, which included;	
• The broadening and strengthening of accountability letters from the Executive Directors. • Clarification of milestones, deliverables and impact in order to understand adaptable work where needed.	
The Committee highlighted the need to prioritise audits as a measure within the framework.	
Performance Escalation Report - Targeted Intervention & Enhanced Monitoring	
The Committee noted that there were no changes to escalation levels to divisions.	
Assurance was provided that quarterly escalation meetings with Judith Paget, Director General for Health and Social Services and the NHS Wales Chief Executive, were held in order to address issues, with lots of positive progress noted in terms of key deliverables, as set out in the escalation framework or deliverable requested as the process progressed.	
Performance Report, December 2024	
The Committee received updates on several key elements of the report.	
The Committee discussed the need for a shift in focus in relation to increasing vaccination uptake, by providing opportunities for easily accessible vaccine clinics such as during evenings and weekends.	
Benefits Realisation: Robotic Process Automation	
The Committee received an update, noting the three principal benefits of RPA, those being;	
• Freeing staff time, • Reducing the need for additional staff, and, • Enhancing data entry quality.	
The Committee queried whether the implementation of RPA would restrict the development of bigger technological change in the future. The Committee noted concern around the Health Board's ability to recruit the necessary skills and engineers into the digital sector.	
The Committee raised the need for further discussion around appropriate financial advice and the development of an appropriate financial scrutiny of service where the benefit of RPA implementation would be cash releasing.	
Information Governance Report, including SIRO Update	
The Committee was advised that mandatory training on ESR had not seen much improvement, as compliance had stayed at 75%.	

The Committee noted that the reduction in training could present an increase in risks. Assurance was provided that there would be a further report presented to the Board in January.

The Committee received key highlights of the report, including the outcome of phishing tests which the Committee noted were unsatisfactory.

Assurance Report from the Digital, Data and Technology Group

The Committee noted the key elements of the report, and the next steps outlined to further progress any ongoing work.

The Committee queried what learning points could be taken from the difficulties and delays experienced. Assurance was given that sufficient distribution of responsibilities would be sought.

The Committee noted the need to maintain close monitoring of developments, and requested that the Director of Digital continued to raise issues as early as possible.

Capital Builds Impairment Report

The Committee received an overview of the three impairments in relation to the large capital schemes completed in 2023/24; the Bevan Health & Wellbeing Centre, the Endoscopy Unit and the Breast Unit at Ysbyty Ystrad Fawr.

It was highlighted that the valuer predicted a reduction in asset value of between 30%-40% after scheme completion, based on a modern equivalent asset basis.

Estates Compliance Overview

The Committee received an update on the current state of some of the estates within the Health Board.

It was highlighted that there were staff shortages for skills such as electricians due to the public sector being unable to match the pay of the private sector. This limitation would increase the risk of reduced compliance.

The Committee sought assurance that the organisation was in an adequate position with the backlog of work to be done, and that staff and patients were safe and noted that a risk-based approach was being taken to address the backlog.

Financial Performance Report

The Committee received an update on the month 7 financial position.

It was noted that an additional £31 million had been provided in order to tackle cost pressures, with the condition that the Health Board provided a three-year plan, with break-even to the control total each year, maintained the 104 week waiting times, and progressed regional work.

Value and Sustainability Assurance Report

The Committee received the quarterly update, noting that at month 7 the savings position was reported as £43.7 million, which was £3.2 million above target levels.

The Committee queried how all of the work laid out within the report, as well as the QIA process, would work together.

Assurance was provided that the QIA process had identified some areas where proposals needed more work to progress and some proposals that should not be pursued for various reasons. It was noted that a formal review would be presented at the Executive Committee.

Efficiency Opportunities and Update Report

The Committee received the report which outlined how benchmarking was utilised within the organisation, and how it would help to identify key areas of focus.

It was noted that the annual exercise within phase 1 of the principled approach to deploying benchmarking would be updated as reports were published throughout the year.

The Committee sought assurance that the benchmarking methodology would be able to capture the comparability of the different demographics within the Health Board’s various catchment areas.

The Committee was informed that a total comparison would not be possible within the strategy, although every effort was being made to off-set the differences.

Review of Committee Annual Programme of Business 2024/25

The Committee Programme of Business 2024/25 was provided to the committee for information.

Committee Risk Report

The Committee Risk Report was provided to the Committee for Information.

Matters Requiring Board Level Consideration or Approval:

None noted

Key Risks and Issues/Matters of Concern:

None noted

Planned Committee Business for the Next Reporting Period:

As per the Forward work plan for 2024/25

Date of Next Meeting: 17th February 2025

Name of Committee:	Charitable Funds Committee
Chair of Committee:	Paul Deneen
Reporting Period:	13th January 2025
Key Decisions and Matters Considered by the Committee:	
Final Accounts & Annual Report 2023/24 The Committee received the final accounts and annual report for year ending 31st March 2024, noting that there had been a few changes from the draft to the final accounts and annual report due to the following areas of error being raised during the audit from Audit Wales: • Donations, legacies and grants • CCLA investments The Committee was assured measures had been put in place to ensure the errors raised within the audit would not happen again. The Committee thanked the finance team and Audit Wales for completing the audit within the deadlines set by Charity Commission. Letter of Representation 2023/24 The Committee received the Letter of Representation which would form part of the annual audit process requested by Audit Wales as evidence that the trustees of the charity acknowledge and accept responsibility for the financial statements and provide assurance of accuracy and that management accept their responsibility for the accuracy and completeness of the financial statements. Charitable Funds ISA 260 report The Committee received the ISA 260 report that provides a summary of the findings from the audit. The Committee noted the audit recommendations for treatment of the grant incomes and assurance was provided that measures were now in place when reviewing new and expired grants against the standard operating procedure.	
Matters Requiring Board Level Consideration or Approval:	
The Charitable Funds Committee recommends to the Board that it: • Approves the Charitable Funds Annual Accounts and Annual Report 2023/24 • Approves the Letter of Representation • Receives the Charitable Funds ISA 260 Report	
Key Risks and Issues/Matters of Concern:	
There were no risks or issues identified for escalation to the Board.	
Planned Committee Business for the Next Reporting Period:	
• Finance & Performance Report • Legislation Changes • Funds available to the Committee • Consideration of Bids/Small Grants • Update on Property Matters	

- | |
|---|
| <ul style="list-style-type: none">• Spending Plans over £25K• Review of Financial Control Procedure• Attendance of fund holders for slow moving funds |
| Date of Next Meeting: Friday 7 th March 2025 |

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Joint Commissioning Committee (JCC) Update Report – November 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Joint Commissioning Committee (JCC) as a Joint Committee of the Board.

Cefndir / Background

On 1 April 2024, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) ceased to exist. They were replaced by the NHS Wales Joint Commissioning Committee. The new Joint Commissioning Committee (JCC) holds the functions of the former EASC and WHSSC together with commissioning of 111 and Sexual Assault and Referral Centres.

The JCC is a Joint Committee of all Health Boards in NHS Wales. Membership of the JCC consists of the Chief Executive Officer of each Local Health Board; an Independent Chair (the Chair); and not more than five Non-Officer Members (NOMs). The Chair and NOMs (to be known as Lay Members) are appointed by the Welsh Ministers. The JCC's membership also includes an Associate Member, who shall have no voting rights, who will be the Chief Commissioner of the Joint Commissioning Committee Team (JCCT). The Chief Commissioner is employed by CTMUHB as the Host Body and this individual holds the Accountable Officer status, as delegated by Welsh Government, for accountability for certain elements of their

role, namely the propriety and regularity for public finances as delegated to them through the JCC from Local Health Boards.

Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services as identified below for residents within their area.

- specialised services for: · cancer and blood disorders
- cardiac conditions
- mental health and vulnerable groups · neurosciences, and · women and children.
- services where there is agreement between the Local Health Boards that they should be arranged on a regional or national basis
- emergency medical services
- non-emergency patient transport services
- emergency medical retrieval and transfer services
- NHS 111 services
- sexual assault referral centres, and
- other services as directed by the Welsh Ministers.

Asesiad / Assessment

The Joint Committee last met on 12th November 2024. The papers for these meetings are available at [Meeting Dates and Papers - NHS Wales Joint Commissioning Committee](#) .

The Committee’s Assurance Report from this meeting is attached at **Appendix A**.

The Committee is due to next meet on 21st January 2025, papers for which can also be accessed at the link above. The assurance report from this meeting will be presented to the Board once made available.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this report by way of an update on NHS Wales Joint Commissioning Committee (JCC) Committee activity.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
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.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. 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)	
	Is EIA Required and included with this paper No does not meet requirements
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	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	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

Glossary of Terms

- EASC – Emergency Ambulance Service Committee
- WAST – Welsh Ambulance Service Trust+
- SDEC- Same Day Emergency Care
- ICAP – Integrated Commissioning Action Plan
- ROSC – Return of spontaneous circulation
- CHARU- Cymru High Acuity Response Units
- NEPTS- Non-Emergency Patient Transport Service
- EMRTS Cymru – Emergency Medical Retrieval and Transfer Service
- CASC – Chief Ambulance Services Commissioner
- BCUHB – Betsi Cadwalader University Health Board
- CTMUHB – Cwm Taf Morgannwg University Health Board
- C&VUHB – Cardiff and Vale University Health Board
- HDUHB – Hywel Dda University Health Board
- SBUHB – Swansea Bay University Health Board
- DHCW – Digital Health and Care Wales
- SEDC – Same Day Emergency Care
- SPC – Statistical Process Control

Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee (JCC)

Dyddiad y Cyfarfod / Date of Meeting	12/11/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Stacey Taylor - JCC Interim Chief Commissioner
Cyflwynydd yr Adroddiad / Report Presenter	Stacey Taylor - JCC Interim Chief Commissioner
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Stacey Taylor JCC Interim Chief Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards	November 2024	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer (CEO) Members of the Joint Committee with a summary of the key issues considered by the Joint Commissioning Committee (JCC) at its public meeting on 12 November 2024.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee is set out in Paragraphs 2.18 and 2.20 of the JCC [Standing Orders](#).

3. HIGHLIGHT REPORT

(Links to reports highlighted [November 2024 - NHS Wales Joint Commissioning Committee](#))

Alert / Escalate	The Chair and Lay Members noted that the Ambulance & 111 Commissioning team had undertaken an in-depth piece of work to review and reset the risks for their commissioning portfolio and the legacy ambulance risks of EASC had been amalgamated into two new risks relating to the Commissioning of sufficient Emergency Ambulance Services capacity and the utilisation of Emergency Ambulance Capacity. Lay members expressed concern at the red 25 high scoring risks. Despite the new risks being articulated to provide more of a commissioner focus, the Chair requested that further work be undertaken in relation to mitigating the risks. These risks will be discussed at the next JCC Strategy session on 10 December 2024.
Advise	- The Chair congratulated Stacey Taylor, on her appointment as the new Interim Chief Commissioner and explained that a Chairs Action would be circulated following the meeting in order to seek approval for and increase to the financial delegation limits for the interim Chief Commissioner. - The Chair gave an update on the recruitment process for securing a substantive Chief Commissioner. - The Chair also welcomed the two new Lay Members to their first JCC meeting, Mandy Rayani and Shameem Nawaz who commenced on 1 November 2024. - An update was received from the Interim Chief Commissioner including details on: - The development of the Integrated Medium-Term Plan (IMTP) 2025-28; - Public Health Input into the JCCs commissioning activities; - Update on the JCC transition – progress to date and plan for actions over the remainder of 2024-2025 including priority areas of focus for the Senior Leadership Team. - Members received Reports from each of the Commissioning Directors; - The Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups highlighted:

- The single Commissioner Project for Secure Care has been extended until April 2026 in order to develop service specifications for low and medium secure hospitals;
- Perinatal Mental Health and work on the new Mother and Baby Unit in Chester has commenced with a completion date of October 2025. A review of demand for perinatal care will be completed by March 2025;
- Updates on Adult and Children Gender Identity Disorder Services were provided;
- A request was made for a deep dive into the mental health portfolio to inform future strategy and this will be undertaken and brought back to a JCC meeting in early 2025.
- The [Director of Commissioning for Ambulance and 111](#) provided updates on:
 - Emergency Medical Retrieval and Transfer Service (EMRTS) Review – Judicial Review;
 - Manchester Arena Assessment;
 - Welsh Health Circular on Ambulance Patient Handover guidance WHC/2024/041;
 - Evolution of the Clinical Response Model;
 - Non-Emergency Patient Transport Services (NEPTS) – Future Vision Update; and
 - Key risks.
- The [Director of Commissioning for Specialised Services](#) provided updates on:
 - Cancer & Blood - Developments in specialised radiotherapy: Repatriation of Peptide Receptor Radionuclide Therapy (PRRT) for neuroendocrine tumours, continued Expansion in Stereotactic Ablative Body Radiotherapy (SABR) provision in Wales and advanced Therapy Medicinal Products (AMTP) implementation;
 - Cardiac - Transcatheter Aortic Valve Implantation (TAVI) performance, cardiac Review Phase 2, South Wales Trauma Network Annual Conference and repatriation of cardiothoracic surgery to the University Hospital of Wales;
 - Intestinal Failure Financial Position update;
 - Neuroendocrine and Long-Term Conditions - Deep Brain Stimulation service update, North Wales Paediatric Cochlear Implants and progress with repatriating patients from Manchester for their follow up care and South Wales Mechanical

	Thrombectomy capacity and Phase 1 investment update; - o Women and Children – Updates on paediatric Strategy Implementation Board, Neonatal Transport Delivery Assurance Group and the Paediatric and Neonatal Escalation Reset meeting; and - o Commissioning risks across the portfolio were highlighted and a discussion in relation to agreed funding cases not being progressed will be taken up outside of the meeting. • An Emergency Medical Retrieval and Transfer Service (EMRTS) Recommendation 4 update was received on progress with the developments of a commissioning proposal for bespoke road-based enhanced and/or critical care service in rural, remote and coastal areas. Members noted that Recommendation 4 was made as part of the EMRTS Review. Recommendation 4 focuses on developing a commissioning proposal for a bespoke road-based enhanced and/or critical care service in rural, remote, and coastal areas. It addresses concerns raised during public engagement about ambulance responses for conditions that do not require EMRTS's specialised pre-hospital critical care. Importantly, it is an additional emergency service development that will work as part of the emergency ambulance service and alongside the air ambulance service for these remote rural and coastal communities.
Assure	• Members endorsed the introduction of rapid clinical screening by the ambulance service as a means of mitigating harm this winter. Item 2.3.2. • Members discussed the findings of the Recommendation 4 Task and Finish Group report and endorsed draft Commissioning Intentions and delivery criteria. These Commissioning Intentions will now be shared with the Welsh Ambulance Services University NHS Trust to develop a comprehensive delivery model for consideration at a future JCC meeting early in 2025 as outlined in item 4.1. • An update on the JCCs sub-committee structure was received. The JCC approved the proposed lay member nominations and acknowledged the advice received from the NHS Wales Directors of Corporate Governance (DoCG) peer group, the Chair proposed that the designation of the CEO members would be amended from attendees to members for the Joint Committee's Planning, Performance

and Finance sub-committee and the Quality, Safety & Outcomes sub-committee. The Terms of Reference will be amended accordingly and brought back to the JCC in January 2025 for endorsement before seeking final approval from HBs at January 2025 Board meetings.

- The September 2024 [JCC risk register](#) was received noting the further work undertaken to consider and benchmark risk appetite. Discussions over the very high risks relating to Ambulance/111 led to a request for further consideration of the ambulance red 25 risks. Members also noted that work on developing a JCC risk appetite was progressing and this will be discussed further at the JCC Development session in December 2024 and also brought back to the JCC meeting on 21 January 2025.
- The Month 6 Financial Performance Report and Financial Plan Update was received noting:
 - £3.776 overspend against the Integrated Commissioning Plan (ICP) financial plan to date with a forecast year-end overspend of £5.640;
 - A presentation providing an update on the financial plan for 2024/2025 and options for financial recovery;
 - An update on the Month 7 position was provided, which has remained stable with £3.5m deficit for the year to date and the year end forecast remaining at £5.6;
 - The key risks of the cardiac (TAVI) over-performance circa £2 million;
 - Opportunity costs of £1.5m of funding slippage as well as potential additional funding following the UK budget;
 - The key areas below were discussed in detail as potential opportunities to improve value;
 1. Cardiac (TAVI)
 2. Artificial Limb and Appliance Service (ALAS)
 3. Referral Management
 4. Improving Patient Flow, Oversight and Repatriation in Mental Health Hospitals
- The [JCC Performance Report](#) for September 2024 was received noting the development of an integrated performance report for the JCC. It was noted that a number of specialised services were on a downward escalation trajectory which was welcomed and the work involved by service providers and the JCC commissioning teams was acknowledged.
- The Committee received the [Corporate Governance update](#) report which included matters considered in-committee at the September meeting.

Inform	- The Chair welcomed Chair of BCUHB, Dyfed Edwards and the CEO of BCUHB, Carol Shillabeer to the meeting who provided an informative update on their experiences of working in partnership with the JCC. Members discussed the importance of creating proactive and accountable partnerships with HBs and BCUHB provided their helpful reflections. - The JCC agreed not to support providing additional funding for the Emergency Medical Technician re-banding case and requested that further information in relation to the costings be brought back to the January 2025 JCC meeting for further consideration. - The JCC noted updates on Implementation of Legacy Plans for Quarter 2. It was noted that this report would also be shared with Welsh Government (WG) for assurance on delivery.
Appendices	None

Note that an “in committee” meeting was also held to provide an update on a judicial review and a quality and safety update. A formal update will be given to the next public JCC meeting on 21 January 2025 under the Corporate Governance report.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality
	Reduce Duplication
	Improve Equality and Population Health
	Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below: A More Equal Wales
Dolen i Hwyluswyr Ansawdd	Data to Knowledge
	If more than one applies please list below: Learning, improvement and research

<i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Whole systems perspective Leadership
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Efficient All of the domains of quality apply If more than one applies please list below: Effective; equitable; person centred; timely and safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

Members are asked to:

- **Note** the highlights outlined in Section 3 of this report.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 January 2025
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership Committee (NWSSP) Update Report – November 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Shared Services Partnership Committee as a Joint Committee of the Board.

Cefndir / Background

NHS Wales Shared Services Partnership Committee (NWSSP) was established in November 2010 and became operational in April 2011 and through its work delivers economies of scale; efficiencies and consistency of quality and process for the business and professional services that are directly managed and delivered by local NHS bodies.

The membership is comprised of representatives from each NHS organisation that use the services and from Welsh Government in an observer capacity. The NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General / CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by an Independent Member, Professor Tracy Myhill OBE.

Asesiad / Assessment

The Joint Committee last met on 21st November 2024 and the papers for meetings are available at [Committee Schedule and Papers - NHS Wales Shared Services Partnership](#) . The Committee Chair’s Assurance Report from this meeting is attached at **Appendix A**.

The Committee is next due to meet on 3rd February 2025. The assurance report from this meeting will be reported to the Board once made available.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this update report on NHS Wales Shared Services Partnership Committee activity.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
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. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: 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)	
	Is EIA Required and included with this paper No does not meet requirements
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Services Partnership Committee
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details	James Quance, Assistant Director of Corporate Services
Date of meeting	21 November 2024
Summary of key matters including achievements and progress considered by the Committee and any related decisions made	
Chair's Report The Chair updated the Committee on activities since the last meeting and forthcoming events. This included: - The most recent Welsh Risk Pool Committee meeting which took place on 24 September 2024, with the next meeting taking place on 26 November 2024. - The Autumn Development Day hosted on 11 October 2024 was positive and provided valuable feedback and insights as regards Committee management, including the induction process for members and highlighting the importance of ensuring Executives are representing organisations to ensure quoracy for meetings. Presentations included Risk Appetite, Transforming Access to Medicines and the refresh of the Customer Charter. Welsh Risk Pool delivered a session covering the life cycle of a claim, opportunities to minimise the length of claims and exploring the impact on people in processes, sharing examples of learning programmes, such as PROMPT. Going forward, the Welsh Risk Pool Team would ensure, where possible, that the useful data collated was made available to NHS Wales to inform organisational planning and decision-making. - Discussions were held at the Chair's Peer Group on 29 September 2024, regarding Clinical Associates in Applied Psychology, the Aspiring Board Member Programme run by the Public Bodies Unit to increase diversity in Board membership across Wales, the Care Action Committee and productivity and performance. Further, the Group received an update from Paul Mears from the Chief Executives. The Llais Strategic Plan and the disciplinary processes for Chairs and Independent Members were also discussed. There was also an update from the Welsh Confederation and Welsh Confederation Conference on 6 November 2024. - NWSSP would be hosting an All-Wales Planning Programme for Learning Autumn Event on 22 November 2024. The Committee NOTED the Chair's Report. Managing Director Update The Managing Director presented his report, which included the following updates: - The Welsh Risk Pool Committee recently highlighted slight delays in terms of deferred cases, potentially due to additional pressures in Health Board Claims	

Teams, but was positive in terms of 209 cases reviewed with £15 million of reimbursements.

- In terms of finance, NWSSP put forward 22 schemes for capital funding and are working through the approvals.
- Positive progress has been made on the South East RadioPharmacy project and subject to Welsh Government (WG) approval and planning permission, works would be looking to commence in January 2025. Notwithstanding there was a current issue regarding the stack diffusion assessment and HEPA filters, which would be discussed with Natural Resources Wales. The Newport Council planners have requested a formal Section 106 Agreement together with a small contribution to the adjoining roadway scheme as part of the planning approval process.
- There was great work being undertaken around lessons learned and organisational learning being taken forward as part of the Welsh Risk Pool programme.
- NWSSP have confirmed the proposed £2 million declaration for distribution to NHS and WG.
- The internal process for the Integrated Medium Term Plan (IMTP) is on-track and we would bring a further update of the plan to the January Committee meeting, for approval.
- The Medical Examiner Service became statutory in September 2024 and we have been working through delays experienced regarding records being returned to us. As such, there had been some press interest in North Wales and we have been working with Betsi Cadwaladr University Health Board (BCUHB) around this.
- As regards accommodation, the Companies House and HQ accommodation position had changed with negotiations ending for the NG2 site which we understand has now been sold. Therefore we are looking to extend our lease of the current HQ site and to downsize Companies House to a smaller footprint.
- In terms of international recruitment, there had been a positive recent visit to Kerala and the Medical Director reported a significant number of doctors and nurses were appointable to positions. In terms of going forward for future visits, it would be helpful for Health Boards to be clear on their available vacancies.
- Laundry Services' achieved the BS14065 accreditation for decontamination of linen at their North Wales and Swansea sites and are progressing on other sites. As expected, there had been a number of challenges in terms, operationally, due to the ageing estate and laundry equipment, which has been as a direct result of the lack of investment in previous years.

The Committee **NOTED** the Managing Director's Report.

Deep Dive

Single Lead Employer Model

A comprehensive deep dive into the Single Lead Employer (SLE) Model was presented to the Committee by the Deputy Director of People and Organisational Development, Sarah Evans.

The SLE model is now fully embedded as part of NWSSP's organisational set up with a Tripartite Agreement in place for NWSSP to work in partnership with Health Education and Improvement Wales (HEIW) and any host organisations. This complex model of working is further underpinned by an Employment Management Agreement. In terms of scope, SLE covers all Medical, Dental and Pharmacy trainees across Wales; the current headcount exceeds 3,700 trainees. The initial implementation began with GP trainees in 2015 and expanded to include Foundation Doctors during the pandemic. The remaining trainees were then transferred between 2020-2022.

Benefits of the SLE model include a simplified employment process, encompassing one pre-employment check, one contract of employment and one payroll form. Further, it ensures easier access to salary sacrifice schemes, mortgages and more effective support for trainees with disabilities. A further benefit includes streamlined payments; for example, ad-hoc duties are paid via one SLE assignment.

The Committee **NOTED** the Deep Dive.

Items Requiring SSPC Approval/Endorsement

Price Increase – Alder House Lease

The report sought the Committee's endorsement for the annual increase of rent at Alder House, prior to obtaining approval of Velindre University NHS Trust Board.

The Committee resolved to **ENDORSE** the proposal.

Charnwood Court Lease Extension

The report sought the Committee's endorsement in order for the Velindre University NHS Trust Board to formally sign and seal the extension of the lease at NWSSP Headquarters at Units 4/5 Charnwood Court, Nantgarw, in accordance with the Standing Orders for the operation of the Committee.

The Committee resolved to **ENDORSE** the proposal.

Purchase to Pay (P2P) Governance Update

The All-Wales P2P Governance Group progress update sought the Committee's approval to cease the auto-release of invoices process from 1 January 2025. The Committee was informed of the progress made against the priorities which were identified in order to achieve the maximum impact and target the greatest improvements across the P2P process.

The Committee **APPROVED** the recommendation to cease the auto-release process from 1 January 2025 and **NOTED** the progress made by the Group.

Risk Appetite Statement

The Statement was brought to the Committee for approval and was last presented at the January 2023 meeting, following significant amendment. It is periodically reviewed by the Senior Leadership Group (SLG) and was discussed at the Autumn Development Day on 11 October 2024.

The Statement reflects guidance from the Good Governance Institute and a bolder approach to taking risk, which was reaffirmed at the Autumn Development Day when the application of the appetite levels for financial, regulatory, quality, reputational and people was discussed. In particular, the balance and interaction between value for money and quality generated a lot of discussion and was something that would need to continue to be monitored closely, and for the Committee to challenge itself as part of decision making and considerations in future.

The Committee **APPROVED** the Risk Appetite Statement.

Items for Noting
NWSSP Decarbonisation Update SD presented an update on decarbonisation, following the commitment to provide a bi-annual update to the Committee. The Decarbonisation Action Plan (2024-2026) had been reviewed by Welsh Government and was rated as amber assurance, with NWSSP having since addressed the areas identified regarding monitoring on a National level. All of the findings in the 2023-24 Internal Audit Report relating to staff training, operational impacts of risks and preparation of a fully costed implementation plan have been addressed. The update provided assurance to the Committee of NWSSP's ongoing efforts and progress in reducing carbon emissions and promoting sustainability within NHS Wales and the Committee NOTED the Decarbonisation Update.
Duty of Quality Update The report outlined steps made to ensure improving quality remains at the heart of the wide variety of services provided by NWSSP, on behalf of NHS Wales and sets out the positive actions taken to meet the Duty. Progress included the establishment of a good practice network across all divisions, which focuses on sharing learning and quality improvement programmes and development of an All-Wales ESR e-learning module. Further, NWSSP's Business Quality Manager had delivered bespoke training sessions and was happy to engage with wider NHS Wales landscape as regards progressing the non-clinical side of quality. It was recognised that the National Group was unable to focus on the non-clinical measures due to clinical pressures, demands and the attendees being largely clinicians. The Committee NOTED the Duty of Quality Update as provided by the NWSSP Medical Director.
Finance, Performance, People, Programme and Governance Updates
Finance - The financial position as at 31 October 2024 with a year-to-date surplus of £2.422m. This was reported as a surplus of £1.899m within our core operational budgets and £0.523m against the recurrent covid allocation. The £1.899m surplus against core budgets is primarily due to ongoing turnover and delays with targeted recruitment to vacancies. Therefore, NWSSP gave a provisional recommendation of a £2.000m distribution to partners, subject to pay award funding allocations. Personal Protective Equipment (PPE) stock, which remains an area of uncertainty requiring WG direction, would be discussed at the meeting with WG on 29 November 2024. Budgets would also be explored as part of our IMTP process and we are identifying particular schemes that NWSSP will need to make investment into in the near future that will require NWSSP to generate internal resource savings or secure investment from WG or partners. In terms of capital schemes, we have submitted an ambitious list of potential capital schemes should additional funding become available and NWSSP is on-track with use of the allocation for the year. The Welsh Risk Pool is forecasting £140m for the current year, which would require invoking of the risk sharing agreement with Welsh Government, confirming at the end of December the allocations from organisations and continue to manage the risk for the remainder of quarter four.

Audit Wales Management Letter 2023-24 - A very positive position was reported and no recommendations were raised. The Director of Finance and Corporate Services noted that she had met with Richard Harris, Engagement Lead for Audit Wales, to consider the year ahead in terms of the key risks being managed as an organisation and any improvements that can be made to working arrangements in the spirit of continuous improvement.

People & Organisational Development – Good progress had been made in relation to the majority of the statutory indicators, for which compliance had increased. The key messages detailed in the overarching report were:

- Sickness absence had increased by 0.3%, to 3.24%, compared to 2.90% for the same period last year (October 2023 to September 2024), but remained under the NHS target of 3.30%.
- PADR compliance remained above target, at 85.74%.
- Statutory and mandatory e-learning compliance remained very high at 93.16%, excluding the SLE Division.
- Turnover was reported at 22.11%, which had decreased by 1.61%, compared to the same period last year. When excluding the SLE Division, where a higher degree of turnover is inherent in the model, the turnover for NWSSP was at 10.15%.
- Agency spend increased to £18,188 in September 2024, from £12,247 in August 2024. However, we had received no new agency requests in October 2024, 3 staff were engaged via agency in September 2024 and the Resource Bank were recruiting for roles for Laundry, Clerical and Drivers.

Performance - Key Performance Indicators (KPIs) from June to September 2024 were reported and there were no significant areas of concern to be brought to the Committee's attention. The Report indicated a stable and positive position with 38 of 40 high-level indicators achieving target, which were explained in detail in the overarching report. Professional influence benefits generated by NWSSP amounted to £198m, as at the end of September 2024 and the Time to Hire target within Recruitment continued to be achieved over recent months.

Outcome Measures Performance Report – The report had been shared with the Senior Leadership Group for scrutiny, prior to being presented to the Committee and focussed on outcomes from the IMTP 2024-2027. Key messages included strong performance across divisions, especially customer satisfaction and employee well-being, noting that there was further progress to be made in demonstrating progress against our Decarbonisation Plan to Welsh Government. There are additional measures in development that will be reported, in addition to trend information as we progress through the year.

Integrated Medium Term Plan (IMTP) Update – The progress report for Quarter 2 of 2024/25 provided assurance that good progress had been made against the current objectives. Quarterly reviews with divisions had taken place to challenge the status of objectives and review any delays identified, which were detailed in the overarching Report. Going forward, the focus would be on targeted actions as we moved into Quarter 3. Additional scrutiny would be applied to objectives identified as off track or at risk. Updates regarding Decarbonisation, Foundational Economy and People & Organisational Development were provided. The Director of Planning, Performance and Informatics also updated the Committee that the 2025-28 IMTP development is well under way and confirmed that it would come to the next SSPC meeting, following further development

with the NWSSP SLG in order to ensure it is submitted to Welsh Government within the required timescales.

Project Management Office & Service Improvement Update Report – Current progress against projects was highlighted and confirmation received that controls were in place to ensure effective monitoring. The majority of the indicators are green, but the red and amber are consistent with the previous report. Updates regarding higher risk projects would continue to be reported, as a matter of course, to the Committee. It was noted that four projects had been closed since the last report: Medical Examiners; Procurement of Implementation of Wales Healthcare Student Hub; Wales General Ophthalmic Service – Primary Care Contract Return; and Charnwood and Companies House Accommodation.

Corporate Risk Update - There are 15 risks identified for action, of which there are six red risks and nine amber risks. The Committee's attention was drawn to the accommodation risk and the Primary Care Workforce Intelligence System risk, which was escalated by the SLG at its last meeting. It is expected that focus by the SLG and very recent management action will see these risks reduced in the next report. The remainder of the Corporate Risk Register position remained stable.

Papers for Information

The following items were provided for information only and the Committee **NOTED** the reports:

- Finance Monitoring Returns (Months 6 and 7 of 2024/25).
- Personal Protective Equipment (PPE) Report.
- Shared Services Partnership Committee Forward Plan.
- NWSSP Audit Committee Assurance Report for October 2024.

Part B (Private Session)

Motion to exclude the public from the meeting in accordance with the provisions of section 1 (2) and (3) of the Public Bodies (Admissions to Meetings) Act 1960

NHS Wales Energy Source Decision November 2024

The Wales Energy Group's (WEG) proposal in respect of All Wales supply of electricity for the financial year 2025-26 was brought to the Committee's attention, for approval. Challenging discussions were had regarding the energy sourcing options available and a unanimous recommendation was made to stay with the current zero carbon for businesses option.

The Committee **APPROVED** the proposal to remain with the current energy provider, Zero Carbon for Business.

Any Other Business (AOB)

TM further thanked the Committee for their contributions and support during 2024.

Matters requiring Board/Committee level consideration and/or approval

The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Matters referred to other Committees

No further matters were referred to other Committees.

Date of next meeting

Monday 3 February 2025 at 9.30am to 11.30am