

**CYFARFOD BWRDD IECHYD PRIFYSGOL  
ANEURIN BEVAN  
ANEURIN BEVAN UNIVERSITY HEALTH BOARD  
MEETING**

**AGENDA**

<b>Date and Time</b>	<b>Wednesday 27<sup>th</sup> March 2024 at 9.30am</b>	
<b>Venue</b>	<b>Conference Centre, Headquarters, St Cadoc's Hospital</b>	
<b>PRESENT</b>	<p>Ann Lloyd Nicola Prygodzicz James Calvert Peter Carr</p> <p>Sarah Simmonds Jennifer Winslade Hannah Evans</p> <p>Robert Holcombe Paul Solloway Leanne Watkins Paul Deneen Dafydd Vaughan Philip Robson Iwan Jones Prof Helen Sweetland Shelley Bosson Penny Jones Pippa Britton</p>	<p>Chair Chief Executive Medical Director Director of Therapies and Health Science Director of Workforce and OD Director of Nursing Director of Strategy, Planning and Partnerships Director of Finance &amp; Procurement Director of Digital Chief Operating Officer Independent Member (Community) Independent Member (Digital) Special Advisor to the Board Independent Member (Finance) Independent Member (University) Independent Member (Community) Independent Member (Community) Vice Chair</p>
<b>ALSO IN ATTENDANCE</b>	<p>Rani Dash Michelle Jones Jemma Morgan Tanya Strange Kathryn Thomas Letitia Hawkins Fern Cook</p>	<p>Director of Corporate Governance Head of Board Business Regional Director, Llais Cymru Deputy Director of Nursing Volunteer Co-ordinator Volunteer Governance Support Officer</p>
<b>• APOLOGIES</b>	<p>Louise Wright</p> <p>Martin Blakebrough Richard Clark</p>	<p>Independent Member (Trade Union) Independent Member (Third Sector) Independent Member (Local Authority)</p>

<b>ABUHB 2703/01</b>	<p><b>Welcome and Introductions</b></p> <p>The Chair welcomed members to the meeting, in particular members of the public who were able to join the meeting to observe in person and on-line. It was noted that the meeting would be recorded and published on the Health Board’s website following the meeting.</p>
<b>ABUHB 2703/02</b>	<p><b>Declarations of Interest for Noting</b></p> <p>There were no declarations for noting.</p>
<b>ABUHB 2703/03</b>	<p><b>Draft Minutes of the Health Board Meeting, held on 24<sup>th</sup> January 2024, for Approval</b></p> <p>The minutes of the meeting held on 24<sup>th</sup> January 2024 were agreed as a true and accurate record.</p>
<b>ABUHB 2703/04</b>	<p><b>Board Action Log for Review</b></p> <p>It was noted that all actions within the Board’s action log had been completed or were in progress as outlined within the paper.</p>
<b>ABUHB 2703/05</b>	<p><b>Report on Sealed Documents and Chair’s Actions</b></p> <p>Rani Dash (RD), Director of Corporate Governance, provided an overview of the use of the Health Board’s Seal and Chair’s Actions that had been undertaken during the period 3<sup>rd</sup> January 2024 to 4<sup>th</sup> March 2024.</p> <p>The Board <b>NOTED</b> and <b>RATIFIED</b> the use of the common seal and Chair’s Actions in line with Standing Orders, as set out within the paper.</p>
<b>ABUHB 2703/06</b>	<p><b>Report from the Chair</b></p> <p>The Chair provided her verbal report, with an overview of the activities she had undertaken, outside of her routine meetings and visits, as follows:</p>

- Chaired two Regional Partnership Board (RPB) meetings and a workshop to explore cost effectiveness and to ensure that the themes were aligned to the work of the RPB; reorganisation of the governance arrangements of the RPB and the determination of strategic aims and noted that this was a valuable exercise with children identified as a key priority within this work.
- Chaired five meetings of the Ministerial Advisory Group that was reviewing the accountability of Health Boards in Wales. The Board noted that the report was nearing completion prior to submission to the Minister.
- Chaired the Health Board Chairs peer group and noted that the focus of the work had been on resources and the ability to meet the ever-rising demand and the associated pressures that this places on the system staff and patients.
- Attended a Ministerial Away Day with Health Board Chairs where concerns were shared as to the challenges that all Health Boards face.
- Attended a meeting with Minister and CEOs and the interfaces with social care. The Chair noted that all attendees were of the same mind in relation to concerns and noted the enthusiasm that exists to collectively resolve the issues which exist between Health and Social Care.

The Board **NOTED** the Chair's Report

**ABUHB  
2703/07**

### **Report from the Chief Executive**

Nicola Prygodzicz (NP), Chief Executive, provided her verbal report, with a focus on the following areas:

- A substantial amount of work in the development of the annual and financial plan in the context of increasing demands and concluded that the balance between ambition and deliverability had been a key consideration.
- The impact of industrial action at a challenging time over the Easter holiday period and thanks were extended to all staff involved.
- The breast unit at Ysbyty Ystrad Fawr had opened and noted that cancer continued to be a top priority for the Health Board.
- Attended the SEEN project that had been developed with Race Council Cymru, Welsh Government and celebrated art through multi-ethnic groups
- Received a visit from the Children's Commissioner for Wales to the CAHMS team and noted the complimentary work that was ongoing amongst the challenges faced.

- Attended the Women’s Health Network launch that builds on the challenges around women’s health and associated inequalities.
- Noted the significant amount of national work ongoing, which included the joint commissioning agenda, EMRTS and the work of the Value and Sustainability Board.
- Noted that the staff workforce survey had been completed and the Executive Team were due to look at the findings.
- Strengthened the communication strategy internally and advised that the Executive team was now undertaking drop-in sessions every month across the health board.
- Noted that a record number of nominations for the staff recognition awards were being received which recognised the excellent work that was ongoing by staff.

The Board **NOTED** the CEO’s Report.

**ABUHB  
2703/08**

**Patient Story – Volunteer to Career**

Tanya Strange (TS), Deputy Head of Nursing, supported by Kathryn Thomas (KT), Volunteer Co-ordinator, introduced the item and presented the volunteer to career story.

Kathryn Thomas (KT), Volunteer Co-ordinator, advised that the process of providing opportunities for volunteer to career was embedded practice within the Health Board. An explanation of the process was provided that supported the exploration of options personal to individuals’ needs. KB noted that the majority of roles have a befriending focus and advised that to date 12 volunteers had gained employment with several others signposted to work experience.

Leticia Hawkins (LH), Volunteer, provided an overview of her background and advised that the opportunity that she had been provided was significant, and concluded that the volunteer to career approach had changed her life outcomes. LH advised that the skills that she had developed had been beneficial in both her personal and professional life and was appreciative of the opportunity provided.

The Chair thanked the individual for attending and extended her best wishes on behalf of the Board for the future.

Sarah Simmonds, (SS), Director of Workforce and OD, extended her congratulation and advised that there was a need to turn such opportunities into meaningful employment opportunities and acknowledged that feedback had been received in terms of the volunteer policy and the widening opportunities for employment.

Pippa Britton (PB), Vice Chair, sought confirmation as to how volunteers may be able to assist with difficulties encountered by those with physical limitations and was advised that the lived experience framework needed to be reviewed to reflect how issues raised may be better addressed.

Nicola Prygodzicz (NP), Chief Executive, sought clarification as to how an individual finds out about such opportunities and whether more could be done to improve this. The Board was advised that the individual had been signposted to the opportunity by a support group and acknowledged that more could be done through improved communication including the use of leaflets. The Board noted that the team visited careers fairs to raise the profile of the opportunities which exist and that the Charitable Funds Committee may be able to assist in supporting the work of volunteers.

The Chair thanked all for attending and noted the excellent work of volunteers.

**ABUHB  
2703/09**

### **Report from Llais, Gwent Region**

Jemma Morgan (JM), Regional Director, Llais, presented Llais' report to the Board, which provided an overview of the current issues of concern and positive observations, being addressed by the Llais Gwent Region in relation to the planning and delivery of health services.

JM also advised of a new matter that wasn't included in the report which was in relation to the EMRTS engagement on a national level. Nicola Prygodzicz (NP), Chief Executive, advised that the letter from Llais had been included in the Board papers for today's meeting under the EASC update.

Paul Deneen (PD), Independent Member, sought clarification as to whether Llais had learnt any lessons following their 12 months of existence. JM reflected that the remit of social care with five local authorities was a challenge and noted that there was a need to rebalance the work of Llais to move forward in a strategic way with its strategy being launched in April.

PD acknowledged that there was also a need to strengthen the Llais report to include the voice of children and young people and was advised that Llais was exploring opportunities to better engage the voice of children and young people in its work.

The Board **NOTED** the report.

**ABUHB  
2703/10**

**Strategic Planning for 2024/25:  
a. IMTP and Annual Plan 2024/25**

Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided an overview of the report and noted that the Health Board had a statutory responsibility to submit an approved Integrated Medium-Term Plan (IMTP) that could financially balance over a three period to Welsh Government.

HE advised that on 16<sup>th</sup> February 2024 the Health Board issued an Accountable Officer letter to Welsh Government confirming that, due to the ongoing financial challenges, the Health Board would submit an Annual Plan with a three-year intent to balance the immediate system sustainability challenges with the population health and care needs. The Board noted that the stated ambition of the plan was for the health board to be in financial balance by 2026/27.

HE acknowledged that the plan had been developed with high level engagement across all teams and provided an overview of the engagement that had taken place. HE provided an overview of the documents appended to the plan and noted that the plan was framed around shorter-term priorities and longer-term priorities and that the life-course approach was applied to the longer term. The Board noted that the plan had been strengthened in terms of deliverables and outcomes as a result, to aid understanding.

HE noted that the plan outlined the priorities and system changes required under the five priority areas:

1. Embedding Prevention and Population Health in all that we do;
2. Improving patient experience and timeliness of care in our urgent and emergency care system focusing on access and discharge pathways;
3. Continuing to prioritise cancer, urgent and the longest waiting patients for planned care;
4. Progressing our place-based models of care in primary and community services;
5. Improving our Mental health services.

HE advised that there had been a greater focus upon children and the work with partners on the best start in life, a focus on long waiting patients, a commitment to sustain no patient waiting over 156 weeks and to reduce the number of specialities not waiting over 104 weeks.

HE noted that to sustain this improvement this would take a significant effort . Within the plan there were quarterly ambitions articulated which would aid accountabilities within the plan. HE noted that certain elements of the plan were dependent upon capital investment and the capacity to deliver the plan in year whilst working on future years.

Paul Deneen (PD), Independent Member, acknowledged the work that was ongoing around children and young people.

Nicola Prygodzicz (NP), Chief Executive, advised that a key message to impart was the need to deliver improved outcomes whilst developing a sustainable plan that achieves financial balance. NP advised that the plan was ambitious given the financial savings for the coming year of up to £50m in addition to significant savings in 2023/24 and acknowledged that more work needed to be done to demonstrate the improved efficiencies.

The Chair asked if the targeted intervention from Welsh Government had commenced. NP advised that a meeting was scheduled for 9<sup>th</sup> April to determine the approach and the associated de-escalation arrangements.

Pippa Britton (PB), Independent Member, acknowledged the significant amount of work in developing the plan and sought confirmation as to whether the plan was ambitious enough in terms of timescales. PB also queried whether the plan was clear enough for the lay person, and asked whether further clarification could be provided to the reader. HE advised that the specifics on a page would be reviewed following today's feedback. In terms of timescales, HE noted that there had been a conscious balance to deliver within year and over the longer term. HE acknowledged that there was a balance between ambition and realism and noted that some of the processes that were required to be followed had determined the timescales for delivery.

Robert Holcombe (RH), Director of Finance and Procurement, acknowledged that the challenge for the Health Board was to live within the parameters provided and that the ambition was to achieve financial balance within 3-years. RH advised that to identify headroom to improve there was a need to determine the priorities for delivery and the approach to delivery.

Iwan Jones (IW), Independent Member sought assurance as to how the financial plan would be realised through the provision of greater detail to the Board and in doing so reduce the risks associated with delivery of the plan.

HE advised that the route map to delivery remained a key consideration and the detail on more significant changes need to be regularly reported to Board.

NP advised that by July 2024 further granularity would be provided around the three-year route map to sustainability and that a report would be submitted to the Board with this detail. NP reflected upon the size and scope of the ask and confirmed that a reflection on this year's financial performance would be undertaken to test the assumptions within the plan. NP concluded that there was a delivery framework in place, with efficiency being a key consideration.

**Action: Chief Executive, Director of Strategy, Planning and Partnerships & Director of Finance and Procurement, to provide a more detailed report on the three-year route map to sustainability to the Board in July 2024**

Dafydd Vaughan (DV), Independent Member, reflected that those aspects that could make the biggest difference were dependent upon substantial capital investment and acknowledged that the level of investment was limited although essential.

The Board:

- **APPROVED** the annual plan 2024/25 and appendices which include the capital prioritisation for submission to Welsh Government.
- **NOTED** the ongoing action to develop a more detailed report on the 3-year route map to sustainability.
- **NOTED** the ongoing actions to further improve delivery of the 104 weeks planned care target.

## **b. Financial Plan 2024/25**

Rob Holcombe (RH), Director of Finance and Procurement, presented the report which outlined that the Health Board had two statutory financial duties.

RH advised that to achieve the duties the Health Board is required to set a financial plan as part of the annual plan for 2024/25. RH noted that in view of the deficit in 2022/23 and forecast deficit in 2023/24 as well as the associated levels of risk there had been increased oversight by the Board, the Executive Committee and the Finance and Performance Committee. RH advised that these arrangements would continue in 2024/25 and acknowledged that it was anticipated that there would be further financial scrutiny through Welsh Government arrangements as part of 'targeted intervention' arrangements.

RH advised that whilst developing the draft financial plan, which had been supported by the Finance and Performance Committee, it was identified that the Health Board would be unlikely to deliver a balanced financial plan for 2024/25 or on a rolling 3- year basis. As a result, an Accountable Officer letter had been sent to Welsh Government.

The Board noted that when developing the financial plan the following had been included:

- Allocation & income funding of £1.7bn that included an uplift of 3.67% for all of Wales
- Assumption that conditional funding of £65m was retained.

RH noted that the approach to development of the financial plan focused on ensuring safe service provision to patients and improved efficiency, whilst minimising new investments.

RH reported that in respect of the plan for 2024/25 a best-case position of a deficit of £48.9M would be reported which included an underlying deficit of £81m. This had been discussed and supported by the Finance and Performance Committee. RH advised that the report also identified those items which drive the deficit which included, investments in safe staffing, nursing pressures, beds remaining open, CHC inflation, medicines both prescribing and NICE high-cost drugs and specialised services commissioning.

Iwan Jones (IJ), Independent Member, reflected that within the deficit reported there were a number of variables that could impact further upon the level of deficit being forecast. RH confirmed that the plan, was the best-case forecast, was ambitious and risks would need mitigating. Phil Robson (PR), Special Advisor recognised the proposed ambition and supported the plan.

The Board **APPROVED** the annual financial plan for the 2024/25 financial year as a forecast deficit of £48.9m, recognising the risks of savings delivery and opportunities for further mitigation and **REQUESTED** further updates on the progress of the work to be completed in developing and achieving the road map to sustainability over the three-year period.

### **c. Delegation of Revenue Budgets 2024/25**

Rob Holcombe (RH), Director of Finance and Procurement, presented the report and advised that the Health Board was required to set budgets prior to the beginning of the financial year, which were in accordance with the aims and objectives of the annual plan for 2024/25. Specifically,

the Board was advised that this means preparing and setting budgets within available funds. RH noted that the final Financial Plan identified a forecast deficit for the Health Board of £48.9m for 2024/25 and that an Accountability letter had been submitted to Welsh Government recognising the need to develop a longer-term financial plan to balance the budget.

RH advised the Board that the 2024/25 Health Board financial plan assumed the following:

- Baseline allocation 2023/24 £1,480m
- Allocation letter funding uplift of £156m
- Anticipated allocation income of £65m
- Additional confirmed GMS allocation £4m
- Other income of £11m

RH advised that the report detailed the principles and proposed approach to delegating funding at the start of the 2024/25 financial year from the total available resources of £1.716bn.

RH commented that the proposed approach involved 2-part budget setting plan which initially delegated the proposed levels and then for a second delegation to be performed during quarter 1 of 2024/25. This would be part of finalising the 2024/25 financial savings and cost pressure plans at a divisional/budget holder level.

The Board noted that the annual financial plan was underpinned by a focus on developing a budget strategy that:

- Ensures budget delegation plan reconciles with Allocation funding.
- Budget allocations were in line with WG allocative planning therefore prioritised to 2024/25 pressures.
- Budget delegation includes recurrently approved budgets, 3.67% NHS Wales LTA's pass through (£8.8m) and regional planned recovery monies (£3.9m) where applicable.
- Reserves were established pending finalisation of some anticipated allocations
- Budget holders should operate & deliver within delegated budgets noting that some areas forecast to be overspent.
- An innovation reserve had been established for a number of key priorities (£3m)
- No contingency reserves were established
- All other risks & pressures will need to be pro-actively managed & mitigated.

The Board **APPROVED** the proposed budget delegations, including:

- Initial revenue budgets to be delegated for the 2024/25 financial year, and
- Those budgets to be held in reserve – both in terms of planned commitments and any contingency (uncommitted reserve).

**ABUHB  
2703/11**

### **Corporate Parenting Charter**

Jennifer Winslade (JW), Director of Nursing, advised that the report outlined the responsibilities upon public sector bodies such as the Health Board to safeguard and promote the rights and life chances of care-experienced children and young people.

JW noted that the proposed charter for adoption was closely aligned with the UN Convention for the Rights of the Child (UNCRC) and the paper sought to develop the understanding of this work for children in care.

Phil Robson (PR), Independent Member, advised that corporate parenting was a key challenge for those young people in care and acknowledged that there were opportunities for further work and asked whether the Public Services Board (PSB) could assist in this field. The Chair and Chief Executive agreed to consider this through the PSB as members.

The Board **AGREED** to the signing of the Pledge to become a corporate parent.

**ABUHB  
2703/12**

### **Strategic Equality**

#### **a. Annual Report**

Sarah Simmonds (SS), Director of Workforce and OD, advised that the report provided the background and context to the Annual Equality Report 2023-24 and the associated improvements made. SS noted that the annual report was required to be published by the 31 March 2024 in line with the requirements set out in the Public Sector Equality Duty (PSED) 2011. The Board noted that the annual report was a useful tool in communicating information about the work the Health Board was undertaking on Equality, Diversity and Inclusion (EDI). SS acknowledged that within the last 12 months there had been improvements in the gender pay gap, staff diversity networks had been supported and the anti-racist action plan had progressed.

The Board **APPROVED** the Strategic Equality Report.

## **b. Strategic Plan**

Sarah Simmonds (SS), Director of Workforce and OD, introduced the report which provided the background context to the Strategic Equality Plan (SEP) and Equality Objectives for 2024 – 2028 following the public consultation and feedback that had been received. SS advised that the revised SEP was due to be published by the 31 March 2024, to comply with the requirements set out in the Public Sector Equality Duty 2011.

The Board was advised that the SEP had been developed following extensive engagement to ensure that the objectives that were set were realistic and relevant. From the engagement several themes emerged that were:

- Meaningfully engaging and actively listening to our people and patients
- Co-production and design
- Access to our services and environment
- Culture and leadership
- Data and systems
- Equal opportunities

SS advised that in developing the plan the context post covid had changed and three core objectives had emerged that were:

- Patients – access to services
- People -Diversity of workforce
- Population - Addressing health inequalities

SS advised that an action plan had been developed and that work was ongoing to identify appropriate measures to track the progress and impact of the plan.

Pippa Britton (PB), Independent Member, recalled an example of accessibility matters across the estate and asked whether this could be linked with the volunteer programme to assist those with physical limitations when accessing services.

The Board discussed the accessibility of accessing certain sites and heard that some sites require improvement and noted that the front of house services were key and that the inclusion of the work of volunteers may further assist.

**Action: Director of Workforce and OD to meet with Director of Nursing to explore the use of volunteers in better managing access considerations.**

	<p>In response to a question the Board was advised that sufficient resources existed to deliver the SEP and noted that a network was being established to support the better delivery of the equalities agenda and positive steps had been made including the use of protected time to grow staff networks.</p> <p>The Board <b>APPROVED</b> the updated SEP.</p>
<p><b>ABUHB 2703/13</b></p>	<p><b>Major Incident Plan</b></p> <p>Hannah Evans (HE), Director of Strategy, Planning and Partnerships, advised that the Health Board has a statutory responsibility under the Civil Contingencies Act 2004, to plan for and respond to a wide range of incidents and emergencies that could impact on health or patient care. HE advised that the plan had been considered by the Partnerships, Population Health and Planning Committee prior to submission to Board. HE noted that the Major Incident Plan outlines the roles and responsibilities of ABUHB in an emergency response, including its activation and deactivation arrangements, command and control structures and recovery arrangements. The Board was advised that a Major Incident exercise was planned for later this year to test the plan across a wide range of response services.</p> <p>Helen Sweetland (HS), Independent Member, sought assurance as to the effectiveness of communication to those delivering services and was advised that rigorous governance arrangements were in place to ensure that regular communication around the plan and its detail were in place.</p> <p>The Board was also provided feedback on some of the details within the plan and noted that the helipad was now open and queried whether a further option should be included as the Grange was now operational and whether the plan could be further enhanced through the inclusion of operational organisations that could also assist when dealing with a major incident.</p> <p><b>Action : Director of Strategy, Planning and Partnerships to reflect the comments of the Board within the final plan.</b></p> <p>The Board <b>APPROVED</b> the revised Major Incident plan for immediate implementation.</p>
<p><b>ABUHB 2703/14</b></p>	<p><b>Establishment of the NHS Wales Joint Commissioning Committee</b></p> <p>Nicola Prygodzicz (NP), Chief Executive, presented the report that detailed the proposed implementation and governance arrangements of the NHS Wales Joint Commissioning Committee that was scheduled to</p>

come into effect on 1<sup>st</sup> April 2024. The Board was advised that the proposal was for Health Boards to establish a Joint Committee that would be operational from 1 April 2024, which would supersede the Welsh Health Specialised Services Committee and the Emergency Ambulance Services Committee and National Collaborative Commissioning Unit (NCCU). The Board noted that the new Joint Committee would be hosted by Cwm Taf Morgannwg University Health Board.

NP advised that the Director of Corporate Governance had provided significant support to this workstream and the proposal when implemented would also include the 111 programme that the Health Board presently hosts.

In response to a question regarding efficiency savings generated as a result of the establishment of the Joint Committee, NP advised that the reorganisation would not cost any more than that of EASC and WHSSC combined and acknowledged that further work was to be undertaken to achieve efficiencies.

The Board:

- a. NOTED** the establishment of the NHS Wales Joint Commissioning Committee (JCC) from 1<sup>st</sup> April 2024, as directed by Welsh Ministers;
- b. NOTED** that the JCC would supersede the Board's current joint committees, Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) with effect from 1<sup>st</sup> April 2024;
- c. NOTED** the development of the JCC's governance framework, as a key component of the Health Board's governance framework;
- d. ADOPTED** the amendments to Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards; and the Standing Orders and Scheme of Delegation and Reservation of Powers for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 18<sup>th</sup> March 2024 (Appendix A);
- e. ADOPTED** the Standing Financial Instructions for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 19<sup>th</sup> March 2024 (Appendix B); and
- f. NOTED** the JCC's Accountability Map for information (Appendix C).

**Director of Public Health Annual Report 2023/24: Our Future, Our Voice - Babies, Children and Young People of Gwent**

Tracy Daszkiewicz (TD), Director of Public Health, informed the Board that the Director of Public Health (DPH) holds a statutory requirement to produce an annual report. The Board noted that the Annual Report was a vehicle for informing local people about the health of their communities, as well as providing necessary information for decision-makers in local health services and authorities on health gaps and priorities that need to be addressed.

TD advised that this year's report, had been informed by families, children, and young people across Gwent, with the intention of producing a report written by those who had informed the report about their experiences. TD provided examples of the findings from the engagement and noted that individuals had shared their stories and experiences of living through and coming out of the Covid-19 pandemic. The Board noted that the report concludes with an open letter to all asking that their voices and instructions on how services could be better delivered were listened to and in turn would enable the outcomes for children and young people in Gwent to improve.

In particular the following was noted as key priorities:

- Vaccination and how children would be kept safe
- Challenging the word gap and the difference in language development across the population by area of deprivation
- Infant mortality
- Obesity and healthy weight and the influences of trauma on weight to remove the stigma associated with this.

TD noted that when engaging with older children it was identified that there was a need to better understand what a healthy relationship was and also the giving and hearing of consent. TD also noted that more work was required in order to address the following themes:

- teenage pregnancies were higher than the Welsh average
- Vape use.
- Children's perspective of safety and contextual safeguarding

TD reflected that all children and young people were very knowledgeable about climate change and the impact upon specific health conditions, such as asthma. In terms of next steps the Board were informed that further engagement with children and young people on the development a babies and children young people's strategy would take place.

The Board provided helpful feedback on the report and advocated that the report be shared with partners and wider groups through various fora.

The Board **NOTED** the report.

**ABUHB  
2703/16**

### **Cancer Services Annual Report 2023**

James Calvert, (JC), Medical Director, reminded the Board that within the Integrated Medium-Term Plan 2023-26, the Board had set out a priority to progress an action to maximise cancer outcomes for the population of Gwent . JC noted that whilst progress has been made in recent years, the Health Board was committed to accelerating the rate of improvement and that this year's annual report described the key achievements, challenges and progress over the past 12 months of a key strategic priority of the Health Board.

In particular the following points were noted:

- Public health plan had been developed to improve the updates in respect of cancer screening and addressing harmful behaviours
- Patient steering group had been established and was informing the design of cancer pathways
- Cancer self-optimisation tool was in use
- Integrated support workers to support patients through their treatment were in place
- Significant challenges for some cancer pathways and the requirement for cancer treatment to start within 62 days against a backdrop of increased cancer referrals
- Reduction in the backlog of patients on the single cancer pathway
- Corporate Cancer team had moved to core clinical services and this has eradicated urgent pathology waits.
- YYF Breast Unit has opened and the satellite radiotherapy unit at Nevill Hall was progressing well.

The Board **NOTED** the report and welcomed the update on work progressed to-date.

**ABUHB  
2703/17**

### **Quarter 3 - Performance and Outcomes Report**

Hannah Evans (HE), Director of Strategy, Planning and Partnerships provided the Board with a progress report against the Integrated Medium-Term Plan (IMTP) 2023/26. HE advised that the report summarised the progress during Quarter 3, through the following:

- Outcomes Framework through Life Course approach
- Clinical Futures Priority Programme progress
- Ministerial priorities progress
- A review of the planning scenario

In particular, the following points were noted:

- Improvement against the best start in life priority 1, particularly notable increase in breastfeeding uptake
- Cancer pathway improvements
- Good progress in eliminating waits over 156 weeks as of the of end January 2024, with 11 patients waiting for treatment compared to 500 at the same time last year

In terms of the challenges the following was noted:

- Waiting lists for planned care continue to grow in 3 speciality areas
- ND pathway for under 5-year-olds and a 600% increase of referrals in the past few years
- Adult Mental Health Service part 1a and 1b measures
- Urgent and Emergency Care System

In terms of broader performance the Board noted that:

- Endoscopy Unit has resulted improvements in cancer performance
- Bed reconfiguration implemented
- Establishment of the YF Breast Unit
- Phase 1 of Tredegar development had been completed with Phase 2 commenced
- Regional cataracts provision in place
- Launch of the joint strategic needs assessment
- Acute frailty model within urgent and emergency care progressed

Nicola Prygodzicz (NP), Chief Executive, advised that despite work being undertaken across the CAMHS service there remained specific challenges around part A and noted that a proposal to address this was being developed for the ND pathway. The Chair requested that an update be provided to a future Board on the ND action plan.

**Action Chief Operating Officer to provide an update on the ND Action plan at a future Board meeting.**

The Board **NOTED** the report and the performance position across the IMTP.

Jennifer Winslade (JW), Director of Nursing, provided the Board with a progress report during Quarter 3. JW advised that public and transparent reporting was a key consideration and a quality outcomes framework had been developed and would be shared with Improvement Cymru.

JW advised that areas of escalation for the Mental Health & LD Division and the Urgent Care Division had been included and noted that in respect of the Mental Health & LD Division, whilst the completion of the 30-60-90 day action plan was complete further work was required to embed actions within sustained working practices.

The Chair expressed concern around the increase of violence and aggression against staff and noted the work that had been ongoing including the need for mandatory training to be prescribed from April. Peter Carr, Director of Therapies and Health Sciences, advised that from a staff viewpoint there was an improved understanding that such incidents were taken seriously and would be a key focus for the future.

The Board **NOTED** the report.

**ABUHB  
2703/19**

#### **Finance Performance Report – Month 10, 2023/24**

Rob Holcombe (RH), Director of Finance and Procurement, presented the paper outlining the financial performance at the end of January 2024. (Month 10)

RH noted the following:

- Deficit of £48.2 m which was an improvement to the forecast of £52.9 m as at month 10
- Capital budget was breakeven
- Public sector performance was above minimum level of 95%
- Assumptions included :
  - £88m would be retained and includes the conditional funding assumptions
  - Full funding of pay awards
- An improvement in the level of deficit since month 9 that resulted in an overall reduction of £3.5m to the deficit.

In terms of month 11, RH provided a verbal update and advised that additional funding had been received from Welsh Government that had reduced the deficit to £49m.

The Board **NOTED** the Month 10 Financial Performance.

<p><b>ABUHB 2703/20</b></p>	<p><b>Decarbonisation Update</b></p> <p>Rob Holcombe (RH), Director of Finance and Procurement, presented the report that provided an update on the Decarbonisation Programme, including progress against the Decarbonisation Action Plan and progress made in achieving the National Programme goal of Net Zero emissions by 2050 and for the public sector to be Net Zero by 2030 .</p> <p>The Board <b>NOTED</b> the progress update.</p>
<p><b>ABUHB 2703/21</b></p>	<p><b>Strategic Risk Report, March 2024</b></p> <p>Nicola Prygodzicz (NP), Chief Executive, presented the report which provided an assessment of strategic risks associated with achieving the Board's strategic priorities for assurance. The Board noted that two risks had been deescalated in the period and would be managed at a divisional level, with a further two risk scores being reduced but maintained on the corporate risk register. The Board noted that new strategic risks had been introduced on the corporate register in respect of performance and financial planning.</p> <p>The Board <b>NOTED</b> the Strategic Risk Report for March 2024.</p>
<p><b>ABUHB 2703/22</b></p>	<p><b>Strategic Partnership Updates: -</b></p> <p><b>a. Public Services Board</b></p> <p>Tracy Daszkiewicz (TD), Director of Public Health, provided a verbal update on the Public Service Board activities. TD advised that a learning event had been held last month and that the Health Board was the only representative from the Gwent PSB. The Board advised that discussions continue regarding achieving cohesion across the strategic partners to better serve the population.</p> <p>The Board <b>NOTED</b> the update.</p> <p><b>b. Regional Partnership Board</b></p> <p>Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided a verbal update on Regional Partnership Board activities with the latest meeting being held on 19<sup>th</sup> March 2024. HE advised that the RPB had received a detailed update on the governance review and that further work was to be completed in determining priorities and how strategically these matters were progressed. From the data it was noted that the following themes were emerging; prevention, longer term, early years and citizen needs.</p>

	<p>The Board noted the utilisation of the RIF had been discussed and that tapering wouldn't be applied until 2027 and that the RPB had endorsed a staged evaluation approach. HE advised that there was a small element of RIF funding that had not been deployed and the Children's Partnership would address this.</p> <p>The Board <b>NOTED</b> the update.</p>
<p><b>ABUHB 2703/23</b></p>	<p><b>Executive Committee Chair's report</b></p> <p>Nicola Prygodzicz (NP), Chief Executive, presented an overview of a range of issues discussed by the Executive Committee at meetings held between 18<sup>th</sup> January 2024 – 15<sup>th</sup> March 2024. From the report the Board attention was drawn to the following areas:</p> <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• CAhMS / ND additional capacity</li> <li>• MS Business case to be considered at a future board</li> <li>• Maternity and neonatal services</li> <li>• Cardio vascular prevention programme being developed</li> <li>• Electronic prescribing medicines programme</li> </ul> <p>The Board <b>NOTED</b> the report.</p>
<p><b>ABUHB 2703/24</b></p>	<p><b>Key Matters from Committees of the Board</b></p> <p>The Board <b>RECEIVED</b> Assurance Reports from the following Committees:</p> <ul style="list-style-type: none"> <li>• Charitable Funds Committee- 22<sup>nd</sup> January 2024</li> <li>• Partnerships, Population Health and Planning Committee – 31st January 2024</li> <li>• Audit, Risk and Assurance Committee – 8th February 2024</li> <li>• Mental Health Act Monitoring Committee -21st February 2024</li> <li>• People and Culture Committee – 22nd February 2024</li> <li>• Patient Quality, Safety and Outcomes Committee – 23<sup>rd</sup> February 2024</li> <li>• Shared Services Partnership Committee: 18<sup>th</sup> January 2024.</li> </ul>
<p><b>ABUHB 2703/25</b></p>	<p><b>An overview of Joint Committee Activity</b></p> <p>Nicola Prygodzicz (NP), Chief Executive, provided an update on the issues discussed and agreed at recent meetings of Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC), as joint committees of the Board.</p>

NP advised of the WHSCC cost pressures and that further work was ongoing as to how costs could be further reduced given the financial context

In terms of EASC, NP advised of the work in respect of the EMRTS service and noted that at present there was an unmet need in Wales and the current base configuration for the service did not meet demand. NP provided an overview of the matter and the three phases of engagement. The Board noted that Llais had raised concerns in relation to the engagement approach and that strong representations had been made by a range of stakeholders including the Powys community. NP advised that discussions continue with a view to reaching a decision by the end of April, noting that the decision would need to be agreed by the Joint Committee and individual Health Boards. NP noted that an extra ordinary meeting may be required prior to the end of April to receive the outcome of the consultation.

In response to a question, clarification was sought on the thrombectomy rate and was advised that the rate across Wales was low and the aspiration was for a more sustainable plan with discussions continuing regarding Cardiff & Vale UHB becoming a thrombectomy centre for South Wales.

The Board **NOTED** the report.

**ABUHB**  
**2703/26**

**Date of the Next Meeting:**

- Wednesday 22<sup>nd</sup> May 2024

**CYFARFOD BWRDD IECHYD PRIFYSGOL  
ANEURIN BEVAN  
ANEURIN BEVAN UNIVERSITY HEALTH BOARD  
MEETING**

**AGENDA**

<b>Date and Time</b>	<b>Wednesday 10<sup>th</sup> April at 2.30pm</b>	
<b>Venue</b>	<b>Conference Centre, Headquarters, St Cadoc's Hospital</b>	
<b>PRESENT</b>	<p>Ann Lloyd Nicola Prygodzicz James Calvert Peter Carr</p> <p>Sarah Simmonds Jennifer Winslade Hannah Evans</p> <p>Robert Holcombe Paul Solloway Leanne Watkins Paul Deneen Dafydd Vaughan Philip Robson Prof Helen Sweetland Penny Jones Louise Wright Richard Clark</p>	<p>Chair Chief Executive Medical Director Director of Therapies and Health Science Director of Workforce and OD Director of Nursing Director of Strategy, Planning and Partnerships Director of Finance &amp; Procurement Director of Digital Chief Operating Officer Independent Member (Community) Independent Member (Digital) Special Advisor to the Board Independent Member (University)</p> <p>Independent Member (Community) Independent Member (Trade Union) Independent Member (Community)</p>
<b>ALSO IN ATTENDANCE</b>	<p>Rani Dash Michelle Jones Jemma Morgan Fern Cook</p>	<p>Director of Corporate Governance Head of Board Business Llais Governance Support Officer</p>
<b>APOLOGIES</b>	<p>Pippa Britton Martin Blakebrough Iwan Jones Stephen Harry</p>	<p>Independent Member (Third Sector) Independent Member (Community) Independent Member (Finance) Chief Ambulance Services Commissioner</p>

<b>ABUHB 1004/01</b>	<p><b>Welcome and Introductions</b></p> <p>The Chair welcomed members to the extraordinary meeting, in particular members of the public who were able to join the meeting to observe in person and online. It was noted that the meeting would be recorded and published on the Health Board’s website following the meeting. The Chair welcomed Ross Whitehead, (RW) Deputy Chief Ambulance Services Commissioner to the meeting.</p>
<b>ABUHB 1004/02</b>	<p><b>Declarations of Interest for Noting</b></p> <p>There were no declarations for noting.</p>
<b>ABUHB 1004/03</b>	<p><b>Emergency Medical Retrieval and Transfer Service (EMRTS)</b></p> <p>The Chair noted that the NHS Wales Joint Commissioning Committee (JCC) had requested that each Health Board meet to consider the proposals contained within the paper that had been developed and to provide advice and an outcome of the decision, prior to the JCC meeting scheduled for 23<sup>rd</sup> April 2024 at which the proposal would be determined.</p> <p>Nicola Prygodzicz (NP), Chief Executive, advised that a substantial amount of work had been completed on this matter, with considerable discussion and welcomed the local consideration as to how the proposals would impact upon ABUHB’s population.</p> <p>Ross Whitehead (RW), Deputy Chief Ambulance Services Commissioner, provided an overview of the paper and noted that in autumn 2022 following receipt of a proposal from EMRTS, the Emergency Ambulance Services Committee (EASC) asked the Chief Ambulance Commissioner to undertake a wider review of the EMRTS Service. The Board was advised that EMRTS provides specialised pre-hospital critical care in Wales, in partnership with the Wales Air Ambulance Charity, that provide 2/3<sup>rds</sup> of funding for the service. RW advised that the purpose of the review was to explore the following four broad areas:</p>

- Unmet need - Across Wales, the Board noted that 2 -3 patients a day across Wales cannot access the service, this was mainly at night and that within the ABUHB boundary this equated to 15%.
- Utilisation of the various bases and assets. - The Board noted a significant variation across bases Wales, with bases in South Wales being utilised far more than those in Mid / North Wales bases.
- Equity of Geographical coverage. The Board noted that there was one asset based in Cardiff that covers the whole of Wales. The Board was advised that the findings identified that by air, there was a significant difference in respect of timely coverage in the north.
- Rapid Response Vehicles: The Board noted significant variation in use. The Board was advised that this was being driven by the closeness of bases to population density.

RW advised that alongside the review a period of engagement took place, utilising a range of approaches and feedback mechanisms, that included engagement with Llais. The Board noted that during Phase 3, the final phase of engagement, 5 online responses from residents of ABUHB were received and this represented circa 1% of the overall feedback received.

The Board noted that the outcome of the review was submitted to EASC in March 2024, that built upon the reports that had been submitted during the period of the review. The final report provided a structured evaluation of the Emergency Medical Retrieval and Transfer Service (EMRTS) within Wales, and outlined the process and methodology used to review the service. In conclusion the report identified four recommendations. RW advised that recommendations 1 to 3 focussed upon the consolidation of the Caernarfon and Welshpool bases into a central location close to the A55, with recommendation 4 focussing upon the development of a bespoke road based enhanced and/or critical care services in rural and remote areas. The Board noted that this was in response to the concerns raised during the engagement around the provision of services. RW noted that, if agreed, a Task and Finish group would be established with a view to report on this recommendation, in September 2024. In conclusion the Board was advised that within the ABUHB geographical area the modelling of the reconfigured service suggested that there would be an improvement in better meeting the level of unmet needs and an improvement in the average response time.

NP reflected that the clarification in respect of the impact upon unmet need and response time was beneficial in terms of ABUHB population and all other Health Board areas in Wales.

Hannah Evans (HE), Director of Strategy, Planning and Partnerships acknowledged that there hadn't been a significant response from the population, notwithstanding the robust communication that had been shared by the Health Board to engage the population and to provide opportunities for feedback.

NP advised that it was clear that benefits existed for ABUHB's population and that clinicians from within ABUHB that support the EMRTS service had verified this. RW advised of the wider perspective and the impact on other health boards and noted that the timing and alignment of recommendation 4 was key.

Jemma Morgan (JM), Regional Director, advised the Board that service development to meet unmet needs must be the primary goal. In terms of engagement, the feedback from the population was clear. JW advised that whilst ABUHB response rate was low, from a national viewpoint the Welshpool/ North Wales population was not assured that enough detail had been provided as to how the proposal affects those communities. JM confirmed that Llais remained unclear as to the rationale for the need for an urgent decision to be made and suggested that the work of the Task and Finish group be progressed, prior to the decision on the other three recommendations being made. JM advised that this would provide the public and Llais with greater assurance.

The Chair sought clarification of the services that would be provided in the more rural areas that would benefit from an EMRTS service and asked whether any diminishment would occur. RW advised that in respect of the areas of Powys and North Wales there would be an overall reduction in unmet need and a reduction in response times and reassured the Board that those services in place now would continue and concluded that overall, the model suggested an overall improvement in provision across all areas in Wales, but not an eradication of unmet need. RW noted that this proposal would not be final development of the service as work would continue to further reduce the level of unmet need.

Sarah Simmonds, (SS), Director of Workforce and OD, sought clarification as to whether changing the location of bases in the north would in turn impact the availability of current staff and impact the 24-7 service. RW advised that there was a mixed picture amongst staff from both affected bases and advised that the EMRTS operational team had provided assurance as to their ability to staff the services. RW

	<p>reflected that Recommendation 4 provided further opportunities for staff.</p> <p>The Chair asked the Board to consider the recommendations as described on the basis that the proposal identifies an improvement of unmet need, with no diminishment of services in rural areas and that the essential work in respect of the bespoke proposal for cover of road services would proceed at pace, with an outcome to be reported upon no later than September 2024</p> <p>The Board <b>AGREED</b> the four recommendations and urged the JCC to progress the work required in respect of recommendation 4 with a view to reporting back to Health Boards in September 2024.</p>
<b>ABUHB 1004/26</b>	<b>Date of the Next Meeting:</b> <ul style="list-style-type: none"><li>• Wednesday 22<sup>nd</sup> May 2024</li></ul>



<b>Outstanding</b>	<b>In Progress</b>	<b>Not Due</b>	<b>Completed</b>	<b>Transferred to another Committee</b>
--------------------	--------------------	----------------	------------------	---

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
24th January 2024	<b>ABUHB 2401/12.2</b>	<b>St Woolos Hospital Consolidation</b>  The Chair requested that an overview of the impact of Patient Safety events, be presented to the Board.	Director of Nursing	March 2024	<b>Complete</b>  <u>May 2024:</u> A report on the Six Goals Programme, including an update on Patient Safety Events, is included on the Board's agenda at item 4.4
24th January 2024	<b>ABUHB 2401/17-</b>	<b>All Wales Individual Patient Funding Request (IPFR) Policy</b>  The Chair requested a report on Individual Patient Funding Requests, including numbers and outcomes, to be presented to a future meeting.	Medical Director	May 2024	<b>Complete</b>  <u>May 2024:</u> A report on IPFR, is included on the Board's agenda at item 4.9
27 <sup>h</sup> March 2024	<b>ABUHB 2703/12</b>	<b>Strategic Equality Plan</b>  To explore the use of volunteers in better managing access considerations across Health Board sites	Director of Workforce and OD & Director of Nursing	May 2024	<b>Complete</b>  <u>May 2024:</u>  Patient Quality, Safety & Outcomes Committee will receive the Volunteering

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					<p>Annual report at the June meeting.</p> <p>Volunteers have a real impact within our hospitals, enhancing the care we provide and the overall hospital experience for our patients as well as playing an important role in supporting our staff.</p> <p>The Health Board continues to develop and grow the contribution of volunteers across sites.</p> <p>A 'Meet and Greet' service, delivered by the Ffrind i Mi, League of Friends and Age Cymru Gwent Robin Service, is currently available at Ysbyty Ystrad Fawr, Nevill Hall Hospital and Royal Gwent Hospital.</p> <p>Meet and Greet Volunteers welcome outpatients and visitors to the hospital and</p>

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					<p>help them to find their way around.</p> <p>All Health Board Volunteers undertake Equality, Diversity and Inclusion and Welsh Language Awareness Training during their induction to ensure that they are aware of the Health Board's obligations under the Equality Act 2010 and the Welsh Language Standards. In addition, bespoke Visual Impairment Awareness Training is being delivered to Volunteers by the Health Board's Disability Inclusion Officer to raise awareness of how to support a person with a visual impairment, reasonable adjustments to ensure you comply with The Equality Act 2010 and sighted guiding principles.</p>

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					<p>The Health Board's Patient Experience and Involvement and Equality, Diversity and Inclusion Teams continue to work collaboratively to support Health Board services in meeting the accessibility needs of patients and the public across sites. Volunteers have been instrumental in supporting referrals made into the Equality, Diversity and Inclusion Team regarding the accessibility needs of patients on wards.</p>
27 <sup>h</sup> March 2024	<b>ABUHB 2703/13</b>	<p><b>Major Incident Plan</b></p> <p>Plan to be updated to include comments made at the Board meeting held on 27<sup>th</sup> March 2024.</p>	Director of Strategy, Planning and Partnerships	April 2024	<p><b>Completed</b></p> <p><u>May 2023:</u> Major Incident Plan has been updated to incorporate the comments from the Board and has been published on the Health Boards intranet</p>

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
27 <sup>h</sup> March 2024	<b>ABUHB 2703/17</b>	<p><b>Quarter 3 - Performance and Outcomes Report</b></p> <p>Update on the CAMHS/ND Action plan to be provided at a future Board meeting.</p>	Chief Operating Officer	July 2024	<b>Not Yet Due</b>

*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**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	<b>Governance Matters: Report on Sealed Documents and Chair’s Actions</b>
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Rani Dash, Director of Corporate Governance
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Michelle Jones, Head of Board Business

**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 the 5<sup>th</sup> March 2024 and 30<sup>th</sup> April 2024.

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 between the 5<sup>th</sup> March 2024 and 30<sup>th</sup> April 2024, there were four (4) 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 5<sup>th</sup> March 2024 and 30<sup>th</sup> April 2024, as outlined below.

<b>Date</b>	<b>Title</b>
11.03.24	Contract signature for Bettws Ward Refurbishment for new CAMHS (Child and Adolescent Mental Health Services) Sanctuary Hub between Aneurin Bevan University Health Board and The Joint Contracts Tribunal Ltd (JCT) located at St Cadoc's Hospital and consisting of several group rooms and two sanctuary spaces for CAHMS patients.
14.03.24	Deed of surrender relating to the Day Surgery and Endoscopy Unit at Nevill Hall Hospital, Brecon Road, Abergavenny between Aneurin Bevan University Health Board and Abergavenny Facilities Ltd.
10.04.24	Delivery Agreement between Aneurin Bevan University Health Board and Morgan Sindall Construction and Infrastructure Ltd for works and services of construction of a new build extension with the remodelling of existing emergency department entrance and waiting area.

### 3.2 Chair's Action

The Chair's Actions approved between 5<sup>th</sup> March 2024 and 30<sup>th</sup> April 2024 are provided below:

Date	Title
11.03.24	To award a contract extension for the provision equipment to support a Network Edge Refresh for the period 1 <sup>st</sup> March 2024 to 31 <sup>st</sup> March 2024 to a value of £600,000 including VAT
11.03.24	To award a contract for the provision of Molecular testing for Sexual Health (Chlamydia) for the period 1 <sup>st</sup> May 2024 to 30 <sup>th</sup> April 2029 (with 1+1year optional extension) to a value of £1,412,526.83.
16.04.24	To award a contract for the replacement of the robotic dispensing system within the pharmacy at Royal Gwent Hospital to a value of £ 1,124,434 – The Board had previously agreed funding of £709,406 for this case and so the Chair's action agreed the additional requirements of £415,028 resulting in an overall contract value of £1,124,434.
23.04.24	To award a contract for the provision of Picture Archiving Communication System (PACS) for the period 2012-2019 to a value of £2,489,217.84 ex VAT

#### Asesiad / Assessment

In endorsing this report the Health Board will comply with its own Standing Orders.

#### Argymhelliad / Recommendation

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  <a href="#">Link to IMTP</a>	Choose an item.  Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	Choose an item. Choose an item. Choose an item. Choose an item.  Not applicable to this report

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper</b> <b>No does not meet requirements</b>
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>	Choose an item. Choose an item.  Not applicable to this report

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



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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Big Conversation (Bereavement) Evaluation Report
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Jennifer Winslade, Executive Director of Nursing
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Tanya Strange, Head of Nursing, Patient Experience and Involvement

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

<b>ADRODDIAD SCAA SBAR REPORT</b>
<p><u>Sefyllfa / Situation</u></p> <p>The National Bereavement Framework for Wales aims to ensure that people who are bereaved are treated with compassion, that their needs and grief reactions are recognised, that there is appropriate and timely support when people need it and that people with protected characteristics can access information and support that meets their needs.</p> <p>The Bereavement Standards define the responsibilities of Health Boards and Commissioned Services and there is a requirement to report progress against the Standards to Welsh Government. Aneurin Bevan University Health Board needs to ensure that it develops an accessible bereavement service in partnership with our population and stakeholders. The model must consider and embed the Standards.</p> <p>The Board is asked to RECEIVE the Big Conversation Evaluation Report and DISCUSS progress and potential implications for organisational/regional implementation.</p>
<p><u>Cefndir / Background</u></p>

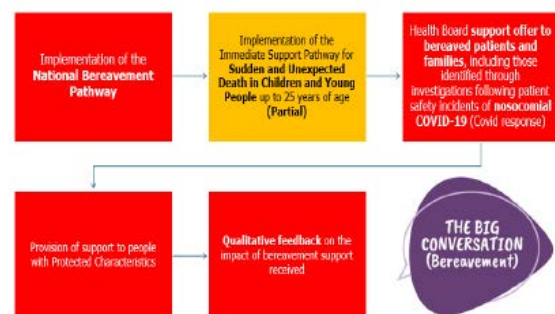
The Aneurin Bevan University Health Board has an established End of Life Care (EoLC) Board. Implementation of the Bereavement Standards for Wales is now integral to the EoLC work programme and is also included in the work programme of the Six Goals for Urgent Care. The Executive Director of Nursing is the Executive Lead for Bereavement, the Assistant Medical Director is Clinical Lead, the Head of Nursing for Patient Experience and Involvement is the Strategic Lead, and the Clinical Lead Nurse for Bereavement is the Operational Lead. Progress against the Bereavement Standards is reported through the EoLC Board, 6 Goals for Urgent Care Board, Executive Committee, Patient Quality, Safety and Outcomes Committee and Board.

The National Bereavement Standards for Wales had not been robustly considered prior to alignment with the End-of-Life Care Board. The needs of bereaved people had not been heard and the support available had not been scoped. The Big Conversation (Bereavement) brought together people who had been bereaved, families, staff, charities, public and voluntary sector, care homes, policy leads etc and provided an opportunity to both raise awareness of the Standards and listen to the experiences of those bereaved and those offering bereavement support. People's feedback will inform a co-produced bereavement model.

## Asesiad / Assessment

### Bereavement Pathway Implementation

The immediate support pathway for sudden and unexpected death in children and young people up to 25 years old, is being partially met by Aneurin Bevan University Health Board. The remaining 4 aspects of the National Bereavement Pathway, whilst work is progressing, are unmet.



### The Big Conversation Event

To develop a new bereavement model and better understand what our local bereavement offer should look like, it was agreed that the Health Board and our partners should reach out to our population through a Big Conversation. 170 people attended the event on 20<sup>th</sup> March. The morning session consisted of several presentations themed around the Standards. The afternoon session consisted of 9 topic specific round table discussions with feedback from each discussion being 'fed' into the big conversation. Facilitators supported group discussions on people's bereavement experience, how they were supported, what would have made a difference and what they wanted to see in the bereavement model.

### Overall Evaluation

Feedback received was overwhelmingly positive with many people stating that these conversations should be ongoing, not just locally but across Wales. People were empowered to talk about their experiences openly and they felt heard. For some, the event helped people recognise that they were 'not alone'. Despite their

personal experiences of loss and the limited support they received at the time, many people expressed an interest in working with us to develop a co-produced and informed model of bereavement support. 50 attendees have indicated that they wish to join our bereavement collaborative.

## Themes for Consideration

The Big Conversation Evaluation Report outlines the themes from each of the round table discussions and indicate what people wish to see in the new bereavement model. In summary:

- There needs to be greater awareness of **Advance and Future Care Planning** (AFCP), to empower the person who has a life limiting condition and to help prepare families for loss. An AFCP public awareness campaign is needed.
- AFCP for people of all **cultures and religious** beliefs should be informed by needs. One size does not fit all.
- More needs to be done around **anticipatory grief** to prepare people for loss.
- There needs to be **recognition of baby loss under 20 weeks**. There is currently national consideration of this.
- People do not want to be 'signposted' to a website. More **face to face or telephone contact is needed** and people should be asked when they wish to be contacted.
- Peer led **support groups** throughout communities would enable people to access informal support. These should be run by people who have been bereaved and those who support bereaved people.
- Support for families who have been **bereaved by suicide** needs to be enhanced. Short term funding compounds sustainability. An all age model is needed.
- Support for families impacted by **sudden loss** and **child loss** needs dedicated resource and improved staff training. A national pathway for people who have lost children and young people is under consideration.
- Bereavement experiences of women who lose babies **after 20 weeks** differs significantly to baby loss **under 20 weeks**. Service protocols in maternity and gynaecology services for such occurrences need to be reviewed to ensure an improvement in loss and bereavement.
- More support is needed for people whose loved ones pass away in the **community**. There are inequities in contact when people die outside of a hospital environment.
- **Staff training** needs to be focussed on all aspects of the bereavement pathway, not least for staff to be able to recognise that someone is at risk of bereavement and how to communicate compassionately.
- There is a need to recognising the changing landscape of **religion** and the provision of both secular and non-secular support needs closer consideration.
- Targeted conversations with people and communities with **protected characteristics** need to take place to better understand needs and access/barriers to bereavement support.
- Dedicated **family rooms** should be available in all hospitals both for when people are at end of life and following bereavement.
- Consideration of the terminology '**Care After Death**' is needed as a number of people find this title 'horrendous'.

- The process of obtaining **death certificates** needs to be 'speeded up' as people wait too long. The Medical Examiner changes may positively impact this.
- The bereavement model must be framed with **cultural competency** underpinning the model from the outset.
- **Single point of contact** for End of Life and bereavement support would help care navigation.
- **More conversations** are needed at local level. Events planned across all 5 boroughs.

## GRACE Bereavement Model



Attendees were asked to comment on the 'Grace' bereavement branding. Grief, respect, advice, compassion and empathy will be overarching principles within the model, supporting the Health Board's Values and Behaviours Model. Feedback indicated that the principles of Grace were fully supported, although the draft logo needed to change as it was viewed as too spiritual. A new logo has been agreed.

## Risk Assessment

### • Staffing

The Health Board has employed a Clinical Lead Nurse for bereavement within the Patient Experience and Involvement Team. The team also has access to 1 day a week of a clinical skills trainer to support our End-of-Life Companion training. The implementation programme for bereavement is significant. A funding proposal for a dedicated PALS officer for bereavement, Volunteer Co-ordinator and additional resource for training and extension of the End-of-Life Care Companion model through Further Faster funding has not been fruitful. This will impact on the organisations ability to embed a 'keeping in touch' model of support.

Despite bereavement being separated from the Care After Death provision, no identified resource could be redeployed to support the bereavement agenda. The PALS team are now proactively supporting a number of bereaved relatives.

### • Training

The Bereavement Lead nurse has undertaken a Bereaved by Suicide 'Train the trainer' programme. There is a need to scope, develop and deliver a suite of staff training to support compassionate communication, anticipatory loss, AACP, End of Life Care and bereavement. This is being considered through the education workstream of the End-of-Life Care work programme. Commissioned training is expensive. To develop structured education across the organisation and region will take time and will need to be supported by appropriate trainer resource.

### • Bereavement Experience

The new bereavement model and support required to improve people's bereavement experience must be informed by the NICE 3 Component model of support (universal, selected and indicated). There is a need to review our organisational bereavement offer and the offer from commissioned services to ensure that support is accessible and equitable based on people's grief experience. There is a requirement that Health Boards survey bereaved people. A bereavement survey is being developed and this will be accessible through CIVICA, PALS and in written format.

- **Financial**

The new bereavement model will require an equality and financial impact assessment.

Representation has been made to Charitable Funds to determine whether there is any funding that would enable the increase the Clinical Skills Trainer post to two days a week. This would allow the trainer to train Companions and other staff to support our organisational bereavement offer. This is being considered. There is also a need to secure funding to support the wider bereavement agenda including training, memory boxes, and specialist grief support (e.g. indicative counselling for those bereaved by suicide). A review of all commissioned services needs to be undertaken to ensure value for money, avoidance of duplication and gap analysis.

**Argymhelliad / Recommendation**

The Board is asked to RECEIVE the Big Conversation Evaluation Report and DISCUSS progress and potential implications for organisational/regional implementation.

<b>Amcanion: (rhaid cwblhau) Objectives: (must be completed)</b>	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	5.1 Timely Access 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 5.1 Timely Access
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	Dying Well as part of life Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	<p>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</p> <p>Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers</p> <p>Improve the access, experience and outcomes of those who require mental health and learning disability services</p> <p>Improve the wellbeing and engagement of our staff</p>
---	--

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	National Bereavement Pathway for Wales
Rhestr Termau: Glossary of Terms:	Within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	End of Life Care Board Quality and Patient Safety Operational Group

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Resource Assessment:</b>	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:
• <b>Workforce</b>	Yes, outlined within the paper
• <b>Service Activity &amp; Performance</b>	Yes, outlined within the paper
• <b>Financial</b>	Yes, outlined within the paper
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<p><b>Yes not yet available</b></p> <p>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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>

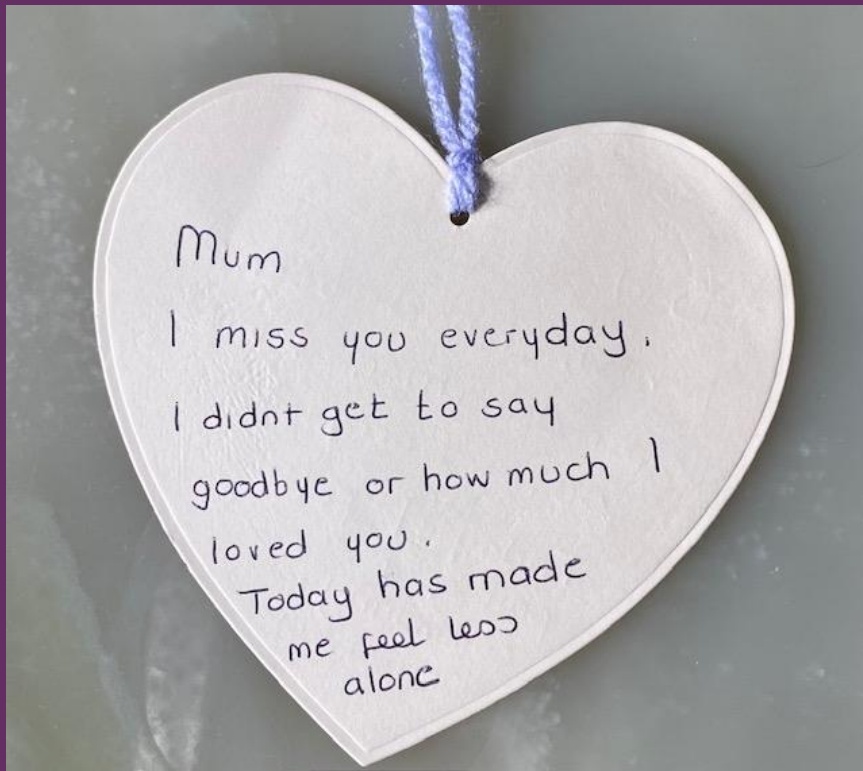
**Deddf Llesiant  
Cenedlaethau'r Dyfodol – 5  
ffordd o weithio  
Well Being of Future  
Generations Act – 5 ways  
of working**

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

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  
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



Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board



# 20<sup>TH</sup> MARCH 2024 Evaluation Report

# Introduction

The Aneurin Bevan University Health Board has an established **End of Life Care** (EoLC) Board. Bereavement is integral to the EoLC work programme and is also included on the work programme of The 6 Goals for Urgent Care. Senior level oversight has been identified:

- **The Executive Director of Nursing** is the Executive Lead for Bereavement.
- The **Assistant Medical Director** is Clinical Lead.
- The **Head of Nursing** for Patient Experience and Involvement is the Strategic Lead.
- The **Clinical Lead Nurse** for Bereavement is the Operational Lead.

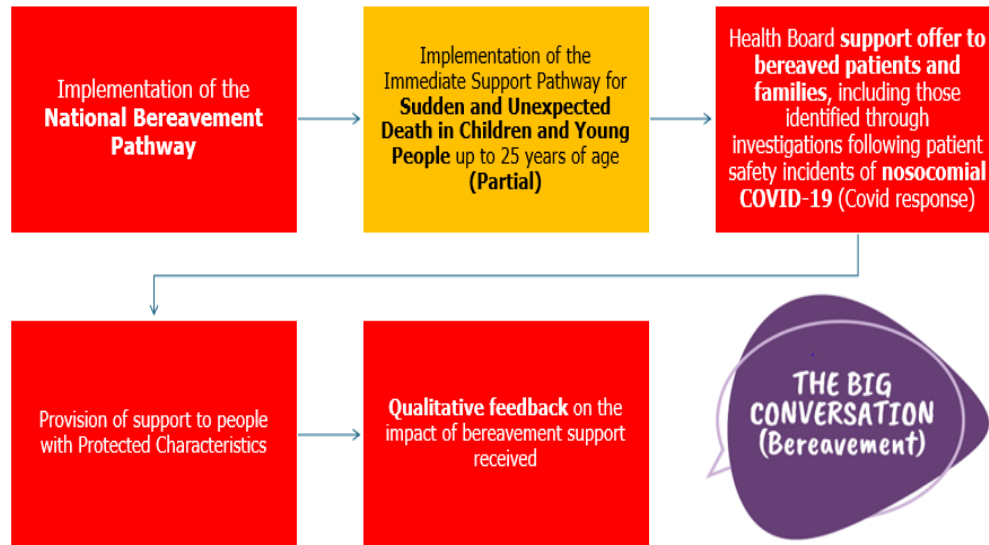
Progress against the Bereavement Standards is reported through the EoLC Board, 6 Goals for Urgent Care Board, Executive Committee, Quality and Patient Safety Committee and Board.

The National Bereavement Framework states that:

- People who are bereaved will be treated with **compassion**, empathy, and kindness, have their wishes, choices and beliefs listened to, considered and respected by all (including pre-bereavement).
- Their needs and grief reactions are **recognised and acknowledged** as being different at different times, (e.g. the need for practical help and/or emotional support).
- There is help to know where to turn for **additional support** when it is needed, this should be available for bereaved people affected by any cause of death, at a time and place when they can access it easily.
- The needs of bereaved people **with protected characteristics** (Equality Act 2010) are recognized.

These key standards will be integral to our local bereavement model.

# NATIONAL BEREAVEMENT STANDARDS: OUR POSITION



The immediate support pathway for sudden and unexpected death in children and young people up to 25 years old, is being **partially met** by Aneurin Bevan University Health Board. The remaining 4 aspects of the National Bereavement Pathway, whilst work is progressing, are **unmet**.

Through the **End-of-Life Care (EOLC) Board**, an action plan to direct the work needed to implement the standards is being monitored. The **Big Conversation** event will enable the Health Board and our partners to understand people's experience, determine what would have helped, prioritise actions and ensure our bereavement offer is improved.

## Attendee Feedback on the Big Conversation:

*" I found today so very useful. Timely too, having lost my son in ICU in December. I am very grateful for this day."*

# WHY 'THE BIG CONVERSATION: BEREAVEMENT?'

To develop a new bereavement model and better understand what our local bereavement offer should look like, it was agreed that the Health Board and our partners should reach out to our population through a Big Conversation.

This would help us to **better understand** their experiences of bereavement support, what 'good' looks like and what needs to change. The model would be **co-produced**, and people's feedback would be used to shape the model.

The **Big Conversation** held on 20<sup>th</sup> March 2024, was representative of bereaved people, those who support bereaved people, the wider public, partners and a range of interested stakeholders and organisations.





GUIDANCE

## National framework for the delivery of bereavement care

This framework supports those commissioning or providing bereavement services. This is to ensure that good quality services are available for those who need them.

First published: 28 October 2021  
Last updated: 28 October 2021

This document was downloaded from GOV.WALES and may not be the latest version.  
Go to <https://gov.wales/national-framework-delivery-bereavement-care.html> for the latest version.  
Get information on copyright.



# PLANNING

## Invitations:

Invitations to the Big Conversation were managed through **Eventbrite** with the option for people to secure a place by telephone or direct email. Consideration of people's specific **dietary requirements** and **accessibility** requirements, including access to an interpreter, were captured through the booking process. The event was publicised 6 weeks in advance of the day and 220 booked via Eventbrite.

## Information:

Attendees were sent the **National Bereavement Framework** prior to the event. An information leaflet with a QR code was provided to all attendees. Scanning the QR code took the reader direct to the Health Boards bereavement page where **information** on local and national bereavement support is available. Bereavement organisations attended and provided information stands on the day.

## Ramadan:

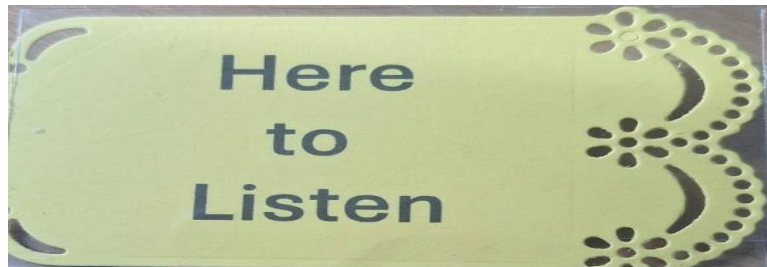
Being held on the 20<sup>th</sup> March, some of the attendees were observing Ramadan. **Two prayer rooms** for males and females were secured at the adjoining hotel. The Health Boards Imam, Farid Kahn, led the prayers.



## The Big Conversation: Bereavement

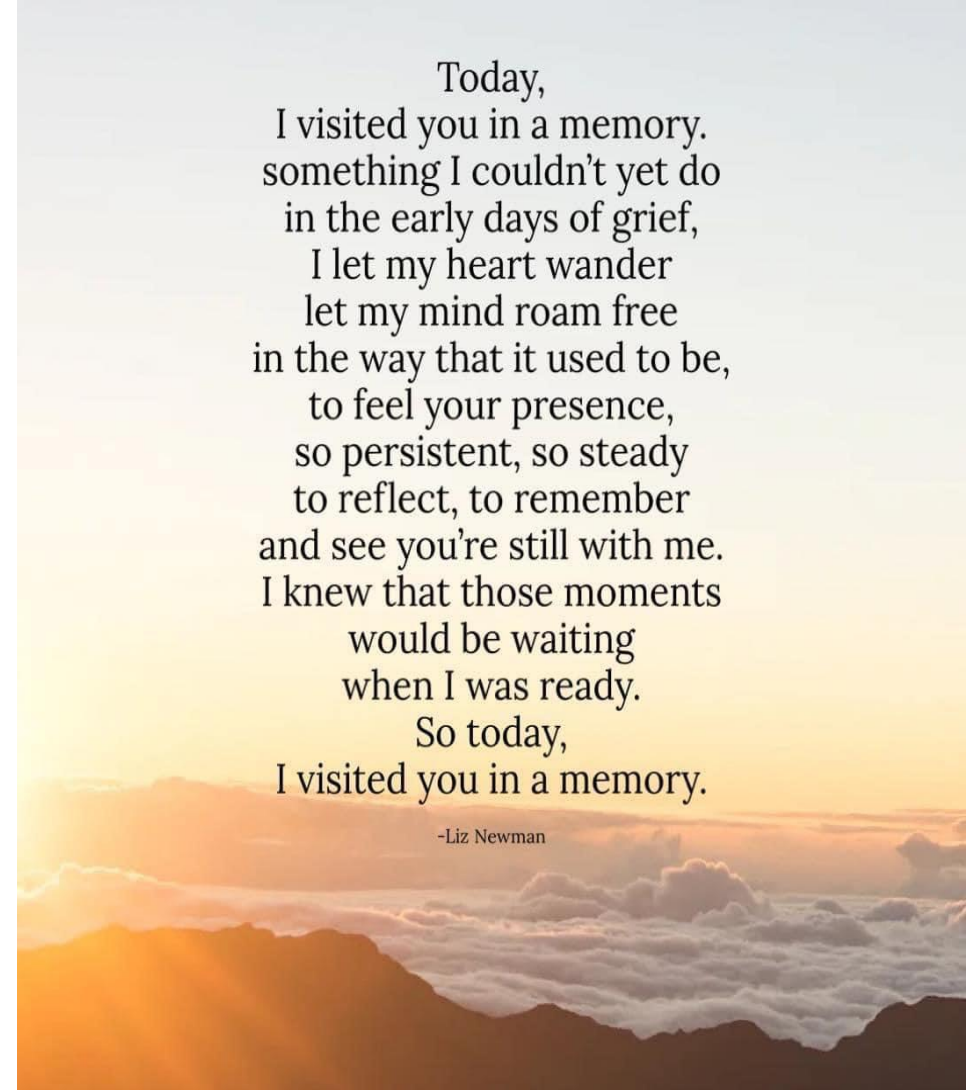
## Hear to Listen

Recognising that the day would be emotive, evoking many memories, 10 dedicated '**Hear to Listen**' staff from within and outside the organisation (who had expert experience in dealing with bereaved people and difficult conversations) were identified to support people on the day. These staff wore '*Hear to Listen*' badges and were identified at the start of the day.

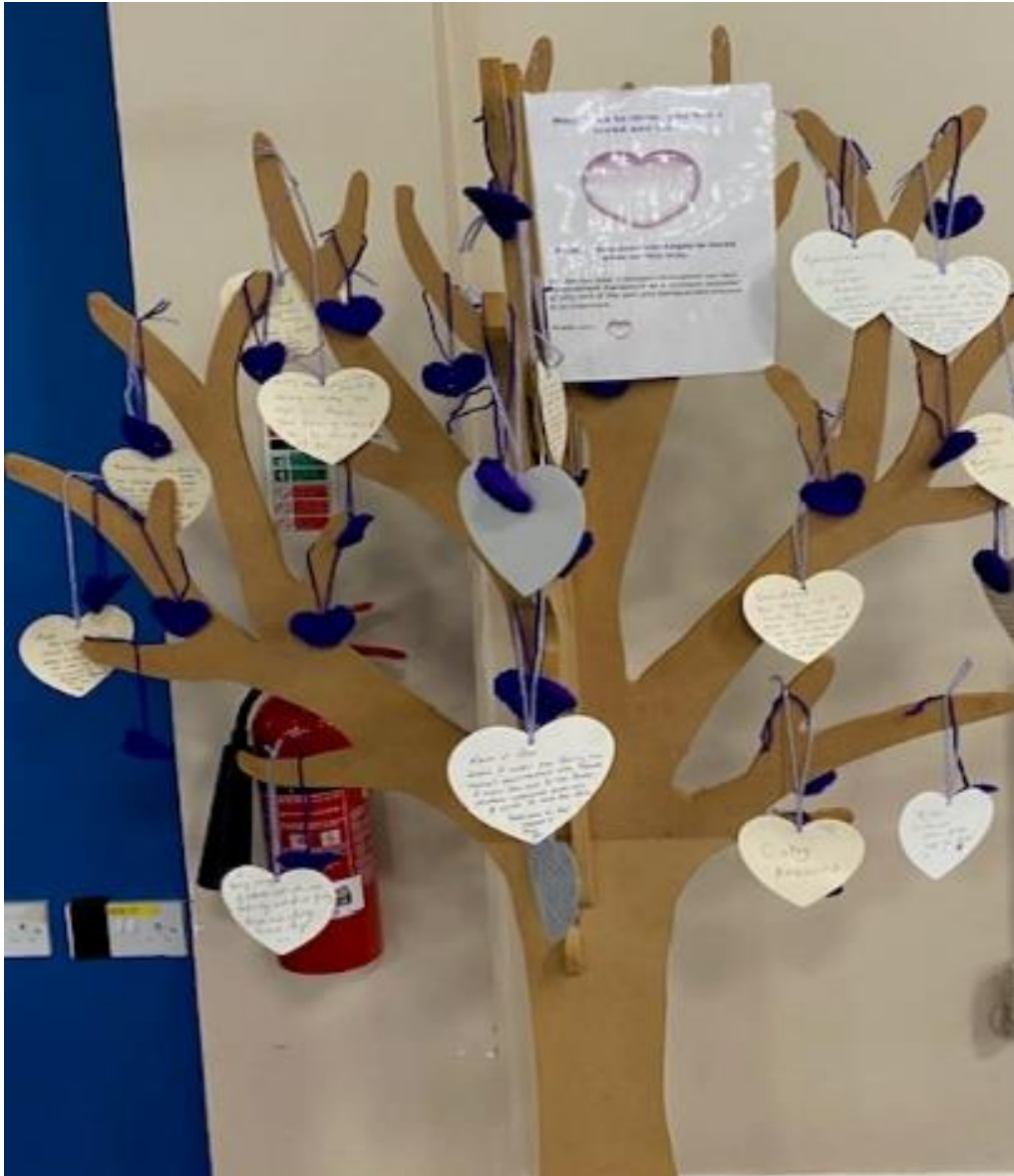


Today,  
I visited you in a memory.  
something I couldn't yet do  
in the early days of grief,  
I let my heart wander  
let my mind roam free  
in the way that it used to be,  
to feel your presence,  
so persistent, so steady  
to reflect, to remember  
and see you're still with me.  
I knew that those moments  
would be waiting  
when I was ready.  
So today,  
I visited you in a memory.

-Liz Newman



# MESSAGES TO LOVED ONES



**Peoples experience matters.** To ensure we are reminded of the reason for improving our bereavement offer, attendees were provided with a paper heart and asked, if they so wished, to write messages to loved ones they have lost and hang them on the **Trees of Hope**.

At the end of the Big Conversation, **51 messages** adorned the Trees of Hope.

These messages will be used within the new bereavement model as a constant reminder that **people's memories** and peoples experience matters.

## **Feedback from an attendee:**

*"I loved the remembrance tree where I left a memory for my brother. A lovely idea".*

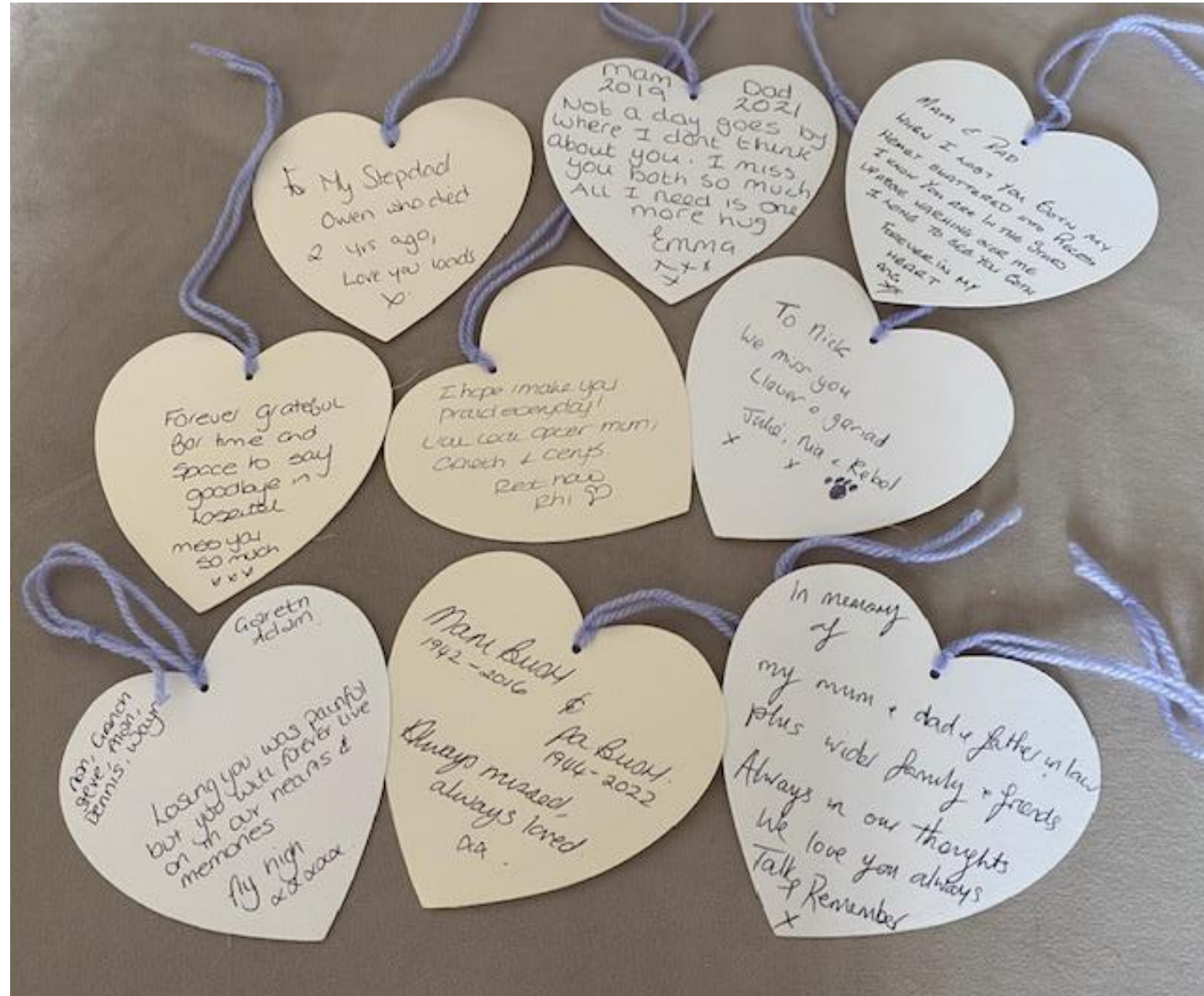
# MESSAGES TO LOVED ONES

"Personally, pre-death was not an option, actual death too quick and post-death is an eternal commitment to changing who I was to who I have become.

It is a dawn of realisation that the end of my relationship with my husband was the start of a whole new life. The 'who am I?' 'Where do I belong?'

The current bereavement model, processes and procedures experienced and seen so far, have not helped me or mine understand what happened".

**(Feedback from attendee at the Big Conversation 20.03.24)**



# ATTENDEES: 170 PEOPLE WITH REPRESENTATION FROM:

Members of the Public (including those bereaved)	Carers	NHS Staff Clinical and non-clinical	National Bereavement Lead	Government Policy Leads	Public Health Teams
Police	Voluntary Sector Staff and Organisations	Charities	Care Homes	Welsh Ambulance Service	Bereavement Support Staff
Diverse Cymru	Sight Cymru	Muslim Doctors Cymru	Religious Leaders	Equality Leads	Counsellors
Patient Advocacy	Llais	Funeral Directors	NHS Executive	Hospice of the Valleys	Cardiff University Health Board



## Morning Programme

9:00am	<b>Arrival, Registration and Refreshments</b>
9:25am	Chair's Welcome Carol Taplin, Specialist Chaplain, Aneurin Bevan University Health Board
9:30am	Opening Remarks Jenny Winslade, Executive Director of Nursing/Executive Lead for End-of-life Care and Bereavement, Aneurin Bevan University Health Board.
9:40am	Opening Address Nicola Prygodzicz, Chief Executive Officer, Aneurin Bevan University Health Board
9:50am	Improving bereavement support in Wales: The new national framework for the delivery of bereavement care and the research which informed it Dr Emily Harrop, Marie Curie Research Fellow, Cardiff University
10:10am	Advance and Future Care Planning: Making your wishes known Dr Clifford Jones, Assistant Medical Director, Aneurin Bevan University Health Board
10:25am	Living with Loss and Post Traumatic Growth Rhian Mannings, Chief Executive Officer 2 Wish
10:40am	The 'Hard to Reach' Myth Chris Dunn, Chief Executive Officer, Diverse Cymru
10:55am	Bereavement Support for People Affected by a Death by Suicide Bethan Bowden, Consultant in Public Health, Aneurin Bevan Gwent Local Public Health Team
11:10am	<b>Refreshments</b>
11.30am	Bereavement Support for People with Sensory Loss Non Ellis, Equality, Diversity, and Inclusion Specialist, Aneurin Bevan University Health Board
11.45am	Religion, Spirituality and Pastoral Care Alan Tyler, Senior Chaplain and Farid Khan, Imam, Aneurin Bevan University Health Board
12:00pm	The Impact of the New Death Certification Reforms Dr Jason Shannon, Lead Medical Examiner for Wales
12:15pm	The Local Vision for Improved Bereavement Services Tanya Strange, Head of Nursing, Patient Experience and Involvement and Louise Jones, Bereavement Lead Nurse, Aneurin Bevan University Health Board
12:30pm	<b>Lunch and Networking</b>

# MORNING PROGRAMME

National and local bereavement discussions identified the importance of attendees understanding the national bereavement priorities and the expectations for Health Boards and commissioned services to **improve the bereavement offer**.

Through the End-of-Life Care Board, the opening address confirmed the Aneurin Bevan University Health Board's and partners commitment to improving the bereavement offer across our communities. Assurance was provided that the new bereavement model would be **developed in partnership** and **co-produced** with bereaved people, those who supported bereaved people and wider stakeholders.

The morning session focused on presentations that would highlight the **bereavement standards** across all ages and loss circumstances, including expected, sudden, and unexpected loss. It was not possible to cover all circumstances of loss, and the round table conversations held in the afternoon were an opportunity for attendees to **raise questions** and advise what they wished to see in the new bereavement model.

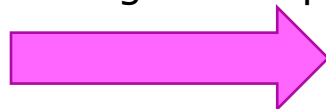
# PRESENTATION 1: IMPROVING BEREAVEMENT SUPPORT IN WALES: THE NEW NATIONAL FRAMEWORK FOR THE DELIVERY OF BEREAVEMENT CARE AND THE RESEARCH WHICH INFORMED IT



To ensure the attendees understood the national bereavement priorities, Dr Emily Harrop, **Marie Curie Research Fellow** at Cardiff University outlined the scoping review of bereavement care in Wales commissioned by the National End of Life Care Board in 2018/2019.

This research identified the **gaps and challenges** of bereavement service provision across Wales and what we need to consider when developing our **local** bereavement offer.

Additional **challenges** identified during the scoping review included:



- **Lack of framework** for commissioning and delivery of bereavement services.
- **Non-prioritisation** of bereavement care.
- Restricted access to **training**.
- Restricted access to **specialist support**.
- **Long waiting lists** and inability to meet demand.
- Restrictive **eligibility criteria**.
- **Unclear** referral pathways.
- Challenges of **rurality** and geographical access.

## PRESENTATION 2: ADVANCE AND FUTURE CARE PLANNING (AFCP): MAKING YOUR WISHES KNOWN.



Prior to focussing on the bereavement standards, it was important to discuss and raise the awareness of **Advance and Future Care Planning (AFCP)**. It is evidenced that where people are supported to make their wishes known at end of life, and these wishes are respected, the impact of grief on the bereaved person can be lessened.

Dr Cliff Jones, Assistant Medical Director at Aneurin Bevan University Health Board, outlined the importance of making your wishes known through an AFCP, whether this be at the point of a diagnosis of a **life limiting condition**, when health deteriorates and at end of life. Key considerations included:

- Why have an Advance and Future Care Plan?
- When to do one? What is the trigger? What to include?
- Involving family, friends and carers.
- Principles of making Best Interest Decisions.
- ACP vs Treatment plans.

The presentation outlined the legal and non-legal aspects of a range of **clinical decision-making tools**, including Do Not Attempt Cardiopulmonary Resuscitation, Lasting Power of Attorney for Health and Welfare, Statement of wishes etc and confirmed that the basis of an AFCP was simply:

An inventory of **what's important** to the person.

An instruction manual of **what matters** to the individual.

A **file note** to store important information.

A **goodbye letter** to loved ones and

Encompasses other information such as '**This is Me**'.

This presentation focussed on what mattered to people and was highlighted as **one of the most important presentations** of the day by those who provided written feedback.



## PRESENTATION 3: **LIVING WITH LOSS AND POST TRAUMATIC GROWTH**

Rhian Mannings MBE, Founder and Chief Executive Officer of **2wish** provided a very impactful personal insight into the devastating loss of her son, George, followed by the traumatic loss of her husband Paul. **2wish** was created in their memory and now supports other parents, witnesses and professionals affected by the **sudden and often traumatic** death of a child or young person aged 25 years and under.

Rhian's presentation reinforced the need to ensure there are **no delays** in the bereavement offer and the importance of considering how to support those who may not be identified as the next of kin, for example, friends, work colleagues, emergency services etc. The compassionate provision of **memory boxes** and **family rooms** was also discussed.

**2wish** has now extended to support those who have experienced sudden deaths of children and young people in England. This presentation received specific **inspirational acknowledgement** in attendee feedback.




**Memory Box**

2wish have made memory boxes for suddenly bereaved parents that include;

- ★ Two small elephants - one for the parent and one to be left with the child or young adult.
- ★ An inkless printing kit to take hand and footprints.
- ★ A small organza bag to place a lock of hair. (Always ask parents permission to cut hair.)

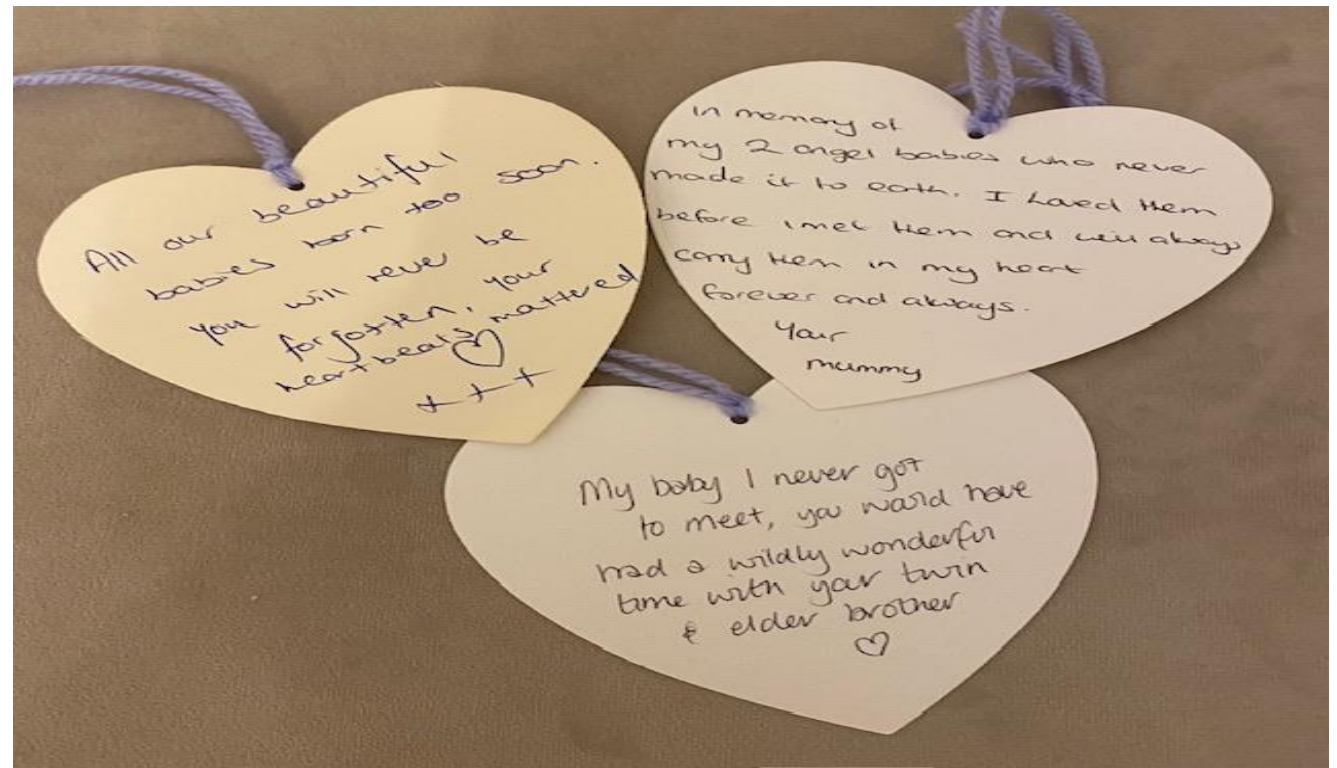
These boxes are now used in every Emergency Dept and Critical Care Unit in Wales. The feedback from both families and staff has been extremely positive.



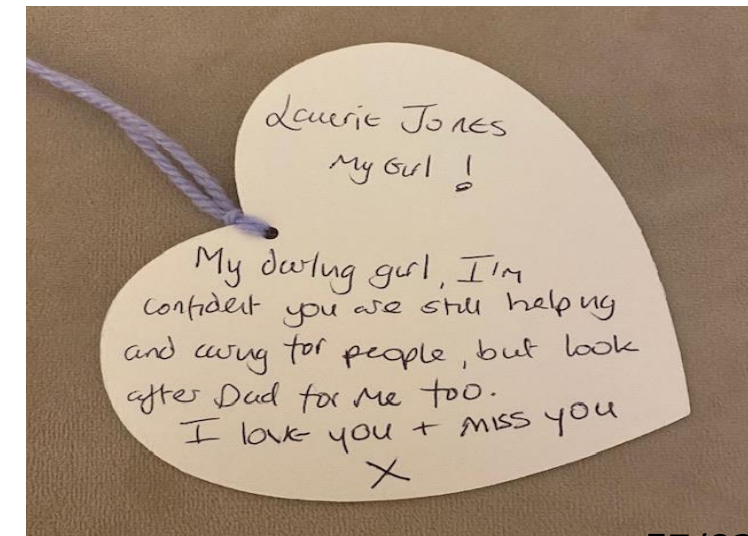
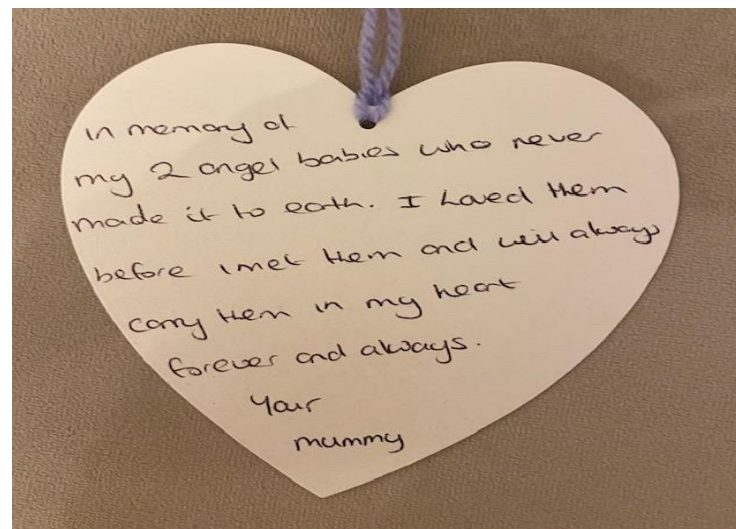
# MESSAGES TO LOVED ONES

Child loss (**including pre-birth**), loss of young people and support for siblings was a key theme at The Big Conversation.

There were emotive arguments for the need to acknowledge child loss **under 20 weeks** gestation.



*'A life is a life when the heart starts beating'.*



## PRESENTATION 4: THE 'HARD TO REACH' MYTH



Chris Dunn, Chief Executive Officer at Diverse Cymru outlined the importance of considering **cultural competency** in developing the bereavement model and bereavement offer. Cultural Competency is a journey, not a tick box. Having translated leaflets and guides yet **sticking to the same playbook is not enough.**

He asserted that the **'hard to reach'** label is lazy, inaccurate, creates barriers and puts the emphasis of blame on the communities rather than the services which are inaccessible for some. He reinforced that services and institutions are 'hard to reach', not people. There are barriers and challenges but it's how we overcome them that should be the first thought not 'they are hard to reach'.

We learned that we need to bring communities with us on this journey, be prepared to be uncomfortable, be prepared to adapt the ways you work and be prepared to accept change. In summary:

**Representation** Matters

**Language of loss** Matters

**Being flexible** Matters

Given the multicultural nature of our society, how we grieve, and the cultural variation need to be acknowledged so stereotypes do not occur. We need to gain greater insight into how beliefs, religion, spirituality and the supernatural can affect access to services as well as responses to support.

*"There is great power in being present with a mourner from any culture. Visiting, calling, showing concern, and offering help and suggestions based on your assessment of their needs goes a long way. Often, all people need is to know that someone cares".*

## PRESENTATION 5: *BEREAVEMENT SUPPORT FOR PEOPLE AFFECTED BY A DEATH BY SUICIDE.*



Dr Bethan Bowden provided an insightful talk around the bereavement experiences for people affected by death by suicide. The audience learned that losing people in this way means they experience:

- Intense feelings of **guilt**
- **Shock** and questioning, searching for answers
- **Abandonment** and rejection
- Re-awaken **earlier losses**
- 'What if's'
- **Blame** and self-questioning
- **Shame**, stigma and isolation

**Specialist support is often needed**

### **What we need locally to support people affected by a death by suicide.**

- Bereavement service for people affected by suicide to reduce their risk.
- All-age service provision.
- Equitable and sustainable provision.
- Immediate support for those bereaved.
- Medium to long term support.
- Adaptable provision for different ages and different needs.
- Integrated into a wider bereavement service.
- Sustainable specialist model offering tailored support.
- More awareness of the support available for bereaved people and families.

# When we get it right

## Bereaved Partner

*"With the support of my counsellor, I have begun to work through the pain and grief and somewhere deep inside I know one day I will be ok again. I would never have been able to achieve this without the support I have received. I have 2 kids who need their mum and the support I am receiving is enabling me to carry on being a mum. Thank you from the bottom of my heart."*

## Bereaved Sister

*The support I've received has been essential to recovery in such a difficult time. The support is prompt which I cannot express how I needed this. With so many mental health services being stretched with long waiting lists. I've had the time to receive support and counselling at the time I've needed it most allowing me to function through daily tasks and gain understanding of my thoughts and feelings."*

## Bereaved Friend

*"The support I have received has helped me immensely, I believe that my grief journey would be far more difficult than it is if it wasn't for this support. I feel comfortable and totally understood and can reach out whenever I need."*

## PRESENTATION 6: BEREAVEMENT SUPPORT FOR PEOPLE WITH SENSORY LOSS

Non Ellis, Equality, Diversity and Inclusion Specialist, talked about how accessing bereavement support can be difficult for some groups of people, including those with **sensory loss**. This can result in their **grief** being unsupported and **unresolved**. Two very powerful patient stories highlighted such issues and what should have been done to improve people's experience at end of life and immediately after loss.

The new bereavement model needs to ensure that **communication is key** :

To ensure people are supported by people who can communicate with them.

Consider the importance of all the senses in helping someone navigate grief.

Tailored support and services.



## PRESENTATION 7: RELIGION, SPIRITUALITY AND PASTORAL CARE



Alan Tyler Chaplain and Farid Khan, Imam discussed the **religious, spiritual and pastoral consideration** at end of life and after loss. The Bereavement Model will need to be supported by awareness and training so that people understand that the expression of grief varies greatly between different **cultures and religions**.

Cultural and religious beliefs help people cope with and express their grief, providing a sense of structure and routine at a distressing time. It is important to have an understanding of people's **particular customs** and funeral rites. How a person grieves will be different for each individual.

The Bereavement Model must consider the specific cultures and religions in regard to:

**Age, Gender , Cultural Behaviour,  
Children, Relationships/Partners  
Memorials.**





# FAITH AND SPIRITUALITY

*"The landscape of faith and spirituality in Wales is changing and it is really important for us to be aware and responsive to these changes.*

*The language and understanding may have evolved, but supporting people spiritually when they seek that care, is fundamental to a good and compassionate bereavement experience".*

(Alan Tyler, Senior Chaplain)



## PRESENTATION 7: THE IMPACT OF THE NEW DEATH CERTIFICATION REFORMS



Dr Jason Shannon, **Lead Medical Examiner** for Wales, outlined the key changes the new death certification reforms will have. From April these reforms will mean that delays in receiving a death certificate and delays in a bereaved person being able to arrange a funeral should significantly reduce. Key changes will mean that:

- No requirement for the **Certifying Doctor** to see the deceased.
- **Digital** MCCD (from July) .
- Aim to widen the pool of potential certifying doctors and **eliminates cremation form.**
- Medical examiner will ensure the **bereaved have a voice** and identify opportunities for health care improvement.
- **Coroner** changes and less bureaucracy.
- Removal of some **Registrar** forms- reduced bureaucracy.

Fundamentally- **Families** must be given the opportunity to **drive**, not be driven by, **the process.**

Medical Examiner Service



Update on Medical Examiner and Death Certification Reforms

Statement made on 14 December 2023

Wales Office

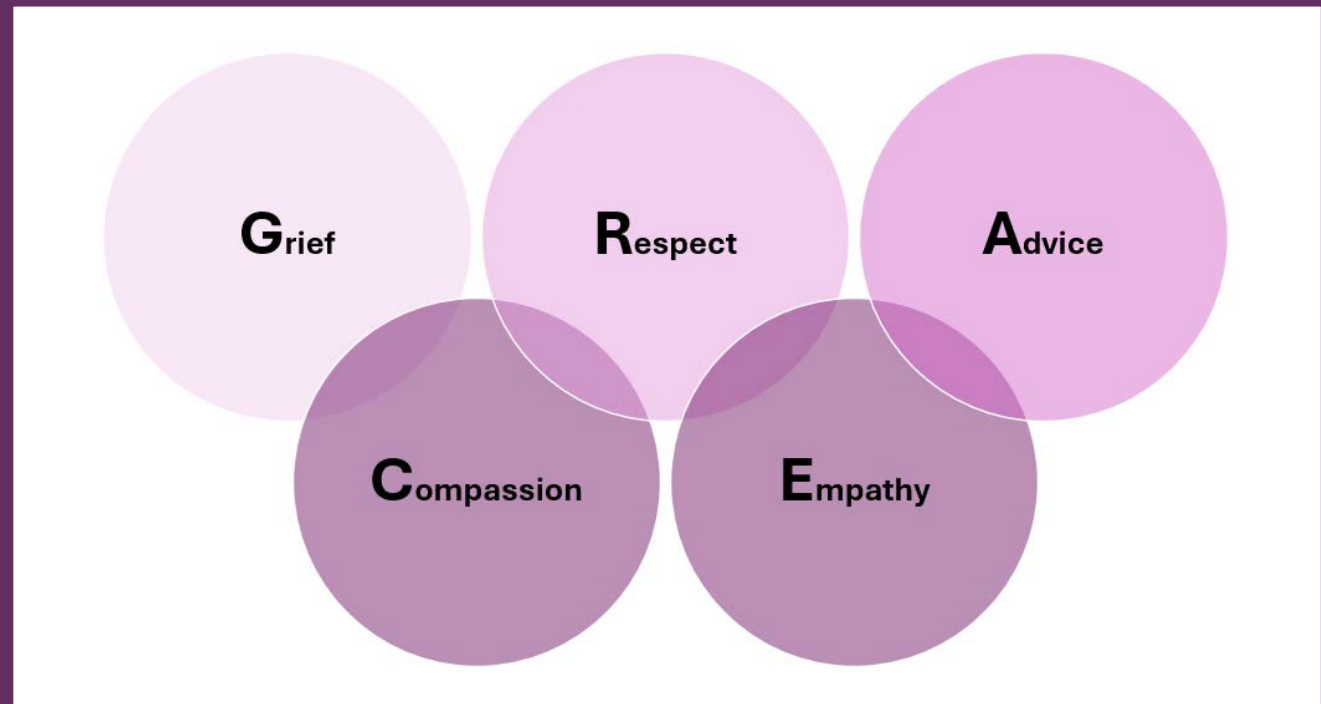
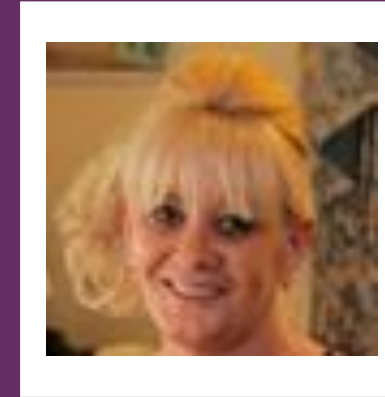


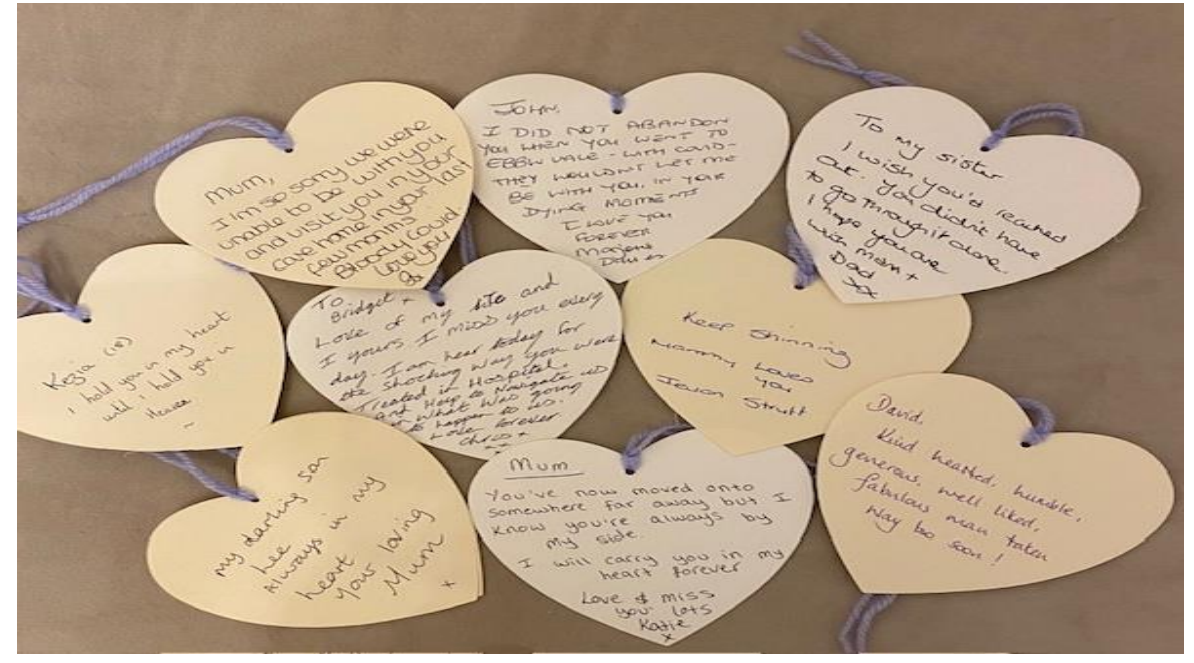
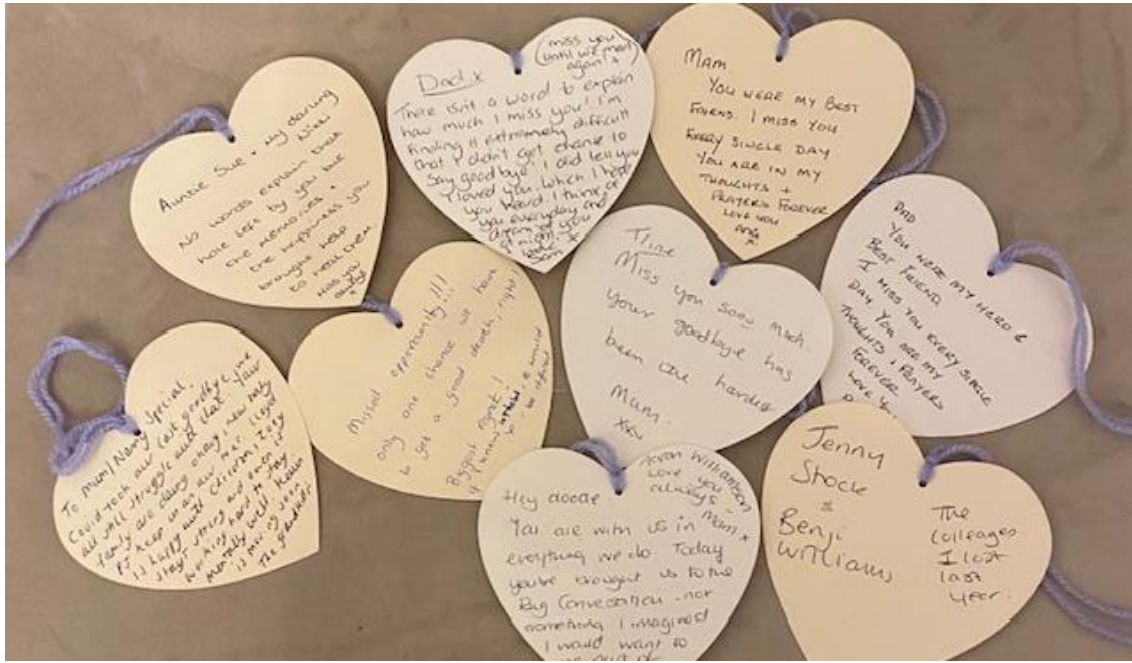
# PRESENTATION 8: OUR LOCAL VISION FOR BEREAVEMENT SUPPORT

Tanya Strange, Head of Nursing and Louise Jones, Lead Bereavement Nurse outlined the Health Boards current position towards implementing the National Bereavement Standards, feedback received to date, the actions already taken, and the staff training being scoped. The vision is to ensure that pathways are inclusive of anticipatory loss, deteriorating conditions, palliative care, end of life care and bereavement. **People's feedback** will be used to inform the new bereavement model.

The concept of **co-production**, putting people at the centre, determining **what matters**, and 'branding' the new bereavement model were explained. The vision and ethos of **GRACE** to improve experience and embed the bereavement standards was outlined.

Attendees were asked to consider and provide feedback on whether they supported the **principles** of GRACE and whether they liked the proposed logo.





# MESSAGES TO LOVED ONES. PEOPLE'S EXPERIENCE MATTERS.

The Bereavement Model must consider **'what matters'** to the person and their families. We must be mindful that support needs to extend beyond the 'next of kin' and be offered at a time when people need it. **Giving leaflets and signposting to a website is not enough.** We should be asking people when they want to be contacted and their chosen communication methods e.g. face to face, telephone etc.

## Afternoon Programme

To encourage conversations around both the key priorities within the National Bereavement Framework and Health Boards strategic programmes, (eg End of Life Care, Bereavement, Equality Plan, Dementia etc), **9 round table conversations** took place. These were facilitated by a number of partners who had expertise in the areas. Attendees were asked to select their chosen conversation ahead of the event although many chose on the day. Targeted facilitator questions asked participants to discuss:

- Their experiences of bereavement.
- Whether people were contacted/offered bereavement support?
- Access to bereavement support/barriers.
- What would have helped at the time?
- Whether they supported the principles of GRACE and the logo?
- What they hoped to see included in the Bereavement Model?
- Further comments and suggestions.

**Top themes** from each discussion were then discussed at the Big Conversation.



## Afternoon Programme

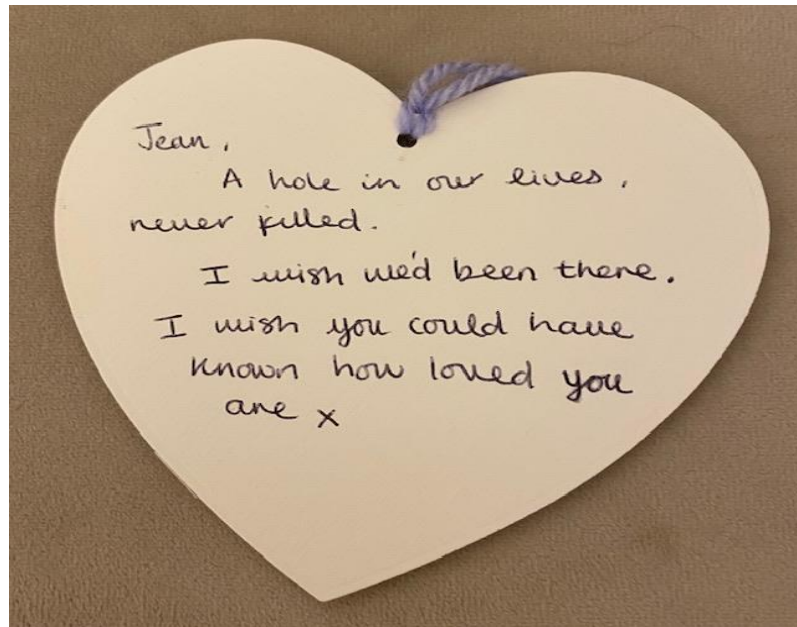
Please see Room/Table Numbers in Main Foyer	
1:15pm	<b>Round Table Conversations - Preparing for loss and bereavement support for:</b>
	• People with <b>sensory loss and disabilities</b>
	• People from <b>Black, Asian and Minority Ethnic</b> Communities
	• People who have lost a <b>child or young person</b>
	• People who have lost someone under <b>traumatic circumstances</b> (including suicide)
	• People whose loved ones have died in <b>hospital/inpatient</b> setting
	• People who have lost loved ones in the <b>community</b>
	• People with identified <b>religious and spiritual</b> , and pastoral support at end of life
	• End of life care and bereavement support for people with <b>cognitive impairment</b> (including dementia)
	• <b>Advance and Future Care Planning:</b> Making your wishes known
2:15pm	<b>The Big Conversation - Attendees to return to Main Hall</b>
2:15pm	<b>Feedback from all discussion groups to inform the Big Conversation</b> Chairs: Grant Usmar, CEO Hospice of the Valleys; Carol Taplin, Specialist Chaplain; Tanya Strange, Head of Nursing, Patient Experience and Involvement
3:15pm	<b>Closing Remarks</b> John Moss, National Bereavement Framework Programme Manager, NHS Wales Executive
3:30pm	<b>Event Close</b>



# THE BIG CONVERSATION BEREAVEMENT: FEEDBACK

## Conversation 1:

Preparing for loss and bereavement support for people with **Sensory Loss** and **Disabilities** and People from **Black, Asian and Minority Ethnic** Communities.



Bereavement is a **journey** over weeks, months and years.

Can't just give a leaflet. Find out **what matters** and who can support the discussions.

E-learning alone does not work- **experiential learning** needed.

**Flexibility**- one size doesn't fit all.

Determine whether people need **interpreters** early on.

What does **compassion feel and look like** for people and communities- focused engagement.

Importance of **language**- always refer to the person by name.

Review **Medical Examiner reports**- what are the themes for people with sensory loss, people from Black, Asian and Minority Ethnic Groups.

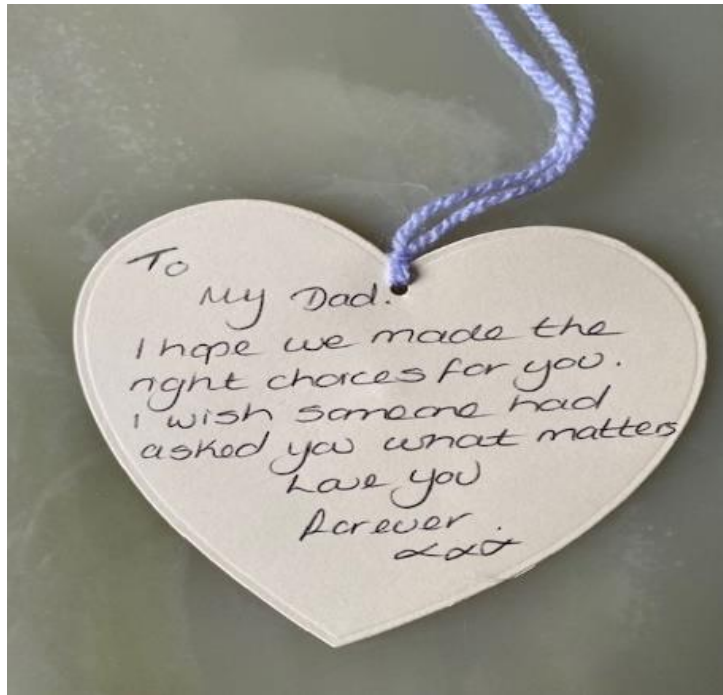
**Wrap around support** needed. Engage with community leaders and champions.

Consider **needs of the bereaved**. Informing a bereaved person that someone is wearing their favourite necklace can bring them comfort.

**Equality, Diversity and Inclusion** to be integral to the Bereavement Model.

## Conversation 2

Preparing for loss and bereavement support- **Advance and Future Care Planning.**



AFCP should be **everyone's business**- more understanding and awareness needed.

**Distrust** since COVID- No discussions with families around DNACPR.

Staff need to be **confident** to have discussions- training.

Lack of information about AFCP in **different languages.**

Need more engagement with **diverse communities.**

When is the right time- people and families need to be empowered to ask about AFCP.

Consider **public information campaign.**

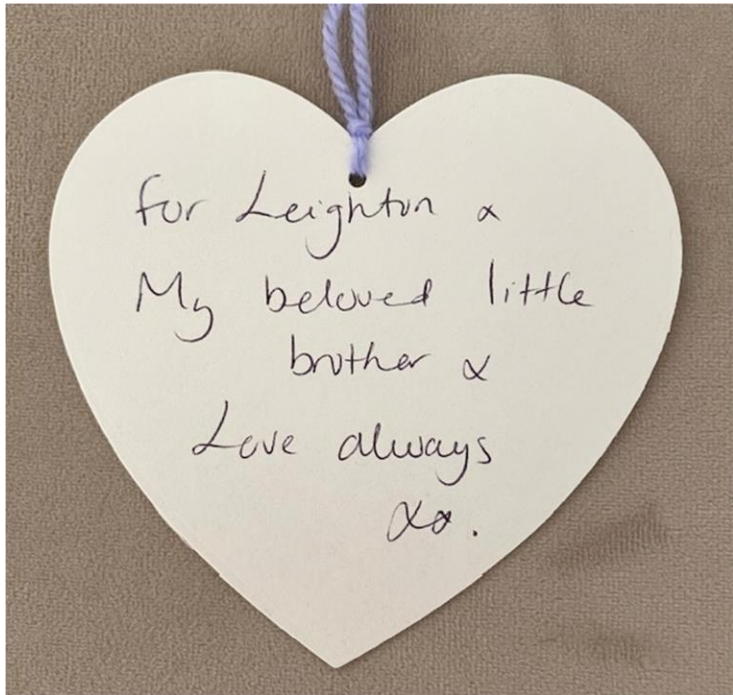
Discuss **earlier** in the persons care journey.

**What Matters** conversations must be held and recorded.

**Bereavement Model** to include AFCP, anticipatory loss, end of life and palliative care training and awareness throughout the pathway.

## Conversation 3

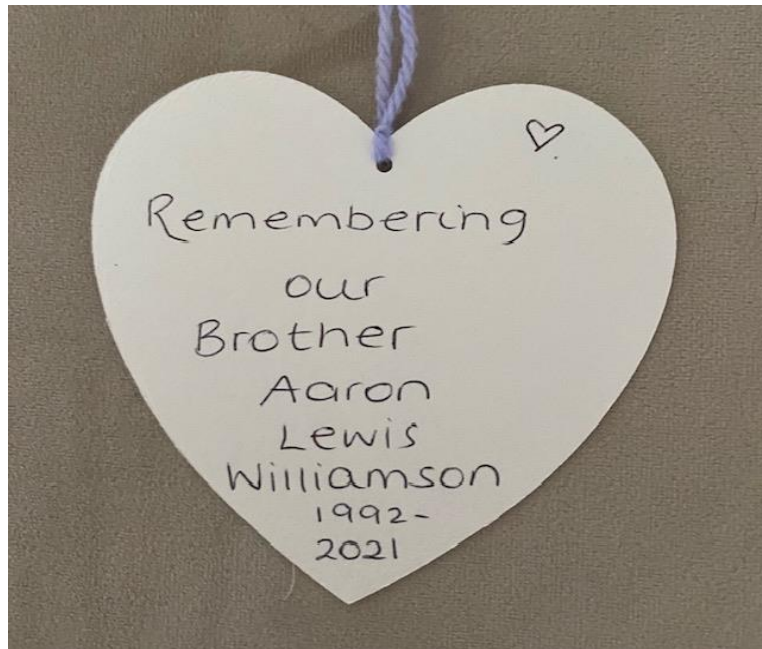
Preparing for loss and bereavement support for people who have lost a **child or young person**.



- Need to consider **grief** impacts on parents, staff, volunteers etc.
- **Person-centred** support essential- don't just rely on guidelines.
- Make **contact** sooner rather than later.
- Explain **options and choices**- including making memories.
- No excuses when **delays** in contact and answers- this adds to bereaved person's 'burden'.
- **Private rooms** needed for breaking bad news and for grieving.
- Preserve persons **clothing and belongings**. These are important to people.
- **Parents voice**- make sure they are heard.
- Also needs to consider loss of the **unborn child** whatever stage of pregnancy- '*a life is a life when the heart starts beating*' .
- **Bereavement model** needs to consider wider impacts of grief on siblings and friends.

## Conversation 4

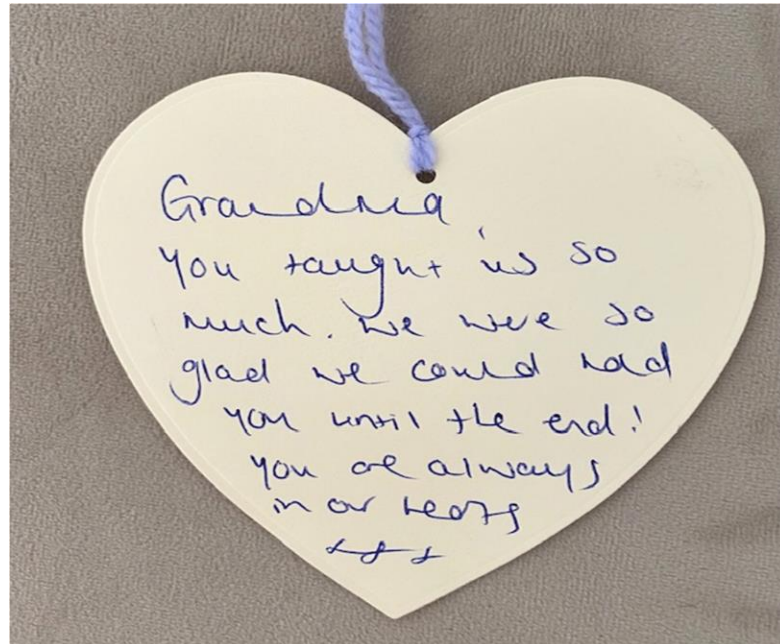
Preparing for loss and bereavement support for people who have lost someone under **traumatic circumstances** (including suicide).



- Lack of **local support**- people feel alone and scared.
- **Specialist support** needs to be available when needed, for the bereaved and those supporting bereaved people.
- People (including staff) do not know what is available, how to access support. **Connections** are poor.
- National Bereavement Standards and bereavement offer is explicit- **short term funding** leads to inequity and risks cessation of services.
- Digital and telephone support not always helpful 'in the moment'. Needs to be **proactive and timely**.
- Need to consider **siblings**.
- **Offer to men** needs further consideration- how do men wish to be supported.
- **Flexibility**- needs to be different support at different times.
- **Bereavement Model** must focus on **equity**- people's experiences are very different, lack of equity on how people are supported.
- A number of attendees wished to see **further discussions** around sudden/traumatic loss.

## Conversation 5

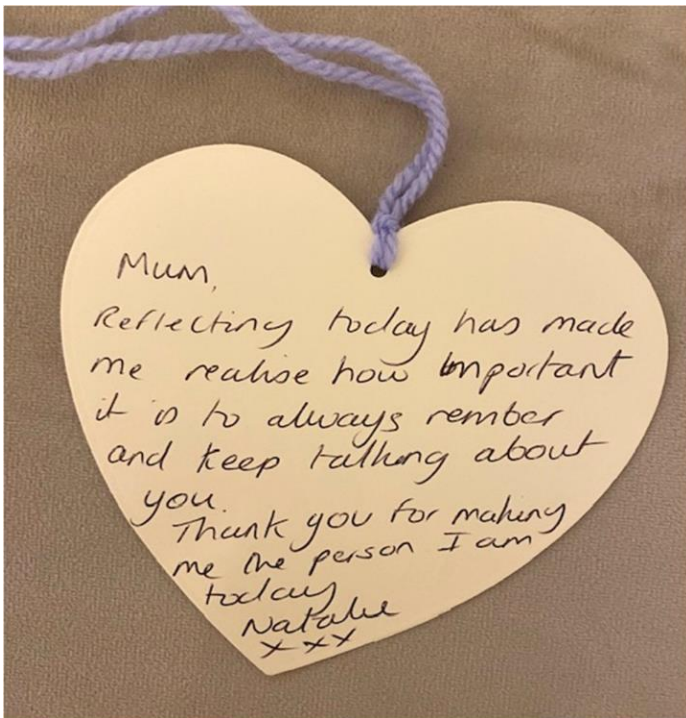
Preparing for loss and bereavement support for people who have lost someone who **died in hospital**.



- **Largest** of all round table conversations.
- **Care After Death-** title not viewed positively. Should be changed- varying experiences.
- **'Too much pressure'** on families to make decisions e.g. DNACPR- reduce the burden on families.
- Death must be **dignified and respectful** of person and family.
- Timely contact needed. Ask families when they want to be contacted. **Single point of contact** needed.
- Staff need to **recognise grief** and complications. Named NOK isn't the only family member grieving. Can impact negatively on wider family grief.
- **Rules** need to be broken- open visiting, allowing pets in, family time and private room. Families should say what the rules are at such sensitive times.
- **Medical conversations-** talk to the person and the family.
- **Communication and collaboration-** what matters to the person and the family.
- **Bereavement Model** must include what matters to person and those closest to them.

## Conversation 6

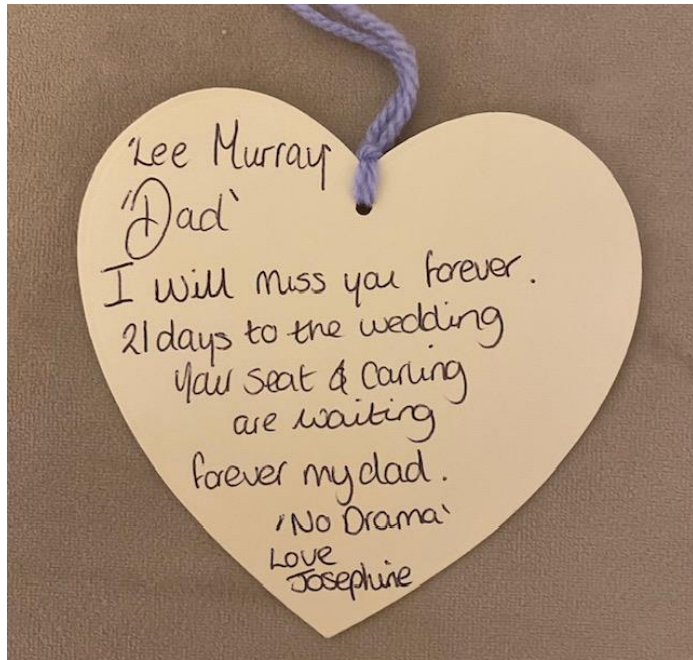
Preparing for loss and bereavement support for people who have lost someone who **died in the community**.



- **Different experience** to when people die in hospital- less support.
- Often **unexpected or sudden**- people don't know who to contact first.
- **Red tape/bureaucracy**- delays in being able to visit the deceased can impact on bereavement.
- **Anticipatory grief**- need to invest in training staff to have what matters conversations.
- **Staff resilience**- need to make sure staff are confident to be 'present in the moment'.
- Need to consider **support** for all who work in the community including NHS, volunteers, police, paramedics etc.
- No right or wrong time to contact but ask people.
- **Bereavement Model** needs to consider the support needed for families when someone dies in the community or care home- *'The door closes to support when someone dies outside of hospital'*

## Conversation 7

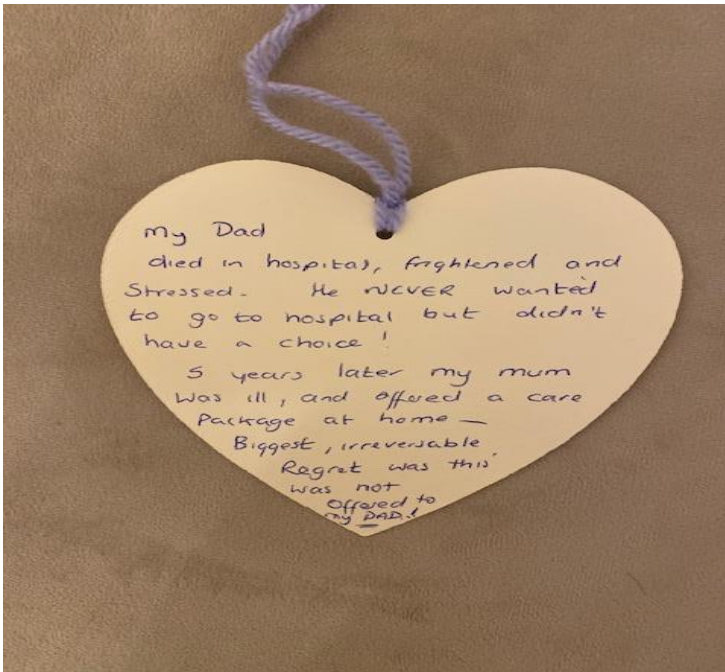
Preparing for loss and bereavement support for people with identified **religious spiritual, and pastoral support** at end of life.



- Needs to be a greater awareness of **cultural** aspects at end of life and when bereaved.
- **AFCP** will need more focussed discussions with diverse groups considering religion and culture.
- Greater awareness of grief and **complex grief** needed.
- Better **engagement** with diverse/religious groups needed.
- Needs wider recognition of **spiritual care** being part of holistic, person-centred care.
- Staff need to be **skilled and confident** to ask questions around spiritual, religious and faith needs and better understanding of care of the person and cultural expectations (e.g. time of funerals).
- **Bereavement Model** needs to be modelled within a culturally competent framework.

## Conversation 8

Preparing for loss and bereavement support during end-of-life care and bereavement support for people with **cognitive impairment** (including dementia).



- **Bereavement** and loss can start before death.
- Traditional 'leave contact for a couple of months' needs to be replaced- **ask people** when and how they want to be supported.
- Offer **practical support and signposting**- Lasting Power of Attorney, capacity assessments, best interest decisions, benefits advice etc.
- **Emotional support** at all stages.
- More consideration to **anticipatory loss**, for the family and staff.
- **Varying experiences**- inconsistent support. Needs to be timely.
- **Carer support**- right through the pathway. Consider what bereavement support would help as will lose the person and their caring role.
- On going support after loss e.g. **grief café's**, peer support.
- **Bereavement Model** should include supporting people who are diagnosed with life limiting conditions and their families early.

# COMMENTS AND SUGGESTIONS

*"Maybe, once someone loses a loved one in hospital, let staff take them into another room and **talk to them**, and explain what services are available and maybe tell them you will be in touch with them to arrange a meeting with a bereavement councillor within the Health Board to see how the family are doing"?*

***"Pregnancy loss under 20 weeks'** gestation needs to be made as important as those pregnancies over 20 weeks. Maternity has protected bed status and 1:1 care. Gynaecology staff deal with baby loss daily, but no protected beds. All baby loss matters, to support our women, we need to be supported to protect them and give the best care possible".*

*"We need to be confident we can meet **strict funeral timelines** depending on culture".*

*"Look at allocating '**Bereavement Champions**' like Dementia Champions across the Health Board to raise awareness and improve education".*

*"Could the model follow a model similar to the **6 principles of trauma** informed practice as this follows a lot of what has been missing".*

# COMMENTS AND SUGGESTIONS

*"Make sure people are aware of the services available and knowing where to direct people to access those services."*

*" Have conversations with EoL or Palliative patients and families about bereavement, grief and available services prior to death. A lot of what is said after someone dies doesn't sink in".*

*" The Bereavement Model must recognise that bereavement encompasses quite a timeline from pre-death, actual death and post death".*

*"There is a long way to go before GRACE becomes the norm".*

*"Knowing what is available and how to access it would be helpful."*

*"Is the Memorial Service provided by the Chaplaincy department going to be re-established? It was greatly supported and gave relatives and loved ones of those who died support and helped to provide the beginning of closure".*

*"The waiting list for PTSD counselling is too long. How do people access it? A 9-month waiting list is too long for someone who has flashbacks. I know there is a shortage of trauma counsellors so how can the gap be filled while traumatised people wait?"*

*"Think about the words you use. One senior member of staff said, 'tell your mam not to die on Christmas Day'. Sadly, mam died Boxing Day".*

# FEEDBACK ON GRACE

Attendees were asked to make comment on whether they:

- a) were supportive of what **GRACE** represents (grief, respect, advice, compassion and empathy) and
- b) whether they liked the **logo**.

Written feedback confirmed that the majority of attendees **supported** what GRACE stood for. However, the overwhelming feedback was that the **logo** appeared too 'religious' and spiritual and **should be changed**.

Several attendees suggested a logo of a **tree** (representing strong roots and long life). This is now being considered with a local artist and graphic designers.

**GRACE:**  
*Because final moments matter*

- **Grief**
- **Respect**
- **Advice**
- **Compassion**
- **Empathy**



*Really like what GRACE represents but the logo is too religious looking.*

*The logo looks too spiritual and appears too 'Westernised'.*

I want to be able to do normal things  
things that I used to love  
things that I should still love.

I can't help

but battle the shame  
that I'm falling behind,  
lagging due to loss  
groaning in my grief.

I can't keep up today.

I just can't keep up.

And she said,

"Some days, you can't 'do normal' when your heart is broken."

There's no set pace

only grace.

only grace.

-Liz Newman

# FEEDBACK: WHAT DID YOU FIND MOST USEFUL ABOUT TODAY (COMMON THEMES)

*To know I am not alone in my grief*

Having honest conversations-ability to **speak freely**

**Power of personal stories (numerous mentions)**

**Networking and variation of attendees in conversation groups**

**Variety of presentations and round table discussions**

**Learning about the changes of the new Death Reform process**

**'Eye opening' informative presentations**

**AFCP (numerous mentions)**

**Awareness of what's available**

**Really good programme, various contributors**

**Hearing about the lived experience of participants (numerous mentions)**

**That change is coming- we need to listen to people's experience**

Learning that there is an obvious **need to talk about bereavement**.

Lack of support can result in **negative grief**.

Sensory loss and bereavement- **opened my mind**.

**Round table** conversations.

**Need to learn** so other families don't go through what we did.

Knowing **you are not alone**.

Ability to **share experiences**.

Everyone now knows that **change is needed**.

Presentations highlighted the fact that **grief is widespread**

**Emotional day** but very worthwhile.

**Information** available.

That **grief can affect all ages**.

*" Today, my voice was heard".*

# FEEDBACK: DO YOU THINK WE NEED TO HAVE MORE CONVERSATIONS ABOUT BEREAVEMENT

**100% of feedback received supported the need for more conversations**

**"Absolutely more conversations"**

**"Yes, and allow people to know what's available"**

**"We need more Big Conversations as it raises important issues from all the public including diverse groups"**

**"Yes, death is feared and not talked about enough"**

**"Yes- could have a rolling conference focussing on different themes?"**

**"Yes, if points raised are listened to and acted upon and not just a tick box."**

**"Definitely- more conversations should be encouraged to normalise death and dying"**

"Yes. We also need more education across the sector to help bereaved people."

"Yes, specifically around pregnancy/baby loss."

"Absolutely! Bereavement still feels like a taboo topic despite everyone experiencing it."

"Yes. Need a broader range of people's experiences with bereavement services."

"Yes, the more the better."

"Absolutely necessary."

"Yes, sharing people's stories to implement change is vital."

"Yes, this is just the start."

"Yes, so people know they are not alone."

"Need to have these discussions across Wales!"

# FEEDBACK: HOW COULD WE HAVE IMPROVED THE BIG CONVERSATION

**"Longer breakout sessions to enable further conversations and listening to be heard and reflected on".**

**"Perhaps hold over more than one day as time constraints prevented longer discussions."**

**"Maybe get a family member who has lost someone to talk about their loss, what they went through, etc. with Q&A straight after. Need positive and negative experiences to learn".**

**"No improvements needed but could maybe open to a wider audience."**

**"Maybe avoid Ramadan as many Muslims may be unable to attend. Need more topics on ethnic minority taboos".**

"Excellent day. I would have liked to have been able to join more than one discussion."

"More time for conversations. Listening more important than transmitting."

"More public feedback if future days planned."

"Invite more on the ground staff."

"Some positive experiences of what worked well would help learning."

"Really good- needs more information and discussion around sudden death- very different experiences."

# FEEDBACK: STAYING CONNECTED AND BEREAVEMENT COLLABORATION

**We asked:** *Would you be interested in helping us **shape** the bereavement model?*



**58** people provided written feedback. Of those, **50** people said they wanted to work with us to develop the new bereavement model.



Including the people already engaged, and those who have asked to be involved through social media, this means we will have around **80 people** engaged through our **bereavement collaborative**.



It is likely that **more people** will come forward as we engage in Big Conversations across all 5 boroughs.



# OTHER FEEDBACK

**"Thank you for hosting such an important event"**

**"I loved the remembrance tree where I left a memory for my brother. A lovely idea."**

**"Would like more presentations on organ donation, PRUDIC, coroner, maybe police presenting, and more information needed on sudden death."**

**"Excellent day- thank you".**

**"A really interesting day, a lot of food for thought".**

**"Needs to be advertised more".**

**"A very informative day. Good venue, good programme and well planned".**

**"A great and informative day. Important to highlight"**

**"Would like more information on services and referral pathways".**

"Very insightful, and I would like to continue working with the team to support and improve"

"A well organised event (numerous affirmations)".

"This feels like a poorly managed change programme, clinically led thus ignoring many principles of change management".

"Need to look at why things close down over a Bank Holiday. Delays in death certificate causes anxiety for the family of the deceased".

"Enlightening from a personal and professional perspective".

"Today has been enlightening and I do hope that the processes and procedures improve".

"The pathways need to change as the system failed me when I lost my son"

"Found it so very useful. Timely too having lost my son in ICU in December. I am very grateful for this day".

"Every Health Board needs to have this conversation""

# BIG CONVERSATION: CLOSING REMARKS

In his closing remarks, John Moss, National Bereavement Framework Programme Manager, reflected that whilst grief is an entirely natural and individual process and not an illness, its effects can be devastating. We often underestimate the significance of the actions we can, and do take, for example the visits and phone calls we make, the cards and messages we send, the practical support we offer to those who have lost someone; these are all part of what makes us compassionate and are incredibly important in providing support to bereaved people .

He commented on the amazing work taking place to support bereaved people outlined today, and to Aneurin Bevan University Health Boards commitment and vision for improving support. He expressed his grateful thanks to the Aneurin Bevan team, the speakers, and everyone who attended and so generously gave of their time and shared their experiences.



# NEXT STEPS

The Big Conversation provided **valuable** insight into the experiences of people who have been bereaved.

People's feedback is now being collated. This will enable the Health Board and our partners (through the Bereavement Collaborative) to prioritise the actions needed to improve our **bereavement offer** across the geographical area and to develop our new bereavement model.

Our existing bereavement implementation plan will be reviewed to ensure people's **feedback** is prioritised. This will be discussed and approved at the End-Of-Life Care Board.

People have told us that they want to see and get involved in more conversations around **anticipatory loss**, end of life care and bereavement across the geographical area. We are now organising a Big Conversation across the 5 boroughs between May and July 2024.

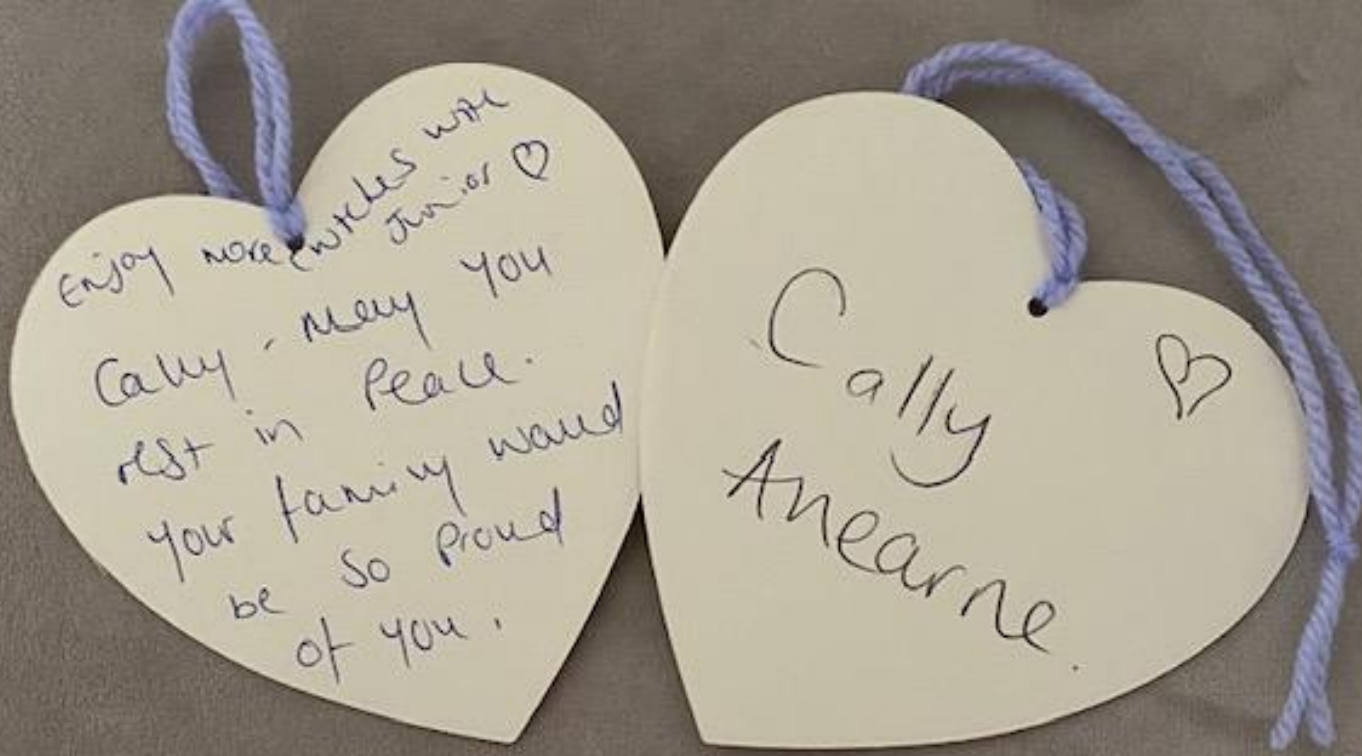
Aneurin Bevan University Health Board and our partners extend a sincere **thank you** to everyone who attended the Big Conversation and to those who have reached out to express an interest in working with us to improve the experiences of bereaved people. Anticipatory loss, end of life care, bereavement and people's experience is really important.

**Together** we can use our collective passion to develop a model that is compassionate, responsive and inclusive to the needs of all bereaved people living in our area.





**GRACE: BECAUSE PEOPLE'S EXPERIENCE MATTERS**



**NEVER  
FORGOTTEN**



# EVALUATION REPORT

5<sup>TH</sup> APRIL 2024

If you would like to tell us about your **bereavement experience** or be involved in further conversations about bereavement, please scan the **QR code** or contact us:

[abb.PALS@wales.nhs.uk](mailto:abb.PALS@wales.nhs.uk)

The Big Conversation:  
Bereavement



THE BIG  
CONVERSATION  
(Bereavement)

# Llais Gwent region – report for aneurin Bevan university health board public board meeting



... on 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 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](mailto:gwentenquiries@llaiscymru.org)

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

[www.llaiswales.org](http://www.llaiswales.org)

[www.llaiscymru.org](http://www.llaiscymru.org)

About Llais .....	4
Introduction.....	<b>Error! Bookmark not defined.</b>
A National Conversation: Llais Strategic Plan 2024-2027.....	6
Llais Gwent Region Update.....	7
Public feedback from our Advocacy Service.....	7
Representations that we have made or been involved in.....	7
Engagement in Gwent.....	9
Engagement with young people.....	9
Survey: Trauma & Orthopaedic - Hip and Knee.....	11
Thanks.....	12
Feedback.....	12
Contact details .....	12



# 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.





The purpose of this report is 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 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:<sup>1</sup>

- 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.

## Llais Gwent region



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

## Current activities and feedback:

### 1. Public feedback from our Advocacy services

From the 1<sup>st</sup> of April 2024 to the 8<sup>th</sup> of May 2024, our Advocacy service has received 39 new contacts from members of the public with enquiries or formal concerns about health or social care.

- 35 of those contacts were about the NHS and 4 of those contacts was in relation to Social Care.
- The concerns regarding the NHS vary greatly, and issues span multiple services like GP, T&O, Paediatrics, Stroke, Cancer, Dermatology, District Nursing and Radiology.

### 2. 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 March 2024, we have been involved in or made representations about:

- A&E handovers from ambulance crew and people's experiences when waiting in the Emergency Department
- Stroke rehabilitation service developments – ongoing conversations with the Planning Team
- eLGH department/unit reconfiguration proposals and public engagement process – ongoing conversations with the Planning Team.
- ABUHB's Strategic plan 2035 engagement session with the Planning Team, Llais Volunteers and the Gwent Citizens' panel.
- ABUHB outpatient steering group
- ABUHB enhances services operational group and primary care sustainability panel.

- Patient Quality, Safety and Outcomes Committee
- ABUHB Adferiad plans

### 3. Engagement in Gwent

As of the start of April until the end of June, we have planned two weeks engagement per borough in Gwent. We have arranged to attend, day centres, community hubs, groups in the community, and supermarkets etc.

Whilst we are engaging with the community and continuing to raise the profile of Llais, we have also created feedback forms for each of our regional priorities:

- 1) Community Services (health and social services)
- 2) Mental Health Services
- 3) Getting care quickly when you need it.

Since April we have carried out engagement in Newport, here is some of the key feedback we have received:

- NHS: Information leaflets in different languages required (specific services were not discussed)
- NHS: People being discharged without an appropriate care package in place.

When we have completed engagement in all of the boroughs in Gwent, a briefing will be produced and sent to the UHB and Local Authorities for their information.

### 4. Engagement with young people

We attended Coleg Gwent Health and Wellbeing Roadshow events at Crosskeys and Usk Campus.' We spoke with students about their experiences of accessing health and social care services.

Some key feedback from **both** campuses:

We received mixed feedback from students when they told us about their access to their GP Practice or Dentist.

#### GP Access:

- One person told us “Access to my GP is good. I prefer a phone call, it’s better than a face-to-face appointment.”
- However, one person told us that they have been unable to get a GP appointment in three years re their eczema. They have been told that their issue is not urgent and is unable to book an appointment in advance.

#### Dentist Access:

- Most students we spoke with were still registered as an NHS patient and their dentist and were regularly called back for a check-up. However, one person told us “I haven’t seen a dentist since I was 16! I’m 24 now. I haven’t seen one since because I can’t register with an NHS dentist, and I can’t afford to pay privately.”
- A student told us they had to wait a very long time to have their braces put on. They were then asked to send a photo of their teeth to their dentist, which resulted in them being seen quicker.

#### Mental Health Services:

Some students completed our feedback forms in relation to mental health services. Comments:

“Waiting times and help wasn’t useful”

“Access to NHS support services – not the best. Waiting list can be too long.”

One student told us they had recently contacted NHS 111 and selected option 2 for mental health help. This person told us this was the first service they contacted, and they helped them become “a much happier person.”

Someone told us that they had been waiting three years to receive an appointment from a mental health service provider. They were referred by their GP and have not yet received an appointment. When they call the team to find out when it is likely they are going to receive an appointment they are told they will be “gotten around to” but not given any further information.

## 5. Survey: Trauma & Orthopaedic – Hip and Knee

We received 47 responses to this survey.

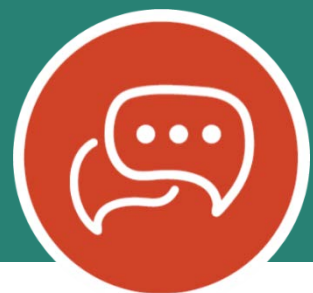
Key feedback received:

- Most people, at the time of completing our survey told us they had been waiting for their surgery between 1-4 years.
- People told us they do not receive any updates or communication from the hospital or clinic whilst they wait for their planned surgery.
- Most people told us they are in pain or discomfort, despite being offered Physiotherapy and pain medication whilst they wait.
- People told us that their general condition has deteriorated, and their quality of life has been affected.
- People told us their independence has been affected and have to rely on others around them to help.

We would like to thank the Health Board for their support with this project. They kindly displayed posters and copies of our survey in the relevant outpatient clinic sites.

The report is in draft and will be submitted to the UHB when finalised.

# 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](mailto:gwentenquiries@llaiscymru.org)  
Website: [www.llaiscymru.org](http://www.llaiscymru.org)  
Facebook: [@gwentllais](https://www.facebook.com/gwentllais)  
twitter: [Llais\\_wales](https://twitter.com/Llais_wales)



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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Multiple Sclerosis Service Expansion
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Leanne Watkins (Chief Operating Officer)
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Tracy Morgan (General Manager – Medicine), Dr Katharine Harding (Clinical Director – Neurology), Rhys Monk (Directorate Manager – Neurology)

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)

**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA**

**SBAR REPORT**

**Sefyllfa / Situation**

Approximately 1,500 patients live with Multiple Sclerosis (MS) across Gwent. The Aneurin Bevan University Health Board MS Team within the Neurology Directorate is responsible for diagnosing, assessing and treating these patients. At present, the MS Team does not have sufficient staffing capacity to fully adhere to clinical guidelines. As a result, the MS Team is not able to prescribe two highly effective therapies, fampridine and Siponimod, nor undertake annual review of all MS patients.

This paper makes recommendations to expand the MS Team to support implementation of fampridine and Siponimod and ensure that all MS patients receive annual review.

The business case has been reviewed by the Pre-Investment Panel and the Executive Committee in order to provide sufficient assurance to the Board that proper governance procedures and due diligence have been followed. Due to commercial sensitivities, the Business Case is not provided with this paper but provided to Board Members under confidential cover.

The Board is asked to agree the recommendations of this paper.

## Cefndir / Background

### **MS**

MS is a chronic disease, characterised by neuroinflammation (an inflammatory response within the brain or spinal cord) and demyelination (damage to the protective myelin sheath around nerves). MS can cause a wide range of symptoms, including problems with vision, arm or leg movement, sensation or balance.

A number of innovative therapies can delay or slow MS progression. Such therapies are not appropriate for all patients and are often associated with a range of potentially dangerous side effects. Therefore, patients must receive a thorough pre-assessment prior to prescription, and must be closely monitored once suitability is confirmed.

Fampridine has been recommended by the All Wales Medicines Strategy Group (AWMSG) as an option for the improvement of walking in adult MS patients with walking disability (AWMSG, 2019). It is worth noting that fampridine has not yet received National Institute for Health and Care Excellence (NICE) approval due to concerns relating to cost efficacy. However, a recent paper submitted to the Aneurin Bevan University Health Board Executive Committee, confirmed its potential cost efficacy in supporting sustained cost avoidance.

Siponimod is recommended by the NICE as an option to slow disability progression and reduce worsening cognitive processing speeds over a number of years (NICE, 2020). NICE also recommends that all MS patients are offered a comprehensive review at least once a year by healthcare professionals with expertise in MS (NICE, 2022).

### **MS Service**

The MS Team is insufficiently staffed to deliver against any of these clinical guidelines, with:

- Four patients prescribed fampridine (who had previously accessed the drug privately, and were therefore not required to undergo the resource intensive screening process);
- No patients prescribed Siponimod;
- Between 42% and 48% of patients receiving annual review over the last five years.

Indeed, comparison of the current MS Team caseload against the Raising the Bar for MS (RtB4MS) report recommendations demonstrates a significant disparity between recommended staffing levels and the whole time equivalent (WTE) within the Team (as per Tables 1 and 3) (Hobart, Mathews, & Rog, 2021). In light of the described disparity, an options appraisal was undertaken to identify current risks and develop a sustainable plan to expand the MS Team.

## Asesiad / Assessment

### **Option 1: Do nothing**

Option 1 represents no change to the current arrangements. The MS Team will not have capacity to prescribe fampridine and Siponimod, nor undertake annual review of all MS patients which is associated with:

- **Clinical risk:** Patients will experience increased disease progression and waiting lists will grow, leading to more demand on primary care, and urgent and emergency care services.
- **Reputational risk:** Both fampridine and Siponimod are prescribed by all other Welsh health boards. The current inequity in service provision and access has attracted patient complaints, alongside enquiries from MS Society Cymru and the Minister for Health and Social Services, and a report from the Ombudsman as per Appendix 1.

The described risks can no longer be mitigated against by the MS Team.

**Option 2: Limited expansion to partially deliver against clinical guidelines**

Option 2 will support the MS Team to partially deliver against AWMSG and NICE guidelines as follows:

- Screening 150 patients per year
- with 76 patients beginning fampridine;
- with 20% patients beginning Siponimod;
- Prescribing Sativex (which is already being prescribed to a limited number of patients) to an additional 20 patients per year.

This option will not allow the service to deliver annual review for all patients. Furthermore, Option 2 will not accommodate intermediate- and long-term demand, which will lead to increased disease progression for patients who are not in receipt of fampridine or Siponimod, and longer waiting lists over a number of years as the MS population grows.

The proposed increase against RtB4MS guidance and growing patient demand is outlined in Table 1 with the financial breakdown provided in Table 2.

**Table 1: Option 2 WTE**

	Current WTE	Option 2 Additional WTE	Option 2 Total WTE	Requisite WTE (RtB4MS) for current demand	Requisite WTE (Rt2 B4MS) for 2028 demand
<b>Doctors</b>					
Consultant	1.33 MS DCC <sup>1</sup> (1.80 WTE)	1.33 MS DCC (2.00 WTE)	2.66 MS DCC (3.80 WTE)	2.44	2.85
<b>MS Registered Nurses (RNs)</b>					
Band 7 MS RN	3.00	1.00	4.00	4.68	5.70
<b>Other RNs</b>					
Band 5 infusion RN	1.00	1.00	2.00		
<b>Coordinators</b>					
Band 4 DMT coordinator		2.00	2.00	1.74	2.28
<b>Other Administrators<sup>2</sup></b>					
Band 4 secretary	1.50	1.00	2.50		
Band 3 secretarial assistant		1.00	1.00		

**Table 2: Option 2 Finance**

Cost summary	Year 1	Year 2	Year 3	Year 4	Year 5
<b>Capital</b>	0	0	0	0	0
<b>Revenue - Staff*</b>	£ 543,200.00	£ 543,200.00	£ 543,200.00	£ 543,200.00	£ 543,200.00
<b>Revenue - Non-Staff</b>	£ 325,919.30	£ 571,583.65	£ 846,179.85	£ 1,012,745.50	£ 1,160,023.25
<b>Set Up costs</b>	£ 6,477.50				
<b>Total</b>	£ 875,596.80	£ 1,114,783.65	£ 1,389,379.85	£ 1,555,945.50	£ 1,703,223.25
<b>Less Savings</b>	-£ 420,225.54 <sup>3</sup>	-£ 420,225.54	-£ 420,225.54	-£ 420,225.54	-£ 420,225.54
<b>Revised Total</b>	£ 455,371.26	£ 694,558.11	£ 969,154.31	£ 1,135,719.96	£ 1,282,997.71

**Option 3: Full expansion to deliver against clinical guidelines**

Option 3 represents the 'gold standard' in MS service delivery which would support the Team to deliver against AWMMSG and NICE guidelines as follows:

- Screening 150 patients per year
- with 76 patients beginning fampridine;

<sup>1</sup> The medical model, including MS DCC, has been developed as per Appendix 2.

<sup>2</sup> The administrative roles are essential to: facilitating the pathways; typing; and providing broad support to clinicians to effectively manage their caseload. Without the administrative support at lower banded levels, this work would fall directly to the clinical staff which would take time away from DCC activity, thus leading to inefficiencies and waste within the system.

<sup>3</sup> Savings are anticipated from moving from a branded to generic MS drug.

- with 20% patients beginning Siponimod;
- Prescribing Sativex to an additional 20 patients per year;
- Undertaking annual review for all patients.

This option is associated with the fewest risks, as additional staffing capacity will be futureproofed in order to ensure service sustainability and minimise the impact on wider healthcare system as demand continues to grow. Indeed, the reduced demand on other services is estimated to result in cost avoidance related to admission avoidance of £715,050.00 per year, and total systemwide economic benefits of £4,492,800.00 by Year 5.

The proposed increase against RtB4MS guidance and growing patient demand is outlined in Table 3 with the financial breakdown provided in Table 4. Notably, with the inclusion of a Band 6 and a Band 8a RN, Option 3 will allow career development in a specialised field; this will serve to both attract newly qualified staff with aspirations for development and also provide opportunities for existing staff to advance. This vertical structure also mirrors the Cardiff & Vale University Health Board and Swansea Bay University Health Board models which are described in further detail in the full business case.

The interdependencies relating to feasibility, resource implications and affordability are described in full in the business case. However, the MS Team is assured that:

- It will be possible to recruit into all posts;
- The Radiology Directorate will support delivery of MRIs as part of the fampridine and Sipaonimod screening process and the annual review process;
- The Pharmacy Directorate will be able to meet increased demand within its current capacity.

**Table 3: Option 3 WTE**

	Current WTE	Option 3 Additional WTE	Option 3 Total WTE	Requisite WTE (RtB4MS) for current demand	Requisite WTE (Rt2 B4MS) for 2028 demand
<b>Doctors</b>					
Consultant	1.33 MS DCC (1.80 WTE)	1.67 MS DCC (2.50 WTE)	2.98 MS DCC (4.30 WTE) <sup>4</sup>	2.44	2.85
<b>MS RNs</b>					
Band 8a MS RN		1.00	5.00	4.68	5.70
Band 7 MS RN	3.00				
Band 6 MS RN		1.00			
<b>Other RNs</b>					
Band 5 infusion RN	1.00	1.00	2.00		
<b>Coordinators</b>					
Band 4 DMT coordinator		2.00	2.00	1.74	2.28
<b>Other Administrators<sup>5</sup></b>					
Band 4 secretary	1.50	1.00	2.50		
Band 3 secretarial assistant		1.00	1.00		

**Table 4: Option 3 Finance**

Cost summary	Year 1	Year 2	Year 3	Year 4	Year 5
<b>Capital</b>	0	0	0	0	0
<b>Revenue - Staff*</b>	£ 683,239.00	£ 683,239.00	£ 683,239.00	£ 683,239.00	£ 683,239.00
<b>Revenue - Non-Staff</b>	£ 692,719.30	£ 958,033.65	£ 1,253,327.85	£ 1,441,377.50	£ 1,611,449.25
<b>Set Up costs</b>	£ 8,489.00				
<b>Total</b>	£ 1,384,447.30	£ 1,641,272.65	£ 1,936,566.85	£ 2,124,616.50	£ 2,294,688.25
<b>Less Savings</b>	-£ 420,225.54	-£ 420,225.54	-£ 420,225.54	-£ 420,225.54	-£ 420,225.54
<b>Revised Total</b>	£ 964,221.76	£ 1,221,047.11	£ 1,516,341.31	£ 1,704,390.96	£ 1,874,462.71

This business case has explored options to address the capacity deficit within the Aneurin Bevan University Health Board MS Team and ensure its long-term

<sup>4</sup> The medical model, including MS DCC, has been developed as per Appendix 2.

<sup>5</sup> The administrative roles are essential to: facilitating the pathways; typing; and providing broad support to clinicians to effectively manage their caseload. Without the administrative support at lower banded levels, this work would fall directly to the clinical staff which would take time away from DCC activity, thus leading to inefficiencies and waste within the system.

sustainability. At present, the MS Team does not adhere to national guidelines around safe staffing, annual review or treatment options which has a subsequent impact on patient safety and experience. Therefore, the Preferred Option seeks to ensure a safe and effective MS service through recruiting additional clinical and administrative staff in accordance with national NICE, AWMSG and MS Society guidelines.

The proposed approach will, in time, bring service provision in line with providers across Wales. It will ensure equity across the system as all eligible patients will have access to appropriate therapies, whilst patients with more advanced disease, who currently receive compromised care, will benefit from additional clinical resource. Indeed, these patients will receive 'care closer to home' as per the ambitions of the Clinical Futures' strategy.

Recognising the significant pressure on Aneurin Bevan UHB's finances, and balancing the requirement to ensure that the noted drugs and associated screening is made available to patients with haste, this business case recommends a two phased approach.

1. To initially enact option two, funding the Directorate to appoint the relevant staff to screen for, and safely prescribe Fampridine which will ensure compliance with AWMSG guidelines and remove the inequality that currently exists for our patients.
2. A commitment should then be given after implementation and a service review, to approve the full implementation of option three, as the service model and provision of other therapeutics within MS change.

Note: Recognising that this case is being presented for final approval mid-year (2024/25), and that there will be a phased implementation period while staff are recruited, the below outlines the potential timelines and costs that will be incurred during this period.

2024/25	Drug Costs	Savings from Switching	Staffing Costs (Consultant)	Staffing Costs (Nursing & Admin)	Total
Quarter 1	£ 6,244.15				£ 6,244.15
Quarter 2	£ 18,732.45				£ 18,732.45
Quarter 3	£ 74,929.83	-£ 70,037.60	£ 35,172.68	£ 58,118.01	£ 98,182.92
Quarter 4	£ 74,929.83	-£ 105,056.40	£ 105,518.04	£ 58,118.01	£ 133,509.48
Total	£ 174,836.26	-£ 175,094.00	£ 140,690.72	£ 116,236.02	£ 256,669.02

### Argymhelliad / Recommendation





The Board is recommended to **APPROVE** the implementation of Option 3 with a review period of one year and to enact Option 2 for the financial year 2024/25, in line with the phased approach set out in the paper.

<b>Amcanion: (rhaid cwblhau)</b> <b>Objectives: (must be completed)</b>	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.6 Medicines Management 3.1 Safe and Clinically Effective Care 5.1 Timely Access 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	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	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	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.

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	AWMSG. (2019). <i>Final Appraisal Recommendation: Fampridine (Fampyra®) 10 mg prolonged-release tablets</i> . Online: All Wales Medicines Strategy Group. Hobart, J., Mathews, J., & Rog, D. (2021). <i>Raising the Bar for MS (RtB4MS) UK service and Disease Modifying Treatment (DMT): Part A: Summary Report, Recommendations, Next Steps</i> . Online: MS UK Audit Group. NICE. (2020). <i>Siponimod for treating secondary progressive multiple sclerosis: Technology appraisal guidance [TA656]</i> . Online: NICE. NICE. (2022). <i>Multiple sclerosis in adults: management: NICE guideline [NG220]</i> . Online: NICE. Retrieved from <a href="https://www.nice.org.uk/guidance/ng220">https://www.nice.org.uk/guidance/ng220</a>
Rhestr Termau: Glossary of Terms:	<b>AWMSG</b> All Wales Medicines Strategy Group <b>DCC</b> Direct clinical contact <b>MS</b> Multiple Sclerosis

	<p><b>NICE</b> National Institute for Health and Care Excellence</p> <p><b>RN</b> Registered nurse</p> <p><b>RtB4MS</b> Raising the Bar for MS</p> <p><b>WTE</b> Whole time equivalent</p>
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Pre-Investment Panel Executive Committee

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
<b>Resource Assessment:</b>	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:
• <b>Workforce</b>	Yes, outlined within the paper
• <b>Service Activity &amp; Performance</b>	Yes, outlined within the paper
• <b>Financial</b>	Yes, outlined within the paper
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>Yes not yet available</b>  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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a>	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

<b>Appendices</b>	
Appendix 1: MS Society and Ministerial Letters	 Access to Fampyra  20230814  Final Public Interest MS Society support Fampridine Respon:Report - 202301069.
Appendix 2: Medical Model	 MS Business Case Medical Modelling †



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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	RGH Decontamination Unit
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Hannah Evans, Director of Strategy, Planning and Partnerships
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Hannah Capel, Assistant Director of Strategic Capital

**Pwrpas yr Adroddiad (dewiswch fel yn addas)**

**Purpose of the Report (select as appropriate)**

Ar Gyfer Penderfyniad/For Decision

The purpose of this SBAR is to present the Business Justification Case (BJC) for a Central Decontamination Unit in the Royal Gwent Hospital (RGH) and to seek Board approval to submit the BJC bid to Welsh Government for All Wales Capital funding of £4.714m and consider the revenue consequences.

**ADRODDIAD SCAA**

**SBAR REPORT**

**Sefyllfa / Situation**

The attached Business Justification Case (BJC) has been prepared to support the proposed development of a Centralised Decontamination Unit at Royal Gwent Hospital (RGH) at a capital cost of £4.714m.

If approved by the Executive Committee and the Health Board, the BJC will be submitted to Welsh Government for funding via All Wales strategic capital. The Health Board will also no longer be required to fund the provision of a mobile decontamination unit at the annual cost of £120K from time of opening of new facility.

There is a revenue consequence of £140k of the full implementation of the central decontamination unit noting £1.046m revenue for decontamination has already been provided in the budget through the original Endoscopy Unit case. This revenue consequence will be off set largely against the decommissioning of the mobile unit leaving a circa £20k pressure.



## Cefndir / Background

Cleaning and decontamination of scopes is currently undertaken at several locations within Royal Gwent Hospital. The facilities are inadequate and in non-compliant settings. The current locations do not have appropriate segregation between dirty and clean areas, have significant space restrictions and are not ventilated to standards recommended in WHTM 03/01 and WHTM 01/06. This includes locations within urology and urology theatres. They are also staffed by a workforce that are largely not dedicated to decontamination services with differing and potentially unsafe working practices.

In addition to the above deficiencies, the recent expansion of endoscopy facilities at RGH from 2 suites to 4 suites has necessitated that a mobile decontamination unit be leased to provide additional capacity for the cleaning and decontamination of endoscopy scopes. The option to utilise the HSDU at the Grange University Hospital (GUH) to support the expansion of endoscopy services in RGH was considered but expansion of services at GUH and concerns regarding the transportation of scopes rendered the mobile unit being chosen as a preferred option.

It is proposed to refurbish / redevelop the redundant Endoscopy Unit in RGH into a Centralised Decontamination Unit (CDU). This will allow all scopes utilised within Royal Gwent to have access to a fully compliant, purpose designed unit with dedicated staff (future use of vacated decontamination spaces within the RGH will be considered as part of the wider eLGH and St Woolos reconfiguration work).

The Investment Objectives for the development are set out below:

<b>Investment Objective 1</b>	Support the planned increase in the demand for clinical diagnostic and treatment services.
<b>Investment Objective 2</b>	Support compliance with existing and emerging national guidance regarding the sterilisation and decontamination of medical devices.
<b>Investment Objective 3</b>	Service provision that is efficient, effective and maximises the use of available resources.

## Asesiad / Assessment

As is normally the case with business cases an option appraisal has been undertaken to assess the capital and revenue costs of possible options. The shortlisted options include:

**Option 1** - Address backlog maintenance and replace equipment in existing facilities (Baseline option)

**Option 2** - Develop the redundant Endoscopy unit for Endoscopy scope decontamination only.

**Option 3** - Develop the redundant Endoscopy unit as a Centralised Decontamination unit

**Option 4** - Construct a new Centralised Decontamination Unit on the RGH site

The capital and revenue costs of each option are as follows:



	<b>Option 1</b>	<b>Option 2</b>	<b>Option 3</b>	<b>Option 4</b>
<b>Capital</b>	£1.569m	£4.939m	£4.714m	£8.358m
<b>Revenue</b>	£0 (1.046m in budget from Endoscopy case)	£0 (1.046m in budget from Endoscopy case)	£140k (1.046m in budget from Endoscopy case)	£356k (1.046m in budget from Endoscopy case)

Option 1 is regarded as the funded baseline from a revenue perspective and includes additional resources for scope decontamination approved as part of the BJC for the development of Endoscopy services at RGH which has increased Endoscopy capacity from 2 suites to 4 suites. This additional capacity came online in November 2023 in tandem with a mobile decontamination unit that has been commissioned to provide additional capacity for scope cleaning. The revenue expenditure has therefore been incurred from November 2023.

The costs for Option 3 include additional staff and consumables to support the cleaning and decontamination of scopes for other services within Royal Gwent. They assume that:

- The redundant old RGH Endoscopy suite will be converted to a central Decontamination Unit for RGH.
- The lease for the mobile unit will be terminated
- Baseline costs on consumables and other non-pay costs currently expended by services, other than Endoscopy, on decontamination of scopes, i.e. Urology will transfer. This equates to £265k (£265k relating to Urology and Theatres)
- As the decontamination of scopes in these areas is undertaken by staff who undertake a range of other duties within the department, staffing costs will not transfer. It is assumed that those staff will remain within those departments if scope decontamination is centralised.

**Affordability**

The revenue difference between Options 1 & 2, and Option 3 is £140k the reasons for which are noted above. Option 4 is not considered affordable from both a capital and revenue perspective.

In terms of revenue implications of option 3, these would be incurred from Summer 2025 (next financial year).

The Health Board is currently funding a £120k annual cost for the provision of a mobile decontamination unit, which is currently being met by facilities. If approved, this will no longer be a cost pressure to the Facilities and Estates Division and would off set the majority of the revenue costs, noting that there would be a small element of double running as staff are appointed before the mobile unit is discontinued.



## Pre-Investment Panel (PiP)

The Business Case was reviewed by the PiP Panel ahead of submission to the Board, with the following key themes and responses identified:

Theme from PiP	Response
Decontamination Units ability to respond to future growth and demand. Response	The unit has been modelled and designed to allow for future growth within services at the RGH site.
Track and trace system as an investment objective and the financial investment required to support this	This is included within the BJC and is a feature within the "Getinge" decontamination equipment.
Workforce and staff duties. As part of the Endoscopy Business Case, a number of staffing positions have already been funded, is this double counting.	The revenue in the BJC is for the additional staff required to take on the other services. The HSDU staff will be trained in all aspects of decontamination services not just focussing on one specific aspect, which will result in an improved utilisation of workforce, providing cross coverage within the department.
Summary of all decontamination units throughout the Health Board	BJC now updated to set this out

## Risks

The decontamination service to support the new Endoscopy Unit is currently being provided from a temporary solution on the grounds of the Royal Gwent Hospital. This is already presenting challenges due to the size, limited facilities and access for staff and equipment. Active dialogue is in place with the NHS Wales Authorising Engineer for Decontamination on how to best manage these issues and risks, however both Shared Services and the Health Boards Decontamination lead have expressed their concerns about the unit due to the number of risks to future sustainability. The temporary unit is also limited to the level of activity which it can support.

Secondly the new Endoscopy unit is currently unable to achieve JAG accreditation, and whilst the accreditation is wider than the physical estate, the estate is the limiting factor to achieving this. This has resulted in the new Endoscopy unit being unable to support the Bowel Screening Wales activity from the Royal Gwent site, due to the lack of appropriate decontamination facilities.

## Benefits

A detailed benefits register is attached as part of the BJC:

- Support JAG accreditation
- Reduce contamination risks
- Provide sufficient capacity to support the increase in activity in the new Endoscopy unit and Bowel Screening Wales.
- Delivers a more flexible and sustainable workforce model – trained in all aspects of decontamination



## Timescales

Submission of the BJC to Welsh Government is currently programmed for the end of May 2024. On the assumption that the BJC is approved within 3 months of submission it has been assumed that the project will commence in October 2024 and will be completed by the end of July 2025.

## Argymhelliad / Recommendation:

The Board is asked to:

- Approve the BJC for submission to the Board and WG based on Option 3 at a capital cost of £4.714 million.
- Note the revenue implications of option 3 equating to £140k (part year effect from 25/26) but off set against the discontinuation of the mobile decontamination (£120k a year).

## Amcanion: (rhaid cwblhau)

### Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix 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  <a href="#">Link to IMTP</a>	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Enabling Estate
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	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:	<ul style="list-style-type: none"> <li>• Welsh Government officials</li> <li>• NHS Shared Services</li> <li>• Independent advisors nominated by Independent Projects Authority</li> </ul>

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper</b>
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>No does not meet requirements</b>  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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a>	Choose an item. Choose an item.





**Royal Gwent Hospital  
Centralised Decontamination Unit  
Business Justification Case**

Version No: 14a  
Issue Date: 9<sup>th</sup> May 2024

## Contents

<b>1.0</b>	<b>INTRODUCTION</b>	3
<b>2.0</b>	<b>THE STRATEGIC CONTEXT &amp; CASE FOR CHANGE</b>	4 - 16
<b>3.0</b>	<b>OPTION APPRAISAL</b>	17 - 26
<b>4.0</b>	<b>THE PROCUREMENT ROUTE</b>	27 - 28
<b>5.0</b>	<b>FUNDING AND AFFORDABILITY</b>	29 - 32
<b>6.0</b>	<b>MANAGEMENT ARRANGEMENTS</b>	33 - 34

## APPENDICES

- Appendix 1: RGH Endoscopy Unit BJC
- Appendix 2: Decontamination Services Audit
- Appendix 3: Benefits Realisation Plan
- Appendix 4: Generic Economic Model (GEM)
- Appendix 5: Contract Strategy
- Appendix 6: Tender Evaluation Report
- Appendix 7: BJC forms
- Appendix 8: Depreciation Calculations

## Table of Acronyms

<b>AE(d)</b>	Authorising Engineer (decontamination)
<b>AEDET</b>	Achieving Excellence by Design Evaluation Toolkit
<b>AER</b>	Automated Endoscope Re-processor
<b>BJC</b>	Business Justification Case
<b>BREEAM</b>	Building Research Establishment Environmental Assessment Method
<b>BSG</b>	British Society of Gastroenterology
<b>CDU</b>	Centralised Decontamination Unit
<b>CSF</b>	Critical Success Factor
<b>eLGH</b>	enhanced Local General Hospital
<b>EAC</b>	Equivalent Annual Cost
<b>ERCP</b>	Endoscopic Retrograde Cholangiopancreatography
<b>EUS</b>	Endoscopic Ultrasound
<b>EWD</b>	Endoscopic Washer Disinfector
<b>GEM</b>	Generic Economic Model
<b>HBN</b>	<b>Health Building Note</b>
<b>HSDU</b>	Hospital Sterilisation Decontamination Unit
<b>JAG</b>	Joint Advisory Group
<b>JCT</b>	Joint Contracts Tribunal
<b>LGH</b>	Llanfrechfa Grange
<b>MHRA</b>	Medicines Healthcare products Regulatory Agency
<b>NPC</b>	Net Present Cost
<b>RGH</b>	Royal Gwent Hospital
<b>SoFP</b>	Statement of Financial Position
<b>VFM</b>	Value for Money
<b>WHTM</b>	Welsh Health Technical Memorandums
<b>WHBN</b>	Welsh Health Building Notes
<b>WTE</b>	Whole Time Equivalent

## 1.0 INTRODUCTION

1.1 The purpose of this Business Justification Case (BJC) is to seek approval for a total capital investment of **£4.714 million** to support the development of a Centralised Decontamination Unit (CDU) at the Royal Gwent Hospital (RGH), Newport.

1.2 Cleaning and decontamination of scopes is currently undertaken at several locations within Royal Gwent Hospital. The facilities are inadequate and in non-compliant settings. The current locations do not have appropriate segregation between dirty and clean areas, have significant space restrictions and are not ventilated to standards recommended in WHTM 03/01 and WHTM 01/06. This includes locations within Endoscopy, Urology and Urology Theatres.

1.3 It is proposed to redevelop the existing Endoscopy Unit into a CDU following the relocation of Endoscopy services to a newly developed four suite unit in November 2023. Through a phased approach, all scopes utilised within Royal Gwent to have access to a fully compliant, purpose designed unit with dedicated staff. Future use of vacated decontamination spaces within the RGH will be considered as part of the wider eLGH and St Woolos reconfiguration work.

### Structure of Document

1.4 This BJC has been prepared using the agreed standards and format for Business Cases, as set out in:

- HM Treasury Guide to Developing the Project Business Case 2018
- NHS Wales Infrastructure Planning Guidance (2018)
- HM Treasury, the Green Book: Appraisal and Evaluation in Central Government: Treasury Guidance (2022).
- Public Sector Business Cases using the Five Case Model: A Toolkit Guidance and Templates (2013)

1.5 The approved format is the 5 Case Model, which comprises of the following key components:

- The **Strategic Case** which sets out the Strategic Context and the Case for Change, together with the supporting investment objectives for the Scheme.
- The **Economic Case** which demonstrates that ABUHB has selected a *preferred way forward*, following evaluation of a number of alternative solutions, which best meets the existing and future needs of the Service

and is likely to optimise Value for Money (VFM).

- The **Commercial Case** which outlines the potential procurement strategy.
- The **Financial Case** which addresses the capital and revenue implications and the issue of affordability.
- The **Management Case** which demonstrates that the scheme is achievable and can be successfully delivered in accordance with accepted best practice.

## **2.0 STRATEGIC CASE**

### **Part A Strategic Context**

#### **2.1 Organisational Overview**

2.1.1 Aneurin Bevan University Health Board (The Health Board) was established in October 2009 and achieved 'University' status in December 2013. The Health Board's principal role is to ensure the effective planning and delivery of our local NHS system, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health and reduce inequalities and achieve the best possible outcomes for our citizens, and in a manner that promotes human rights. To fulfil this role, we are required to work with our partners and stakeholders in the best interests of the population we serve.

2.1.2 The Health Board serves an estimated population of over 592,000 in the region of Gwent which reflects the five local authority areas: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the south Wales valleys.

2.1.3 The Health Board has an annual budget from the Welsh Government of around £1.7 billion per year which is deployed to commission and/or deliver services for the population of Gwent. The Health Board, as well as providing services locally, works in partnership to seek to improve health and well-being in the area, particularly through our partnership arrangements to respond to the Social Services and Well-Being (Wales) Act 2014 and the Well Being of Future Generations (Wales) Act 2015.

2.1.4 The Health Board employed 14,714 whole time equivalent (WTE) staff as at 31st October 2023. The staff group has remained relatively unchanged in the last year. The largest staff group are Nursing & Midwifery at 30% of the total workforce followed by additional Clinical services at 20%. The workforce is ageing, as is the demographic profile of our population and the

health inequalities of the population are also found within the workforce. 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of preventative plans.

## **Services**

2.1.5 The Health Board provides a comprehensive range of acute hospital based, Community based, Mental Health and Primary Care services via a large and complex estate consisting of the following:

- 4 Acute Hospitals – Grange University Hospital, Royal Gwent, Nevill Hall, Ysbyty Ystrad Fawr
- 5 Community Hospitals - County, Ysbyty Aneurin Bevan, St Woolos, Chepstow and Monnow Vale
- 4 Mental Health Hospitals - St Cadoc's, Llanfrechfa, Maindiff Court, Ysbyty'r Tri Chwm
- 8 Locality based Mental Health Units and 1 Residential Unit on LGH site, 4 unoccupied units across Gwent.
- 30 Locality based Community clinics

2.1.6 The Health Board contracts with independent practitioners in respect of primary care services which are delivered by General Practitioners, Opticians, Pharmacists and Dentists. Outside of normal practice hours the University Health Board has responsibility for and provides an Out of Hours Primary Care Service.

2.1.7 There are 281 WTE General Practitioners and Salaried GPs providing general medical services from 72 General Practices. Supporting these are 194.8 WTE practice nurses, 156.8 health care support workers 689.7 WTE administrative staff, including practice managers, receptionists, secretaries and IT officers. Around 375 General Dental Practitioners provide general dental services from 79 practices. There are 131 Community Pharmacies and 69 Optometry premises across the University Health Board.

2.1.8 A wide and growing range of community-based services are increasingly being delivered in patient's homes, through community hospitals, health centres and clinics. There are a number of smaller community hospitals, integrated health and social care centres, and health centres providing important clinical services to our residents closer to home.

2.1.9 The Health Board also provides comprehensive Mental Health and Learning Disabilities services in both hospital and community settings to the population of Gwent and South Powys

## 2.2 National Policy /Service Context

2.2.1 **'A Healthier Wales'** sets out a long term, future vision of a whole system approach to health and social care which is focussed on health and wellbeing and on preventing illness. The ambition is for the continued development of a seamless, integrated system of health and social care, predicated on a place-based approach to service delivery, to improve service sustainability, quality and safety and to improve population wellbeing.

2.2.2 **The Social Services and Wellbeing (Wales) Act** and **Wellbeing of Future Generations (Wales) Act 2015** provide an enabling legislative framework which requires the Health Board and partners to work collaboratively in an integrated way across the whole system, involving the public in developing long term solutions to prevent avoidable illness and provide sustainable services in the future.

2.2.3 The **Wellbeing of Future Generations (Wales) Act established 7 National goals and places a Well-being duty on Welsh Public Bodies. The legislation requires the Health Board to carry out Sustainable Development by taking action in accordance with the Sustainable Development Principle through applying five ways of working to its decision making**, namely:

1. **Long term thinking** (where consideration should be given to the balance between current demands and longer term impacts over a 25 year period).
2. **An Integrated approach** (how wellbeing objectives impact upon each other and in turn on the objectives of other public bodies and then how decisions impact on supporting the 7 national well-being Goals).
3. **Preventative Action** (deploying resources now in order to prevent problems occurring or getting worse).
4. **Collaboration** (acting collaboratively with other bodies or with other parts of the Health Board to assist in the achievements of the objectives of all).
5. **Involvement** (involving the people and communities whose well-being is being considered and engaging them and others in finding sustainable solutions).

2.2.4 By applying these ways of working the Health Board will bring about the organisational culture change needed to deliver on the ambition of **'A Healthier Wales'**.

2.2.5 Through the **All Wales Capital Prioritisation** exercise, the Health Board scored the Decontamination Unit 6<sup>th</sup> out of 20 schemes. Due to the deliverability of the scheme however, it is shown as a Phase 1 priority (1-3 years) to be taken forward.

2.2.6 The proposed decontamination unit will support the Health Board in delivering against Goal Four of the Five Goals for Planned Care: *Treat accordingly: Access to appropriate care at the right time at the right place.* Through streamlining and standardising the decontamination process for a range of clinical services at RGH, the Health Board will deliver more efficiencies to support more timely care closer to home. Furthermore, the new unit will further support delivery of the Welsh Government's programme for transforming and modernising planned care through:

- Prioritising diagnostic services: The unit will provide direct support to the newly opened endoscopy unit at RGH, and once at full capacity, will support additional lists in accordance with decontamination requirements as per the ambitions of the Bowel Screening Wales programme;
- Focusing on early diagnosis and treatment of suspected cancer patients: The Gastroenterology Directorate has been focussed on these priorities, and the efficiencies achieved through the opening of the decontamination unit will support this work in the medium- and longer-term;
- Eliminating long waiters at all stages of the pathway: Efficiencies will support a reduction in patients breaching all targets, with a particular focus on the 8-week target in the first instance;
- Building sustainable planned care capacity: The proposed unit has been designed to accommodate both current and future demand to support the sustainability and longevity of clinical services.

2.2.7 In the context of A Healthier Wales, Welsh Government announced in September 2018 a new nationally directed approach for Endoscopy service improvement in recognition of the fact that Endoscopy services play an essential part in investigating suspected cancer, as well as providing follow-up for people with prior diagnoses and delivering interventional treatment. The service covers several modalities of diagnosis and treatment with waiting lists being subject to diagnostic target subject to WG targets:

- Gastroscopy
- Capsules
- Colonoscopy
- Flexi- sigmoidoscopy
- Other procedures such as ERCP and EUS

2.2.8 Welsh Government recognised the pressures facing endoscopy services in Wales and the fact that the number of diagnostic endoscopy procedures required was increasing due to population changes, a lower threshold for suspected cancer investigation, the demand for surveillance and the need to expand the bowel-screening programme.

2.2.9 The strategic drivers for this investment and associated strategies, programmes and plans are as follows:

- The National Endoscopy Programme.
- JAG accreditation.
- Welsh Government guidance on best practice for decontamination of flexible endoscopes.
- Bowel Screening Wales plans.
- Rapid expansion of Endoscopy services
- Standards for decontamination facilities i.e., WHTM 01-01, 01-06 and other relevant HBN's and WHTM's.

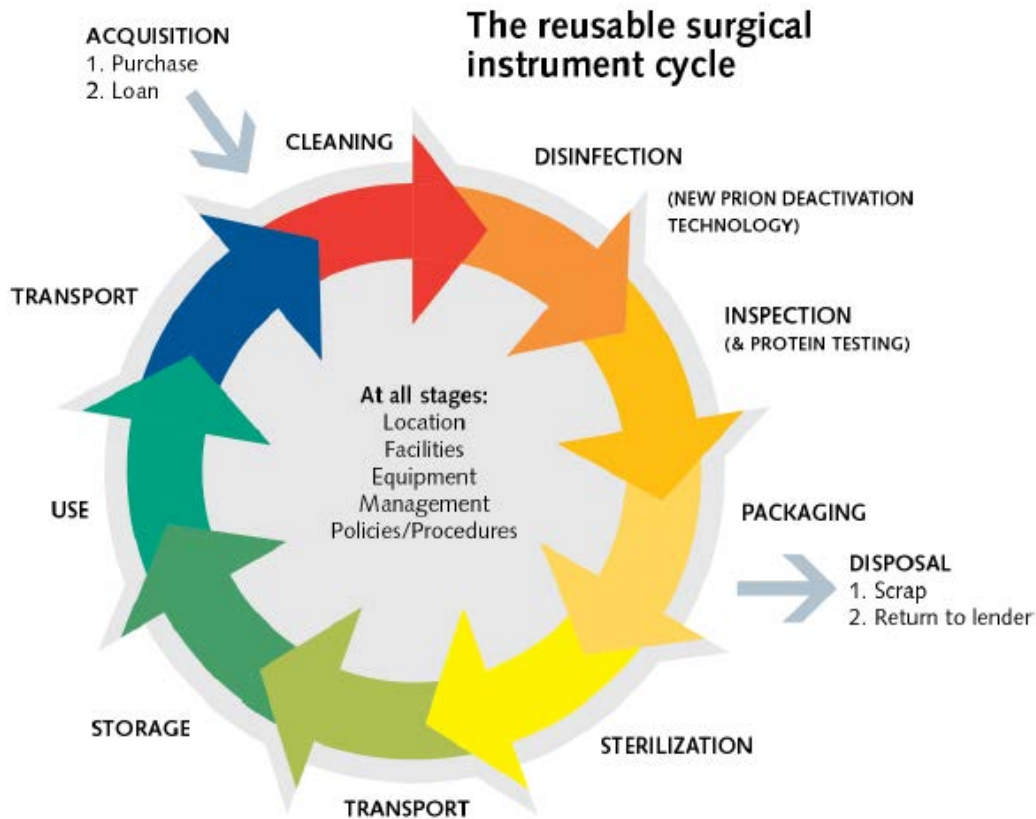
2.2.10 Since 2014, Welsh Government have carried out 3 all Wales surveys of arrangements for decontaminating flexible endoscopes in 2014, 2016 and 2018 and a survey of medical and surgical instruments (2017). The expectation is that all services will comply with relevant standards and guidelines e.g. WHTM's, HBN's, MHRA advice and British Standards quality systems.

2.2.11 This is recognised in line with the work which is currently being discussed from an all Wales perspective in relation to Business Continuity concerns for Decontamination.

2.2.12 In particular, this has meant that, where possible, health boards should seek to standardise systems and training. The most effective way to ensure this is to centralise arrangements, with automated and validated systems replacing manual systems. Tracking and traceability should also be computerised where possible rather than completed manually. Welsh Health Circular (WHC) (2015) 050 states that the essential requirements for good decontamination practice are:

- management controls are in place and effected;
- medical devices are used appropriately i.e.
  - fit for purpose;
  - in accordance with manufacturers' instructions;
  - properly maintained, monitored and validated;
  - used by staff who are fully trained and competent;
  - conforming to standards and requirements;
  - track and trace systems link device usage to individual patients;
  - robust records are maintained throughout the process;
- appropriate facilities are provided; and
- single use instruments are not decontaminated for subsequent use

2.2.13 To undertake decontamination effectively requires all the processes, illustrated in the life-cycle below, to be implemented correctly and consistently – with all appropriate controls and monitoring in place.



2.2.14 To minimise risk there should be a movement from local, manual decontamination at department level to automated and validated systems in centralised decontamination units on eLGH sites. Decontamination of flexible endoscopes is ideally carried out in automated endoscopic reprocessors (AER's), linked to a computerised track and trace system. Set out below is a direct extract from the All-Wales Endoscopy Survey Closure Report 2016 (p. 12):

**"Centralisation of decontamination of flexible endoscopes services**

*There should be a clear move to create central endoscope decontamination units, or central decontamination units (CDU) appropriate for purpose (CDUs are integrated into the sterile service department). Such centralisation enhances consistent compliance to quality standards, clinical activity, engineers a workplace environment in compliance with WHTM 01-06-part B and the Health and Safety at Work Act. Such units are designed to physically segregate dirty and clean activities with one way flow of endoscopes to prevent cross contamination. Other advantages of a centralised unit are that they ensure that key elements of the process (e.g., engineering services, trace-ability systems, training regimes etc.) are carried out by dedicated*

*operational management who are qualified in the field of medical device decontamination.”*

**2.3 Local Policy Context**

2.3.1 In response to the need to increase endoscopy capacity, the Health Board received Welsh Government approval to develop a 4-suite Endoscopy Unit at Royal Gwent Hospital in 2022. The approved BJC is attached at **Appendix 1**. This was opened in November 2023 and increased the number of Endoscopy suites from 2 to 4.

2.3.2 The increase in endoscopy activity requires that decontamination services be expanded whilst at the time recognising the significant limitations that exist with the current accommodation for decontamination of scopes at Royal Gwent Hospital which are provided from several disparate locations including Endoscopy, Urology and Urology operating theatres.

2.3.3 Decontamination services are not centralised and do not currently comply with many of the recommendations outlined above from points 2.2.8 to 2.2.11.

**Part B: The Case for Change**

**2.4 Investment Objectives**

2.4.1 The agreed Investment Objectives for this project are to provide a configuration of Decontamination services within Royal Gwent Hospital that:

<b>Investment Objective 1</b>	Support the planned increase in the demand for clinical diagnostic and treatment services.
<b>Investment Objective 2</b>	Are compliant with existing and emerging national guidance regarding the sterilisation and decontamination of medical devices.
<b>Investment Objective 3</b>	Are efficient, effective and maximises the use of available resources.

**2.5 Existing Arrangements**

**Infrastructure**

2.5.1 Decontamination services at Royal Gwent Hospital are currently provided from several locations including Endoscopy, Urology and Urology operating theatres.

2.5.2 Services provided from the existing Endoscopy Unit closed in November 2023 following the opening of a newly expanded Endoscopy Unit. As the location of the existing was set within the old Endoscopy Unit and was not large enough to deal with the increase in demand, a mobile decontamination unit has been procured via lease arrangements, to provide an alternative decontamination facility during the refurbishment of the site of the new centralised decontamination unit. The temporary solution however, is struggling to meet the current increased demand and has no mitigation available should the unit breakdown. The layout and size of the temporary unit is not ideal for staff working within over a prolonged period, the unit is cramped, there is no weather protection to account for transportation during winter months, and no welfare facilities. This is currently funded from revenue.

Other Health Board Decontamination include –

- NHH Endoscopy decontamination unit, WHTM compliant consists of two sinks and 4 washer chambers staffed by trained decontamination technicians
- GUH Endoscopy decontamination unit, WHTM compliant consists of two sinks and 4 washer chambers staffed by trained decontamination technicians
- YYF Endoscopy decontamination unit, JAG accredited WHTM compliant unit with two sinks and 4 washer chambers, staffed by decontamination technicians.

### Existing and approved activity

2.5.3 The table below documents the current and future demand of clinical services that currently utilise decontamination facilities. The demand has been calculated based on current demand with an expected growth of up to 50% following the opening of the expanded Endoscopy Unit.

Current Demand						Demand with increase in Endoscopy Activity from November 2023					
Service	Mon	Tue	Wed	Thu	Fri	Service	Mon	Tue	Wed	Thu	Fri

Endoscopy	24	24	24	24	24	Endoscopy	48	48	48	48	48
Theatres	16	4	6	16	6	Theatres	16	4	6	16	6
Urology	25	50	45	50	38	Urology	25	50	45	50	38
	65	78	75	90	68		89	102	99	114	92

Future Demand + 5%					
Service	Mon	Tue	Wed	Thu	Fri
Endoscopy	50	50	50	50	50
Theatres	17	4	6	17	6
Urology	26	53	47	53	40
	93	107	104	120	97

Future Demand + 10%					
Service	Mon	Tue	Wed	Thu	Fri
Endoscopy	53	53	53	53	53
Theatres	18	4	7	18	7
Urology	28	55	50	55	42
	98	112	109	126	101

Future Demand + 15%					
Service	Mon	Tue	Wed	Thu	Fri
Endoscopy	56	56	56	56	56
Theatres	19	5	7	19	7
Urology	29	58	52	58	44
	103	118	115	132	107

Future Demand + 20%					
Service	Mon	Tue	Wed	Thu	Fri
Endoscopy	58	58	58	58	58
Theatres	19	5	7	19	7
Urology	30	61	55	61	46
	108	124	120	139	112

Future Demand + 25%					
Service	Mon	Tue	Wed	Thu	Fri
Endoscopy	60	60	60	60	60
Theatres	20	5	8	20	8
Urology	31	63	56	63	48
	111	128	124	143	115

Future Demand + 50%					
Service	Mon	Tue	Wed	Thu	Fri
Endoscopy	63	63	63	63	63
Theatres	21	5	8	21	8
Urology	33	66	59	66	50
	117	134	130	150	121

2.5.4 The table above demonstrates the current position and potential increase in demand for decontamination services across all services in the Royal Gwent Hospital. The endoscopy service currently use 24 scopes per day, this activity has increased to 48 per day Monday – Friday, and 24 per day on Saturday and Sunday from November 2023. From April 2024, 4 Theatres will run Monday to Sunday, utilising 336 scopes per week.

### Existing and approved Revenue costs

2.5.5 As noted above in section 2.3, in response to the need to increase Endoscopy capacity the Health Board received Welsh Government approval to develop a 4-suite Endoscopy Unit at Royal Gwent Hospital in 2022.

2.5.6 The increase in Endoscopy activity required that decontamination services be expanded and a recurrent sum of **£1.046 million** has been made available to support that expansion via the Endoscopy development business

case. For the purposes of this business case, and in the context of ongoing discussions regarding the recurrent revenue funding of the Endoscopy expansion, this is regarded as the funded baseline.

## 2.6 Business Needs

### Service Infrastructure

2.6.1 The current decontamination services are fragmented as they are based in several locations across the hospital. Most practices take place in environments that are not compliant with standards e.g. incorrect workflows with poor segregation between clean and dirty equipment.

2.6.2 More detail regarding current services are provided below:

**Endoscopy:** The existing facilities were situated within the RGH endoscopy department and have closed following the completion of a newly completed Endoscopy Suite in November 2023. There are currently four double endoscope washer disinfectors (EWD) machines of which two are located adjacent to each procedure room. There is some existing storage, but this is minimal and shared with endoscopy itself, which is insufficient. Whilst retaining the unit was considered within the long list of options, the unit currently does not meet the clinical requirements of the service moving forward and the layout is not conducive to efficient flows for clean and dirty scopes. As the previous Decontamination Unit was situated within the endoscopy suite, the size and lack of capacity would not be able to deal with the increase demand from the unit. The old unit was deemed non-compliant from an estate and would not achieve the JAG accreditation in order to support the requirements to support the new endoscopy suite, with further rationale set out in the following paragraphs.

Following an audit which was undertaken by the Senior Decontamination Engineer for Specialist Estates Services, the following was raised and is further elaborated in **Appendix 2**.

*"Please accept AE(D) assessment, measured against JAG national requirements (IHEEM audit tool v12), for the decontamination facilities, systems and governance within the Endoscopy Unit and related systems and services assigned for decontamination of flexible endoscopy within Royal Gwent Hospital. The assessment will be required as part of JAG assessment documents and has also been completed by NWSSP/SES on behalf of the NHS Wales Health Collaborative team and the report will be forwarded onto them for information.*

*Assessment is a mix of Red and Red/Amber when measured against JAG audit specification for decontamination standards. The rating has been based upon acknowledged need for essential infrastructure improvements to meet the required accountability and governance to be accepted as a JAG standard facility. It is recognised that HB teams have been working together to develop solutions to facilitate an infrastructure upgrade in alignment with expanded diagnostic services on the RGH site, it is essential such a decontamination infrastructure upgrade is completed as priority.*

*There is the need to implement further continual improvement process for any non-conformances raised in short term period the current systems are to remain. It would be expected the HB address the remedial actions on the points raised. NWSSP/SES will assist the team on any subsequent action plans.*

*The hard work of the team within ABUHB is recognised and it is acknowledged they have tried to put systems in place to mitigate potential risks as best they can within a severely restricted environment dedicated for decontamination”.*

Therefore, following the opening of the new 4 suite Endoscopy facility in RGH, a mobile decontamination unit was procured to provide improved functionality and increased scope cleaning capacity. It is anticipated that the scopes from services will be brought into the unit on a phased approach, Phase 1 Endoscopy, Phase 2 Urology Theatres. Timescales for each phase will be determine and assessed as part of the opening process.

**Urology and Urology Theatre:** Both these units were redeveloped after the 2014 and 2016 Welsh Government surveys and were presented as an intermediate option prior to the anticipated transfer of decontamination services to a Central HSDU on the site. Despite a number of explorations of this transfer project, it was deemed difficult to dedicate the required space within the existing HSDU. The built environments dedicated to decontamination within these units is not appropriate, presents no physical segregation between dirty and clean procedures and has a significant risk of inadvertent release of non decontaminated endoscopes for further patient use.

The EWD's are slowly reaching end of anticipated service life within the next 2 years. The ventilation within the facilities is not compliant with guidance specified within WHTM 01/06 or WHTM 03/01. The proximity of the decontamination facility to the patient area presents a significant risk of major disruption within a clinical zone in the event of major chemical spillages. Such an accident would present major COSHH issues and would be problematic evacuating patients. With the advancement in facilities used for

decontamination of flexible endoscopes over the last 10 years, both these facilities are deemed obsolete and not fit for current purpose. Urology are using disposable units in the medium term, there are concerns on the environment using these type of units.

### **Development of Options**

2.6.3 Whilst the Health Board's alternative HSDU premises were considered as part of the long list of options, they were discounted based for the following reasons –

- Transportation of Scopes – scopes are at high risk of breaking during transportation which will see an increase in equipment costs
- Transport would exceed original anticipated runs considerably and consequently transport costs. Delay in delivery of scopes would result in procedures being cancelled
- No resilience in HSDU EWDs if breakdown or maintenance required
- Vac Pac system would be required to store dried scopes predominately to extend the 3hr deadline - Minimum of 3 hrs drying time before vac pack
- Would be impossible to deliver wet scopes as these would likely exceed shelf life of 3hrs from decontamination to use,
- Endoscopy do not want scopes typhoon packed as believe this causes damage to fuji scopes

More specifically –

HSDU at The Grange:

- Footprint in the HSDU is comparable to the temporary unit, so would not cope with extra capacity of almost additional 13000 scopes per annum as estimated on the volume of scopes processed in the first quarter in the temporary unit on the RGH site
- There is no resilience in HSDU EWDs if there is a breakdown or if maintenance required

HSDU at the Royal Gwent:

- The footprint would not accommodate installation of 4-6 EWD's to process RGH endoscopy decontamination, 40% of RGH HSDU work moved to GUH 2023 partly to alleviate congestion
- No Reverse Osmosis or Cascade system which are specific technical requirements for decontamination units
- 3-5yrs machines in HSDU will require replacement likely upgrade of supporting infrastructure and fabric of unit

### **Workforce & Working Practices**

2.6.4 Staff in Endoscopy, Urology and Theatres currently undertake decontamination as part of wider roles within each department i.e., are not dedicated to decontamination. These wider roles have varying levels of competencies i.e., nursing staff, healthcare support workers and supervision of staff. Their duties range from decontamination to specialist patient care, including supporting the Theatre environment and recovery stage of patient care. The multitasking roles result in inconsistencies of decontamination services across Divisions and in some cases lead to non-compliance.

2.6.5 The transfer of staff duties (endoscopy only) has already occurred as of November 2023 as a consequence of decontamination service transferring to HSDU team, which formed part of the Endoscopy Business Case.

2.6.6 One example of inconsistency across services is the traceability of scopes. This inconsistency is a major risk in how decontamination services are undertaken in the tracking and traceability of scopes and processes. This inconsistency leads to risks of cross-contamination of flexible scopes and probes used on hundreds of patients a week. The new Centralised Decontamination Unit will have dedicated specialist trained staff with purpose-built facilities to ensure compliance against current decontamination unit guidelines and conform to JAG accreditation.

## **Demand and Capacity**

2.6.7 The planned and forecast increase in demand for scope decontamination services is outlined in point 2.5.3 above. The Endoscopy service currently use 24 scopes per day, this activity will increase to 48 per day Monday – Friday, and 24 per day on Saturday and Sunday from November 2023. From April 2024, 4 Theatres will run Monday to Sunday, utilising 336 scopes per week.

## **Summary and Conclusion**

2.6.8 Decontamination services at Royal Gwent Hospital are:

- Disparate, inadequate and non-compliant.
- Staffed by a workforce that are largely not dedicated to decontamination services with differing and potentially unsafe working practices
- Unable, due to capacity constraints, to meet planned future predicted demands for scope decontamination services

## 2.7 Potential Scope

2.7.1 This section describes the potential scope of the project to meet the investment objectives and associated business needs:

- *Minimum scope* – essential or core requirements/outcomes
- *Intermediate scope* – essential and desirable requirements/outcomes
- *Maximum scope* – essential, desirable and optional requirements/outcomes.

2.7.2 The table that follows describes the potential scope against each continuum:

Minimum	Intermediate	Maximum
Retain existing decontamination services and upgrade existing estate to Condition B	Redevelop existing estate at RGH to provide a CDU that will provide a centralised decontamination services servicing multiple clinical services	New build CDU on the RGH site to provide a centralised decontamination services servicing multiple clinical services

## 2.8 Benefits

2.8.1 This section describes the main outcomes and benefits associated with the implementation of the potential scope in relation to business needs with the full Benefits Realisation Matrix (BRM) shown in Appendix 3. Satisfying the potential scope for this investment will deliver the following high level strategic and operational benefits, which will be of both a quantitative and qualitative nature, which are as follows:

Objective	Benefit
<b>Investment Objective 1:</b> To provide a configuration of Decontamination services that supports the planned increase in the demand for clinical diagnostic and treatment services.	<ul style="list-style-type: none"> <li>• Scope Decontamination capacity is increased</li> <li>• Supports the delivery of local provision of general and routine services.</li> <li>• Can respond to changes in demand for HSDU services</li> <li>• Reduced delays / cancellations of front-line services because of lack of equipment availability</li> </ul>

<p><b>Investment Objective 2:</b> To provide a configuration of Decontamination services that are compliant with existing and emerging national guidance regarding the sterilisation and decontamination of medical devices.</p>	<ul style="list-style-type: none"> <li>• Reduces infection risk to staff and patients for all relevant clinical services</li> <li>• Reduces risks to staff working with hazardous chemicals</li> <li>• Standardisation of procedures</li> <li>• Improved tracking, monitoring and documentation of working practices (included within the specification of the Gentinge equipment).</li> <li>• Improved morale and motivation for staff by delivery of good quality health care – reduced turnover &amp; sickness</li> <li>• Achievement of JAG Accreditation</li> </ul>
<p><b>Investment Objective 3:</b> To provide a configuration of Decontamination services that are efficient, effective and maximises the use of available resources</p>	<ul style="list-style-type: none"> <li>• Improved utilisation of assets, estate and equipment</li> <li>• Improved resource utilisation – consumables, energy through better procurement, technologies and consistent practices</li> <li>• Rationalisation of the existing estate, release of space within existing clinical departments allowing greater flexibilities within those localities.</li> <li>• Improved utilisation of the workforce</li> <li>• Reduced duplication</li> <li>• Robust service with 95% uptime for AER's, autoclaves &amp; washer disinfectors – therefore improved efficiency</li> <li>• More sustainable service, by optimising use of energy/utility resources and opportunity to utilise more carbon reducing technologies, to include reclamation of waste water from central water purification plant.</li> </ul>

## 2.9 Risks

2.9.1 The main business and service risks associated with the potential scope across all the options for this project are shown below, together with their counter measures.

2.9.2 In accordance with the ABUHB Corporate Risk Strategy, the Programme will use the National Patient Safety Agency (NPSA) risk matrix to score each risk based on the following simple calculation:

<b>Potential Consequence x Likelihood of Adverse Outcome = Risk Score</b>		
(Where consequence and likelihood are allocated a score of between 1 and 5)	1 - 3	Low risk
	4 - 8	Moderate risk
	8 - 12	High risk
	15 - 25	Extreme risk

<b>Risk Category</b>	<b>Risk Description</b>	<b>Consequence 1-5</b>	<b>Likelihood 1-5</b>	<b>Risk Score</b>	<b>Mitigating Action</b>
Funding risk - Reduced availability of capital funding	May lead to a delay or reduction in scope of project	5	3	15	No contractual commitments will be made until affordability and availability of capital is assured. Mobile unit will need to be retained for longer than anticipated
Planning risk - planning constraints or issues	May impede progression of preferred option	3	3	9	Planning permission is not required but building regulations are, and will be adhered to at all stages
Demand and usage risk	The size and capacity are not appropriate for eventual need of the user group.	3	3	12	The preferred option has been planned in close collaboration with service users and a reasonable assessment of future demand

Implementati on Risk	Working adjacent to clinical areas, potential disruption / delay	4	3	12	Engagement with clinical services on programme of works, on-site communication
Revenue Affordability	May prevent immediate full utilisation of capacity	4	3	12	The unit can be opened in phases with Phase 1 covering endoscopy only via funding already approved

## 2.10 Constraints

2.10.1 The project is subject to following constraints:

- **Availability of capital** - The availability of capital funding is an obvious constraint which may hinder project progression.
- **Site Constraints** – The development of new services on an existing hospital site and adjacent to clinical services will require careful planning and ongoing communication with relevant stakeholders.
- **Revenue affordability** - The project must demonstrate revenue affordability and that sufficient savings will be achieved to justify any investment.
- **Ability to future proof against changing needs** - the design of any new facilities must be flexible and adaptable to take into account the changing needs of the organisation and future service delivery.
- **Timescale** – New services must be in place as soon as possible to address a number of adverse service impacts including recruitment and patient waiting times.

## 2.11 Dependencies

2.11.1 The success of the project will be dependent on: -

- **Stakeholder Consultation** - The introduction of a new model of services will require consultation with existing staff and key users of the service. It is essential therefore to ensure a clear communication and engagement plan is in place so that stakeholders have a clear understanding of the model and can influence the way the new working environment is designed.
- **Leadership** - A commitment from the Board and within the Division is required to implement a shift to the agreed model of service delivery. Commitment to drive through the required changes is paramount.

### 3.0 Option Appraisal

3.1 This section of the business case outlines:

- The critical success factors for the scheme.
- The range of options identified for appraisal in response to the potential scope of the scheme (the long list).
- The shortlisted options selected for the purpose of cost benefit analysis.
- The preferred option identified on the basis of value for money.

#### Critical Success factors

3.2 The key Critical Success Factors (CSF) are based on those already embedded in the Clinical Futures Programme and Strategy. They have been identified to allow evaluation of the potential options for the development of Endoscopy services. The CSF's are shown below:

<b>Critical Success Factor</b>	<b>Description</b>
CSF1: Strategic Fit	<ul style="list-style-type: none"><li>• Consistent with national and regional strategies</li><li>• Consistent with Clinical Futures strategy</li><li>• Meets national standards and guidance</li></ul>
CSF2: Acceptability	<ul style="list-style-type: none"><li>• Has support from key stakeholders.</li><li>• Compliance with legislation (service, workforce and building).</li><li>• Compliance with relevant HBNs and HTMs</li></ul>
CSF3: Sustainability	<ul style="list-style-type: none"><li>• Allows for flexibility of use and adaptable to future changes.</li><li>• Improves staff retention and recruitment.</li></ul>
CSF4: Efficiency	<ul style="list-style-type: none"><li>• Demonstrates effective use of resources.</li><li>• Supports the delivery of efficient processes and systems.</li><li>• Reduces duplication.</li></ul>
CSF5: Achievability	<ul style="list-style-type: none"><li>• Does not have a material effect on existing services</li><li>• Will obtain planning consent</li></ul>

#### Options Framework

3.3 An options framework is required to demonstrate a robust analysis of a number of possible options and this review has been carried out with

Careful reference to the Five Case Model Guidance as part of the Business Case Toolkit. The options framework was used by the project delivery team to first generate and secondly evaluate a range of possible solutions. This was undertaken using a SWOT analysis and a simple scoring mechanism to record how well each option satisfied the critical success factors (CSFs):

- x - the option did not satisfy the CSF's;
- □ - the option did satisfy the CSF's;
- ? - the option partially satisfied the CSF's but had an element of uncertainty.

3.4 This work was then used to draw up a shortlist of potential solutions or options which were assessed for value for money against the 'Do Nothing' benchmark.

**Framework of Strategic Options (or Potential Solutions)**

<b>Category of Choice</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
<b>Service Scoping Option</b>	<b><u>SO1</u></b> Scope Decontamination services continue as per current arrangements	<b><u>SO2</u></b> All Scope Decontamination services at RGH are delivered from a central location				<b><u>SO3</u></b> Endoscopy Scopes transported to HSDU GUH Decontamination facility.
<b>Estate Solutions</b>	<b><u>ES1</u></b> As now, address Backlog Maintenance and equipment replacement only	<b><u>ES2</u></b> Refurbishment of existing Endoscopy Suite for Endoscopy only	<b><u>ES3</u></b> Refurbishment of existing Endoscopy Suite for all services	<b><u>ES4</u></b> Provision of a mobile Decontamination Unit on the RGH site	<b><u>ES5</u></b> New build on the RGH site	<b><u>ES6</u></b> As now, address Backlog Maintenance and equipment replacement only
<b>Service Delivery</b>	<b><u>SD1</u></b> As per current arrangements	<b><u>SD2</u></b> Decontamination				<b><u>SD3</u></b> As per current arrangements

	nts, all services provided by ABUHB	services are outsourced				, all services provided by ABUHB
<b>Implementation Options</b>	<b><u>IO1</u></b> Single Phase	<b><u>IO2</u></b> Phased				<b><u>IO3</u></b> Single Phase
<b>Funding Options</b>	<b><u>FO1</u></b> Public sector capital	<b><u>FO2</u></b> Private sector capital				<b><u>FO3</u></b> Public sector capital

## Long List

3.5 The long list has identified and appraised a wide range of possible options. A summary of inclusions, exclusions and possible options is given in the table below:

Options	Finding
<b>1.0 Scoping Options</b>	
<b>SO1</b> - Scope Decontamination services continue as per current arrangements	This option would <b>not</b> meet the majority of the critical success factors. It offers no opportunity to sustain the service, support the growth in demand or address current infrastructure issues. <b><u><i>This option is rejected but is retained as a benchmark for cost comparison against other shortlisted options.</i></u></b>
<b>SO2</b> – All Scope Decontamination services at RGH are delivered from a central location	This option would meet the vast majority of the critical success factors <b><u><i>This option is possible and is carried forward to the shortlist.</i></u></b>
<b>SO3</b> - Endoscopy Scopes transported to HSDU GUH Decontamination facility.	This option would <b>not</b> meet the majority of the critical success factors. It offers no opportunity to sustain the service, support the growth in demand or address current infrastructure issues.

	<b><u>This option is rejected but is retained as a benchmark for cost comparison against other shortlisted options.</u></b>
--	---

<b>2.0 Estate Options</b>	
<b>ES1</b> - As now, address Backlog Maintenance and equipment replacement only	<p>This option does not meet any of the investment objectives or critical success factors.</p> <p><b><u>This option is discounted, but is retained as a benchmark for cost comparison as part of the Do- Nothing option</u></b></p>
<b>ES2</b> - Refurbishment and development of existing Endoscopy Suite (Do minimum)	<p>This option would meet the vast majority of the critical success factors for <b>Endoscopy services only</b>. Other services would continue as now.</p> <p><b><u>This option is possible and is carried forward to the shortlist.</u></b></p>
<b>ES3</b> - Refurbishment of existing Endoscopy Suite for all services	<p>This option would meet the vast majority of the critical success factors for all services.</p> <p><b><u>This option is possible and is carried forward to the shortlist</u></b></p>
<b>ES4</b> - Provision of a mobile Decontamination Unit on the RGH site	<p>The temporary mobile decontamination unit located on the Royal Gwent Hospital (RGH) site is a <b>short-term solution</b> to service the new Endoscopy Unit. This solution is not sustainable medium to long term. The unit is not designed in accordance with WHTM requirements. Space is very limited, and we do anticipate short term concerns in cramped/congested work areas. Due to limited space and cost, the unit has not been designed to meet JAG requirements, ventilation is basic and will present H&amp;S issues in the event of significant chemical spills. There are fire safety implications due to the close proximity to RGH, however given its importance to business continuity the unit can be sited as a short-term solution.</p> <p>The position of the unit, albeit acceptable short term, is not ideal as we are leaving the main building to transfer scopes outside, resulting in staff being exposed to weather and potential damage to scopes, because of the external transfer.</p>

	<p>There are no staff rest or welfare facilities, staff will need to use the main hospital facilities for welfare provision and staff breaks, thus taking them off the unit which will impact on efficiency.</p> <p><b><u>This option is discounted.</u></b></p>
<b>ES5</b> - New build on the RGH site	<p>This option would meet the vast majority of the critical success factors assuming a suitable site adjacent to clinical services can be found.</p> <p><b><u>This option is possible and is carried forward to the shortlist</u></b></p>
<b>ES6</b> - As now, address Backlog Maintenance and equipment replacement only	<p>This option does not meet any of the investment objectives or critical success factors.</p> <p><b><u>This option is discounted, but is retained as a benchmark for cost comparison as part of the Do- Nothing option</u></b></p>
<b>3.0 Service Delivery Options</b>	
<b>SD1</b> – As per current arrangements	<p>This option maintains the current ABUHB delivery of services.</p> <p><b><u>This option is preferred and is carried forward to the shortlist.</u></b></p>
<b>SD2</b> – Decontamination services are outsourced	<p>This option is rejected as it would not be acceptable from a policy perspectives.</p> <p><b><u>This option is discounted</u></b></p>
<b>SD3</b> - As per current arrangements, all services provided by ABUHB	<p>This option does not meet any of the investment objectives or critical success factors.</p> <p><b><u>This option is discounted, but is retained as a benchmark for cost comparison as part of the Do- Nothing option</u></b></p>
<b>4.0 Implementation Options</b>	
<b>IO1</b> – Single Phase	<p>This option meets all of the investment objectives and critical success factors.</p> <p><b><u>This option is possible and is carried forward to the shortlist.</u></b></p>

<b>IO2</b> - Phased	This option meets some of the investment objectives and critical success factors although it might not create the most efficient solution, could take longer to deliver all the benefits, may not align with programme milestones, and may cost more. <b><u>This option is possible and is carried forward to the shortlist.</u></b>
<b>IO3</b> - Single Phase	This option meets all of the investment objectives and critical success factors. <b><u>This option is possible and is carried forward to the shortlist.</u></b>
<b>5.0 Funding Options</b>	
<b>F1</b> - Public sector capital	<b>Possible</b> - This is likely to present the most cost- effective solution <b><u>This option is retained as the preferred funding solution</u></b>
<b>F2</b> – Private sector capital	This option is rejected as it would not be acceptable from a policy perspectives. <b><u>This option is discounted</u></b>
<b>FO3</b> - Public sector capital	This is unlikely to present the most cost-effective solution <b><u>This option is retained as the preferred funding solution</u></b>

### Short-listed Options

3.6 The 'preferred' and 'possible' options identified above have been carried forward into the short list for further appraisal and evaluation. All the options that were discounted as impracticable have been excluded at this stage.

3.7 On the basis of this analysis the recommended short list for further appraisal is as follows:

<b>Service Options</b>	<b>Estate Solution</b>	<b>Service Delivery</b>	<b>Implementation</b>	<b>Funding</b>
<b>Option 1</b> – Scope Decontamination services continue as per current arrangements	As now, address Backlog Maintenance and equipment replacement only	As per current arrangements	Phased	Public sector capital
<b>Option 2</b> - Scope Decontamination services continue as per current arrangements	Refurbishment and development of existing Endoscopy Suite for Endoscopy only (Do minimum)	As per current arrangements	Single Phase	Public Sector Capital
<b>Option 3</b> – Scope Decontamination services delivered from a single source with dedicated staff	Refurbishment and development of existing Endoscopy Suite for all services	Services delivered from a single source with dedicated staff	Single Phase or Phased	Public Sector Capital
<b>Option 4</b> – All scope Decontamination services at RGH are delivered from a central location	New build on the RGH site	Services delivered from a single source with dedicated staff	Single Phase or Phased	Public Sector Capital

### **Economic Appraisal of Shortlisted Options**

3.8 This section describes the economic appraisal that has been undertaken to assess the overall value for money to the NHS of each short-listed option. A discounted cash flow for each of the options has been undertaken over 60 years (plus initial construction) in line with the requirements of HM Treasury and the Green Book.

3.9 Both the Net Present Cost (NPC) and Equivalent Annual Cost (EAC) have been calculated. The EAC is used for the main basis of comparison in

this case due to the different life spans of the options, as it converts the NPC to an annual comparative figure.

3.10 The following sections of this chapter summarise the cost categories and values associated with each short-listed option that are input into the cash flow model, in order to calculate net present costs and equivalent annual costs. The categories are:

- Capital costs.
- Equipment Lifecycle costs.
- Revenue costs.

### **Capital Costs**

3.11 The costs of each option have been quantified and compared over the life of the scheme using discounted cash flow techniques. Costs (i.e. cash flows) have been assigned to each year of the scheme and have been subjected to the technique of discounting which takes account of different timings of cash flows for options, so that more weight is given to earlier costs than to later costs.

3.12 The discounted cash flows for each year of the scheme are added together to calculate the Net Present Cost (NPC) of total expenditure. An alternative measure is the Equivalent Annual Cost (EAC) which is the total discounted cash flow divided by the sum of the discount factors, to give an average discounted cost per year. This allows schemes that span different time periods to be compared.

3.13 The economic appraisal has been completed using the Treasury developed Generic Economic Model (GEM) this is a standard template now used for all business cases. The economic appraisal focuses on the real economic consequences to the public sector as a whole. Indirect taxes (e.g. VAT), non-cash transfer (e.g. depreciation) and income from public sector bodies are excluded.

### **Capital Cost Comparison**

3.14 A summary of the capital cost of the options is provided in the following table (costs exclude sunk costs and VAT for purposes of the economic appraisal):

	<b>Option 1 BAU address backlog &amp; equipment replacement £000</b>	<b>Option 2 *Redevelop Endo Unit for Endoscopy only £000</b>	<b>Option 3 Redevelop Endo Unit for all services £000</b>	<b>Option 4 New Build CDU £000</b>
Works Cost	0.380	2.223	2.223	4.525
Fees	0.066	0.422	0.267	0.940
Non-Works	0.052	0.112	0.112	0.140
Equipment (inc. IT)	0.670	1.038	0.832	0.832
Contingency	0.150	0.391	0.411	0.685
<b>Total Cost</b>	<b>1.318</b>	<b>4.186</b>	<b>3.844</b>	<b>7.122</b>

***\*NB Option 2 costs include the relevant equipment replacements from option 1 for services that will not utilise the redeveloped unit.***

### **Capital Disposals**

3.15 There are no estate disposals associated with this OBC.

### **Revenue Costs**

3.16 The revenue costs presented are derived from a detailed analysis undertaken on:

- Estate and Non-pay implications
- Consumables
- Workforce requirements

3.17 The assessed annual revenue costs for each option are outlined in the table below:

<b>Economic Case</b>	<b>Option 1 £000</b>	<b>Option 2 £000</b>	<b>Option 3 £000</b>	<b>Option 4 £000</b>
<b>Net Cost to the ABUHB</b>	<b>1046</b>	<b>1046</b>	<b>1186</b>	<b>1402</b>

3.18 Option 1 is regarded as the baseline option and is based on costs agreed as part of the approved BJC for the expansion of the Endoscopy service due to be implemented from November 2023.

3.19 Option 2 costs assume the same baseline as Option 1 and will contain sufficient washer capacity for Endoscopy only.

3.20 Option 3 costs assume that a centralised unit is developed with sufficient capacity for Endoscopy and Urology. It includes the additional staff and non-pay to support the assessed additional workload offset by a transfer of non-pay costs from Urology.

3.21 Option 4 from a service perspective is identical to Option 3 but additional costs are incurred by virtue of this being a new build stand-alone option with a larger overall footprint.

### Net Present Cost Analysis

3.22 The Generic Economic Model (GEM), discounted cash flow analysis, has been carried out for each option using the capital and revenue costs shown in the previous tables of this chapter. Summary outcome reports are included in **Appendix 4**. The following table summarises the results of the analysis on both an NPC and EAC basis due to the differing life spans of each option:

### Summary Outcome of GEM for Shortlisted Options

	Option 1		Option 2		Option 3		Option 4	
	Total Cost £000	NPC £000	Total Cost £000	NPC £000	Total Cost £000	NPC £000	Total Cost £000	NPC £000
<b>Capital Costs</b>	1,319	1,285	4,186	4,094	3,844	3,794	7,121	6,683
<b>Revenue Costs</b>	41,958	25,880	41,958	25,880	38,129	23,585	47,380	28,324
<b>Total Costs</b>	<b>43,277</b>	<b>27,166</b>	<b>46,144</b>	<b>29,974</b>	<b>41,974</b>	<b>27,379</b>	<b>54,502</b>	<b>35,007</b>
<b>EAC</b>		1,376		1,519		1,387		1,716
<b>Rank</b>		n/a *		2		1		3

**\* NB. Option 1 retained as a benchmark for cost comparison purposes only**

3.23 Based on the economic appraisal, Option 3 provides the best value for money as the initial capital costs and on-going revenue consequences are lower than options 2 and 4.

3.24 The Financial Case in section 5.0 is based on the capital costs and revenue costs of Option 3 i.e., the redevelopment of the vacant Endoscopy

Unit at RGH to provide a Centralised Decontamination Unit which will support the services listed in the Business Case, increase Gwent wide capacity, provide a robust decontamination service and the JAG accreditation for the compliant four suite Endoscopy Unit. The capital costs included in the financial case are higher than those reported as part of the economic case as they include sunk costs already incurred and VAT.

3.25 The preferred option utilises space that has become vacant as a result of the refurbishment of the 4 theatre Endoscopy Unit. The preferred site is located in C Block level 3.

3.26 The preferred location (existing Endoscopy Unit) is 264m<sup>2</sup>, the space currently houses two theatres, associated recovery beds and a decontamination area.

3.27 The functional requirements for the proposed Centralised Decontamination Unit are based on current WHBN, JAG recommendations and feedback from stakeholders, requirements below:

- Scope Processing (Dirty)
- Store (Clean)
- Consumables Store
- Chemical Store
- Cleaners Store
- Clean and dirty lobby areas (PPE DON /DOF)
- Office (1 Workstation)
- Male and Female Staff Change
- Separate unisex shower and WCs
- Staff Rest
- Reverse Osmosis Plant Room
- Switch room

3.28 The configuration of the unit is as proposed below:

# Proposed layout

**Key**

- Decontamination
- Support Facilities
- Stores
- Staff Support Facilities
- Circulation
- Plant

Existing Department Area = 264m<sup>2</sup>



## 4.0 PROCUREMENT ROUTE

4.1 The procurement process has been undertaken in compliance with ABUHB Procurement Policy, Standing Orders, Standing Financial Instructions and relevant procurement law.

4.2 The proposed Contract / Tender Strategy attached at **Appendix 5** has been prepared in the context of an existing contract that exists with Lancer Scott Construction Limited for the development of a new Endoscopy Suite at RGH. That contract is JCT SBXQ 2016.

4.3 The advantages of such an approach are set out below:

- A single point of responsibility for both schemes without the need for a lengthy tendering process.
- Early engagement with the main contractor to develop any design risks prior to start on site.
- No down time between completion of Endoscopy and commencement of Decontamination.
- No risk of delaying start of works.
- Enabling works will be taken on by appointed contractor.
- Continuity between schemes and continuation of good working relationship of main contractor.
- Early cost certainty for budgeting purposes as well as reliable costs from informed contractor.
- Cost efficiencies of preliminaries, making best use of current site set up, and no demobilisation cost.

4.4 Whilst ABUHB is prohibited from negotiating directly with a preferred contractor, the current construction contract includes provisions which allow the Employer to request a quotation for additional works.

4.5 Subsequent to the above and in order to inform the contractor's quotation the design team have produced and submitted a detailed pack of information for consideration by Lancer Scott. The following documents were required to be returned by Lancer Scott:

1. Form of Tender
2. Completion of Fully Inclusive Contract Sum
3. Tenderer's Project Specific Programme
4. Breakdown of MEP installation

4.6 The resulting Schedule 2 Quotation Report from Faithful+Gould is attached at **Appendix 6** This report summarises the tender process and Faithful+Gould's evaluation of the quotation received. It concludes that Lancer Scott's adjusted construction costs of £2,222,834 (excluding VAT) is

compliant with procurement regulations in relation to being instructed under the existing contract. Under procurement governance, it would not be appropriate to instruct a piece of work that exceeded 50% of the original contract value. The aforementioned adjusted construction cost for the CDU is £2.223 million set against the original contract value for the Endoscopy Unit which was £4.799 million. Therefore the proposed works are under the 50% threshold.

4.7 A costed risk register has been produced which is included in the ***Estates Annex***. It proposes a client risk allowance of £411k (excluding VAT).

4.8 The agreed construction programme is 36 Weeks the detail of which is in the ***Estates Annex***.

## 5.0 FUNDING & AFFORDABILITY

### Introduction

5.1 The purpose of this section is to set out the financial implications of the preferred option, as set out in the Option Appraisal and the outcome of the Procurement process.

### Capital Costs

5.2 The preferred option is Option 3 the redevelopment of the vacant Endoscopy Unit at Royal Gwent Hospital to a centralised decontamination unit. The estimated outturn costs for the preferred option are £4.714 million, the detail of which is set out below:

	<b>Option 3 – Redevelopment of vacant accommodation (£000)</b>	
	<u>Exc. VAT</u>	<u>Inc. VAT</u>
<b>Works Cost</b>	2.223	2.667
<b>Fees</b>	0.422	0.506
<b>Non-Works</b>	0.112	0.134
<b>Equipment (including IT)</b>	0.832	0.998
<b>Contingency</b>	0.410	0.493
<b>VAT (net of reclaim)</b>		-0.084
<b><u>Total Option Costs</u></b>	<b><u>3.999</u></b>	<b><u>4.714</u></b>

5.3 A more detailed breakdown of the capital cost calculations is contained within the BJC Forms attached at **Appendix 7**.

5.4 In terms of design status, AEDET and BREEAM workshops have been undertaken and will continue to be reviewed and assessed throughout the project lifecycle.

5.5 A risk register has been prepared for the preferred option in order to inform the level of planning contingency required. The format of the risk register is consistent with the standard Designed for Life and the latest guidance for preparing Business cases. This is included in the Estates Annex.

5.6 Submission of the BJC to Welsh Government is currently programmed for the end of May 2024. On the assumption that the BJC is approved within 3 months of submission it has been assumed that the project will commence in October 2024 and will be completed by the end of July 2025.

5.7 The detailed cash flow for the preferred option is contained with the BJC forms attached at **Appendix 7** and is summarised below, this assumes mobilisation in August 2024:

<b>Prior years</b>	<b>2024/25</b>	<b>2025/26</b>	<b>Total</b>
£0.155m	£2.810m	£1.749m	£4.714m

5.8 The BJC assumes all capital costs and inflation will be funded by Welsh Government in each of the years as per the above, in accordance with current Welsh Government policy. The following key assumptions have been made in the capital case:

- The Works Cost is based on tendered costs submitted via the procurement strategy outlined in section 4. These have been thoroughly reviewed by the project cost advisors and their evaluation report is attached at **Appendix 6**.
- Non-Works Costs are based on estimated capital costs that will be incurred in developing the scheme through to Operational Completion and include Planning Fees and Commissioning costs. A breakdown as included in the BJC forms at **Appendix 7**.
- Equipment costs are based on a schedule of equipment taking into account a level of transfers from existing shared premises. This is included in the Estates Annex. The equipment costs include an allowance for ICT provision.
- VAT has been applied at the rate of 20% to all relevant cost components has been assumed. Full VAT recovery has been applied against project fees. Further advice on the potential VAT reclaim in relation to works costs will be sought as the project progresses.

## **Revenue Costs**

5.9 The table below summarises the revenue costs associated with the preferred option, Option 3, compared to the costs of Option 1. Option 1 is regarded as the funded baseline and includes additional resources for scope decontamination approved as part of the BJC for the development of Endoscopy services at RGH which will increase Endoscopy capacity from 2 to 4 suites. This additional capacity came online in November 2023 in tandem with a mobile decontamination unit that has been commissioned to provide additional capacity for scope cleaning. The revenue expenditure has therefore been incurred from November 2023.

5.10 The costs for Option 3 include additional staff and consumables to support the cleaning and decontamination of scopes for other services within Royal Gwent. They assume that:

- The existing services delivered from existing RGH Endoscopy suite will cease and that facility will be converted to a central Decontamination Unit for RGH.
- The vacated accommodation for scope cleaning within Urology will be assessed and considered for future use as part of the wider eLGH reconfiguration work.
- As the decontamination of scopes in these areas is undertaken by staff who undertake a range of other duties within the department, staffing costs will not transfer. It is assumed that those staff will remain within those departments if scope decontamination is centralised.

	<b>Option 1</b>	<b>Option 3</b>
Net Cost to the ABUHB	£1.046	£1.186

### **Affordability**

5.11 The net forecast difference between Option 1 (baseline funding) and Option 3 is £140k (as identified above).

5.12 The breakdown of the £140k is as follows

#### Phase 1 – Endoscopy

- Revenue neutral, part of the original endoscopy case

#### Phase 2 - Urology and Urology Theatres

- Additional £140k required which is
  - £188k extra staffing for HSDU = 5.8 WTE's
    - 4.8wte x Band 3 Technicians
    - 1 x Band 4 Supervisor
  - £217k extra non pay for HSDU (scope processing costs for 511 extra scopes)
  - Offset by £265k non pay savings from Urology etc
  - This figure can be further offset by the relinquishing of the £120k annual rental cost for the mobile decontamination unit.

## Preferred Option Depreciation and Impairment

5.13 A profiled summary of the depreciation and impairment costs associated with the preferred option are set out in the table below:

	2024/25	2025/26	2026/27 On wards
<b>Option 3</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Depreciation	0	-91	-182
Impairment	0	-3,301	0
<b>Total Costs</b>	<b>0</b>	<b>-3,392</b>	<b>-182</b>

5.14 Impairment has been calculated based on advice from the District Valuer. The asset value post impairment has been depreciated over the estimates of useful economic life provided by the District Valuer. The detailed calculations are attached at **Appendix 8**.

5.15 The BJC assumes all impairment and depreciation will be funded by WG in each of the years as per the above, in accordance with current WG policy.

## Impact on the Organisations Statement of Financial Position (SoFP)

	2024/25	2025/26
<b>Option 3</b>	<b>£000</b>	<b>£000</b>
<b>Non-Current Assets b/f:</b>		
Assets Under Construction	175	2,028
Buildings	960	960
Equipment	0	998
<b>Total Non Current Assets b/f</b>	<b>1,135</b>	<b>3,986</b>
<b>Non-Current Assets Additions:</b>		
Assets Under Construction	1,853	1,689
Equipment	998	0
<b>Total Additions</b>	<b>2,851</b>	<b>1,689</b>
<b>Non-Current Assets Impairment:</b>		

Buildings	0	-3,301
<b>Total Impairments</b>	<b>0</b>	<b>-3,301</b>
<b>Non-Current Assets Depreciation:</b>		
Buildings	0	-24
Equipment	0	-67
<b>Total Depreciation</b>	<b>0</b>	<b>-91</b>
<b>Closing NBV Impact on SoFP</b>	<b>3,986</b>	<b>2,283</b>

5.16 As shown in the extracts above, all assets will be shown on the Health Board's balance sheet. Whilst the Unit is being built it will be shown as a non-depreciating asset under construction. The asset will be valued on completion and recorded on the balance sheet at that value. Therefore, it will be treated as per the Health Board's capital accounting policy.

## **6.0 MANAGEMENT ARRANGEMENTS**

### **Introduction**

6.1 This section sets out information on the management arrangements for the RGH Central Decontamination project.

### **Project Management Arrangements**

6.2 The project is being managed in accordance with the requirements of the All Wales Designed for Life: Building for Wales Framework, the NHS capital investment manual and PRINCE 2 methodology.

6.3. There is a dedicated Project Team that will report to the Strategic Capital and Estates Programme Board.

### **Project Roles and Responsibilities**

6.4 The Senior Responsible Owner (SRO) – Hannah Evans, Director of Strategy, Planning and Partnerships , is responsible for ensuring that the Project’s objectives are delivered on time and within the desired cost and quality constraints. The SRO oversees the effectiveness of the Project Management Team ensuring that the Project Management structure is appropriate to ensure the project objectives are delivered and that the benefits are realised.

6.5. The Project Director – Hannah Capel, Assistant Director of Strategic Capital is accountable to the Director of Strategy, Planning and Partnerships and has specific responsibility for the project management structures and organisation of the project, including appropriate controls and monitoring mechanisms. The Project Director is ultimately responsible for the Risk Register but delegate’s day to day management to identified risk leads. The Project Director is supported by a Project Manager for the day-to-day planning and design phases of the project as well the technical, procurement and construction phases.

6.6 The Service / Clinical Lead – Nicola Merry, HSDU Manager, is accountable for the effective co-ordination of clinical and user professional input to the project both from the perspective of the service / clinical provision.

6.7 Other key project team members include internal ABUHB estates and operational service managers, finance, personnel, information and procurement. Further expertise has been provided by NHS Shared Services.

## Outline Project Plan

6.8 The table below lists the main milestones for the Endoscopy Development:

Milestone	Completion Date
Submission of BJC to Health Board and WG	22/ 05 / 24
Anticipated WG approval of BJC	23/ 08 / 24
Contractor appointment/mobilisation	01/ 08 / 24
Construction completion	May 2025

## Assurance

6.9 An Integrated Assurance Approval Plan has yet to be agreed with Audit and will be provided as soon as possible.

## Benefits Realisation

6.10 The Benefits Realisation plan is attached at **Appendix 3**. This sets out the potential benefits and the framework for monitoring the realisation of the benefits.

## Risk Management

6.11 The Project Team oversees the current risk management process. The project risk management process has included a number of risk workshops involving key personnel from the UHB and the Design Team.

6.12 The current costed capital project risk register is found in the **Estates Annex**.

## Communications and Engagement

6.13 There has and will continue to be extensive communication and engagement with internal clinical staff. A User group comprised of a range of professional medical, clinical and non-clinical staff has developed the User brief, the Schedule of Accommodation and the 1:200 / plans in close collaboration with the external Design Team. The subsequent stage 3 and 4 design and the associated Derogations schedule has been signed off by the relevant Users, via the Project Team.

## **Post Project Evaluation**

6.14 The project will be evaluated by undertaking the following investigations:

- a review of the strategic case to confirm that it is still relevant;
- a review of the Business Justification Case capital and revenue costs to confirm that the capital costs were robust and adhered to; and that the actual and projected revenue costs were realistic;
- a review of the Project Programme and adherence to it throughout the life of the project;
- a review of the benefits detailed in the Benefits Realisation Plan and confirmation that they have been met.



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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Gender Pay Gap Report 2023
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Sarah Simmonds, Executive Director Workforce & Organisational Development
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Non Ellis, Equality, Diversity & Inclusion Specialist

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

This paper provides the Board with the proposed Gender Pay Gap Statement to be published by the Health Board as part of our statutory obligations.

This paper went to the Executive Committee on 02 May 2024 where the report was endorsed. The Board is asked to receive assurance that the Health Board is compliant with its legal duty to publish its Gender Pay Gap annually in compliance with Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and is asked to approve the publication of this report as the Health Board's organisations detailed pay gap report.

**Cefndir / Background**

Under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, the Health Board, along with all public bodies with more than 250 employees, is required to publish gender pay gap information by 30 March each year.

The Health Board's pay gap data was uploaded to the Gender Pay Gap government website portal in line with the statutory deadline of 31 March 2024 (for the 2023 report).

Producing a narrative report is not a requirement but is good practice.

The gender pay gap shows the difference in average pay between all men and women in an organisation. It is different to equal pay, which examines the pay differences between men and women who carry out the same or similar jobs, or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

The Health Board aspires to be an employer of choice who provides a great place to work and can recruit and retain the right talent with the wide range of knowledge, skills and capabilities we need. We are committed to a diverse and inclusive culture which supports the fair treatment and reward of all colleagues, irrespective of gender, and our pay framework is based on the principles of fairness, transparency, and consistency.

## **Asesiad / Assessment**

The Health Board has a statutory duty to publish our organisation's Gender Pay Gap data annually. This paper provides a formal report to the Board of the Health Board's Gender Pay Gap at March 2023.

The report includes information about the:

- mean and median gaps in hourly and bonus pay
- proportion of men and women who received bonuses
- proportion of male and female employees in each pay quartile.

The data is based on a snapshot of all employees as of 31 March 2023. The calculations used are those set out in the relevant legislation to ensure the data is calculated consistently across organisations.

The report fulfils the Health Board's reporting requirements and also explains what we are doing as an organisation to address the gender pay gap. The Health Board are committed to addressing its gender pay gap and are taking a wide range of actions to continue to reduce this.

It is important to note that the Health Board, and indeed the NHS nationally, has Job Evaluation and national Pay systems that set the grade for a job regardless of gender. Anyone in that job would receive the grade and pay attached to it regardless of gender.

The Gender Pay Gap work is an opportunity to look at societal and organisational factors or characteristics that may impact pay parity e.g. education, working time, occupational segregation, skills and experience. The initial data is a starting point, and the action plan provides for early actions around further data analysis to better understand the specific issues found in this Health Board and put in place actions to address them.

The data for the report is drawn from the national Electronic Staff Record (ESR) Business Intelligence standard report.

For the purposes of these calculations, pay includes basic pay, full paid leave, including annual, sick, maternity, paternity, adoption or parental leave, bonus pay, area and other allowances, shift premium pay, pay for piecework. Pay does not include overtime pay, expenses (payments made to reimburse expenditure

wholly and necessarily incurred in the course of employment, e.g. mileage for use of vehicle), remuneration in lieu of leave, the value of salary sacrifice schemes, benefits in kind (e.g. child-care vouchers), redundancy pay and tax credits.

Bonus pay relates to the National Clinical Impact Award (NCIA) scheme for consultants, following the NHS Employers Gender Pay Gap Guide.

### **Gender Pay Gap 2023, Appendix 1**

When comparing median hourly pay for Agenda for Change employees, in the Health Board, women earn 83p for every £1 that men earn.

The mean and median pay gap numbers have however reduced since 2022; The mean pay gap has dropped from 2.70% to 2.66% and the median pay gap from 18.72% to 16.20%.

When comparing median hourly pay for Non-Agenda for Change employees, in the Health Board, women earn 96p for every £1 that men earn.

### **Benchmarking**

Benchmarking data is available from the Government Gender Pay Gap web site but because NHS organisations in our region generally published their pay gaps in March of the following year this data is not available to review if our pay gap reductions are shared by other similar organisations.

### **Financial**

There are no specific financial considerations associated with this report.

### **Compliance – Legal/Regulatory**

This paper is relevant to compliance with the Equality Act 2010 including s.149 of the Act, the Public Sector Equality Duty.

The paper supports the specific requirement in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 to publish our pay gap data annually.

### **Risk Assessment**

Should appropriate actions to address our gender pay gap not be taken, the potential reputational risk for the Health Board is that it could be perceived as less than fully committed to fair pay, promotion and development opportunities for women.

### **Next steps**

The Health Board will be working in collaboration with Cardiff University during 2024, engaging the support of a statistician, to support the Health Board in better understanding the reasons for our pay gap and undertaking the analysis and action required by the 'equal pay duty'. The Health Board will then be better placed to report accurately and effectively on actions that can positively close the gender pay gap.

The current Equality, Diversity and Inclusion programme of work will also be reviewed in light of this report to ensure that the recommendations consider the analysis.

### **Argymhelliad / Recommendation**

The Board is asked to receive assurance that the Health Board is compliant with its legal duty to publish its Gender Pay Gap annually in compliance with Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and is also asked to approve the publication of this report as the Health Board's detailed pay gap report.

### **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):	7. Staff and Resources 7.1 Workforce Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	Gender and pay - Develop a fuller understanding of the reasons for any differences and take the necessary action to address this Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers

### **Gwybodaeth Ychwanegol:**

### **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	ESR – Electronic Staff Register NCIA - National Clinical Impact Award
Partion / 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)**

<p><b>Resource Assessment:</b></p>	<p>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:</p>
<ul style="list-style-type: none"> <li>• <b>Workforce</b></li> </ul>	<p>Not Applicable</p>
<ul style="list-style-type: none"> <li>• <b>Service Activity &amp; Performance</b></li> </ul>	<p>Not Applicable</p>
<ul style="list-style-type: none"> <li>• <b>Financial</b></li> </ul>	<p>Not Applicable</p>
<p><b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b></p>	<p><b>No does not meet requirements</b></p> <p>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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b></p> <p><a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a></p>	<p>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives</p> <p>Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs.</p>



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board



# GENDER PAY GAP ■ ■

The following report provides a summary of conclusions drawn from the analysis of statistics in relation to the gender pay gap (snapshot of 31 March 2023), together with an outline of intended aims and future positive action.



# CONTENTS

Summary.....	Page 01
Introduction.....	Page 01
Background.....	Page 01
Useful Definitions.....	Page 02
Gender Profile.....	Page 03
The Proportion of males & Females in each Quartile Band..	Page 04 - 05
Mean & Median Gender Pay Gap.....	Page 06 - 07
Mean & Median Bonus Gender Pay Gap.....	Page 08 - 09
Conclusions.....	Page 09 - 11
Next Steps.....	Page 11 - 12

# SUMMARY

The Health Board's workforce is predominantly female, this is similar to most NHS organisations. Whilst national pay scales, supported by local starting salary and pay progression processes are designed to support equity and fairness, we have identified a gender pay gap across the workforce.

## INTRODUCTION

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (the "Regulations") set out a public authority's gender pay gap reporting duties, which form part of its public sector equality duty under the Equality Act 2010.

The Regulations set out the requirements for organisations with more than 250 employees to calculate and publish their gender pay gap information.

Greater transparency in pay gap reporting is designed to help organisations better understand the issues that give rise to, and sustain gaps in average pay between men and women, and to encourage organisations to take steps to tackle them.

## BACKGROUND

The publication of the Agenda for Change white paper in 1999 set out a consistent set of pay bands and job evaluations that cut across occupational groups and aimed to provide equal pay for work of equal value. An important goal of Agenda for Change (AfC) was to ensure the NHS had a pay system that addressed unwarranted differences in the pay of men and women in the NHS.

All Aneurin Bevan University Health Board staff, except for medical staff, executives and very senior managers are paid on the AfC pay, terms and conditions of service. For this report, this group of staff will be referred to as Non-Agenda for Change (Non-AfC). Around 94% of Aneurin Bevan University Health Board staff are included in the AfC system. The pay and terms of conditions of Non-AfC staff are determined through other locally and nationally negotiated contracts.



# USEFUL DEFINITIONS

## EQUAL PAY AND GENDER PAY GAP

The NHS Terms and Conditions of Service ensure that pay within the NHS is consistent with the requirements of equal pay law.

It is important to appreciate that the gender pay gap and equal pay are two distinct concepts:

- Equal pay is concerned with men and women earning equal pay for the same, or similar, work.
- The gender pay gap is about the difference between men's and women's average pay within an organisation.

## MEAN AND MEDIAN GENDER PAY GAP

Calculating the mean gender pay gap involves adding the hourly rates for all male full pay employees and then for all female full pay employees in two groups and then dividing these totals by the number of male or female full pay employees in each list. The employer then needs to subtract the standard female hourly rate from the standard male hourly rate, divide the total by the standard male hourly rate, and multiply the figure by 100. This will give a percentage difference in pay. A positive percentage means women are paid a lower average hourly rate.

To calculate the median, the hourly rates need to be ranked from lowest to highest in two groups: one male and one female.

The median is the midpoint in each ranked list. Again, a percentage calculation is to be carried out. The employer needs to subtract the median female hourly rate from the median male hourly rate, divide by the median male rate and multiply by 100. The median figure can be seen as the most representative of the average male and female employee but pay distribution and increases amongst staff are rarely even and so the median figure does not account for a concentration of high earners. The mean can be seen as more accurately reflecting the gender pay gap where there are more men in high paying senior positions.

## GENDER IDENTITY

It is important to note that sex and gender are terms that are often used interchangeably but they are in fact two different concepts. The World Health Organisation describes sex as characteristics that are biologically defined and identified at birth, whereas gender is based on socially constructed features and is a personal, internal perception of oneself. We recognise that an individual can identify as more than male or female. The Gender Pay Gap mandates the use of male and female as comparators and therefore may not be representative of everyone at Aneurin Bevan University Health Board.

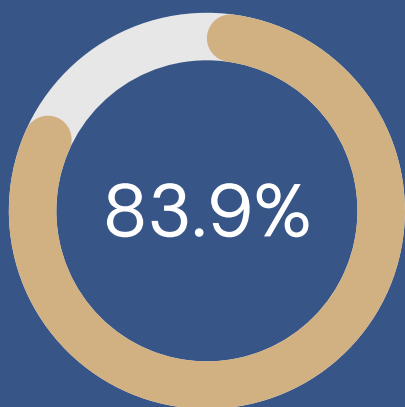


# GENDER PROFILE

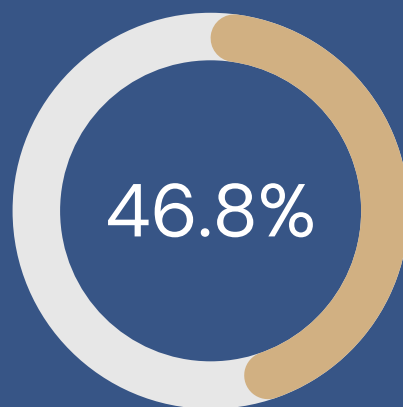


Our workforce is predominately female, which is reflective of the majority of NHS Health Boards in Wales.

On the 31 March 2023, ABUHB employed 12207 (10134.65 FTE) women and 2757 (2554.26 FTE) men therefore, 81.58% of the workforce was female, total headcount is 14964.



AfC breakdown was 11770 (9762.66 FTE) women and 2261 (2096.41 FTE) men, therefore 83.89% of AfC workforce was female.



Non-AfC employee breakdown was 437 (371.99 FTE) women and 496 (457.85 FTE) men, therefore 46.84% of Non-AfC workforce was female.

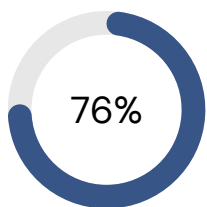


# OUR ANALYSIS

## Positioning of male and female AfC employees across quartile pay bands

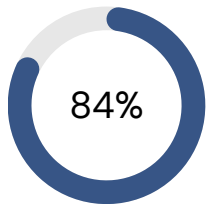
Organisations are required to publish details of the positioning of male and female employees according to quartile pay bands.

The hourly pay rate for each AfC employee has been established, and all employees (male and female together) are ranked from lowest to highest paid and then divided into four pay bands. The gender split in each quartile is then calculated as a percentage.



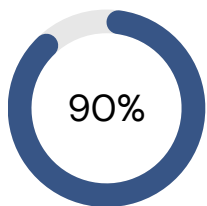
### Quartile 1: Lower Quartile (Lowest Paid)

76% Female  
24% Male



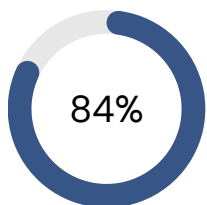
### Quartile 2: Lower Middle Quartile

84% Female  
16% Male



### Quartile 3: Upper Middle Quartile

90% Female  
10% Male



### Quartile 4: Upper Quartile (Highest Paid)

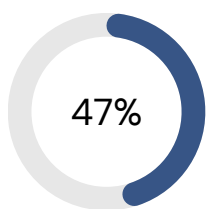
84% Female  
16% Male



## Positioning of male and female Non-AfC employees across quartile pay bands

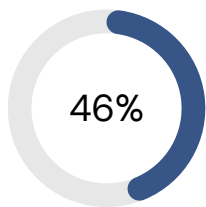
Organisations are required to publish details of the positioning of male and female employees according to quartile pay bands.

The hourly pay rate for each Non-AfC employee has been established, and all employees (male and female together) are ranked from lowest to highest paid and then divided into four pay bands. The gender split in each quartile is then calculated as a percentage.



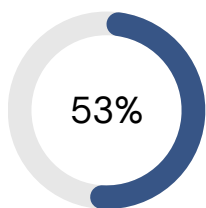
### Quartile 1: Lower Quartile (Lowest Paid)

47% Female  
53% Male



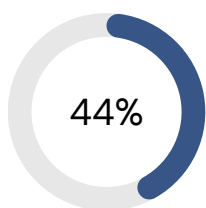
### Quartile 2: Lower Middle Quartile

46% Female  
54% Male



### Quartile 3: Upper Middle Quartile

53% Female  
47% Male



### Quartile 4: Upper Quartile (Highest Paid)

44% Female  
56% Male



## AfC Mean and Median Hourly Rates

**Table 1** outlines our mean and median gender pay gap in hourly pay between our female and male AfC workforce, the mean hourly pay gap is 2.66% and the median hourly pay gap is 16.20%.

	Mean Hourly Rate	Median Hourly Rate
Male	£16.57	£18.46
Female	£16.13	£15.47
Difference	£0.44	£2.99
Pay Gap %	2.66%	16.20%

When comparing median hourly pay for AfC employees, in this Health Board, women earn 83p for every £1 that men earn.

The mean and median pay gap numbers have however reduced since 2022; The mean pay gap has dropped from 2.70% to 2.66% and the median pay gap from 18.72% to 16.20%.

## Non – AfC Mean and Median Hourly Rates

**Table 2** outlines our mean and median gender pay gap in hourly pay between our female and male Non–AfC workforce, the mean hourly pay gap is 3.32% and the median hourly pay gap is 5.41%.

	Mean Hourly Rate	Median Hourly Rate
Male	£47.22	£43.44
Female	£45.65	£41.09
Difference	£1.57	£2.35
Pay Gap %	3.32%	5.41%

When comparing median hourly pay for Non–AfC employees, in this Health Board, women earn 96p for every £1 that men earn.

## Mean and Median Bonus Gender Pay Gap

**Table 3** outlines our mean and median bonus gender pay gap. For this year's calculations, relevant bonus pay relates to the National Clinical Impact Award (NCIA) scheme in England and Wales – formerly the National Clinical Excellence Awards (NCEA) scheme. The scheme aims to reward the consultants who contribute most to the delivery of safe and high-quality care and the improvement of NHS services. This includes consultants and senior academic GPs who do so through their contribution to academic medicine.

	Mean Bonus Pay	Median Bonus Pay
Male	£36,934	£36,934
Female	£36,934	£36,934
Difference	0	0
Pay Gap %	0%	0%

The NCIA's awarded to eligible consultants who applied for 2023, were all given the same amount, resulting a 0% difference

**Table 4** outlines the proportion of males and females receiving a bonus payment. For this year's calculations, relevant bonus pay relates to the NCIA scheme

Gender	Number of Employees receiving a bonus	Total Relevant Employees Eligible for Bonus	%
Male	4	496	0.81%
Female	1	437	0.23%

## CONCLUSIONS

The gender pay gap within the Health Board is showing a mean pay difference in favour of males by 2.66% and a median in favour of males of 16.20% difference. Both of which have shown a steady decrease over the time the Health Board has been reporting on the gender pay gap.

The Health Board has seen a decrease in the AfC median gender pay gap over the last year from 18.72% to 16.20%, this represents a 2.52% decrease from 2022, moving in the right direction. However, the gap between men's and women's pay remains notable, particularly in an organisation where women are employed in significantly greater proportions than men at almost all levels.

It is important to note that NHS terms and conditions determine the pay structure for those on AfC contracts. The Job Evaluation system matches job roles to nationally agreed profiles and pay bands. Pay increases in each band are determined by the length of service, and pay rises occur when an individual reaches a "pay step". When the top of the pay band is reached, there are no further rises in that pay band.

AfC is having a positive impact on our gender pay gap, and we are seeing a steady decline. However, we know that female representation in the Medical and Dental staff group, as well as the most senior levels of our organisation, needs to be improved.

Indeed, the Medical and Dental staff group is the only staff group where there are more males employed than females (56% male to 44% female ratio). Overall, whilst the numbers involved in the Health Board's data are relatively small they make a significant difference to the percentage. Historically there has been an over-representation of males in the Consultant workforce (largely due to a lack of females recruited as students in medical school) and there is a recognition that the medical profession still has some way to go to be fully inclusive. This historical context and legacy working conditions will take some time to change. This impacts our ability to make progress at pace to decrease the gender pay gap within the Medical and Dental Consultant body. However, we are confident that this will change as more women progress in the profession.

In the quartile analysis of the AfC workforce, when considering the AfC data set, the gender split across the pay quartiles is generally representative of the overall 82:18 female-male split in the organisation. However, when considering the Non-AfC data set, this is not the case, demonstrating the inverse proportion of men in the high-paying staff groups, for example, Medical and Dental.

It is also worth noting that the largest staff group is Nursing and Midwifery, which amounts to just under 30% of our workforce. This staff group makes up the majority of the AfC clinical workforce at the Health Board and 92% of this staff group are female. When considering that entry-level is Band 5, this may account for why we have a larger proportion of females in Band 5 and 6 positions. Indeed, historically, we have seen more females than males in this profession, although this is changing.

One explanation which is often given for the gender pay gap is that women, generally, work fewer hours. Due to societal factors, females have traditionally taken career breaks, or been carers and this has led to more female staff working less than full-time to balance family life and child care. The cost of childcare has been identified as a particular problem that affects women's participation in the labour market. A [2017 report](#) from Working Families found that childcare costs account for a significant proportion of family expenditure and that the high cost of childcare has a great influence on whether parents, particularly mothers, choose to either give up work or reduce their working hours. Moreover, generally, women are more likely than men to be carers.

A survey carried out by Carers UK in 2022 found that 80% of carers are female. For many women, these factors have resulted in barriers to progression for women, resulting in fewer women progressing into the higher quartile pay bands, contributing to a gender pay gap.

In addition, generally, hourly rates of pay for part-time work tend to be lower than for full-time work and, with such a high percentage of women working part-time, their low hourly rates of pay mean that the gender pay gap for all employees is greater than that for full-time employees alone.

The introduction of policies around maternity and paternity leave, flexible working, and more inclusive working practices has brought more flexibility around family life and career choices. If we control for this dimension of effort or activity, we would expect to see that men and women earn similar salaries. To make meaningful comparisons, in future reporting, we will need to further split the sample into staff groups according to their contract types and explore the relationship between salary and hours worked. Furthermore, given that the ONS UK Labour Force Survey highlights that men tend to work part-time at the beginning and end of their working lives, whereas women do so in their middle years, it also recommended that the sample is further split into age groups according to their contract types and explore the relationship between salary and age.

## NEXT STEPS

We are not content with reviewing the Gender Pay Gap data each year and hoping that things will change with time. Before we develop dedicated and detailed actions in collaboration with our diversity steering groups, Trade Unions and other stakeholders, we would like to engage the support of a statistician to enable the Health Board to better understand the reasons for the pay gap. We will be working in collaboration with Cardiff University during 2024 to undertake the analysis and action required by the 'equal pay duty', to ensure its effectiveness and to make a lasting impact on gender pay disparities in the Health Board.

In the interim, we will further develop our Women's Network, established in March 2023, for the support and development of female staff. We recognise that the Network holds the potential not only to support co-production in the reduction of gender inequality like the pay gap but to also build up stronger peer-to-peer support and confidence amongst staff, as well as being a safe place for women to talk about the issues that mean most to them at work such as how to navigate work-life balance, flexible working, women's health, and upskilling for promotion opportunities.

We will also work to increase access to leadership and development opportunities – We need to ensure our female staff at lower bands have the confidence, skills and support to apply for posts at band 8A and above. Positive action plans are being developed in line with the Strategic Equality Plan for 2024 – 2028.

Finally, we know that the gender pay gap is about more than just gender. When we analyse our data, we need to consider the diversity of our workforce. The gender pay gap can also be impacted by protected characteristics and wider intersectionality. As we progress our work to better understand our gender pay gap, we will apply an intersectional lens to our gender pay gap analysis.



## GET IN TOUCH



Website

<https://abuhb.nhs.wales/>



Email

[abb.edi@Wales.nhs.uk](mailto:abb.edi@Wales.nhs.uk)



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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Ethnicity Pay Gap Report 2023
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Sarah Simmonds, Executive Director Workforce & Organisational Development
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Non Ellis, Equality, Diversity & Inclusion Specialist

<b>Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)</b>
Er Sicrwydd/For Assurance

**ADRODDIAD SCAA / SBAR REPORT**

**Sefyllfa / Situation**

This paper provides the Board with the proposed Ethnicity Pay Gap Statement to be voluntarily published by the Health Board as part of its anti-racist approach.

This paper went to the Executive Committee on 02 May 2024 where the report was endorsed. The Board is asked to approve the publication of this report as the Health Board’s detailed ethnicity pay gap report.

**Cefndir / Background**

The UK government in 2017 published the first report to examine the barriers people from Ethnic Minorities face in employment, named Race in the Workplace. Their report highlighted the need to first be able to measure the disadvantage some ethnic groups face in order to address the barriers to earning as much as their white colleagues. In 2018, the Race Disparity Unit and CIPD led the call for the introduction of ethnicity pay gap reporting in “Our Manifesto for Work”. This led to the government consultation on whether to introduce mandatory ethnicity pay gap reporting, which ran from October 2018 to January 2019. The Women and Equalities Committee published a report calling for the Government to implement mandatory reporting of ethnicity pay by April 2023. The Government confirmed no mandatory ethnicity pay gap reporting.

As of March 2022, the Health Board has committed to report on its ethnicity pay gap as part of its anti-racist approach and our obligations under the Welsh Government’s Anti-Racist Wales Action Plan.

In the absence of a mandatory framework for ethnic pay gap reporting, organisations who do take the steps to report their ethnicity pay gaps have to select their own reporting measures.

The Health Board aspires to be an employer of choice who provides a great place to work and can recruit and retain the right talent with the wide range of knowledge, skills and capabilities we need. We are committed to a diverse and inclusive culture which supports the fair treatment and reward of all colleagues, irrespective of gender, and the Health Board's pay framework is based on the principles of fairness, transparency, and consistency.

### **Asesiad / Assessment**

The Health Board has chosen to replicate the measure used in gender pay gap reporting with some changes, to account for the different data sets. The gender pay gap report compares two distinct groups – male and female – whereas ethnicity recorded on ESR can fall into one of four broad categories: White, Black, Asian and Minority Ethnic, blank (not recorded) and unspecified (chose not to answer).

The way that gender is recorded on ESR means that there can be no blank or unspecified records. In calculating the mean and median differences, we have chosen to focus on those who have specified their ethnicity to give the most precise view of the ethnicity pay gap in the Health Board, as people with blank or undeclared ethnicities could either be Black, Asian and Minority Ethnic or White. The blank and unspecified records are included in the Health Board average.

The report includes:

- The mean and median ethnicity pay gaps.
- The mean and median ethnicity bonus pay gap.
- The proportion of Black, Asian and Minority Ethnic and White employees who received a bonus.
- The proportions of Black, Asian and Minority Ethnic and White employees in each pay quartile.

The data for the report is drawn from the national ESR Business Intelligence standard report.

The ethnicity pay gap is different to equal pay. Ethnic pay disparities are not primarily about those from a white background and other ethnic groups being paid differently for the same job. The Equality Act 2010 makes it unlawful to discriminate (both directly and indirectly) against employees (and people seeking work) because of their race. Therefore, unless there is a failure to comply with existing law, pay disparities between ethnic groups are likely to be due to other factors that impose disadvantage on people from ethnicity minorities.

It is important to note that the Health Board, and indeed the NHS nationally, has Job Evaluation and national Pay systems that set the grade for a job regardless of gender. Anyone in that job would receive the grade and pay attached to it regardless of ethnicity.

## **Ethnicity Pay Gap 2023, Appendix 1**

In the Health Board, Black, Asian & Minority Ethnic Agenda for Change staff earn 96.69p for every £1 that White staff earn when comparing the mean (average) hourly rate.

Black, Asian and Minority Ethnic and White Agenda for Change staff's median hourly rates are equal.

When comparing median hourly pay for Non-Agenda for Change employees, in this Health Board, Black, Asian and Minority Ethnic staff earn 85p for every £1 that White staff earn.

### **Benchmarking**

As there is currently no mandate for Health Board's in Wales to report ethnicity pay gap, benchmarking data is not available.

### **Financial**

There are no specific financial considerations associated with this report.

### **Risk Assessment**

Should appropriate actions to address the Health Board's ethnicity pay gap not be taken, the potential reputational risk for the Health Board is that it could be perceived as less than fully committed to fair pay, promotion and development opportunities for Black, Asian and Minority Ethnic employees.

### **Next steps**

It is important to recognise that the group referred to as "Black, Asian and Minority Ethnic" is not homogeneous. We recognise the need to ensure that the pay gap data analysis considers the significant differences in pay gaps between staff from within the groups otherwise defined as Black, Asian and Minority Ethnic within this report. With this in mind, future reporting will include detailed ethnic breakdown.

In-depth analysis is needed to investigate warranted and unwarranted pay differences and to better understand and quantify the relative contributions of different reasons leading to the overall pay gap across all staff. An intersectional lens to this analysis is vital to ensure a deeper understanding of pay inequalities and actions to address these. For example, rather than looking at the effect of gender or ethnicity in isolation, we need to explore the combined impact of gender and ethnicity on pay and position in the workforce.

We will be working in collaboration with Cardiff University during 2024, engaging the support of a statistician, to support the Health Board in better understanding the reasons for the pay gap and undertaking the analysis and action required by the 'equal pay duty'. The Health Board will then be better placed to report accurately and effectively on actions that can positively close the ethnicity pay gap.

## Argymhelliad / Recommendation

The Board is asked to approve the publication of this report as the Health Board's detailed ethnicity pay gap report.

### **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):	7. Staff and Resources 7.1 Workforce Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives  <a href="#">Strategic Equality Objectives 2020-24</a>	Improve the Wellbeing and engagement of our staff Gender and pay - Develop a fuller understanding of the reasons for any differences in pay and take the necessary action to address this

### **Gwybodaeth Ychwanegol: Further Information:**

Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	CIPD – Chartered Institute of Personnel and Development ESR – Electronic Staff Register
Partion / 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)**

<b>Resource Assessment:</b>	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:
• <b>Workforce</b>	Not Applicable
• <b>Service Activity &amp; Performance</b>	Not Applicable
• <b>Financial</b>	Not Applicable
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>No does not meet requirements</b>  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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/ about-us/future-generations-act/</a>	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



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board



## ETHNICITY PAY GAP ■ ■

The following report provides a summary of conclusions drawn from the analysis of statistics in relation to the ethnicity pay gap (snapshot of 31 March 2023), together with an outline of intended aims and future positive action.



# CONTENTS

Introduction.....	Page 01 - 02
Background.....	Page 02
Equal Pay & Ethnicity Pay Gap.....	Page 03
Ethnicity Profile.....	Page 04 - 05
Ethnicity across Quartile Bands.....	Page 06 - 07
Mean & Median Ethnicity Pay Gap.....	Page 08 - 09
Conclusions & Next Steps.....	Page 10 - 12

# INTRODUCTION

In 2017, the UK government published the first report to examine the barriers people from Ethnic Minorities face in employment, named “Race in the Workplace”. Their report highlighted the need to first be able to measure the disadvantage some ethnic groups face to address the barriers to earning as much as their white colleagues.

A year later in 2018, the Race Disparity Unit and Chartered Institute of Personnel and Development (CIPD) led the call for the introduction of ethnicity pay gap reporting in “Our Manifesto for Work”. This led to the Government consultation on whether to introduce mandatory ethnicity pay gap reporting, which ran from October 2018 to January 2019. The Women and Equalities Committee published a report calling for the Government to implement mandatory reporting of ethnicity pay by April 2023. The Government confirmed no mandatory ethnicity pay gap reporting. Nevertheless, the Health Board voluntarily started to report on its ethnicity pay gap as part of its anti-racist approach in 2022.

In the absence of a mandatory framework for ethnic pay gap reporting, Health Boards who do take the steps to report their ethnicity pay gaps have to select their own reporting measures. As a Health Board, we have aligned our reporting framework with the gender pay gap, but recognise the complexity of ethnicity pay reporting compared with gender pay reporting. We have chosen to replicate the measure used in gender pay gap reporting with some changes, to account for the different data sets. The gender pay gap report compares two distinct groups – male and female – whereas ethnicity recorded on Electronic Staff Record (ESR) can fall into one of four broad categories: white, Black, Asian and minority ethnic, blank (not recorded) and unspecified (chose not to answer).



The way that gender is recorded on the ESR (Electronic Staff Register) system means that there can be no blank or unspecified records. In calculating the mean and median differences, we have chosen to focus on those who have specified their ethnicity to give the most precise view of the ethnicity pay gap in the Health Board, as people with blank or undeclared ethnicities could either be Black, Asian and minority ethnic or White. The blank and unspecified records are included in the Health Board average.

The ethnicity pay gap report shows the difference in the average pay between Black, Asian and minority ethnic staff in our workforce. Where there is a positive percentage, this means that the pay of white staff is higher than the pay of Black, Asian and minority ethnic employees; the higher the percentage, the greater the ethnicity pay gap.

## BACKGROUND

The publication of the Agenda for Change white paper in 1999 set out a consistent set of pay bands and job evaluations that cut across occupational groups and aimed to provide equal pay for work of equal value. An important goal of the Agenda for Change (AfC) was to ensure the NHS had a pay system that addressed unwarranted differences in the pay of employees in the NHS.

Around 94% of Health Board staff are included in the AfC system. The pay and terms of conditions of non-AfC staff – largely senior managers and doctors – are determined through nationally negotiated contracts.

It is important to recognise that collating both AfC and non-AfC data sets can have an impact on overall data and averages. Our data tells us there is a difference in the ethnicity pay gap depending on your role. Therefore, for this report, we have analysed the data so we can see the differences between those who are on AfC contracts, and those who are not, this will help us focus our efforts where it is most needed.

## EQUAL PAY AND ETHNICITY PAY GAP

The ethnicity pay gap is different from equal pay. Ethnic pay disparities are not primarily about those from a white background and other ethnic groups being paid differently for the same job. The Equality Act 2010 make it unlawful to discriminate (both directly and indirectly) against employees (and people seeking work) because of their race. Therefore, unless there is a failure to comply with existing law, pay disparities between ethnic groups are likely to be due other factors to that impose disadvantage on people from ethnic minorities.

This report aligns the ethnicity pay reporting with gender pay reporting but recognises the differences. All calculations relate to the pay period in which the snapshot day falls – 31 March 2023. Health Board staff report their ethnicity. Ethnicity was not known for 13.43% of AfC staff assignments and 41.80% of non-AfC staff assignments.



# ETHNICITY PROFILE

## BREAKDOWN OF AFC WORKFORCE BY ETHNICITY



On the 31 March 2023, Aneurin Bevan University Health Board employed 14031 members of staff, equating to 11859.07 FTE on Agenda for Change (AfC) contracts.

**Table 1** below shows the proportions of the relevant workforce from a Black, Asian and minority ethnic background and a white background, as well as those who had not completed their ethnicity on Electronic Staff Record (ESR) (“Blank”) and those who had indicated they did not wish to disclose their ethnicity (“Not Stated”).

	Heads (Number)	Heads (%)
Black, Asian & Minority Ethnic	956	6.81%
White	11191	79.76%
Blank/Not stated	1884	13.43%
Grand Total	14031	100.00%



## BREAKDOWN OF NON-AFC WORKFORCE BY ETHNICITY



On the 31 March 2023 the Health Board employed 933 members of staff which equates to 829.84 FTE on Non-AfC contracts, (this is predominately Medical and Dental employees).

**Table 2** below shows the proportions of the relevant Non-AfC workforce from a Black, Asian and minority ethnic background and a white background, as well as those who had not completed their ethnicity on Electronic Staff Record (ESR) (“Blank”) and those who had indicated they did not wish to disclose their ethnicity (“Not Stated”).

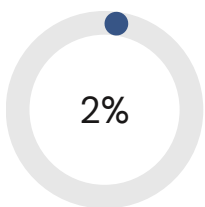
	Heads (Number)	Heads (%)
<b>Black, Asian &amp; Minority Ethnic</b>	260	27.87%
<b>White</b>	390	30.33%
<b>Blank/Not stated</b>	283	41.80%
<b>Grand Total</b>	933	100.00%



# OUR ANALYSIS

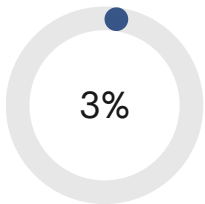
## Positioning of Black, Asian & Minority Ethnic and White AfC employees across quartile pay bands

The quartile data ranks our employees from highest to lowest paid, this is divided into four equal parts or quartiles and then works out the percentage of Black, Asian and minority ethnic and White staff in each. The employees identified as 'Blank/Not Stated' ethnicity equates to 13.43%.



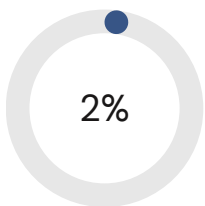
### Quartile 1: Lower Quartile (Lowest Paid)

2% Black, Asian & Minority Ethnic  
22% White



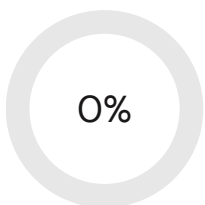
### Quartile 2: Lower Middle Quartile

3% Black, Asian & Minority Ethnic  
29% White



### Quartile 3: Upper Middle Quartile

2% Black, Asian & Minority Ethnic  
27% White



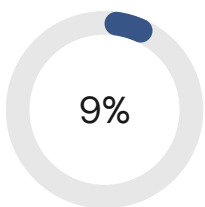
### Quartile 4: Upper Quartile (Highest Paid)

0% Black, Asian & Minority Ethnic  
2% White



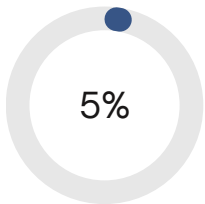
## Positioning of Black, Asian & Minority Ethnic and White Non-AfC employees across quartile pay bands

The quartile data ranks our Non-AfC employees from highest to lowest paid, this is divided into four equal parts or quartiles and then works out the percentage of Black, Asian and Minority Ethnic and White staff in each. The employees identified as 'Blank/Not Stated' ethnicity equates to 41.80%.



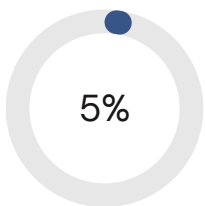
### Quartile 1: Lower Quartile (Lowest Paid)

9% Black, Asian & Minority Ethnic  
6% White



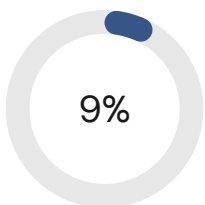
### Quartile 2: Lower Middle Quartile

5% Black, Asian & Minority Ethnic  
5% White



### Quartile 3: Upper Middle Quartile

5% Black, Asian & Minority Ethnic  
9% White



### Quartile 4: Upper Quartile (Highest Paid)

9% Black, Asian & Minority Ethnic  
22% White



## AfC Mean and Median Hourly Rates

The mean ethnicity pay gap is defined as the difference between the mean hourly rate of pay of all white full-pay relevant employees and the mean hourly rate of relevant employees from a Black, Asian and minority ethnic background.

The median ethnicity pay gap is defined as the difference between the median hourly rate pay of all white full-pay relevant employees and that of full-pay relevant employees from a Black, Asian and minority ethnic background.

**Table 3** outlines our mean and median ethnicity pay gap in hourly pay between our Black, Asian & Minority Ethnic and White AfC workforce, the mean hourly pay gap is 3.31% and the median hourly pay gap is 0%.

	Mean Hourly Rate	Median Hourly Rate
<b>Black, Asian &amp; Minority Ethnic</b>	£15.75	£17.32
<b>White</b>	£16.29	£17.32
<b>Difference</b>	£0.54	£0
<b>Pay Gap %</b>	3.31%	0%

In this Health Board, Black, Asian & minority ethnic staff earn 96.69p for every £1 that White staff earn when comparing the mean (average) hourly rate.

Black, Asian and Minority Ethnic and White staff's median hourly rates are equal.

## Non – AfC Mean and Median Hourly Rates

**Table 2** outlines our mean and median ethnicity pay gap in hourly pay between our Black, Asian and Minority Ethnic and White Non-AfC workforce, the mean hourly pay gap is 15.81% and the median hourly pay gap is 15.46%.

	Mean Hourly Rate	Median Hourly Rate
<b>Black, Asian &amp; Minority Ethnic</b>	£41.79	£37.78
<b>White</b>	£49.64	£44.69
<b>Difference</b>	£7.85	£6.91
<b>Pay Gap %</b>	15.81%	15.46%

When comparing median hourly pay for Non-AfC employees, in this Health Board, Black, Asian and Minority Ethnic staff earn 85p for every £1 that White staff earn.

# CONCLUSIONS & NEXT STEPS

Currently, there is a legal requirement for organisations employing over 250 people to routinely report gender pay gaps but no requirement for ethnicity pay gaps. This is the second voluntary Ethnicity Pay Gap Statement published by Aneurin Bevan University Health Board, demonstrating our active commitment to better understand recruitment, staff development and retention in relation to the experiences of our ethnic minority staff.

In 2023, our reported median ethnicity pay gap was 34.16% (based on data from the 31st March 2022). It is important to note that this pay gap was calculated including the pay of AfC staff and non-AfC staff. Recognising that collating both AfC and non-AfC data sets can have an impact on overall data and averages and that there is a difference in the ethnicity pay gap depending on your role, for this year's report, we have analysed the data so we can see the differences between those who are on AfC contracts, and those who are not, to help us focus our efforts where it is most needed. The pay of doctors and consultants and staff such as senior managers, which is not covered by AfC, has a disproportionate impact on aggregate pay differences across all Health Board staff. Their pay is usually higher than other staff groups and they also have a very different ethnic composition.

This report has found a significantly greater proportion of Black, Asian and minority ethnic staff (27.87%) not covered by AfC than Black, Asian and minority ethnic staff paid under the terms and conditions of AfC (6.81%).

There are several aspects to note about the distribution of ethnicity within the pay bands. There is no significant variation in the proportion of people who chose not to declare their ethnicity throughout the quartiles for staff who are paid under the terms and conditions of AfC. The highest proportion of people with no ethnicity completed is within the upper quartile of the non-AfC staff group, suggesting the records of those paid the most are more likely to be incomplete.

Black, Asian and minority ethnic staff are broadly under-represented across the majority of the AfC pay bands with the proportion of Black, Asian and minority ethnic staff declining across the higher pay bands.

The highest proportion of Black, Asian and minority ethnic staff are in the Band 5 pay band. We know that the Health Board's largest staff group is Nursing and Midwifery, which amounts to just under 30% of our workforce and Nurses make up the majority of the AfC clinical workforce at the Health Board. The Health Board employs approximately 500 Internationally Educated Nurses, with the majority from the Philippines and India. The entry-level is Band 5, which may partly explain why we have a larger proportion of Black, Asian and minority ethnic staff in Band 5 roles.

For the 94% of Aneurin Bevan University Health Board staff paid under the terms and conditions of AfC, the ethnicity pay gap between White staff and Black, Asian and minority ethnic staff is equal. However, this disguises the complexities of pay inequalities within the Health Board, particularly when considering that Black, Asian and Minority Ethnic staff on non-AfC contracts mean hourly rate is 15.81% lower than White staff on non-AfC contracts. Much of this seems due to the concentration of Black, Asian and minority ethnic staff under non-AfC contracts (largely Medical and Dental). Whilst for staff paid under the terms and conditions of AfC, there is an under-representation of Black, Asian and minority ethnic staff in the highest bands. To get the full story, we need to distinguish between different ethnic groups and analyse the pay gap at lower levels, for example, by staff group and within pay bands for AfC staff.

Furthermore, in-depth analysis is needed to investigate warranted and unwarranted pay differences and to better understand and quantify the relative contributions of different reasons leading to the overall pay gap across all staff. An intersectional lens to this analysis is vital to ensure a deeper understanding of pay inequalities and actions to address these. For example, rather than looking at the effect of gender or ethnicity in isolation, we need to explore the combined impact of gender and ethnicity on pay and position in the workforce. Expanding to other sources of pay (such as overtime payments) would also add a further perspective on the extent of pay differences, whilst comparing pay gaps within staff groups and occupations may provide another view; We know that staff numbers vary considerably for different ethnic groups and occupation – and this will have a bearing on pay and, in turn, on pay differences between groups.

It is also important to note that this gap is a combined estimate for all ethnic minorities – comparing White staff with specific ethnic groups would reveal a more nuanced picture (there are 47 ethnic groups specified within the ESR data set).

In line with the recommendations made in last year's report, we have:

- Expanded the Health Board's Cultural Competence Scheme with Diverse Cymru to more divisions;
- Developed a reverse mentorship programme aimed at raising awareness of the barriers faced by Black, Asian and minority ethnic staff;
- Developed a 'buddy scheme' to support International Medical Graduates (IMGs) with personalised guidance that facilitates the transition of new IMGs into their roles; and
- Endorsed protected time and Executive Sponsorship for our staff diversity networks.

We aim to continue to reduce our gender and ethnicity pay gap year on year, to create greater equality in our pay frameworks. To effectively reduce the pay gaps a holistic approach is needed to attraction, recruitment, development and retention initiatives.

Given the proportion of employees identified as 'Blank/Not Stated' ethnicity equates to 13.43% (AfC) and 41.80% (non-AfC), we will seek to improve staff ethnicity disclosure rates by encouraging staff to speak about their lived experiences to their managers and identify and record their ethnicity on ESR.

We will work to increase access to leadership and development opportunities – We need to ensure our female staff at lower bands have the confidence and skills and are supported to apply for posts at band 8A and above. Positive action plans are being considered as part of the revised Strategic Equality Plan for 2024 – 2028, this includes the delivery of a Reverse Mentorship programme for ethnic minority staff.

Structured interviews with balanced recruitment panels who have received unconscious bias training is a key process change that can improve access to external and internal roles for diverse candidates. We, therefore, need organisational commitment to diversify interview panels for all positions at Band 8+ and to provide culturally competent and active bystander training as part of recruitment training for managers. As a first step towards achieving this ambition, a Recruitment and Retention Policy is being developed with embedded Equality, Diversity and Inclusion measures.

Before we develop dedicated and detailed actions to address our ethnicity pay gap in collaboration with our diversity steering groups, Trade Unions and other stakeholders, we would like to engage the support of a statistician to enable the Health Board to better understand the reasons for the pay gap. We will be working in collaboration with Cardiff University during 2024 to undertake the analysis and action required by the 'equal pay duty', to ensure its effectiveness and to make a lasting impact on ethnicity pay disparities in the Health Board.

## GET IN TOUCH



Website

<https://abuhb.nhs.wales/>



Email

[abb.edi@Wales.nhs.uk](mailto:abb.edi@Wales.nhs.uk)



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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Finance Report – Budget Delegation Second Stage Proposal 2024/25
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Rob Holcombe - Director of Finance & Procurement
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Tristan Harris – Interim Head of Financial Strategy

**Pwrpas yr Adroddiad  
Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

The Board is asked to approve the proposed further budget delegations, including:

- Revenue budgets to be delegated for the 2024/25 financial year, and
- Those budgets to be held in reserve.

**ADRODDIAD SCAA  
SBAR REPORT**

Sefyllfa / Situation

The Health Board is required to set budgets prior to the beginning of the financial year, which are in accordance with the aims and objectives of the Annual Integrated Plan for 2024/25. Specifically, this means preparing and setting budgets within available funds.

The final Financial Plan identifies a forecast deficit for ABUHB of £48.9m for 2024/25.

The 2024/25 Health Board financial plan assumes the following:

- Baseline allocation 2023/24 £1,480m
- Allocation letter funding uplift of £156m
- Anticipated allocation income of £65m
- Additional confirmed GMS allocation £4m
- Other income of £11m

This equates to an available resource limit to support expenditure of £1,716bn.



The initial budget-setting paper approved by the Board on the 27<sup>th</sup> March 2024 provided revised budgets for the start of 2024/25, however this results in significant operational variances with an off-set in reserves in order to describe the forecast deficit. The board agreed a two stage budget setting process to allow a review of how budgets could be delegated to best manage performance delivery at a delegated level.

This paper sets out the further principles and proposed approach to delegating funding from reserves for the 2024/25 financial year with total available resources of £1.7bn.

It is noted that there will be further additional allocations and adjustments throughout the financial year and the aim is to make delegated budgets achievable and to provide a stretch in order to provide the most likely chance of achieving the forecast deficit of £48.9m which includes a level of pipeline opportunities to be delivered.

The summary table below outlines the level of income and previously approved recurrent delegated budgets, with a reserve balance held for 2024/25 financial plan issues.

Budget	Initial budget - setting 2024/25 (£m)	April - 24 adjustments (£m)	Current 2024/25 position as at Month 1 (£m)
<b>Total UHB income</b>	1,716.1		1,716.1
Delegated budgets	1,681.2	0.2	1,681.3
Budget held in reserves	34.9	(0.2)	34.8
<b>Total UHB budget</b>	1,716.1	(0.0)	1,716.1

The requirement to set budgets based on income levels effectively requires a decision on where and which budgets will be expected to report a deficit (ie. delegated or reserves). As a result, consideration has been given to the establishment of a deficit reserve to monitor the financial performance against a forecast net spend of £1,765bn driving the £48.9m forecast deficit.

The proposed second stage approach establishes a negative budget reserve of £48.9m and delegates budgets to enable monitoring of performance through established budget and financial performance systems and reporting mechanisms. This effectively maintains the corporate governance arrangements for managing delegated performance and strengthens accountability.

Savings in excess of the new 2024/25 target of £40m will contribute to improving the £48.9m deficit.

The Board is asked to approve the proposed further budget delegation 2024/25.



## Cefndir / Background

The financial provisions and obligations of the Health Board are set out under Sections 174 to 177 of the National Health Service (Wales) Act 2006 (c. 42) (Schedule 8 of the Act). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure that the Health Board meets its statutory obligation to perform its functions within its available financial resources.

For 2024/25, due to the expected forecast deficit an annual plan has been developed in line with WG guidance.

The Health Board is required to set budgets, prior to the start of the financial year, and these should be in accordance with the aims and objectives of the Annual Plan for 2024/25. Specifically, this means preparing and setting budgets within available funds and delegating them in line with the Health Board's Standing Financial Instructions (SFIs) and financial policy on budgetary control.

The Health Board has a well-established budgetary control procedure that describes delegation and accountability plus a revised Accountability Framework launched in 2023/2024. The budget planning principles are concerned with how the amount delegated to individual areas is determined.

## Asesiad / Assessment

The Ministerial letter to Chairs formally issued the baseline 2024/25 revenue allocations to Health Boards, received by the Health Board on the 22<sup>nd</sup> December 2023. The allocation reflects the Minister for Health and Social Services decisions about the distribution of resources to Health Boards for the forthcoming year (summarised in the Allocation letter briefing).

As at month 1 (2024/25), the Health Board is anticipating funding of £1,716.1m for the financial year 2024/25.

This is made up of confirmed allocations of £1,636.6m, anticipated allocations of £67.8m (see appendix) and other income of £11.7m. As always anticipated allocations carry the risk of not being received or received at a different value.

Income	2024/25 income as at March 2024 (£'m)
Confirmed allocations	1,636.6
Anticipated allocations	67.8
SIFT income	2.0
Junior Doctor income	9.2
PGMDE income	0.5
<b>Total income</b>	<b>1,716.1</b>

The Health Board has a recurrent allocation baseline to enable the planning of core services. The Health Board receives in year allocations from WG usually for specific



areas of spend. These are delegated to the most suitable service area following agreement from the CEO and are listed in the Board finance reports. The delegation is reflective of whether the allocation is recurrent or not. In 2023/24 uplifts were applied to delegated budgets based on forecast expenditure net of savings opportunities which resulted in the IMTP deficit shown in reserves. The residual element of this deficit will continue to be shown in reserves pending further opportunities to eliminate this underlying pressure.

### **Updated methodology for 2024/25**

The updated methodology for 2024/2025 is based on the following:

1. Recurrent budgets per the financial ledger, as at month 1 24/25,
2. Delegate the funding for the 3.67% uplift to be passed through to NHS Wales LTA's,
3. Establish a new £3m innovation and development reserve to support investment in urgent priorities and invest to save opportunities (in line with the annual plan assumption),
4. Delegate specific directed reserve commitments in line with Annual Plans,
5. Fund delegated budgets in line with the annual plans submitted as at the end of January 2024, this would include delegating remaining discretionary funding leaving a residual deficit in reserves,
6. Undertake corporate and technical adjustments for current intelligence,
7. Remove funding from delegated budgets in line with savings plans submitted to WG, this would not include pipeline opportunity values pending stretch targets,
8. Enact stretch targets for delegated budgets based on current information and further opportunities which re-establish the pipeline opportunity values,
9. A small number of commitment reserves are held for specific issues.

The following steps have been used for the delegation of budgets to Division / Executive areas as outlined below.

#### **Step 1 – delegate directed commitments from reserves**

Funding is delegated for specific directed commitment reserves in line with specific allocations received, anticipated or those received as part of the baseline allocation letter and not delegated previously. These elements include the following areas:-

- Mental Health SIF (anticipated)
- Health Protection
- PPE
- Planned Care recovery
- Further Faster
- Community Admission Avoidance Team (CAAT)
- Palliative Care funding

#### **Step 2 – Fund Delegated budgets in conjunction with items included within the Annual Financial Plan**



Divisional plans submitted included a wide range of financial pressures which were included within the UHB annual plan. These financial pressures include:-

- Underlying pressures (non-recurrent funding, non-recurrent underspends, full year effect of expenditure)
- Full year effect of savings – included in underlying issues
- National cost pressures
- Macro-economic / inflationary pressures
- Unavoidable demand pressures
- Local / Divisional pressures
- Reduction for those issues already funded through step 1

### **Step 3 – Reduce budget for expected savings plans**

The next phase is to reduce funding for the agreed savings plans. Pipeline opportunity values have not been delegated.

### **Step 4 - Undertake corporate and technical adjustments for current intelligence**

After Divisional plans were submitted in January a number of technical adjustments were made either within or across Divisions, for the purposes of budget-setting these are adjusted for in this section. In addition, adjustments have been made across Corporate areas given forecast changes and adjustments made as part of step 2. This is to mitigate pressures and provide further stretch targets as necessary.

### **Step 5 - Enact stretch targets for all delegated budgets based on current information and further opportunities, which re-establish pipeline opportunities into the budget plan**

Stretch targets are required in order for the total reserves balance excluding commitments to balance to annual plan of £48.9m. A number of directed targeted opportunities have been included which were noted as part of month 1 2024/25 reporting.

Key issues noted include:-

- Covid Anti-Viral costs below annual plan forecast,
- Prescribing growth risk
- FNC growth below forecast,
- CHC cost reductions in complex care and mental health reductions in 2023/24 resulting in reduced growth and CHC Care at home and other vacancies,
- Stretch targets for complex care and mental health which could be mitigated through reduced costs or funding for elements such as real living wage,
- Rates rebates in estates and facilities,
- Reduced bed contract (rental) and facilities workforce costs,
- Family & Therapies vacancies, and
- Litigation forecast reduction

The remaining element is a stretch target applied to all delegated budgets based on expected opportunities, efficiencies and further targets to achieve. The aim is for



budgets to be set at an achievable but ambitious level. The level of additional stretch targets are considered realistic.

The below is a summary of proposed revised budgets for the financial year 2024/25:-



Division	2024/25 budgets as at Month 1 £000s	Proposed budgetary delegation £000s	Proposed 2024/25 budget £000s
Primary Care	288,149	3,985	292,134
Prescribing	114,518	1,042	115,560
Community CHC & FNC	72,004	(2,419)	69,585
Mental Health	124,481	18,665	143,146
<b>Total Primary Care, Community and Mental Health</b>	<b>599,152</b>	<b>21,273</b>	<b>620,425</b>
Surgery	133,253	6,665	139,917
Clinical Support Services	123,176	1,975	125,151
Medicine	148,596	12,225	160,821
Urgent Care	34,514	4,891	39,405
Family & Therapies	129,264	4,809	134,072
Estates and Facilities	86,897	9,033	95,930
Chief Operating Officer	8,283	(9)	8,273
<b>Total Director of Operations</b>	<b>663,981</b>	<b>39,589</b>	<b>703,570</b>
<b>Corporate / Exec budgets:-</b>			
Finance & Performance	5,984	(509)	5,475
Workforce & OD	8,698	(267)	8,430
Nurse Director	6,669	18	6,687
Chief Executive and non officer members	9,253	(17)	9,236
Planning	21,053	940	21,993
Digital Services	27,921	1,556	29,477
Therapies	2,591	(38)	2,553
Corporate Governance	1,373	(144)	1,229
Public Health	4,595	7,311	11,906
Medical Director	4,170	74	4,244
Litigation	(357)	2,856	2,500
Shared Services	0		
<b>Total Corporate Divisions</b>	<b>91,948</b>	<b>11,781</b>	<b>103,729</b>
WHSSC	146,864	520	147,384
EASC	41,209	54	41,263
<b>Total Specialist Services</b>	<b>188,073</b>	<b>574</b>	<b>188,647</b>
External Commissioning - LTAs' + Access Plans	89,992	3,686	93,678
<b>Total External Contracts</b>	<b>89,992</b>	<b>3,686</b>	<b>93,678</b>
<b>Total Delegated Position before Capital Charges</b>	<b>1,633,146</b>	<b>76,903</b>	<b>1,710,049</b>
Capital Charges	48,197	0	48,197
<b>Total Delegated Position</b>	<b>1,681,343</b>	<b>76,903</b>	<b>1,758,246</b>
<b>Reserves</b>			
Annual Plan 24-25 deficit	30,533	(79,391)	(48,859)
Innovation reserve	3,000		3,000
Commitments	1,220	2,488	3,708
<b>Total Reserves</b>	<b>34,753</b>	<b>(76,903)</b>	<b>(42,151)</b>
<b>Total UHB</b>	<b>1,716,096</b>	<b>0</b>	<b>1,716,096</b>

The table below summarises the level of 'stretch' (aligned with the £11m annual plan savings opportunities) for delegated budgets:



Division	Proposed 2024/25 budget £000s	Stretch target (%) based on month 1 £000s
Primary Care, Community and Mental Health	620,425	0.8%
Acute / Hospital Divisions	703,570	1.1%
Corporate	103,729	1.8%
Commissioning	282,326	0.2%
Capital charges / Reserves	6,046	0.0%
<b>Total</b>	<b>1,716,096</b>	<b>0.87%</b>

At present there is no contingency assumed within reserves and therefore further cost pressures will need to be managed in the first instance pending any further funding or re-allocation of resources.

In line with the Health Board established governance arrangements, delegation letters will be issued to ensure clarity of responsibility and accountability based on the increased level of budget delegation.

The Chief Executive and Executive Directors may wish to move budgets between budget heads during the year within their delegated portfolios, this will be reported as part of monthly financial reporting.

### Summary

This paper is the second stage of a 2 stage budget delegation of the Health Boards funding for 2024/25, it describes the methodology used and the impact on delegated budgets. The budget delegation is in line with the total current income expected for 2024/25.

### Argymhelliad / Recommendation

The Board is asked to approve the proposed budget delegations, including:

- revised revenue budgets to be delegated for the 2024/25 financial year and:
- those budgets to be held in reserve.

Appendix attached – anticipated allocations

### Amcanion: (rhaid cwblhau)

### Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:  
Datix Risk Register Reference and Score:

Financial sustainability



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  <a href="#">Link to IMTP</a>	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  <a href="#">Strategic Equality Objectives 2020-24</a>	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 Financial and Other systems data Service plans
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  
 NCSSO – No Cheaper Stock Obtainable  
 NI – National Insurance  
 NICE – National Institute for Clinical Excellence  
 NHH – Neville Hall Hospital  
 NWSSP – NHS Wales Shared Services  
 Partnership  
 ODTCC – 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



	<p>WHSSC – Welsh Health Specialised Services Committee</p> <p>WLI – Waiting List Initiative</p> <p>WLIMS – Welsh Laboratory Information Management System</p> <p>WRP – Welsh Risk Pool</p> <p>YAB – Ysbyty Aneurin Bevan</p> <p>YTD – Year to date</p> <p>YYF – Ysbyty Ystrad Fawr</p>
<p>Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:</p>	<p>Finance &amp; Performance Committee</p>

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
	<p><b>Is EIA Required and included with this paper</b></p> <p><b>No does not meet requirements</b></p>
<p><b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b></p>	<p>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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b></p> <p><a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a></p>	<p>Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs</p> <p>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives</p>



Appendix - Anticipated allocations (total £67.8m) are listed below:-

WG Revenue Resource Limit : Anticipated Allocations (April)			
Funding Type	Description	Value £'000	Recurrent / Non Recurrent
GMS	GMS Refresh	1,603	R
GMS	Primary Care Improvement Grant	142	R
GMS	Shingles Vaccine - GMS element (24/25 anticipated element)	120	NR
GMS	GP Pay/expenses uplift 23-24	3,801	R
HCHS	Capital - DEL Depreciation - IFRS 16 Leases	3,690	NR
HCHS	Capital - AME Depreciation - IFRS 16 Leases (Peppercorn)	109	NR
HCHS	Capital - AME Depreciation - Donated Assets	326	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Equip)	(2,210)	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Prop)	(1,402)	NR
HCHS	2023-24 Pay award funding at 90%	38,033	R
HCHS	Pay award-Medical and Dental 5% 23-24	639	R
HCHS	ESP Pay award 23-24 5%	160	R
HCHS	A4C Pay award 23-24	2,655	R
HCHS	Consolidated pay award 1.5% Apr-23	932	R
HCHS	Exceptional-Incremental Real Living Wage	2,773	R
HCHS	Technology Enabled Care National Programme (ETTF)	1,800	R
HCHS	Informatics - Virtual Consultations	1,065	R
HCHS	Memory Assessment Services - Gwent RPB	565	R
HCHS	(Provider) Substance Misuse & increase	3,402	R
HCHS	(Provider) SPR's	125	R
HCHS	(Provider) Clinical Excellence Awards (CDA's)	298	R
HCHS	CAMHS In Reach Funding	778	R
HCHS	Invest to Save Omnicell	(440)	R
HCHS	National Clinical Lead for Falls & Frailty	30	R
HCHS	AHW:Prevention & Early Years allocation	1,114	R
HCHS	WHSSC - National Specialist CAMHS improvements (Tier 4)	234	R
HCHS	Same Day Emergency Care (SDEC)	1,451	R
HCHS	Learning Disabilities-Improving Lives	64	R
HCHS	Urgent Primary Care	1,302	R
HCHS	VBH: Heart Failure and Rehab in the Community	506	R
HCHS	New Medical Training Posts 2017-2022 cohorts	1,100	R
HCHS	CAMHS Sanctuary provision	50	R
HCHS	Welsh Risk Pool Risk Share agreement 23-24	(5,511)	NR
HCHS	Shingles Vaccine (24/25 element)	1,201	NR
HCHS	Mental Health SIF 22-23 (final 25%)	4,050	NR
HCHS	Mental Health SIF 23-24 (final 50%)	942	NR
HCHS	Planned Care Transformation-3Ps funding	340	NR
HCHS	Community Nursing-B3 and B4 staff development	28	R
HCHS	RIF Dementia	1,611	NR
HCHS	RIF Carers Short Breaks	247	NR
HCHS	Learning disabilities Health Checks	50	NR
<b>Total Anticipated: Per Ledger</b>		<b>67,774</b>	





**CYFARFOD BWRDD IECHYD PRIFYSGOL  
ANEURIN BEVAN  
ANEURIN BEVAN UNIVERSITY HEALTH BOARD  
MEETING**

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Finance Performance Report – April 2024 (2024/25 Month 1)
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Rob Holcombe - Director of Finance, Procurement & VBHC
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Suzanne Jones – Interim Assistant Director of Finance

**Pwrpas yr Adroddiad  
Purpose of the Report**

Er Sicrwydd/For Assurance

This report sets out the following:

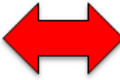


- The financial performance at the end of April 2024 and the forecast position against the statutory revenue and capital resource limits,
- The savings position for 2024/25,
- The revenue reserve position on the 30<sup>th</sup> of April 2024,
- The Health Board’s underlying financial position,
- The 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, at the 30<sup>th</sup> of April 2024 (month 1) 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.

<b>Apr-24</b>					
<b>Performance against key financial targets 2024/25</b>					
+Adverse / ( ) Favourable					
Target	Unit	Current Month	Year to Date	Movement	Year-end Forecast
<b>Revenue financial target</b> 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	4,959	4,959		<b>48,860</b>
<b>Capital financial target</b> 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	5,105	5,105		<b>0</b>
	£53,551	9.5%	9.5%		
<b>Public Sector Payment Policy</b> To pay a minimum of <b>95%</b> of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	96.0%	96.0%		<b>&gt;95%</b>
<b>Performance against requirements 23/24</b>		<b>21/22</b>	<b>22/23</b>	<b>23/24</b>	<b>3 Year Aggregate (21/22 to 23/24)</b>
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	<b>x</b>	<b>(249)</b>	<b>36,842</b>	<b>49,754</b>	<b>86,347</b>
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	<b>✓</b>	<b>(50)</b>	<b>(43)</b>	<b>(41)</b>	<b>(134)</b>
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	<b>x</b>				
<b>Underlying Financial Position (Brought Forward ULP)</b>		<b>20/21</b>	<b>21/22</b>	<b>22/23</b>	<b>23/24</b>
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.		<b>£16.261m Deficit</b>	<b>£20.914m Deficit</b>	<b>£89.6m Deficit</b>	<b>£81.410m Deficit</b>

The 2024/25 financial year budget performance as at month 1 is an adverse variance of **£4.959m**.

The 2024/25 reported forecast is a £48.860m deficit reflective of the annual plan however there are risks to the forecast position in relation to the delivery of pipeline opportunities and other operational factors.

The 2024/25 forecast of £48.860m is £36m greater than the Welsh Government control total of a £13m deficit.

## Cefndir / Background

Key points to note for month 1 include:

- Year to date position is a deficit of **£4.959m**.
- A reported full year position of **£48.860m deficit**, this is in line with the submitted annual plan financial forecast.
- Income includes anticipated funding for a number of areas including; 2023/24 pay awards, Mental Health Service Improvement funding and CHC real living wage funding.
- Pay Spend (excluding the notional pension adjustment from March 2024), is £5.6m lower compared with March. Reasons are linked to a reduction in managed GP practices and reduced variable pay.
- Non-Pay Spend (excluding capital adjustments) – has decreased by c.£10m due to funded areas of spend in March.
- Savings – overall in-month achievement is £1.22m, against the annual identified savings plan of £29.1m. Further pipeline opportunities of £11.4m are included in the plan which are assumed will be achieved.

***At Month 1, the reported revenue position is a £4.959m deficit and the reported capital position is break-even. The revenue position is in deficit and there are risks in achieving the reported forecast.***

The underlying financial deficit coming into the 2024/25 financial year is £81.4m, the revised underlying financial deficit for 2024/25 is currently assessed as **£51.9m** in line with the 2024/25 annual plan forecast deficit position.

## 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)
- Savings plans and pipeline opportunities – (£40.5m)
- **Total 2024/25 forecast deficit - £48.9m**

The table below describes the annual plan in further detail:-

Financial Plan 2024/25	2024/25 Deficit /
------------------------	----------------------

	(surplus) (£'m)
2023/24 forecast position (as at Month 9)	56.4
WG non-recurrent funding	14.4
Underlying deficit - accounting to reflect recurrent implications	10.6
<b>Underlying deficit going into 2024/25</b>	<b>81.4</b>
National Pressures	14.4
Inflationary Pressures	21.7
Contractual and Unavoidable Pressures	15.7
Local Investment Pressures	8.0
<b>Sub-total 2024/25 including new cost pressures</b>	<b>141.2</b>
Discretionary funding	(51.8)
<b>Sub-total 2024/25 inc. discretionary funding</b>	<b>89.4</b>
2024/25 savings	(29.1)
<b>Total 2024/25 position before further pipeline opportunities</b>	<b>60.3</b>
Additional amber opportunities	(6.9)
<b>Total 2024/25 position before red pipeline opportunities (Likely case)</b>	<b>53.4</b>
Red pipeline opportunities (67% assumption)	(4.5)
<b>ABUHB financial plan 2024/25 total (best case)</b>	<b>48.9</b>
<b>Note</b>	
Additional QIA plans of £6.2m - assumption of 20% achievement would result in c.£47.8m deficit	

A summary of the financial performance is provided in the following table, by delegated area.

Summary Reported position - April 2024 (M01)	Full Year Budget £000s	YTD Reported Variance £000s
<b>Operational Divisions:-</b>		
Primary Care and Community	288,290	206
Prescribing	114,518	354
Community CHC & FNC	72,004	68
Mental Health	124,481	1,335
<b>Total Primary Care, Community and Mental Health</b>	<b>599,293</b>	<b>1,963</b>
Surgery	133,253	1,037
Clinical Support Services	123,176	225
Medicine	148,795	957
Urgent Care	34,514	307
Family & Therapies	129,264	465
Estates and Facilities	86,897	983
Director of Operations	8,283	48
<b>Total Director of Operations</b>	<b>664,180</b>	<b>4,022</b>
<b>Total Operational Divisions (Chief Operating Officer)</b>	<b>1,263,473</b>	<b>5,985</b>
Corporate Divisions	91,608	627
Specialist Services	188,073	92
External Contracts	89,992	341
Capital Charges	48,197	(0)
<b>Total Delegated Position</b>	<b>1,681,343</b>	<b>7,044</b>
Total Reserves	34,753	(2,085)
Total Income	(1,716,096)	(0)
<b>Total Reported Position</b>	<b>0</b>	<b>4,959</b>

### Summary of key operational pressures for Month 1

- During April 2024, pay expenditure (excluding the effect of the notional pension costs adjustment from March 2024) was £64.2m a decrease of c.£5.6m (8%) compared with March.
- Substantive pay spend was £58.3m (March £62.3m).
- Variable pay spend was £6m (March £7.5m).

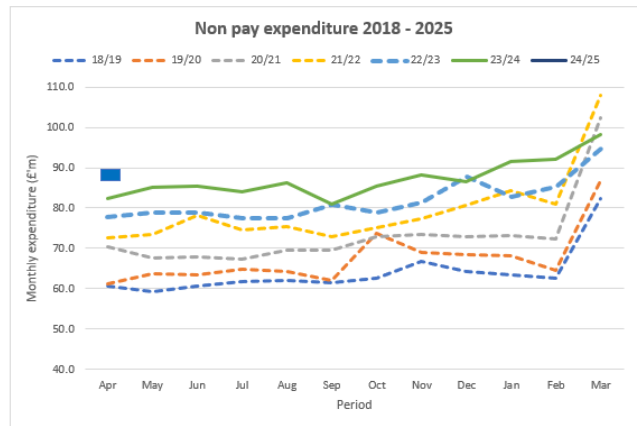
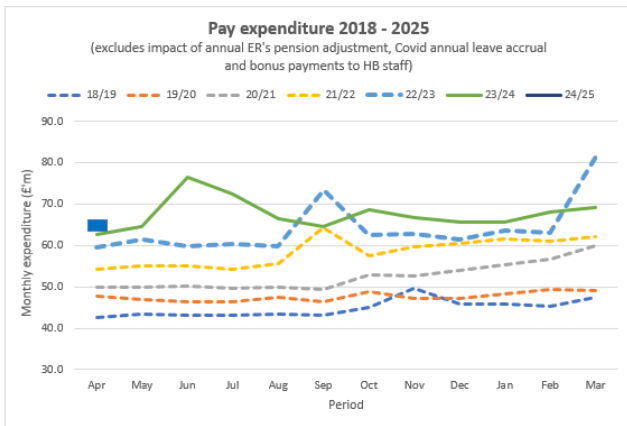
#### Key **Pay** issues include:

- Specific Sessional GP and Managed Practice expenditure accounted for in March 2023 - £1.5m reduction
- Substantive consultant pay reductions linked to Managed Practice and Industrial Action (off-set by Medical agency increase) - £1.4m reduction
- Nursing agency pay - £0.5m reduction through reduced usage to cover vacancies
- Bank, overtime and WLI usage reduced - £1.4m reduction
- Administration & Clerical substantive decrease relating to Managed Practices becoming independent contractors and externally funded posts (6 goals/111) - £0.8m reduction

- Non-Pay Spend (excluding capital adjustments) was £88.1m a decrease of c.£10m (10.2%) due to funded expenditure for JCC (WHSSC/EASC) pass through costs, RPB and TEC Cymru/E-system spend reported in March. 111/6 goals costs are now transferred outside of the Health Board for 2024/25.
- 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 are 289 inpatients who are fit for discharge as at the end of April; approximately 28% of the blocked bed days are health related, 45% are social care and package of care related with the remaining 27% relating to other reasons e.g. patient/family related, nursing homes, etc.
- The estimated cost for the year of continued blocked bed days for all reasons is c.£15.5m using a £150 cost per bed day. The challenges in terms of demand and flow across the Health Board drive surge bed capacity requirements which result in increased demand in high cost temporary staff, impacting overspends across the Health Board. The delays need to reduce to avoid the requirement for this capacity and optimise appropriate bed capacity to support financial sustainability for 2024/25, through the discharge and bed reduction saving programme.
- In month other significant issues include:-
  - Prescribing average price per item of £7.44 is significantly above the annual plan estimate of £7.29, this is only reflected in the year to date position as limited data is currently available to revise the forecast
  - CHC fees and growth pressures continue in Mental Health off-set by FNC numbers below annual plan
  - Enhanced cleaning, additional security and other facilities legacy costs continue
  - Continued diabetes pump costs
  - Surgery – homecare drug cost increases
  - Additional WLI and backfill costs above plan to support cancer and 156 week targets.
  - On-going use of variable pay by mental health wards for acuity as well as sickness and vacancy cover, (Mental Health nursing variable pay estimated over 45% linked to enhanced care),
  - A number of Payment in Lieu of Notice (PILON) claims and associated costs, and
  - Increased non-pay costs driven by inflationary growth across a number of areas including facilities provisions.

### **Expenditure run-rates**

Pay and Non-Pay expenditure run-rates for the last six financial years are shown below, along with a chart showing annual total pay and the impact of pay awards;

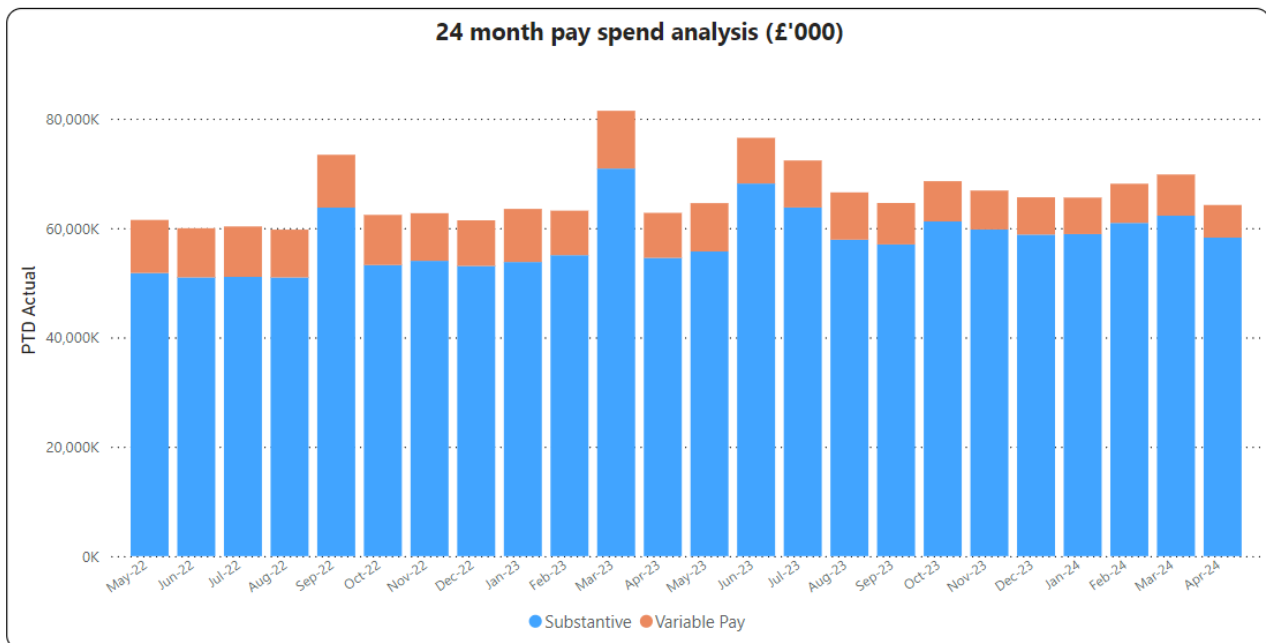


The expenditure run-rates need to significantly reduce in order for the Health Board to progress towards its annual plan deficit and to a break-even position in future financial years.

### Workforce

The Health Board spent £64.2m on workforce in month 1 24/25, a decrease of £5.6m compared with March (excluding the notional pension uplift in month 12). To note 2023/24 monthly average expenditure was £67.7m.

Workforce expenditure is shown below differentiating between substantive and variable pay<sup>1</sup>:

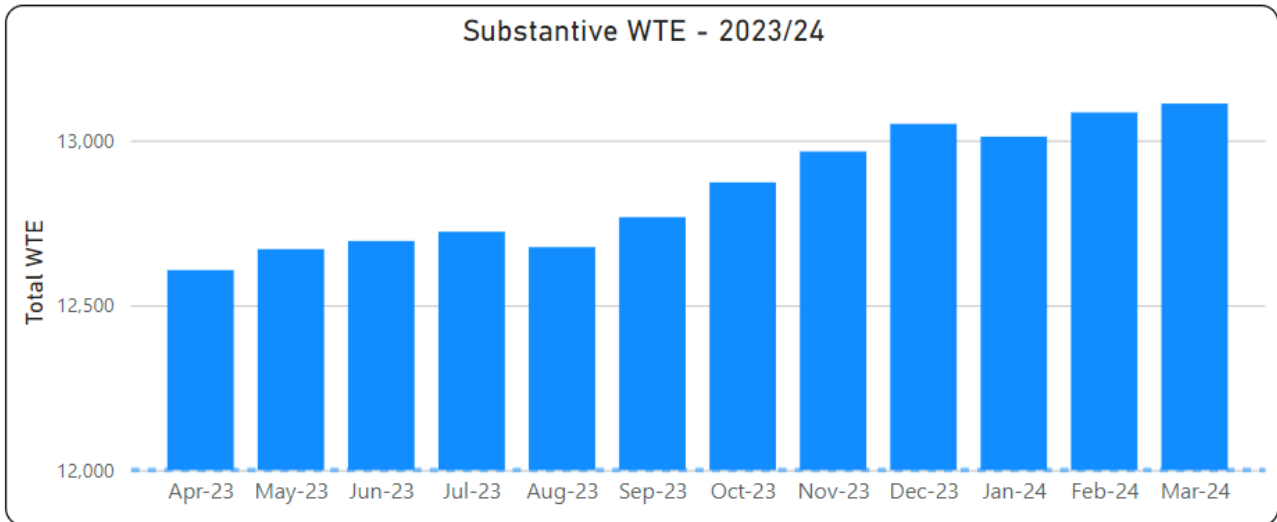


### Substantive staff

<sup>1</sup> 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).

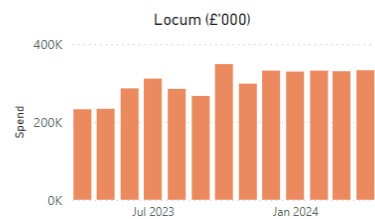
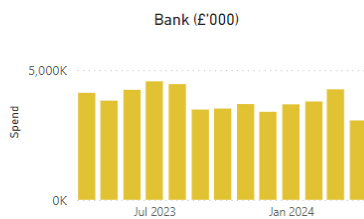
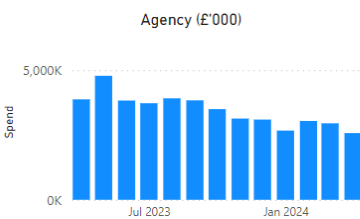
Substantive pay was £58.3m in March (excluding notional pension contributions) - costs decreased by £4m compared with March.

Month 1 includes 12,937 wte employed staff, a decrease of 175 wte over the prior month much of this relates to funded posts now moved outside of the HB as well as managed practice staff which are now part of independent contractor costs.

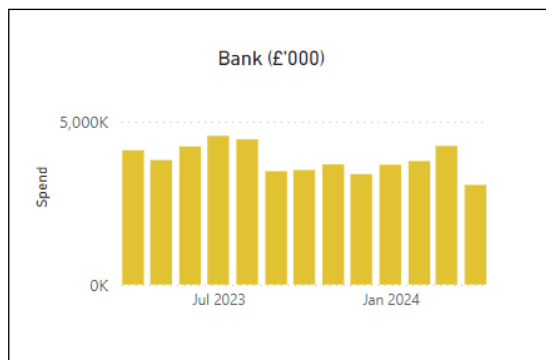


### Variable pay

Variable pay (agency, bank and locum) was £6m in April. The monthly average variable pay was £7.75m for 2023/24 (£9.2m average 22/23). Vacancy cover along with sickness and enhanced care continue to drive a financial pressure as well as pressure on our workforce.



### Bank staff

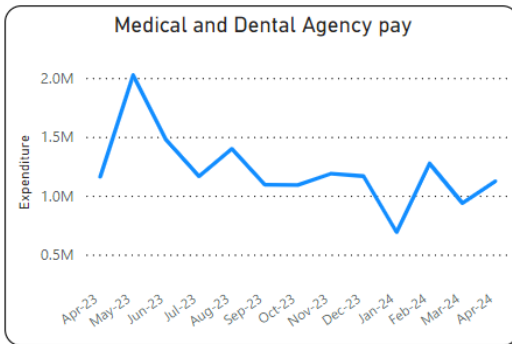


In-month spend of £3m, a £1.2m decrease compared with March, (2023/24 average monthly spend £3.9m).

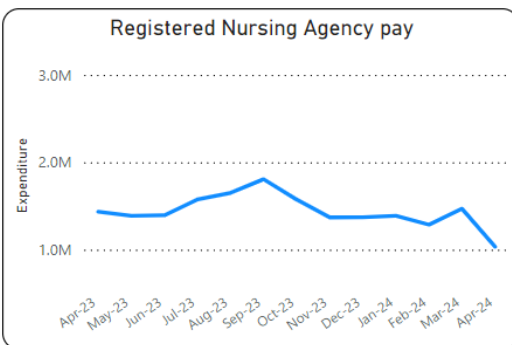
- Continued pressures in Medicine wards/ Urgent Care, GUH Acute Medicine and GUH ED - £1.3m
- Facilities bank staff - £0.2m
- Community Hospitals/localities - £0.4m
- Enhanced care / observation shifts particularly linked to Mental Health - £0.4m
- Continued expenditure in Critical Care, General Surgery and Trauma & Orthopaedics for operational pressures / elective activity - £0.4m

## Agency

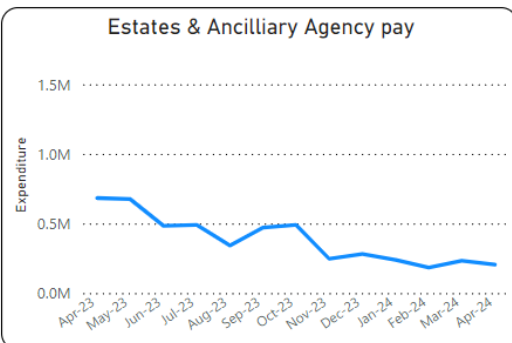
Total agency spend in April was £2.6m compared with £2.9m in March.



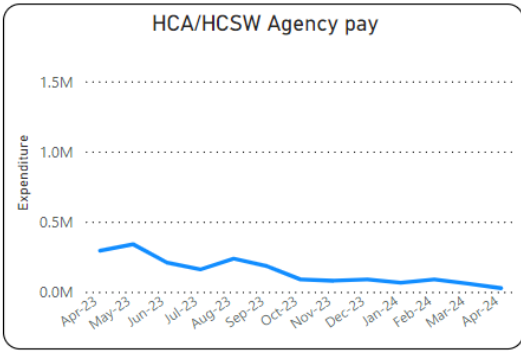
- In-month spend of £1.1m, a £0.2m increase compared with March (2023/24 average monthly spend of c.£1.2m).
  - On-going expenditure in specialist Mental Health, Managed Practices and Community Hospitals - £0.2m
  - Continued pressures in Medicine wards and Urgent Care to cover operational pressures - £0.4m
  - Trauma & Orthopaedics costs for junior rota (vacancies) and orthogeriatric cover that was implemented post GUH - £0.2m



- In-month spend of £1m, a £0.4m decrease compared with March. (2023/24 average monthly spend of c.£1.5m).
- Reasons for use of registered nurse agency include:
  - Vacancy cover
  - Additional service demand
  - Enhanced care and increased acuity of patients across all sites, and
  - On-going sickness and international recruitment costs
- On-going costs in GUH Emergency Department £0.15m and medicine wards £0.45m linked to enhanced care, sickness pressures as well as vacancy cover. Mental Health agency costs of £0.1m mainly linked to enhanced care cover.



- In month spend of £0.2m on Estates & Ancillary agency.
- 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.



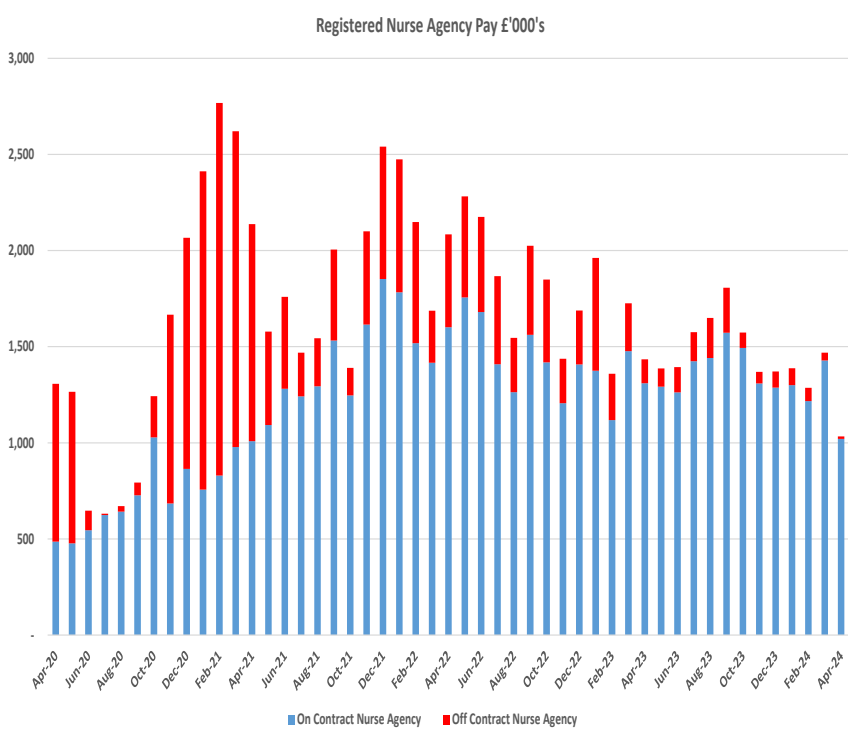
- In month spend of £0.03m on HCSW agency, a decrease of £0.03m compared with March (2023/24 average monthly spend of c.£0.16m).
- Areas where spend remains are:
  - MH&LD £14k,
  - PCCS £2k,
  - Medicine £6k
  - Family & Therapies £12k

### Registered Nurse Agency

Health Board spend in April 2024 on RN agency is £1m which is a £0.5m decrease compared with March.

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 decreasing but remains a pressure and last resort for the Health Board.



The Health Board spent £0.01m on “off” contract RN agency in April which is a lower level compared with March. These costs reflect the on-going vacancy cover as well as smaller usage for other operational pressures such as:

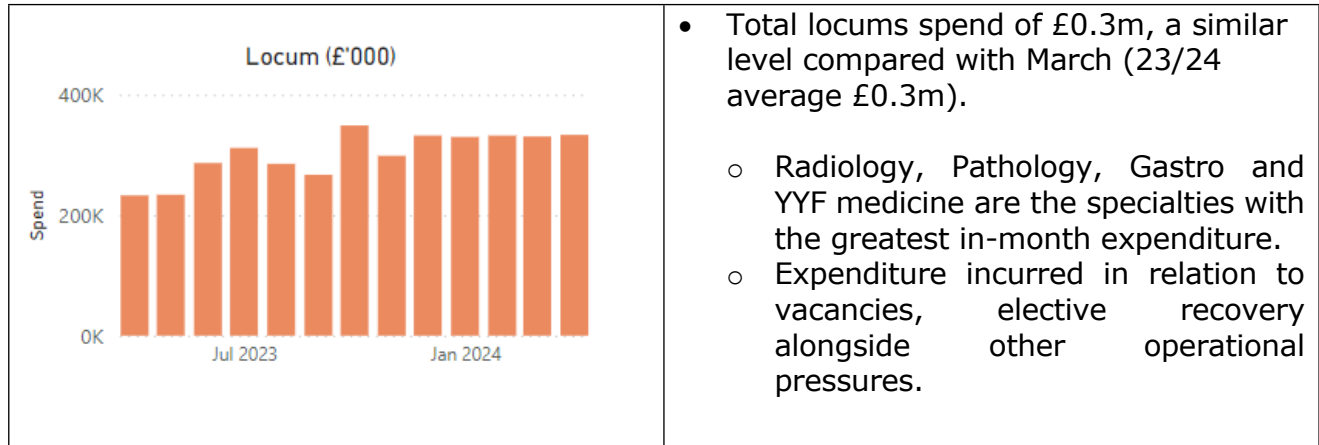
- Enhanced care,
- Additional capacity, and
- Increased sickness

### Implications of Nursing Shift ‘Fill Rate’

It should be noted that there remain high levels of unfilled shifts. Whilst filling these shifts may improve workforce and service provision, there would be an increased cost. In April there were approximately 100 unfilled registered nursing shifts and

420 unfilled HCSW shifts, which could have increased the spend by a further c.£0.2m if these shifts were filled. The increase in substantive appointments has now decreased the level of unfilled shifts which demonstrates a service improvement but presents a financial risk in terms of the variable pay saving opportunity due to possible increased availability to cover more shifts.

**Medical locum staff**

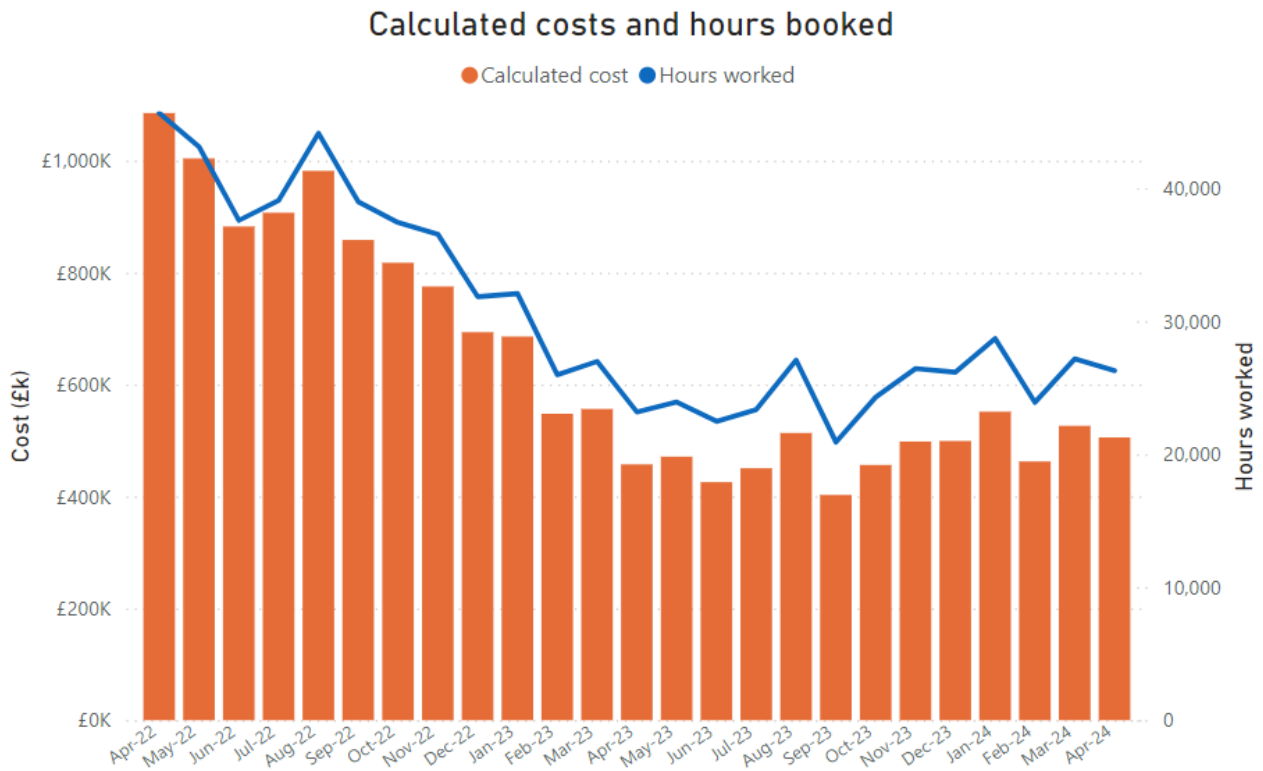


**Enhanced Care**

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 for the period April 2022 to April 2024 (£0.5m 'notional calculated' expenditure in April) using bank and agency registered nurses and health care support workers.

## Enhanced Care bank and agency calculated costs and hours booked.



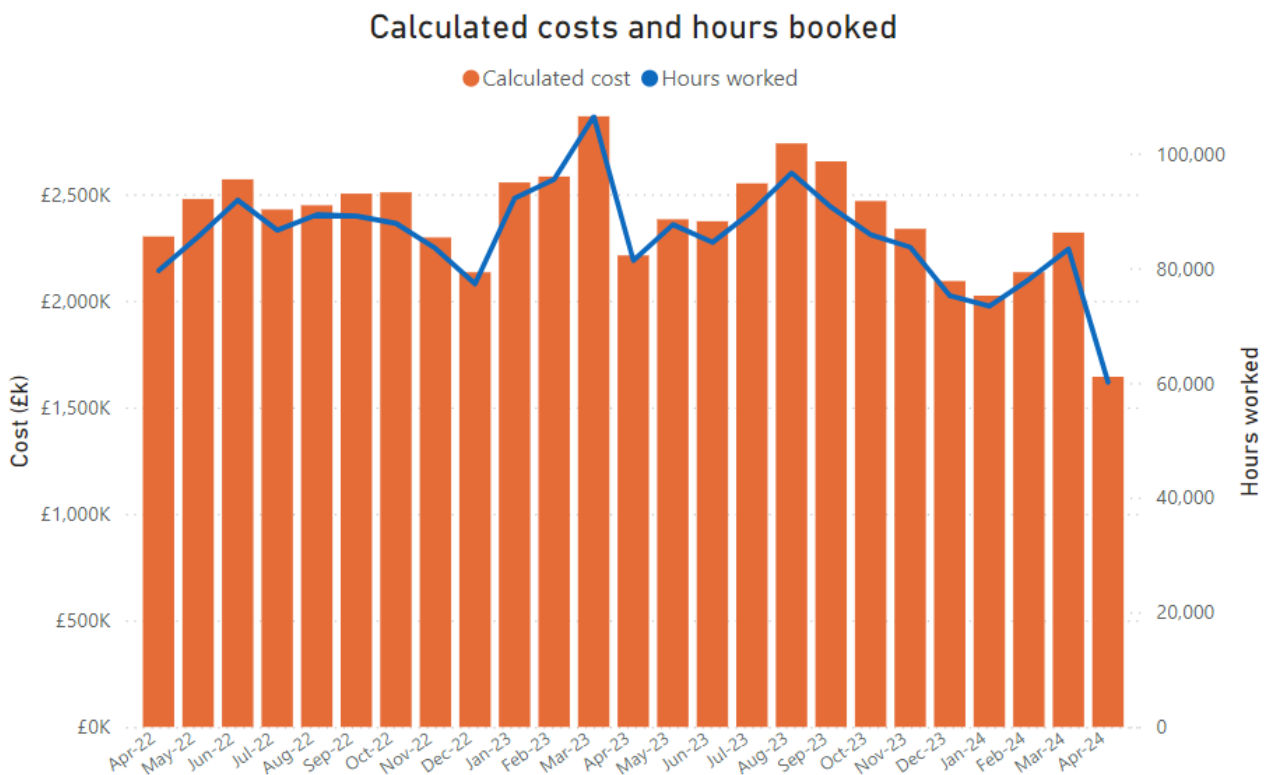
The level of the provision of enhanced care for patients within the Medicine Division for 2024/25 is shown below and will be monitored throughout 2024/25 in order to review further progress against enhanced care in the Division.

	2023/24 average	Apr-24
<b>RGH</b>		
Total no of Medicine beds	192	192
Monthly average enh care patients	34	28
%age of beds in receipt of enh care	18%	15%
<b>NHH</b>		
Total no of Medicine beds	164	164
monthly average enh care patients	22	23
%age of beds in receipt of enh care	13%	14%
<b>GUH</b>		
Total no of Medicine beds	91	91
monthly average enh care patients	12	13
%age of beds in receipt of enh care	13%	14%
<b>YYF</b>		
Total no of Medicine beds	148	148
monthly average enh care patients	24	27
%age of beds in receipt of enh care	16%	18%
<b>Total</b>		
Total no of beds	595	595
Total monthly average enh care patients	92	91
	15%	15%

## 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 April 2024 variable pay relating to vacancies is c.£1.6m ('notional calculated' expenditure). There was a significant reduction in April which is being reviewed as this may be as a result of reduced annual leave taken in April.

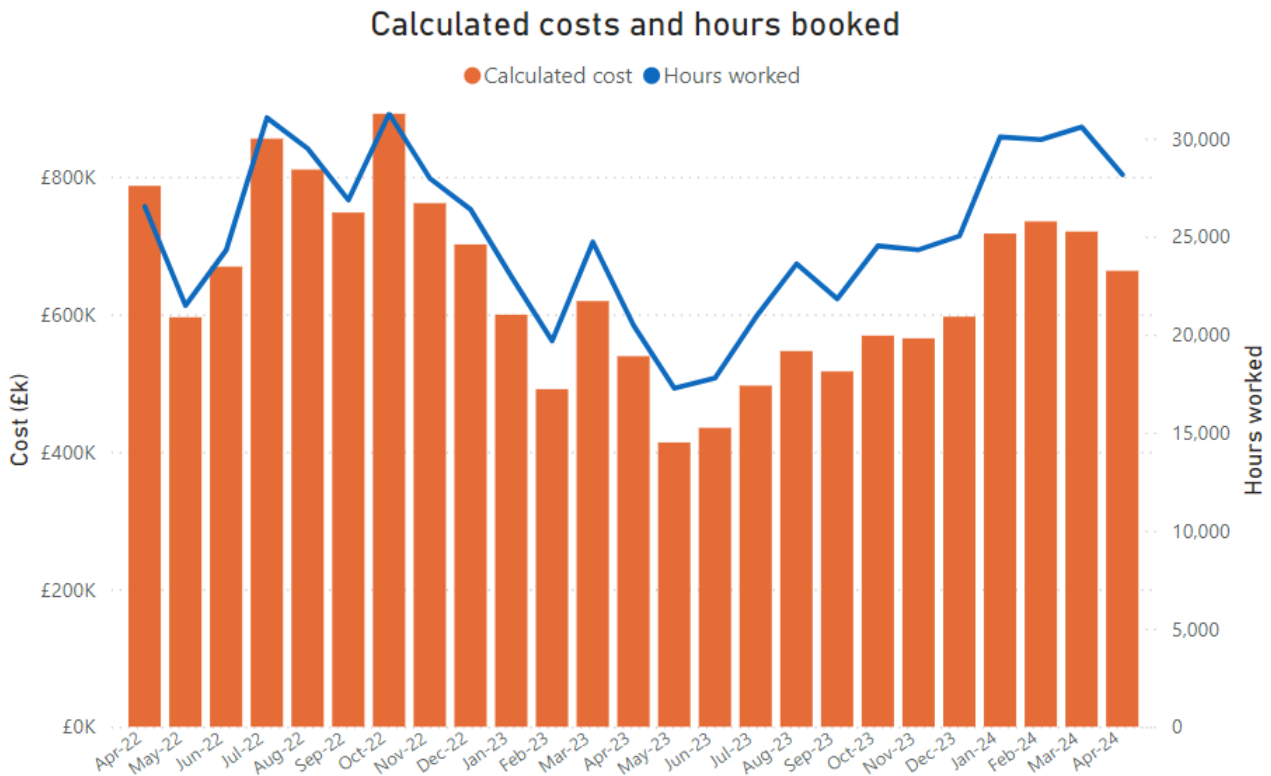
### Calculated bank and agency costs / hours booked to cover shifts resulting from vacancies.



## 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 April 2024 variable pay relating to sickness is c.£0.7m ('notional calculated' expenditure).

**Calculated bank and agency costs / hours booked to cover shifts resulting from sickness.**

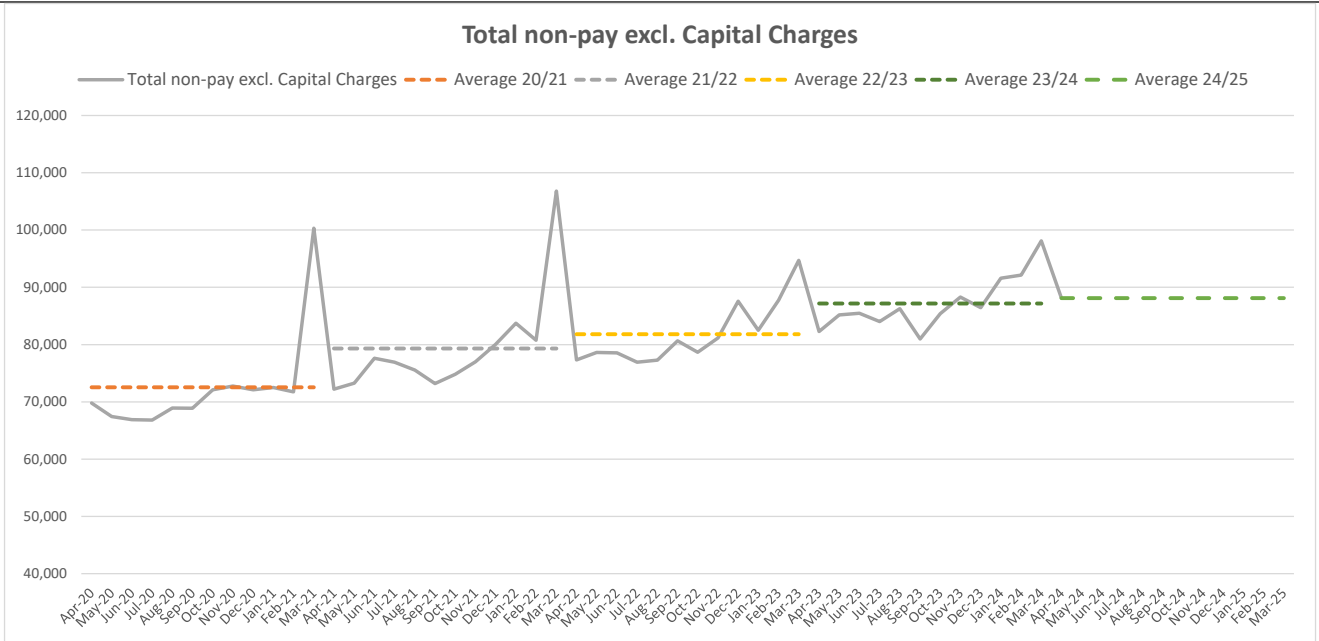


**Non-Pay**

Spend (excluding capital) was £88.1m in April, which is a £10m decrease when compared with March. Key reasons include:-

- Funded WHSSC, EASC costs incurred in March - £3m
- 111/6 goals cost reduction, now moved to NHS Executive - £3m
- RIF funded spend in March - £2m
- Funded TEC Cymru and E-system cost reductions - £1.5m
- Various other areas including CHC / FNC cost reductions - £0.5m.

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 volatile cost pressure with a forecast annual growth of £1.8m compared with 2023/24 expenditure using the latest data estimates received. The following table reflects the current position for 2024/25:-

<b>Gas &amp; Electricity</b>	<b>2022/23 Actuals £'000s</b>	<b>2023/24 Actuals £'000s</b>	<b>2024/25 Forecast £'000s</b>
Total Shared Service Contract Energy Cost	21,612	16,834	18,961
Total Other Energy costs	571	777	447
<b>Total</b>	<b>22,183</b>	<b>17,611</b>	<b>19,408</b>

Note 2022/23 experienced a significant energy cost increase over 21/22 of £13.7m.

**CHC**

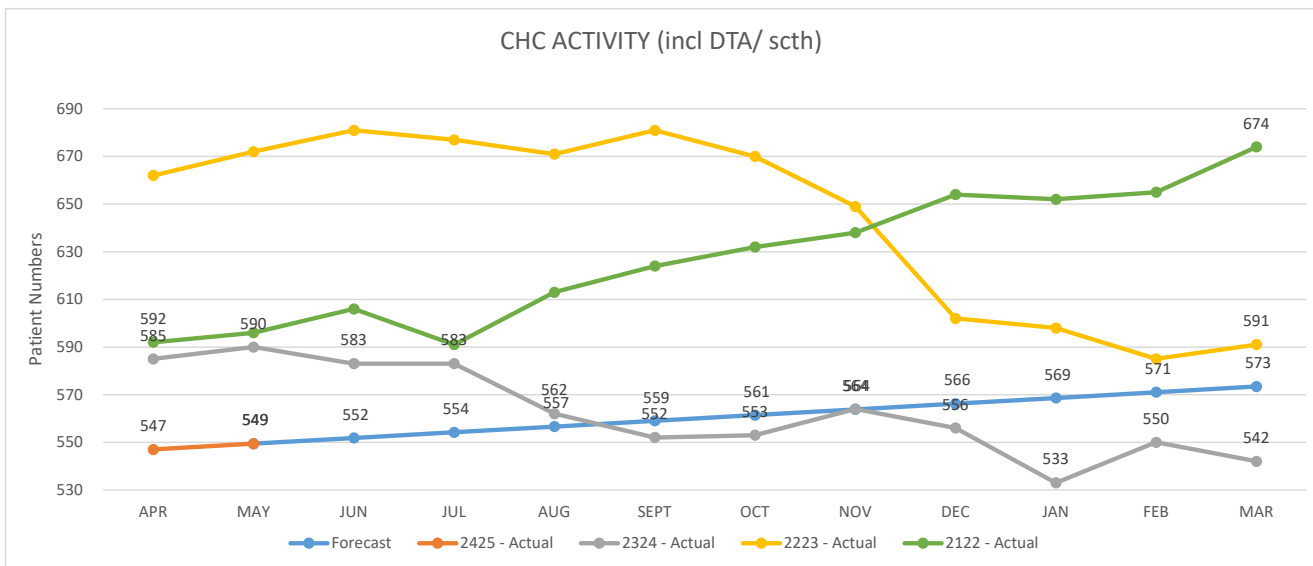
- CHC Mental Health – the patient numbers at the end of April were 421 at a cost of £4.6m (419 patients at a cost of £4.3m in March).
- CHC Adult / Complex Care - 547 total active placements on 30<sup>th</sup> of April at a cost of £4.8m in-month (increase of 5 from previous month). There was a decrease in the number of D2A patients but no change to the number of 'Step Closer to Home' (SCTH) patients in April.
- Delays in the step closer to home pathway, where patients are not eligible for CHC, are being caused due to delays in confirming social care support. This is impacting the number of patients being discharged.
- The table below summarises the current position (patient numbers and costs):

Activity	Apr 2024	Mar 2024	Movement
D2A	18	22	-4
Step Closer to Home	4	4	0
All Other CHC	529	520	+9
<b>Total</b>	<b>547</b>	<b>542</b>	<b>+5</b>

£'000	2024/25 forecast	2023/24 out-turn position
D2A	1,677	2,093
Step closer to home	563	407
All other CHC	43,136	41,053
<b>Total</b>	<b>45,376</b>	<b>43,553</b>

- FNC - currently 1,040 active placements, which is a decrease of 19 compared with March (expenditure of £1m in April).

Adult Complex Care CHC activity over the last four financial years is summarised in the chart below: -



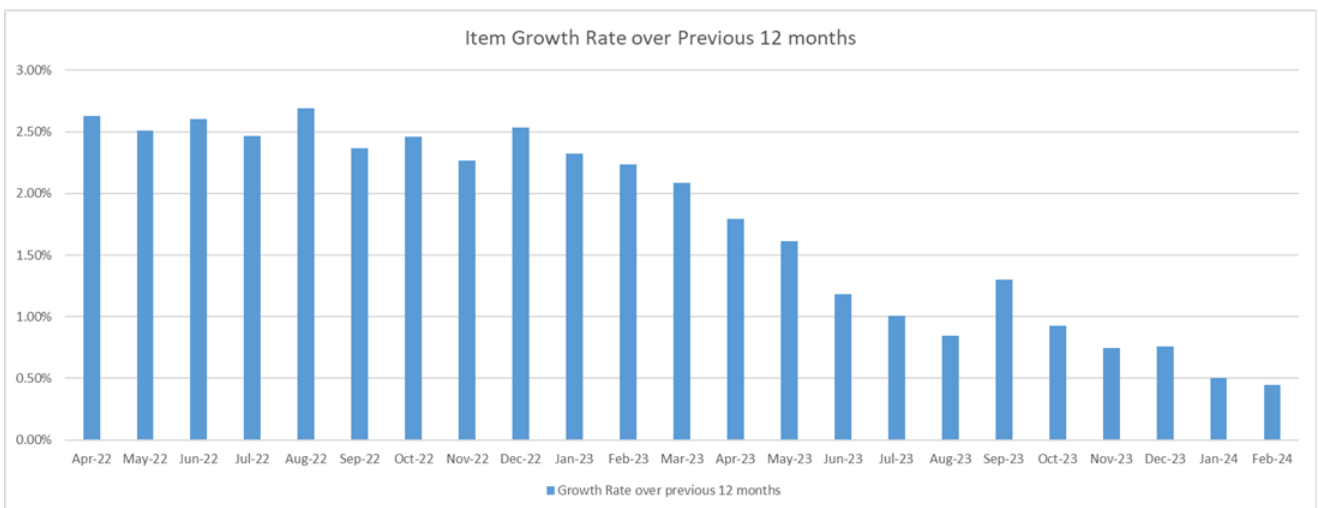
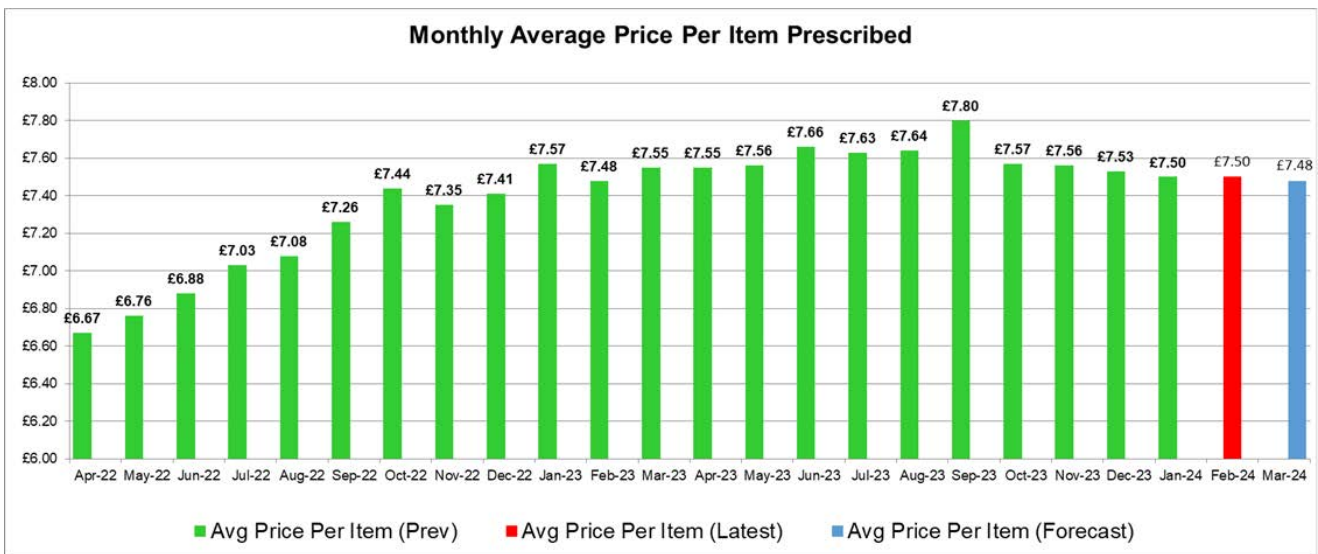
- CHC Paediatric – currently 20 Out of County patients (April in-month cost of £0.18m, 2023/24 total cost of £4.1m) and 17 internal packages (15 patients). There are 6 external and 4 internal high cost packages which continue to be a cost pressure (>£100k expenditure). There is also a high cost case awaiting a dispute panel discussion.

## Prescribing

- Primary Care prescribing – April 2024 expenditure is £9.9m (2023/24 expenditure is £121.9m). The April 2024 costs are based on February PAR data, but is only reflected in the year to date reporting: -

- 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.16.9m)
- Current growth rate for 2023/24 (Apr-Feb) is 0.36%, taking into account the number of prescribing days.
- 2024/25 Annual Plan average cost per item is estimated as £7.29.
- Average cost per item price for 2023/24 (April-March) is estimated at £7.58.
- Average cost per item price for April reporting is currently estimated at £7.25.

The graphs below show the monthly average price per item and item growth: -



### Scheduled Care treatments and outpatients

Elective Treatments for April '24 is 1,985 (March '24 was 1,783).  
 Elective Activity in April has increased by 202 treatments compared with March (11% increase). The number of in month treatments are 71 above plan for April.

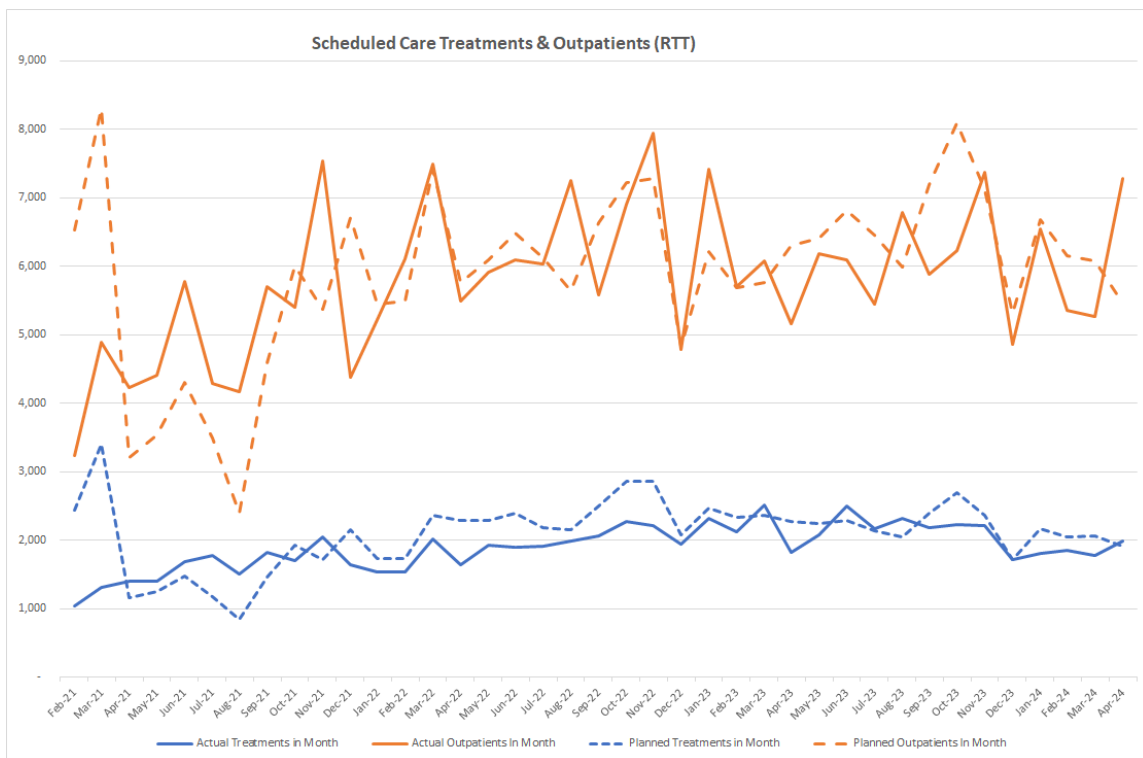
Outpatient activity for April '24 is 7,288 (March '24 was 5,265).

Outpatient activity has increased in comparison with the level achieved in March and is considerably above planned levels, part of this is in relation WLI/backfill activity (increase of 2,023 attendances above March and 1,822 above plan).

There were WLIs in-month for cancer treatments and elective work to improve the 156 week position for ENT (298 outpatients).

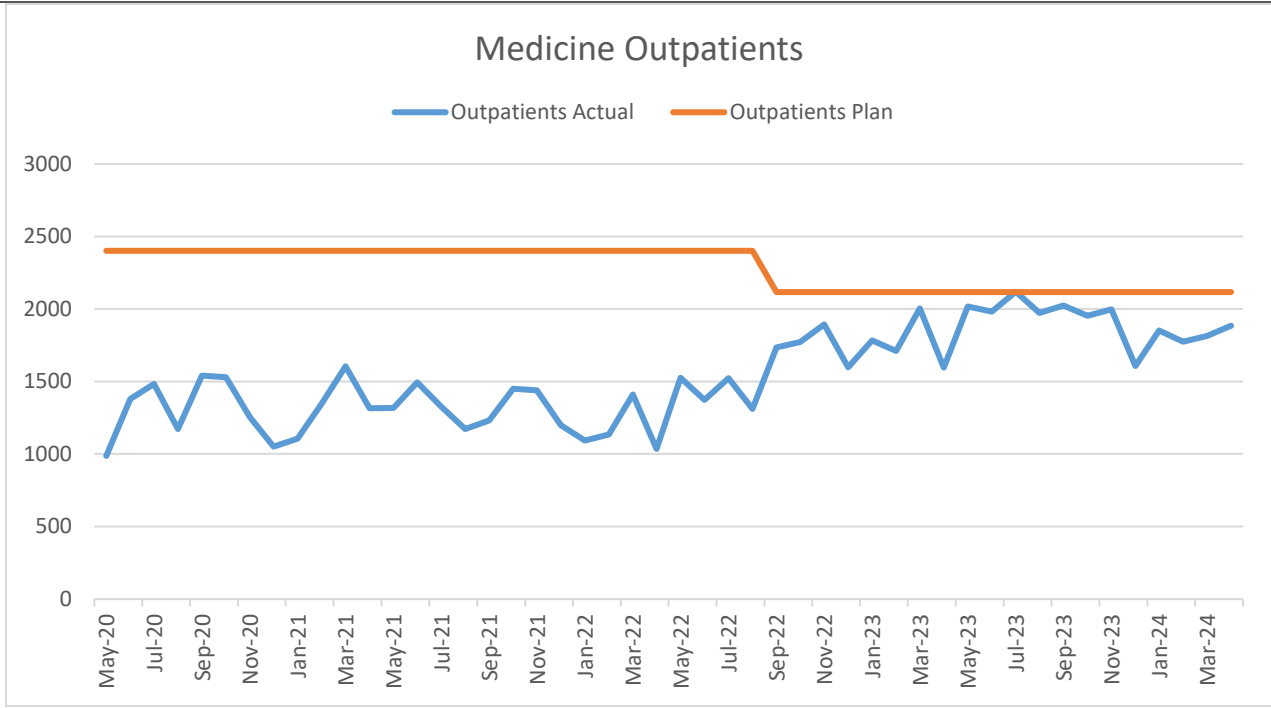
There are instances where WLI rates are being paid for backfill sessions outside of the agreed rate card.

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

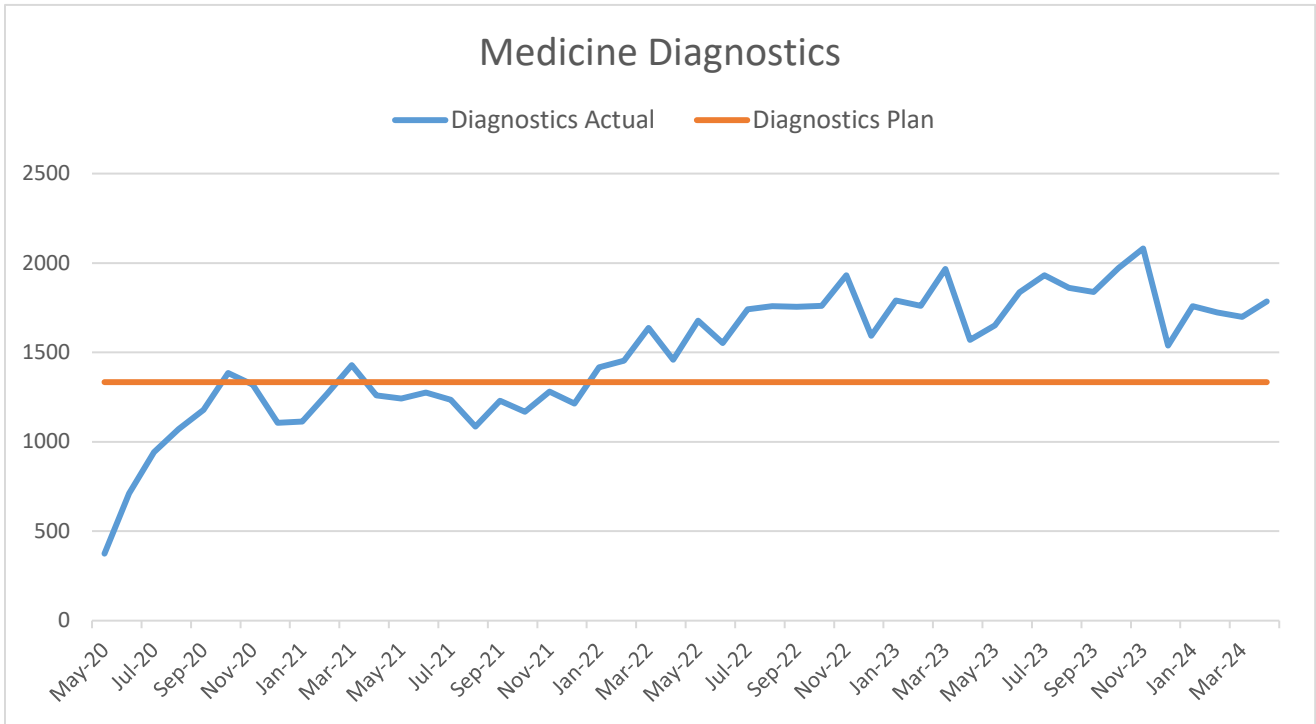
Medicine Outpatient activity for April '24 was 1,884 attendances, which was 232 below plan (March '24 was 1,815 attendances), the activity is presented below:



**Medicine Diagnostics (Endoscopy) Activity**

Medicine endoscopy activity for April '24 was 1,785 procedures which is 451 cases more than plan (March '24 activity was 1,699).

The activity undertaken since May '20 is shown below.



## Divisional 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 which continue to be reported in line with the annual plan for month 1, these will be reviewed in month 2 and revised following stage 2 budget delegation and savings review.

Summary Reported position - April 2024 (M01)	Annual Year Budget £000s	Full-year forecast at M1 £000s
<b>Operational Divisions:-</b>		
Primary Care and Community	288,290	4,362
Prescribing	114,518	1,042
Community CHC & FNC	72,004	(169)
Mental Health	124,481	17,455
Surgery	133,253	6,592
Clinical Support Services	123,176	1,240
Medicine	148,795	9,184
Urgent Care	34,514	5,097
Family & Therapies	129,264	5,297
Estates and Facilities	86,897	11,260

## Covid-19 – 2024/25 Revenue Financial Assessment

Covid-19 funding of £12.4m has been received as part of the 2024/25 allocation letter and is broken down as follows:

- PPE - £1.120m
- Health Protection, Immunisation and Mass Vaccination - £10.080m made up of:-
  - Public Health – Health Protection costs – £8m
  - Covid Anti-Viral costs - £1.4m
  - All other related costs - £0.7m
- Adferiad (Long Covid) - £1.216m

The Health Board is forecasting costs in line with the funding received.

The Health Board continues to incur additional costs that were originally related to Covid-19 responses, these include enhanced cleaning standards, security and rental costs. These costs are expected to be incurred into the future and form part of the Health Board's underlying deficit.

## **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. Some allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific purpose or they remain subject of further delegation approval as part of the 2024/25 two stage process.

A summary of all Health Board reserves on 30<sup>th</sup> of April, along with details of amounts approved for delegation by the CEO in Month 1 can be found in the appendices.

As agreed by the Board, the Finance Director on behalf of the Chief Executive Officer will present the stage two budget setting recommendation to the Board under separate cover to finalise the 2024/25 delegated budget plan.

## **Long Term Agreements (LTA's)**

ABUHB is currently agreeing LTA documentation with organisations, there are discussions regarding the application of the directed uplift of 3.67%.

During 2023/24 ABUHB went through the WG arbitration process with CTMUHB to settle the LTA dispute, this secured ABUHB a significant financial saving related to underperformance in commissioned activity. Meetings have continued with CTMUHB to establish an appropriate revised future activity and cost plan for the LTA for 2024/25, currently there remain continued differences between the positions of each Health Board and discussions has been escalated to the Directors of Finance.

The deadline for signed agreements is 30<sup>th</sup> of June 2024.

## **Underlying Financial Position (ULP)**

The Underlying (U/L) forecast position is a brought forward opening deficit of £81.4m. The closing underlying position assumes recurrent savings planned are fully delivered and is reported in line with the 2024/25 forecast of a £51.9m deficit.

The analysis of the c/f underlying deficit is as follows:-

- Forecast 2024/25 deficit - £48.9m
- Non-recurrent savings – £3m
- Total £51.9m

Financial sustainability is an on-going priority and focus for the Health Board and a 3 year recovery plan is being developed.

The cost drivers underpinning the b/f underlying position are summarised as follows;

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
<b>Total underlying deficit b/f into 2024/25</b>	<b>81</b>

It should be noted that although the 2023/24 £64.5m mid-year support allocation 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 currently a £13m deficit for ABUHB.

### Savings delivery

As part of the annual plan submitted by the Board to Welsh Government, the financial plan for 2024/25 identified £9.7m of full year effect savings brought forward from 2023/24 and an ambitious new savings target of £40.5m in 2024/25 (total savings 2024/25 of £50.2m). The £40.5m is made up of £29.1m of savings plans plus a further £11.4m of pipeline opportunities.

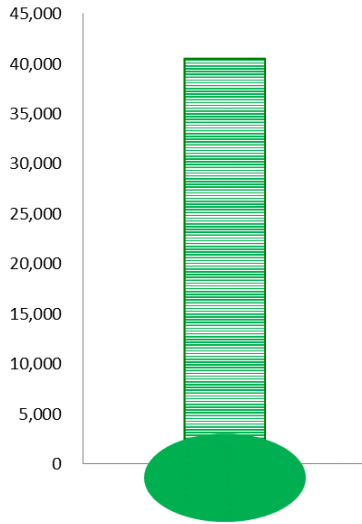
Actual savings delivered to date for 2024/25 is £1.22m.

The table below presents the updated savings profile:

RAG Rating	£m	
	MDS	Month 1 forecast
Divisional plans - Green	1.6	16.9
Divisional plans - Amber	26.9	12.2
Divisional plans - Red	0.6	-
Pipeline Opportunities	11.4	11.4
<b>Total</b>	<b>40.5</b>	<b>40.5</b>

**Savings Progress as at Year to Date  
Month 01**

- ABUHB Savings required to be Identified Per IMTP Submission
- ◊ IMTP Savings Identified to WG
- Savings Plans Forecast Delivering
- Savings Achieved to M01



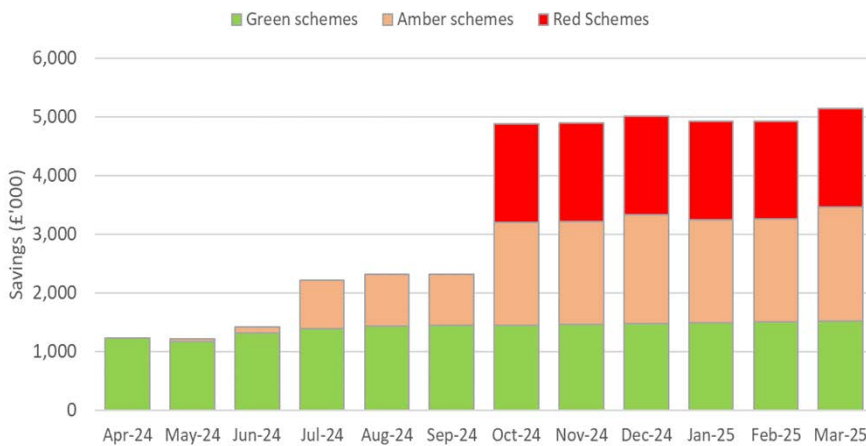
**Month 1 Savings Plans**

WG Category	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	5,543	1,440	4,103	4,103
Commissioned Services	2,805	0	2,805	2,805
Medicines Management (Primary and Secondary Care)	2,188	1	2,187	2,187
Pay	16,848	575	16,273	16,274
Non Pay	13,124	813	12,311	12,312
<b>Total</b>	<b>40,508</b>	<b>2,828</b>	<b>37,680</b>	<b>37,681</b>

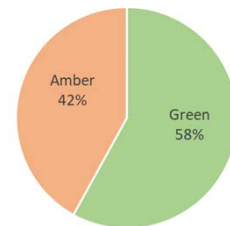
**Month 1 Savings Plans – Green**

Green Savings schemes	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	3,357	0	3,357	3,357
Commissioned Services	0	0	0	0
Medicines Management (Primary and Secondary Care)	2,188	1	2,187	2,187
Pay	6,219	575	5,644	5,644
Non Pay	5,110	517	4,593	4,593
<b>Total</b>	<b>16,874</b>	<b>1,092</b>	<b>15,782</b>	<b>15,782</b>

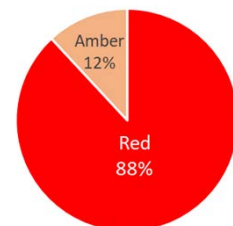
**Savings profile £40.5m - RAG rating**



**Plan savings (£29.1m)**



**Pipeline opportunities (£11.4m)**



## **Risks & Opportunities (2024/25)**

There are significant challenges to achieving the financial forecast for 2024/25, which include:-

- Ensuring full delivery of the savings plans identified in the annual plan including the pipeline opportunity values,
- Identifying savings to mitigate any further financial pressures identified outside of the annual plan,
- Receipt of all anticipated allocations,
- Workforce absence / vacancies, availability of staff for priority areas,
- Delayed transfers of care due to LA service challenges (estimated pressure £0.6m for year to date using £150 per bed day),
- Funding for any wage award or change in terms and conditions,
- Prescribing growth in items and average cost per item,
- Further CHC growth and fee uplifts above forecast levels,
- Impact of any further strike action,
- Long Term agreements sign off, possible arbitration on financial quantum and how the 3.67% pass through should be used
- 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, and
- VAT rebate opportunities,
- Re-review of previously 'discounted' and other savings ideas, 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 1 totalled £53.551m. A forecast over-spend of £1.340m against All-Wales Capital Programme (AWCP) schemes (detailed further below) is being offset by a corresponding under spend against the Discretionary Capital Programme (DCP). The forecast outturn at Month 1 is breakeven.

The VAT reclaim for the Grange University Hospital scheme continues to be progressed with HMRC and should be finalised during 2024/25.

Phase 2 of Bevan Health and Well-being Centre (demolition of the existing Health Centre and car-parking) is continuing and is anticipated to complete in October 2024. The scheme is forecasting an overspend of £0.822m in 2024/25 which is being offset by the DCP. Discussions continue with the contractor in relation to the resolution of a number of disputed compensation events. An additional funding bid

to WG is also planned to be made in 2024/25 for unfunded costs in relation to inflation allowances on works and fees, EV charging and other required changes. These currently total circa £1.2m plus VAT.

Works at NHH Satellite Radiotherapy Centre are progressing well with planned completion currently forecast to be 30th January 2025. The overall scheme is currently forecast to be £0.523m under budget largely as a result of additional VAT recovery savings. The impact on the 2024/25 allocation will be worked through in May and reported at Month 2.

Works on Newport East H&WBC continue with scheme completion expected to be April 2025. The overall project budget remains under pressure due to additional asbestos and utility costs. There is a forecast overspend of £0.406m on the project overall which is being funded via the DCP.

A forecast over-spend of £0.110m is being reported against the RGH Blocks 1 & 2 Demolitions and Car Park scheme as a result of additional asbestos and delays due to nesting birds. Plans for the new car park are expected in the next month. The programme will be confirmed once these plans have been received and agreed.

Works are on-going on the CAMHS Sanctuary Hub scheme with scheme completion currently anticipated to be August 2025.

The GUH Emergency Department extension scheme is underway with completion of the extension currently estimated to be February 2025. The scheme is forecast to be in line with budget.

The Health Board Discretionary Capital Programme (DCP) funding available for 2024/25 is £8.770m 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

The opening DCP for 2023/24 was approved at the January 2024 Board meeting. The current forecast spend for approved DCP schemes is £7.430m. This equates to an under spend of £1.340m that is required to offset the overspends on AWCP schemes. The DCP contingency remaining as at Month 1 is £0.735m.

## **Cash**

The cash balance on the 30<sup>th</sup> of April is £2.780m, which is within 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 April (96.0%). 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 April is 96.4%, which is encouraging. NHS Invoices in breach of the 30-day payment terms continue to be followed up accordingly with Divisional Managers as necessary.

### Argymhelliad / Recommendation

#### **The Board is asked to note for assurance:**

- The financial performance at the end April 2024 and forecast position against the statutory revenue and capital resource limits,
- The savings position for 2024/25,
- The revenue reserve position on the 30<sup>th</sup> of April 2024,
- The Health Board’s underlying financial position,
- The cash position,
- Public sector payment policy performance, and
- The capital position.

Note: The April 2024 Monthly Monitoring Return is included for reference.

Note: the appendices attached providing further detailed information.

Appendices:



Board%20Finance% Appendix%202%20- ABUHB%20MMR%20Report%20appen%20WG%20MMR%20Commentary-Mont

<b>Amcanion: (rhaid cwblhau)</b>	
<b>Objectives: (must be completed)</b>	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
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  <a href="#">Link to IMTP</a>	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  <a href="#">Strategic Equality Objectives 2020-24</a>	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
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  
 ODTG – 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

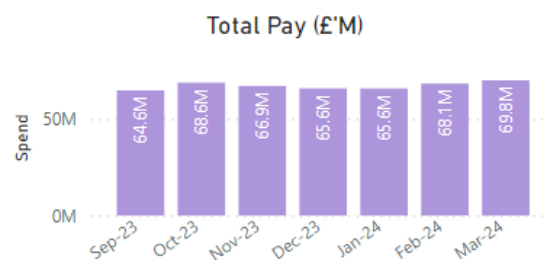
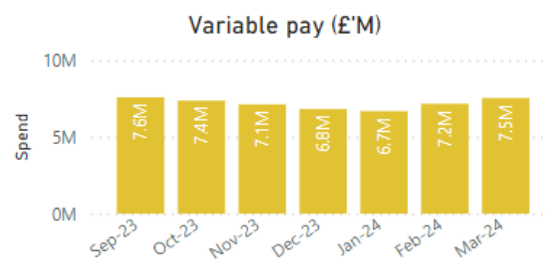
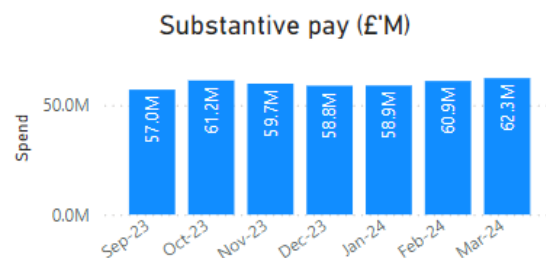
	<p>WHC – Welsh Health Circular          WHSSC – Welsh Health Specialised Services Committee          WLI – Waiting List Initiative          WLIMS – Welsh Laboratory Information Management System          WRP – Welsh Risk Pool          YAB – Ysbyty Aneurin Bevan          YTD – Year to date          YYF – Ysbyty Ystrad Fawr</p>
<p>Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:          Parties / Committees consulted prior to University Health Board:</p>	<p>Finance &amp; Performance Committee</p>

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper</b>
<p><b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b></p>	<p><b>No does not meet requirements</b></p> <p>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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b></p> <p><a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a></p>	<p>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</p>

<b>Aneurin Bevan University Health Board</b>
<b>Finance Report – March (Month 12) 2023/24</b>
<b>Appendices</b>

<b>Section</b>	<b>Page Number(s)</b>
Pay Summary 1	2
Pay Summary 2 Substantive Pay	3
Pay Summary 3 Variable Pay	4
Non Pay Summary	5
RTT & Waiting List Initiatives	6-7
Divisional analysis	8-19
National Covid-19 Funding Assumptions	20
Reserves	21
Cash / Public Sector Payment Policy	22
External Contracts – LTA’s	23
External Contracts – Specialised Services	24
Balance sheet	25
Health Board Income	26
Capital Planning & Performance	27

## Pay Summary (1) (subject to change excluding annual leave effect Pension employer costs):



### Substantive (£'000)

Pay category	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Change	%	Avg 22/23
ADD PROF SCIENTIFIC AND TECHNICAL	2,150	2,139	2,305	2,334	2,335	2,342	2,351	9	0.4%	2,027
ADDITIONAL CLINICAL SERVICES	7,755	7,816	8,001	7,746	7,712	8,226	7,866	-360	-4.4%	7,111
ADMINISTRATIVE & CLERICAL	9,893	10,076	10,379	10,192	9,962	10,305	10,502	197	1.9%	9,419
ALLIED HEALTH PROFESSIONALS	4,009	4,035	4,152	4,171	4,111	4,140	4,159	19	0.4%	3,839
ESTATES AND ANCILLIARY	2,875	2,868	2,973	2,888	2,900	3,049	2,920	-129	-4.2%	2,781
HEALTHCARE SCIENTISTS	1,111	1,112	1,136	1,131	1,160	1,146	1,167	21	1.9%	1,039
MEDICAL AND DENTAL	13,213	16,884	14,212	13,998	14,178	14,942	16,450	1,508	10.1%	13,085
NURSING AND MIDWIFERY REGISTERED	15,996	16,281	16,582	16,346	16,539	16,797	16,848	50	0.3%	15,603
STUDENTS	4	2	2	4	2	1	2	0	7.9%	9
<b>Total</b>	<b>57,006</b>	<b>61,213</b>	<b>59,741</b>	<b>58,810</b>	<b>58,899</b>	<b>60,948</b>	<b>62,264</b>	<b>1,315</b>	<b>2.2%</b>	<b>54,913</b>

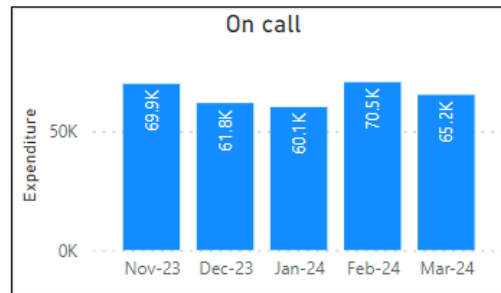
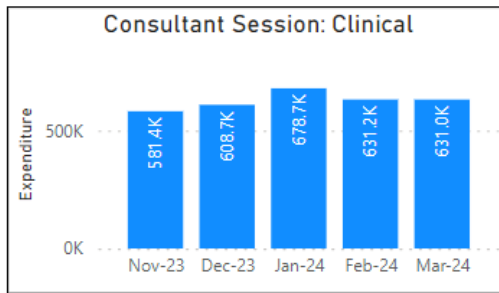
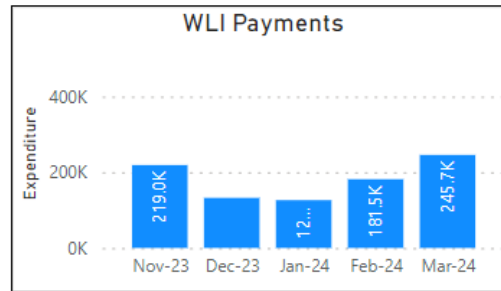
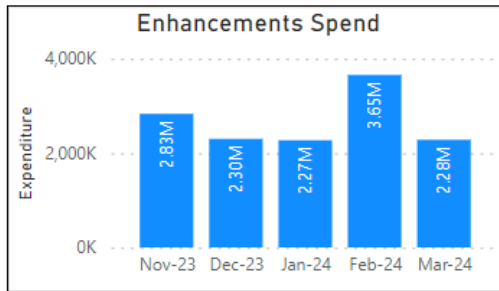
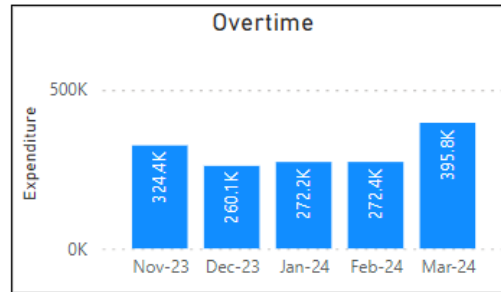
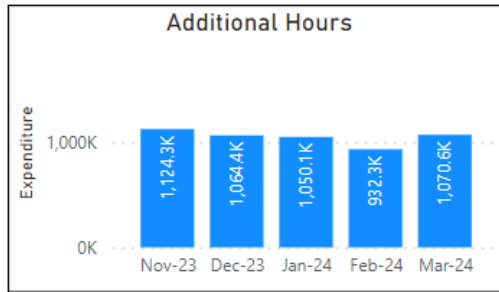
### Variable pay (£'000)

Pay category	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Change	%	Avg 22/23
Agency	3,835	3,497	3,132	3,093	2,668	3,040	2,948	-91	-3.0%	5,077
Bank	3,480	3,519	3,692	3,392	3,681	3,790	4,259	468	12.4%	3,831
Locum	267	349	299	332	330	332	330	-2	-0.5%	260
<b>Total</b>	<b>7,582</b>	<b>7,365</b>	<b>7,122</b>	<b>6,817</b>	<b>6,678</b>	<b>7,162</b>	<b>7,537</b>	<b>375</b>	<b>5.2%</b>	<b>9,169</b>

### Total pay (£'000)

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Change	%	Avg 22/23
Pay	64,588	68,578	66,863	65,627	65,577	68,110	69,801	1,691	2.5%	64,082

## Pay Summary (2): Substantive Pay



Analysis type by Division

Analysis type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
<b>ENHANCEMENTS</b>						
Medicine	540	437	438	726	445	2,587
Scheduled Care	454	363	361	573	369	2,120
Estates and Facilities Division	382	316	315	469	316	1,798
Primary Care and Community	336	268	268	510	278	1,660
Family and Therapies	351	295	280	428	284	1,638
Mental Health and LD	257	212	207	338	207	1,221
Urgent Care	240	191	187	288	175	1,081
CHC and FNC	120	96	93	143	88	539
Clinical Support Services	113	89	90	132	88	512
Corporate	38	32	32	47	30	179
<b>Total</b>	<b>2,831</b>	<b>2,300</b>	<b>2,270</b>	<b>3,654</b>	<b>2,281</b>	<b>13,336</b>
<b>Additional Hours</b>	<b>1,120</b>	<b>1,068</b>	<b>1,050</b>	<b>932</b>	<b>1,071</b>	<b>5,242</b>
<b>CONSULTANTS SESSION: CLINICAL</b>	<b>581</b>	<b>609</b>	<b>679</b>	<b>631</b>	<b>631</b>	<b>3,131</b>
<b>OVERTIME</b>	<b>324</b>	<b>260</b>	<b>272</b>	<b>272</b>	<b>396</b>	<b>1,525</b>
<b>Waiting List Payments: Consultants</b>	<b>219</b>	<b>132</b>	<b>126</b>	<b>181</b>	<b>246</b>	<b>905</b>
<b>ON CALL</b>	<b>70</b>	<b>62</b>	<b>60</b>	<b>71</b>	<b>65</b>	<b>328</b>
<b>Total</b>	<b>5,146</b>	<b>4,432</b>	<b>4,457</b>	<b>5,742</b>	<b>4,689</b>	<b>24,466</b>

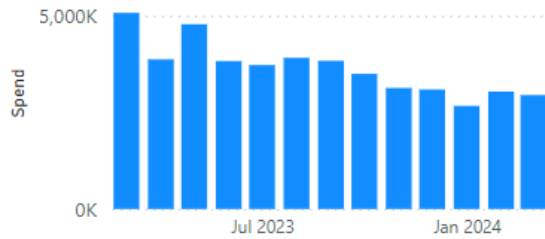
### Pay Summary (3): Variable Pay (£'k)

Pay category	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
<b>Agency</b>													
Admin & Clerical Agency	147	72	64	77	49	41	39	86	38	29	67	82	59
Allied Health Prof Agency	165	171	219	147	196	196	192	123	165	135	120	86	82
Estates & Ancilliary Agency	1,036	683	675	483	490	341	471	489	246	281	239	184	232
Medical Agency	1,271	1,162	2,025	1,474	1,165	1,399	1,093	1,091	1,187	1,166	690	1,274	938
Nurse HCA/HCSW Agency	625	293	339	209	160	236	183	89	79	89	65	88	59
Other Agency	105	58	70	43	90	49	50	46	47	21	99	39	109
Registered Nurse Agency	1,726	1,434	1,387	1,394	1,575	1,650	1,807	1,574	1,369	1,371	1,388	1,286	1,469
<b>Total</b>	<b>5,075</b>	<b>3,873</b>	<b>4,781</b>	<b>3,827</b>	<b>3,724</b>	<b>3,913</b>	<b>3,835</b>	<b>3,497</b>	<b>3,132</b>	<b>3,093</b>	<b>2,668</b>	<b>3,040</b>	<b>2,948</b>
<b>Bank</b>													
Admin & Clerical Bank	123	94	86	108	114	92	92	82	89	87	95	84	119
Estates & Ancilliary Bank	204	138	142	166	216	201	215	216	224	243	254	235	263
Nurse HCA/HCSW Bank	1,765	1,598	1,485	1,635	1,811	1,816	1,438	1,520	1,572	1,473	1,711	1,523	1,784
Other Bank	0	0	0	0	1	-1	0	2	-2	0	0	0	0
Registered Nurse Bank	3,014	2,295	2,110	2,332	2,425	2,352	1,736	1,699	1,808	1,589	1,620	1,949	2,093
<b>Total</b>	<b>5,105</b>	<b>4,125</b>	<b>3,823</b>	<b>4,242</b>	<b>4,568</b>	<b>4,460</b>	<b>3,480</b>	<b>3,519</b>	<b>3,692</b>	<b>3,392</b>	<b>3,681</b>	<b>3,790</b>	<b>4,259</b>
<b>Locum</b>													
Medical Locum	385	233	234	286	311	285	267	349	299	332	330	332	330
<b>Total</b>	<b>385</b>	<b>233</b>	<b>234</b>	<b>286</b>	<b>311</b>	<b>285</b>	<b>267</b>	<b>349</b>	<b>299</b>	<b>332</b>	<b>330</b>	<b>332</b>	<b>330</b>
<b>Total</b>	<b>10,565</b>	<b>8,230</b>	<b>8,838</b>	<b>8,355</b>	<b>8,603</b>	<b>8,658</b>	<b>7,582</b>	<b>7,365</b>	<b>7,122</b>	<b>6,817</b>	<b>6,678</b>	<b>7,162</b>	<b>7,537</b>

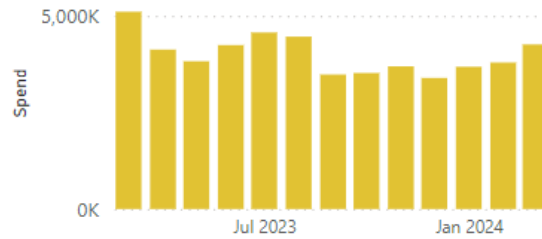
Change	%
-23	-27.5%
-4	-4.5%
48	26.1%
-337	-26.4%
-29	-33.3%
70	182.4%
183	14.2%
<b>-91</b>	<b>-3.0%</b>
35	41.9%
29	12.2%
261	17.1%
0	-782.1%
144	7.4%
<b>468</b>	<b>12.4%</b>
-2	-0.5%
-2	-0.5%
<b>375</b>	<b>5.2%</b>

Avg 22/23
128
179
644
1,327
883
84
1,833
<b>5,077</b>
106
174
1,413
0
2,139
<b>3,831</b>
260
260
<b>9,169</b>

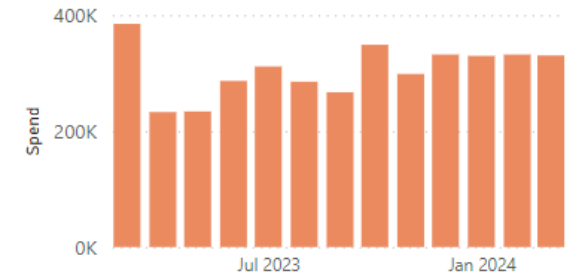
Agency (£'000)



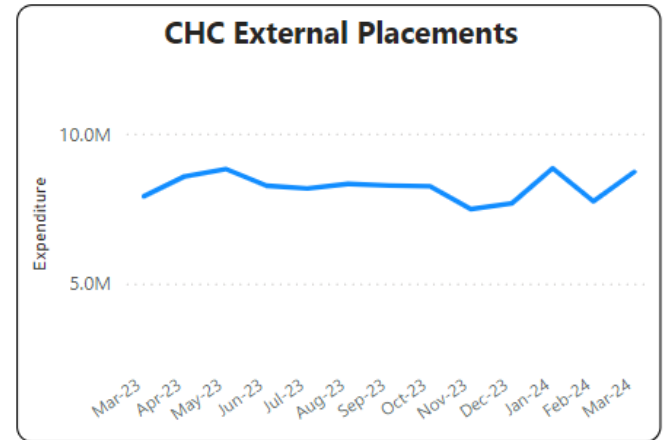
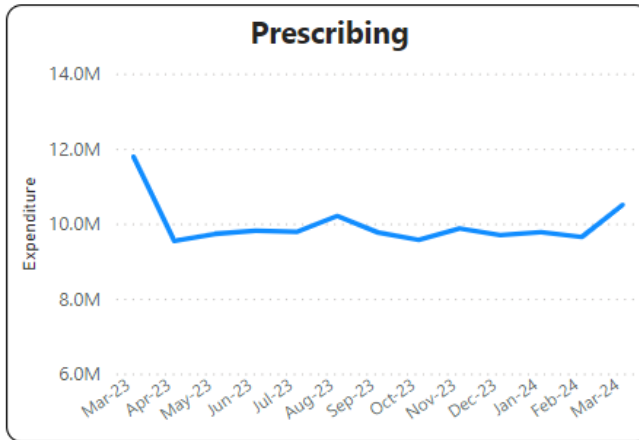
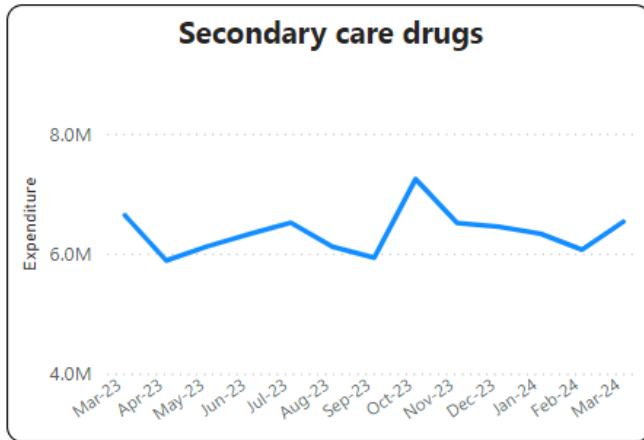
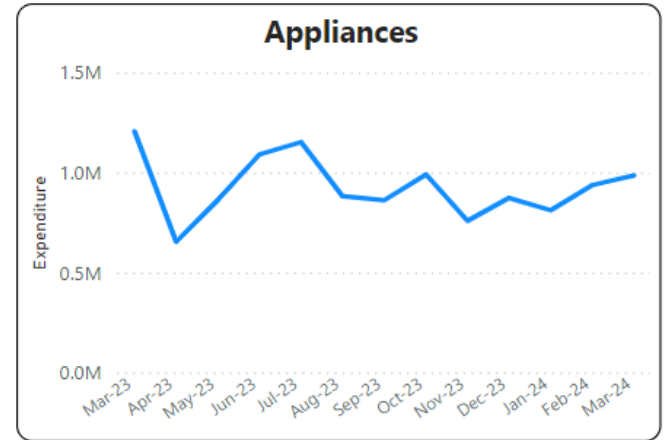
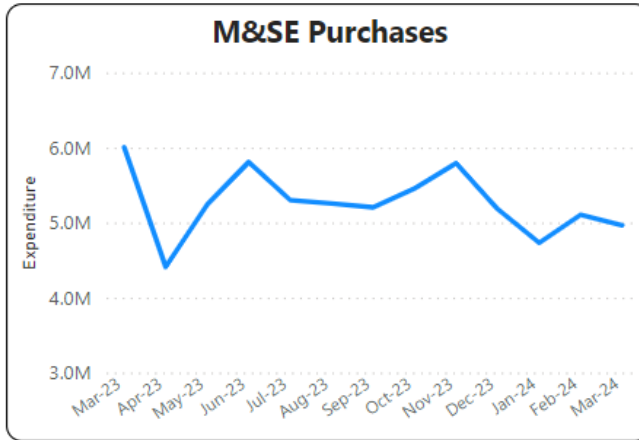
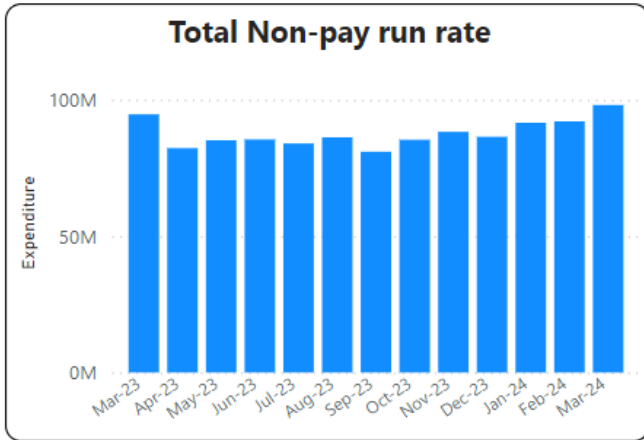
Bank (£'000)



Locum (£'000)



**Non-Pay Summary:**



## Referral to Treatment (RTT):

Elective activity has significantly reduced as part of the Health Board's Covid-19 planned response. Whilst routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

- Elective Treatments for March '24 was 1,783 (February '24: 1,854. 2022/23 total: 22,327, 2019/20 total: 28,004)

Planned Treatments (M12)						Actual Treatments (M12)						Treatment Variance (M12)				
Treatment	Core	Backfill	WLI	Other	Total	Treatment	Core	Backfill	WLI	Other	Total	Treatment	Core	Backfill	WLI	Total
N107-Dermatology	187	0		0	187	N107-Dermatology	219	16	0	0	235	Derm	32	16	0	48
N147-ENT	111	0		0	111	N147-ENT	119	16	0	0	135	ENT	8	16	0	24
N105-General Surgery	249	56		0	305	N105-General Surgery	274	17	0	0	291	GS	25	(39)	0	(14)
N146-Oral Surgery	147	12		0	159	N146-Oral Surgery	181	0	0	0	181	Max Fax	34	(12)	0	22
N148-Ophthalmology	333	0		0	333	N148-Ophthalmology	312	0	0	0	312	Ophth	(21)	0	0	(21)
N108-Rheumatology	0	0		0	0	N108-Rheumatology	0	0	0	0	0	Rheum	0	0	0	0
N115-Trauma & Orthopaedics	349	138		0	487	N115-Trauma & Orthopaedics	360	25	2	0	387	T&O	11	(113)	2	(100)
N106-Urology	490	0		0	490	N106-Urology	239	3	0	0	242	Urology	(251)	3	0	(248)
Total	1,866	206	0	0	2,072		1,704	77	2	0	1,783		(162)	(129)	2	(289)

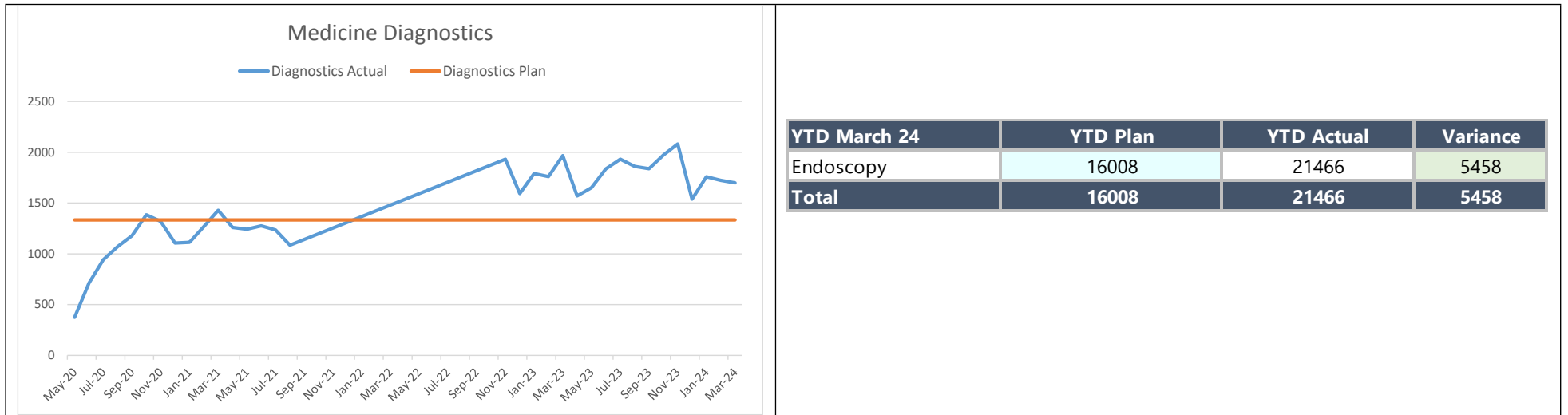
- Outpatient activity for March '24 was 5,265 (February '24: 5,359. 2022/23 total: 65,873, 2019/20 total: 75,707)

Planned Outpatients (M12)						Actual Outpatients (M12)						Outpatient Variance (M12)					
Outpatient	Core	Backfill	WLI	Other	Total	Outpatient	Core	Backfill	WLI	Other	Total	Outpatient	Core	Backfill	WLI	Other	Total
N107-Dermatology	1,075	0		0	1,075	N107-Dermatology	923	0	0	0	923	Derm	(152)	0	0	0	(152)
N147-ENT	552	0		0	552	N147-ENT	369	20	101	0	490	ENT	(183)	20	101	0	(62)
N105-General Surgery	1,623	0		0	1,623	N105-General Surgery	1,455	52	48	0	1,555	GS	(168)	52	48	0	(68)
N146-Oral Surgery	314	40		0	354	N146-Oral Surgery	281	0	37	0	318	Max Fax	(33)	(40)	37	0	(36)
N148-Ophthalmology	690	0		0	690	N148-Ophthalmology	595	15	0	0	610	Ophth	(95)	15	0	0	(80)
N108-Rheumatology	112	0		0	112	N108-Rheumatology	188	0	0	0	188	Rheum	76	0	0	0	76
N115-Trauma & Orthopaedics	897	287		0	1,184	N115-Trauma & Orthopaedics	534	4	1	0	539	T&O	(363)	(283)	1	0	(645)
N106-Urology	468	18		0	486	N106-Urology	637	0	5	0	642	Urology	169	(18)	5	0	156
Total	5,731	345	0	0	6,076		4,982	91	192	0	5,265		(749)	(254)	192	0	(811)

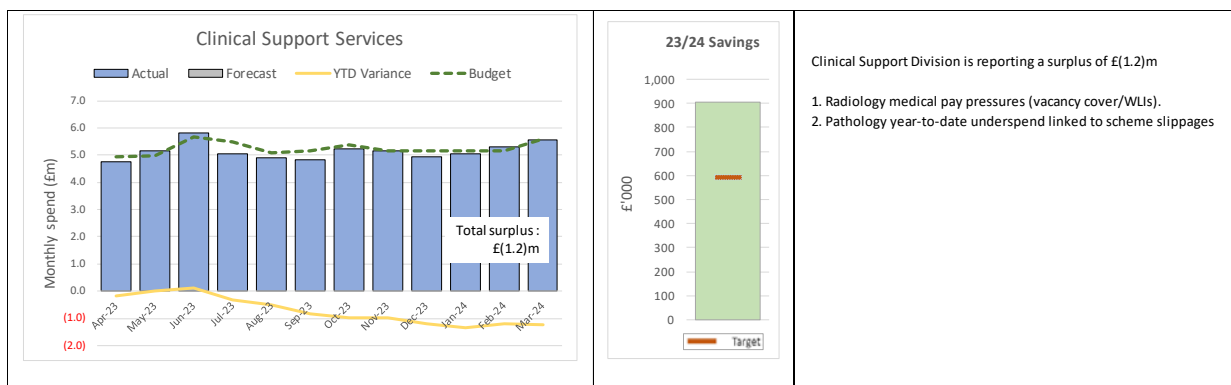
**Medicine Outpatients activity for March '24 was 1,815 (February '24: 1,775, 2022/23: 19,258):**

Mar-24				Mar-24			
	Assumed monthly activity	Actual activity	Variance	YTD Mar-24	YTD Plan	YTD Actual	Variance
Gastroenterology	475	418	-57	Gastroenterology	5700	4325	-1375
Cardiology	430	331	-99	Cardiology	5160	4966	-194
Respiratory (inc Sleep)	455	410	-45	Respiratory (inc Sleep)	5460	5333	-127
Neurology	257	304	47	Neurology	3084	3619	535
Endocrinology	186	167	-19	Endocrinology	2232	1969	-263
Geriatric Medicine	313	185	-128	Geriatric Medicine	3756	2496	-1260
<b>Total</b>	<b>2116</b>	<b>1815</b>	<b>-301</b>	<b>Total</b>	<b>25392</b>	<b>22708</b>	<b>-2684</b>

**Medicine Diagnostics activity for March '24 was 1,699 (February '24: 1,723, 2022/23: 36,246):**

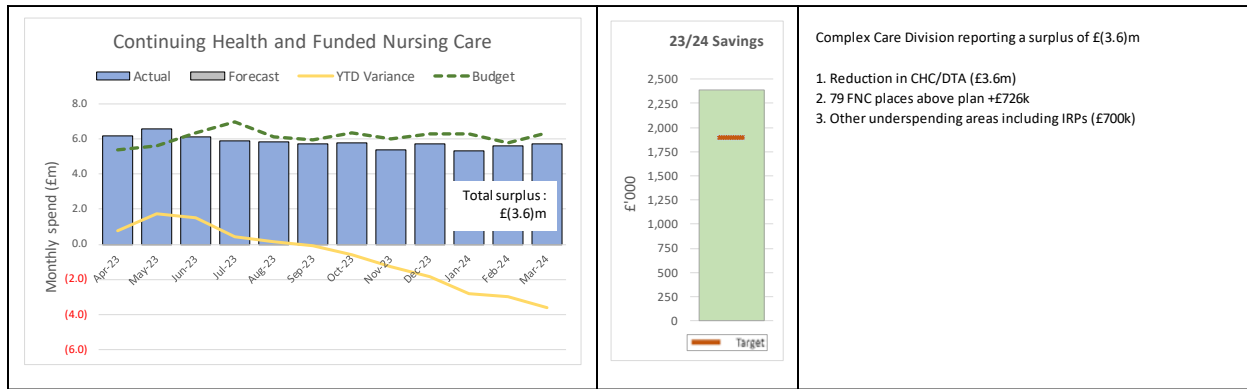


# Divisional analysis – Clinical Support Services



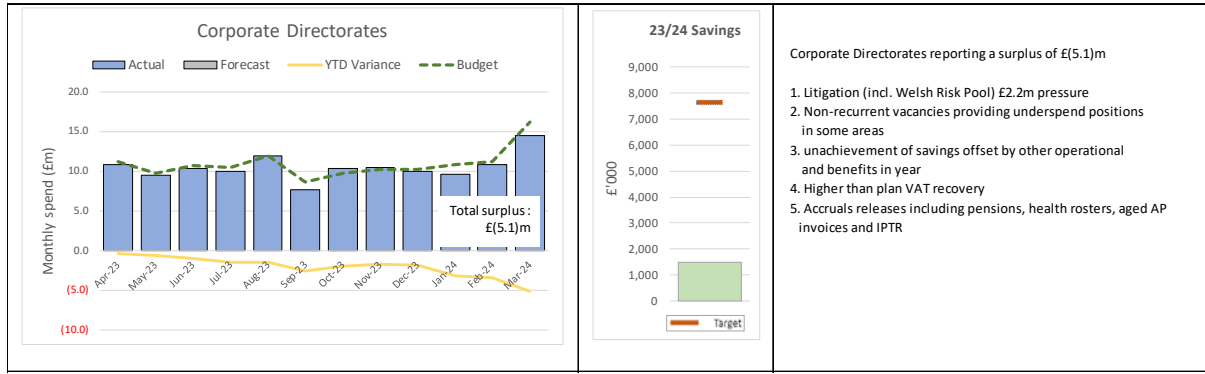
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Clinical Support Services	CSS-01	Generic CIP - Pay	R	IMTP	Red	190	0	(190)
Clinical Support Services	CSS-02	Procurement	R	IMTP	Red	138	0	(138)
Clinical Support Services	CSS-03	Rostering Efficiencies	R	IMTP	Red	139	0	(139)
Clinical Support Services	CSS-04	procurement	R	IMTP	Red	21	0	(21)
Clinical Support Services	CSS-05	Generic CIP - Non-Pay	R	IMTP	Red	105	0	(105)
Radiology	CSS-06	Radiology - IPFR patients via WhSSC	R	In Year	Green	0	25	25
Radiology	CSS-07	Radiology - WHSSC other Commissioning Costs	R	In Year	Red	0	0	0
Radiology	CSS-08	Radiology - Reduce Dosage of CT IV Contrast	R	In Year	Green	0	50	50
Radiology	CSS-09	Radiology - PICC Line - change of supplier / change of consum	R	In Year	Green	0	30	30
Radiology	CSS-10	Radiology - Review Agency Sonographers	R	In Year	Green	0	100	100
Radiology	CSS-11	Radiology - Review of overtime CT & MR	R	In Year	Green	0	50	50
Radiology	CSS-12	Radiology - Non Pay All Other	R	In Year	Green	0	75	75
Pathology	CSS-13	Pathology - Agency Scientist cost reduction	R	In Year	Green	0	214	214
Pathology	CSS-14	Pathology - KPI rebates on MSC's - Siemens and Sysmex	NR	In Year	Green	0	145	145
Pathology	CSS-15	Pathology - SLA's - Income review	R	In Year	Green	0	60	60
Pathology	CSS-16	Pathology - repatriation of tests	R	In Year	Red	0	0	0
Pathology	CSS-17	Pathology - DHCW SLA Haemonetics	R	In Year	Green	0	13	13
Pathology	CSS-18	Pathology - All Wales Non Pay Procurement scheme	R	In Year	Green	0	47	47
Radiology	CSS-19	Radiology - Decommission YF Room 2 - maintenance contra	R	In Year	Green	0	10	10
Pathology	CSS-20	Pathology - Fibrinogen concentrate - change of supplier	R	In Year	Green	0	12	12
Pathology	CSS-21	Pathology - Use of Taxis	R	In Year	Green	0	29	29
Radiology	CSS2	Radiology - Decommission Flouroscopy Equipt NHH - mainte	R	In Year	Green	0	6	6
Radiology	CSS3	Radiology	NR	In Year	Red	0	0	0
Radiology	CSS4	Radiology - restricted GP access MSK scans	R	In Year	Green	0	40	40
						593	906	313

# Divisional analysis – Complex Care



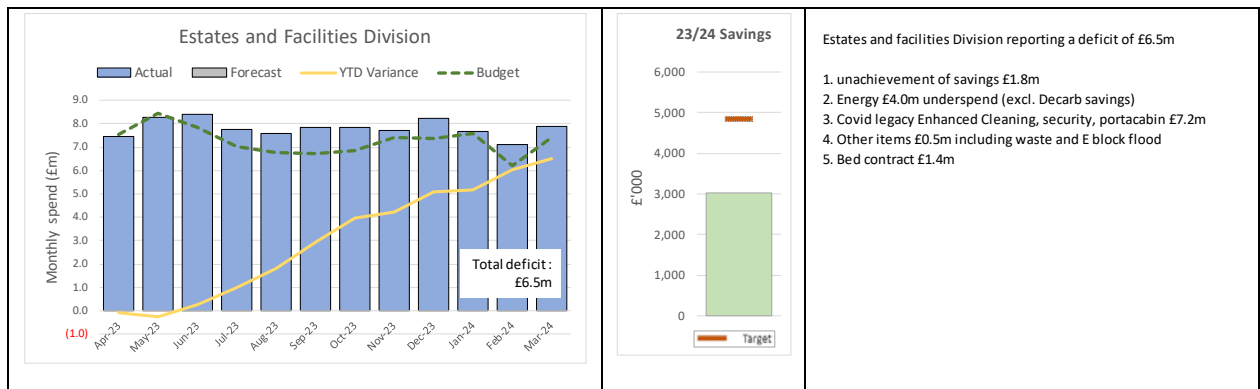
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Complex Care	CHC-01	Generic CIP - Pay	R	IMTP	Red	34	0	(34)
Complex Care	CHC-02	Rostering Efficiencies	R	IMTP	Red	305	0	(305)
Complex Care	CHC-03	Adult CHC Care at home team	R	IMTP	Green	100	112	12
Complex Care	CHC-04	Adult CHC high cost packages, 1:1 & chages for hospital visits	R	IMTP	Red	100	0	(100)
Complex Care	CHC-05	Adult CHC (balance to NP plan (3m target @40% of spend for	R	IMTP	Red	1,000	0	(1,000)
Complex Care	CHC-06	procurement	R	IMTP	Red	56	0	(56)
Complex Care	CHC-07	Generic CIP - Non-Pay	R	IMTP	Red	288	0	(288)
Complex Care	CHC-08	Right Sizing Commitments	R	In Year	Green	0	463	463
Complex Care	CHC-09	Enhanced care working group and panel	R	In Year	Green	0	266	266
Complex Care	CHC-10	CHC review assessments	NR	In Year	Green	0	41	41
Complex Care	CHC-11	Enhanced care cohort model - TBC	R	In Year	Red	0	0	0
Complex Care	CHC-12	CHC placements review	NR	In Year	Green	0	1,312	1,312
Complex Care	CHC1	Enhanced care	R	In Year	Green	0	199	199
Complex Care	CHC3	Hospital admissions	R	In Year	Red	0	0	0
Complex Care	CHC4	Days after death	R	In Year	Red	0	0	0
Complex Care	CHC5	Deputyship SLA	R	In Year	Red	0	0	0
						<b>1,883</b>	<b>2,393</b>	<b>510</b>

# Divisional analysis – Corporate



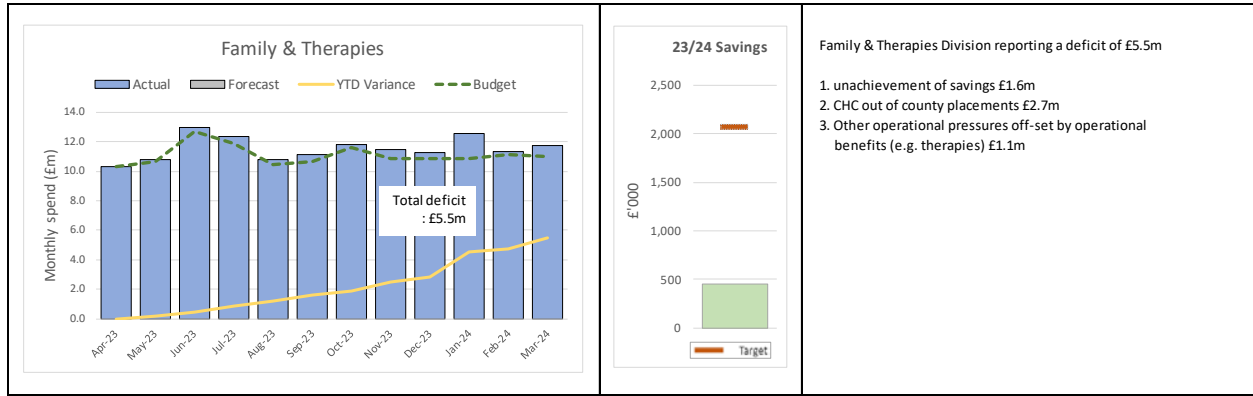
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Corporate-ABCI	CORP-01	Generic CIP - Non-Pay	R	IMTP	Red	4	0	(4)
Corporate-CEO	CORP-02	Generic CIP - Pay	R	IMTP	Green	0	130	130
Corporate-CEO	CORP-03	Review of RIF expenditure	NR	IMTP	Red	300	0	(300)
Corporate-CEO	CORP-04	Review of Health protection expenditure	NR	IMTP	Red	1,200	0	(1,200)
Corporate-CEO	CORP-05	Generic CIP - Non-Pay	R	IMTP	Green	415	203	(212)
Corporate-DirFin	CORP-06	Generic CIP - Pay	R	IMTP	Green	46	322	276
Corporate-DirFin	CORP-07	Generic CIP - Non-Pay	R	IMTP	Green	5	5	0
Corporate-DirNurs	CORP-08	Generic CIP - Pay	R	IMTP	Red	34	0	(34)
Corporate-DirNurs	CORP-09	procurement	R	IMTP	Red	1	0	(1)
Corporate-DirNurs	CORP-10	Generic CIP - Non-Pay	R	IMTP	Red	6	0	(6)
Corporate-DirOps	CORP-11	Generic CIP - Pay	R	IMTP	Red	61	0	(61)
Corporate-DirOps	CORP-12	procurement	R	IMTP	Red	2	0	(2)
Corporate-DirOps	CORP-13	Generic CIP - Non-Pay	R	IMTP	Red	16	0	(16)
Corporate-DirPCMH	CORP-14	Generic CIP - Pay	R	IMTP	Green	2	76	74
Corporate-DirPH	CORP-15	Generic CIP - Pay	R	IMTP	Green	33	17	(16)
Corporate-DirPH	CORP-16	Generic CIP - Non-Pay	R	IMTP	Green	3	38	35
Corporate-DirPH	CORP-17	Health protection review	NR	IMTP	Red	1,000	0	(1,000)
Corporate-DirPH	CORP-18	procurement	R	IMTP	Green	1	13	12
Corporate-DirPH	CORP-19	Health protection review	NR	IMTP	Red	3,000	0	(3,000)
Corporate-DirTher	CORP-20	Generic CIP - Pay	R	IMTP	Green	6	58	52
Corporate-DirTher	CORP-21	Generic CIP - Non-Pay	R	IMTP	Green	2	6	4
Corporate-DirTher	CORP-22	Rostering Efficiencies	R	IMTP	Red	47	0	(47)
Corporate-Governance	CORP-23	Generic CIP - Pay	R	IMTP	Green	7	7	0
Corporate-Governance	CORP-24	Generic CIP - Non-Pay	R	IMTP	Red	2	0	(1)
Corporate-Litig	CORP-25	Generic CIP - Non-Pay	R	IMTP	Red	11	0	(11)
Corporate-Litig	CORP-26	procurement	R	IMTP	Red	2	0	(2)
Corporate-MedDir	CORP-27	Generic CIP - Pay	R	IMTP	Red	19	0	(19)
Corporate-MedDir	CORP-28	Generic CIP - Non-Pay	R	IMTP	Green	10	3	(7)
Corporate-PlanICT	CORP-29	Generic CIP - Pay	R	IMTP	Red	77	0	(77)
Corporate-PlanICT	CORP-30	procurement	R	IMTP	Green	113	113	0
Corporate-PlanICT	CORP-31	Generic CIP - Non-Pay	R	IMTP	Red	63	0	(63)
Corporate-WOD	CORP-32	Generic CIP - Pay	R	IMTP	Green	43	304	261
Corporate-WOD	CORP-33	procurement	R	IMTP	Green	6	6	0
Corporate-WOD	CORP-34	Generic CIP - Non-Pay	R	IMTP	Green	43	130	87
Corporate-DirOps	CORP-35	NEPT & INTERSITE	R	IMTP	Red	1,000	0	(1,000)
Corporate-PlanICT	CORP-36	Generic CIP - Non-Pay	R	IMTP	Green	20	20	0
Corporate-PlanICT	CORP-37	Generic CIP - Pay	R	IMTP	Green	25	25	0
Corporate-DirOps	FAC-41	Reduced Bed Capacity	R	In Year	Red	0	0	0
Corporate - CAPITAL CHARGE	CAP1	Disposal of unused equipment	NR	In Year	Green	0	22	22
						7,623	1,497	(6,126)

## Divisional analysis – Estates & Facilities



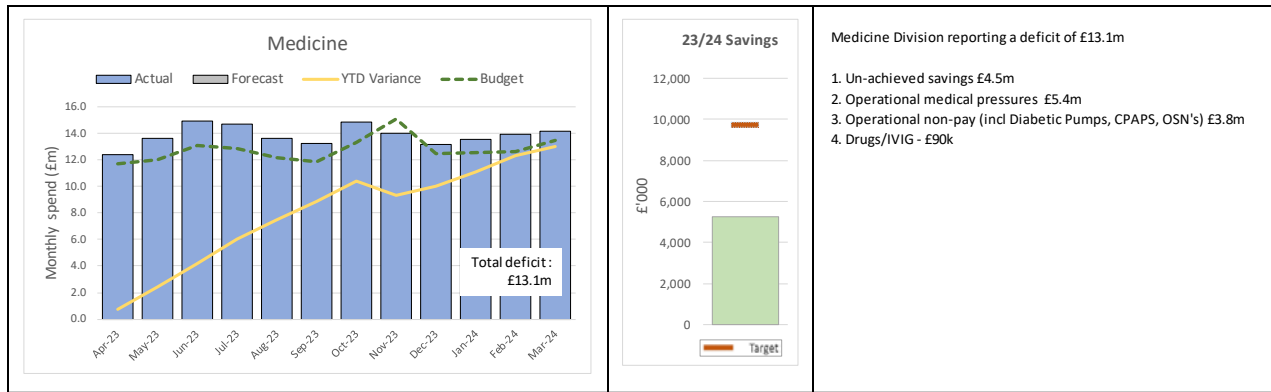
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Estates and Facilities	ESF-01	Generic CIP - Pay	R	IMTP	Red	161	0	(161)
Estates and Facilities	ESF-02	Parking	R	IMTP	Green	210	210	0
Estates and Facilities	ESF-03	Procurement	R	IMTP	Green	40	27	(13)
Estates and Facilities	ESF-04	Rostering Efficiencies	R	IMTP	Red	642	0	(642)
Estates and Facilities	ESF-05	estates and facilities strategy	R	IMTP	Red	170	0	(170)
Estates and Facilities	ESF-06	Decarbonisation	R	IMTP	Green	1,000	1,000	(1)
Estates and Facilities	ESF-08	Estates Opps / leases (running costs)	R	IMTP	Red	1,000	0	(1,000)
Estates and Facilities	ESF-09	procurement	R	IMTP	Red	181	0	(181)
Estates and Facilities	ESF-10	Estates and Facilities avoid agency premiums (50%)	R	IMTP	Green	1,095	391	(704)
Estates and Facilities	ESF-11	Generic CIP - Non-Pay	R	IMTP	Red	340	0	(340)
Estates and Facilities	ESF-12	Rates Rebates	NR	In Year	Green	0	584	584
Estates and Facilities	FAC-02	Pod-point chargers	R	In Year	Green	0	4	4
Estates and Facilities	FAC-03	Catering Subsidy Removal	R	In Year	Green	0	117	117
Estates and Facilities	FAC-04	Hot Vending	R	In Year	Green	0	14	14
Estates and Facilities	FAC-12	Security @ GUH	R	In Year	Red	0	0	0
Estates and Facilities	FAC-13	Security @ NHH	R	In Year	Red	0	0	0
Estates and Facilities	FAC-14	Security @ STC	R	In Year	Red	0	0	0
Estates and Facilities	FAC-15	Security @ RGH	R	In Year	Red	0	0	0
Estates and Facilities	FAC-17	Enhanced Cleaning - reduced WTE's	R	In Year	Green	0	170	170
Estates and Facilities	FAC-22	GUH Carparking	R	In Year	Green	0	38	38
Estates and Facilities	FAC-23	All Wales Buying Group Credit for sale of energy procured	NR	In Year	Green	0	423	423
Estates and Facilities	FAC-24	NCC Parking - Kingsway & Park Square	R	In Year	Green	0	39	39
Estates and Facilities	FAC-28	Window Cleaning	R	In Year	Green	0	15	15
Estates and Facilities	FAC-29	Removal of water coolers	R	In Year	Green	0	2	2
						<b>4,840</b>	<b>3,034</b>	<b>(1,806)</b>

# Divisional analysis – Family & Therapies



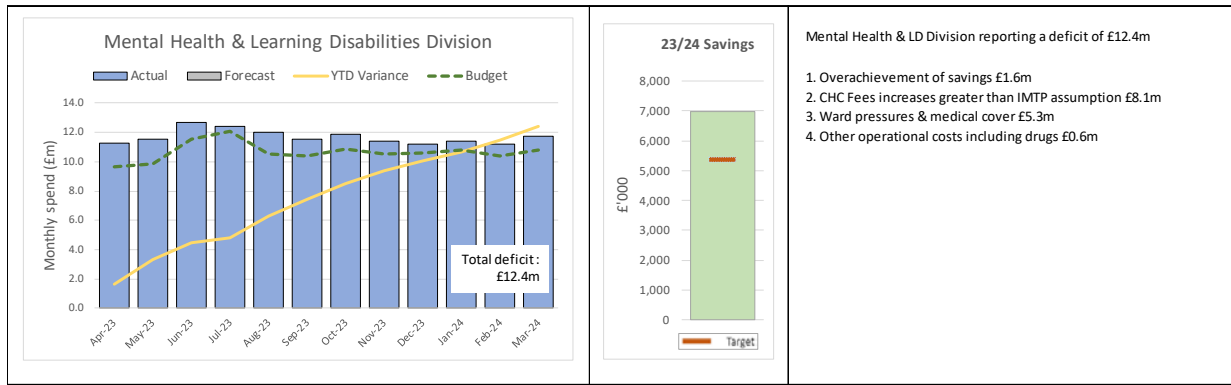
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Families and Therapies	FAT-01	Generic CIP - Pay	R	IMTP	Green	558	211	(347)
Families and Therapies	FAT-02	BADS	R	IMTP	Red	25	0	(25)
Families and Therapies	FAT-03	Outpatient transformation (F2F and Virtual)	R	IMTP	Red	93	0	(93)
Families and Therapies	FAT-04	Outpatient transformation (New to Follow Up ratio)	R	IMTP	Red	134	0	(134)
Families and Therapies	FAT-05	Procurement	R	IMTP	Red	25	0	(25)
Families and Therapies	FAT-06	Rostering Efficiencies	R	IMTP	Green	1,021	164	(857)
Families and Therapies	FAT-07	Medicines management	R	IMTP	Green	50	42	(8)
Families and Therapies	FAT-08	procurement	R	IMTP	Red	72	0	(72)
Families and Therapies	FAT-09	Generic CIP - Non-Pay	R	IMTP	Red	96	0	(96)
Families and Therapies	FAT-10	ABUHB Exec decision to cease Flexible Rewards from end of	R	In Year	Green	0	26	26
Families and Therapies	FAT-11	Medicines management (VRIII Fluids - supplier Switch)	R	In Year	Green	0	1	1
Families and Therapies	FAT-12	Procurement - Bakri Balloons	R	In Year	Green	0	5	5
						2,074	449	(1,624)

# Divisional analysis – Medicine



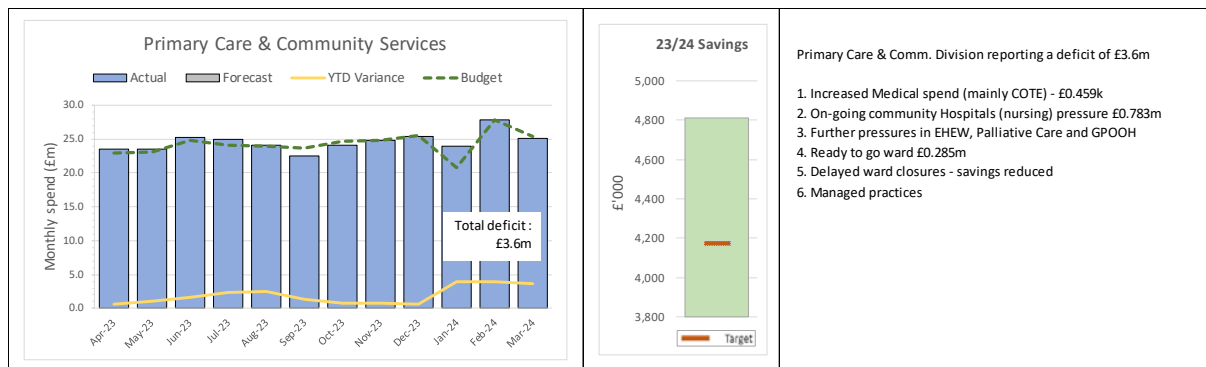
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Medicine	MED-01	Generic CIP - Pay	R	IMTP	Green	516	42	(474)
Medicine	MED-02	Outpatient transformation (F2F and Virtual)	R	IMTP	Red	95	0	(95)
Medicine	MED-03	Outpatient transformation (New to Follow Up ratio)	R	IMTP	Red	656	0	(656)
Medicine	MED-04	Beds ( 1 ward Med)	R	IMTP	Red	2,223	0	(2,223)
Medicine	MED-05	Procurement	R	IMTP	Red	25	0	(25)
Medicine	MED-06	Rostering Efficiencies	R	IMTP	Green	738	609	(128)
Medicine	MED-07	Insourcing review	R	IMTP	Red	1,066	0	(1,066)
Medicine	MED-08	Medicines management	R	IMTP	Green	150	189	39
Medicine	MED-09	procurement	R	IMTP	Green	35	77	42
Medicine	MED-10	Slippage in spend regional eyes / endo / path	NR	IMTP	Green	4,000	3,987	(13)
Medicine	MED-11	Generic CIP - Non-Pay	R	IMTP	Red	184	0	(184)
Medicine	Med-12	Green Schemes - Drugs MED 12 & MED 13	R	In Year	Red	0	0	0
Medicine	Med-13	Green Sheme - Medical MED 05 & MED 19	R	In Year	Green	0	83	83
Medicine	Med-14	Green Schemes - Non Pay Wound Clinic REF MED-06	R	In Year	Green	0	25	25
Medicine	Med-15	Green Schemes - Income Spy Glass MED-07	R	In Year	Red	0	0	0
Medicine	Med-16	Green Scheme - Virtual Outliers	R	In Year	Green	0	96	96
Medicine	Med-18	RGH reduction in bed base	R	In Year	Green	0	140	140
Medicine	Med-22	Green Scheme - HCRU	R	In Year	Red	0	0	0
						9,688	5,249	(4,439)

# Divisional analysis – Mental Health and Learning Disabilities



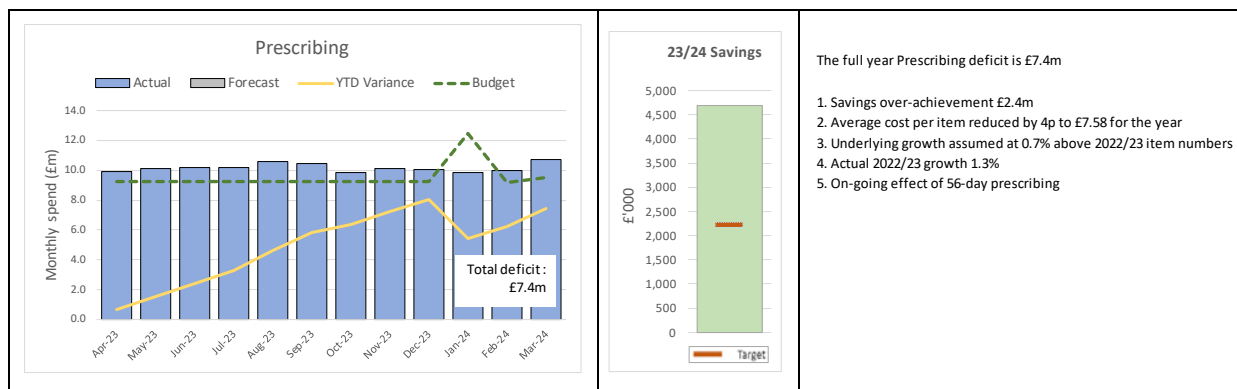
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Mental Health and Learning Disabilities	MHLD-01	Generic CIP - Pay	R	IMTP	Red	107	0	(107)
Mental Health and Learning Disabilities	MHLD-01a	MH Adults - Reduction of agency costs due to appointment o	R	IMTP	Green	142	122	(20)
Mental Health and Learning Disabilities	MHLD-01b	OAMH - Reduction in LT Med Agency due to successful recrui	R	IMTP	Green	50	50	0
Mental Health and Learning Disabilities	MHLD-01c	Flexi rewards ceasing	R	IMTP	Red	9	0	(9)
Mental Health and Learning Disabilities	MHLD-02	Generic CIP - Non-Pay	R	IMTP	Red	0	0	0
Mental Health and Learning Disabilities	MHLD-02a	Maximise ECT Income generation from private patient refer	R	IMTP	Green	70	70	0
Mental Health and Learning Disabilities	MHLD-02b	PCMHS Counselling commissioning	R	IMTP	Green	218	100	(118)
Mental Health and Learning Disabilities	MHLD-02c	SLA Recovery works & Sanctuary	NR	In Year	Green	0	285	285
Mental Health and Learning Disabilities	MHLD-03	Rostering Efficiencies	R	IMTP	Red	562	0	(562)
Mental Health and Learning Disabilities	MHLD-04	MH CHC - LD	R	IMTP	Red	922	0	(922)
Mental Health and Learning Disabilities	MHLD-05	MH CHC High cost packages	R	IMTP	Green	250	200	(50)
Mental Health and Learning Disabilities	MHLD-06	MH Older Adults Beds	R	IMTP	Red	206	0	(206)
Mental Health and Learning Disabilities	MHLD-06a	OAMH - Capped beds on Annwylfan (YYF) resulting in lower v	R	IMTP	Green	150	30	(120)
Mental Health and Learning Disabilities	MHLD-07	Review of Mental Health expenditure	NR	IMTP	Red	2,000	0	(2,000)
Mental Health and Learning Disabilities	MHLD-08	MH CHC (balance to NP plan (3m target @60% of spend for M	R	IMTP	Red	628	0	(628)
Mental Health and Learning Disabilities	MHLD-09	procurement	R	IMTP	Red	55	0	(55)
Mental Health and Learning Disabilities	MHLD-10	CHC Eligibility Reviews	R	In Year	Green	0	403	403
Mental Health and Learning Disabilities	MHLD-11	CHC Repatriations to in house wards	R	In Year	Green	0	1,123	1,123
Mental Health and Learning Disabilities	MHLD-12	CHC Right Size Packages	R	In Year	Green	0	432	432
Mental Health and Learning Disabilities	MHLD-13	CHC Step Down	R	In Year	Green	0	727	727
Mental Health and Learning Disabilities	MHLD-14	CHC Change in Need	R	In Year	Green	0	1,349	1,349
Mental Health and Learning Disabilities	MHLD-15	Structured Clinical Management	R	In Year	Green	0	157	157
Mental Health and Learning Disabilities	MHLD-16	Paliperidone HC FYE	R	In Year	Green	0	110	110
Mental Health and Learning Disabilities	MHLD-17	Paliperidone Non HC FYE	R	In Year	Green	0	81	81
Mental Health and Learning Disabilities	MHLD-18	Clozapine repatriation FYE	R	In Year	Green	0	71	71
Mental Health and Learning Disabilities	MHLD-19	Clozapine price reduction	R	In Year	Green	0	6	6
Mental Health and Learning Disabilities	MHLD-20	Flexi Rewards Ceasing	R	In Year	Green	0	301	301
Mental Health and Learning Disabilities	MH2	Step 9 People Down From Secure Placements	R	In Year	Green	0	336	336
Mental Health and Learning Disabilities	MH3	Repatriate Individuals From OOA And In House Placements	R	In Year	Green	0	75	75
Mental Health and Learning Disabilities	MH6	Review SIF SLAs	NR	In Year	Green	0	200	200
Mental Health and Learning Disabilities	MH10	Review secure transport options	R	In Year	Green	0	10	10
Mental Health and Learning Disabilities	MH11	Flexi Rewards Ceasing	R	In Year	Red	0	0	0
Mental Health and Learning Disabilities	MH4	West Sussex Dispute	NR	In Year	Green	0	742	742
Mental Health and Learning Disabilities	MH12	Non Pay Reduction	R	In Year	Green	0	10	10
						5,369	6,990	1,621

## Divisional analysis – Primary Care and Community



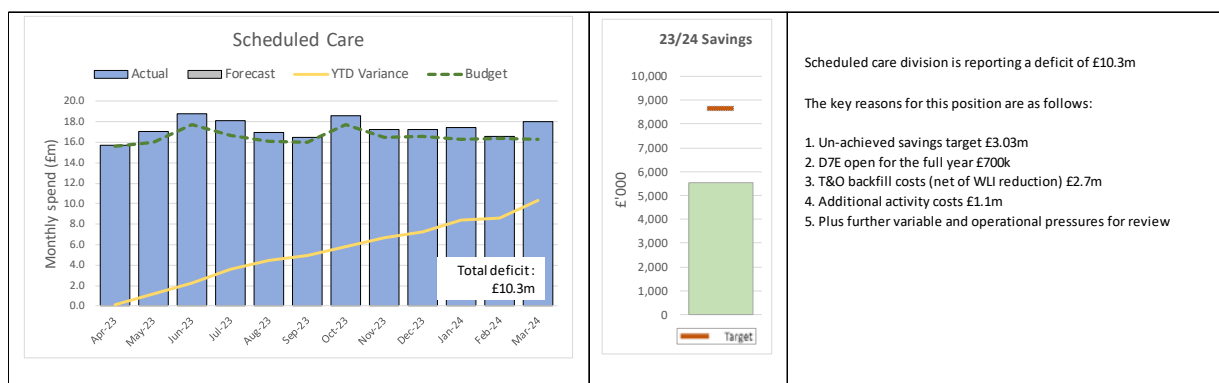
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Primary Care and Community	PCC-01	Generic CIP - Pay	R	IMTP	Green	278	278	0
Primary Care and Community	PCC-02	Generic CIP - Non-Pay	R	IMTP	Green	291	291	0
Primary Care and Community	PCC-04	Beds ( 1 ward Community)	R	IMTP	Green	2,223	215	(2,009)
Primary Care and Community	PCC-05	Procurement	R	IMTP	Red	85	0	(85)
Primary Care and Community	PCC-06	Rostering Efficiencies	R	IMTP	Green	1,008	116	(892)
Primary Care and Community	PCC-08	Managed practices	R	IMTP	Green	100	100	0
Primary Care and Community	PCC-10	procurement	R	IMTP	Red	185	0	(185)
Primary Care and Community	PCCS11	Reduce Face To Face CPD Cost	NR	In Year	Green	0	15	15
Primary Care and Community	PCCS2	NCN Development Programme Manager No Backfill	NR	In Year	Green	0	37	37
Primary Care and Community	PCCS20	Non-Pay Cas Gwent	NR	In Year	Red	0	0	0
Primary Care and Community	PCCS21	Non Pay DNS	NR	In Year	Green	0	13	13
Primary Care and Community	PCCS3	Dental Professional Collaborative On Hold	NR	In Year	Green	0	25	25
Primary Care and Community	PCCS36	GMS IT Services	NR	In Year	Green	0	33	33
Primary Care and Community	PCCS37	GMS Improvement Grants	NR	In Year	Green	0	270	270
Primary Care and Community	PCCS4	Uncommitted SPPC Funding	NR	In Year	Green	0	27	27
Primary Care and Community	PCCS45	Withdraw Band 7 Advert PC Contracting Team	NR	In Year	Green	0	37	37
Primary Care and Community	PCCS58	Remove Band 3 Admin Post Newport	NR	In Year	Green	0	20	20
Primary Care and Community	PCCS6	Hold Current SPCC Vacancy Band 4	NR	In Year	Green	0	10	10
Primary Care and Community	PCCS7	Reduce Spend On SPCC Promotion	NR	In Year	Green	0	5	5
Primary Care and Community	PCCS8	Delay Recruitment Of Band 8A Academy Nurse	NR	In Year	Green	0	24	24
Primary Care and Community	PCCS9	Delay Recruitment Of Lead Pharmacist for academy	NR	In Year	Green	0	24	24
Primary Care and Community	PCCS1	NCN Academy Funding	NR	In Year	Green	0	175	175
Primary Care and Community	PCCS10	Amendment to ANP Programme	NR	In Year	Green	0	9	9
Primary Care and Community	PCCS26	GMS LES Additional Clinics	NR	In Year	Green	0	139	139
Primary Care and Community	PCCS30	GDS UDA Clawback 22/23	NR	In Year	Green	0	282	282
Primary Care and Community	PCCS32	GDS CR Clawback 22/23	NR	In Year	Green	0	1,187	1,187
Primary Care and Community	PCCS67	Review ONN Overnight vehicle hire	NR	In Year	Green	0	5	5
Primary Care and Community	PCCS69	Reduce GP & Nurse mobiles	NR	In Year	Green	0	18	18
Primary Care and Community	PCCS33	GDS CR Clawback 23/24	NR	In Year	Green	0	1,194	1,194
Primary Care and Community	PCCS73	Review Current Workforce In Managed Practicies	NR	In Year	Green	0	28	28
Primary Care and Community	PCCS59	Non Pay Stock Review	NR	In Year	Green	0	10	10
Primary Care and Community	PCCS79	Flexi rewards saving	NR	In Year	Green	0	200	200
Primary Care and Community	PCCS77	Reduce Variation In Managed Practices	NR	In Year	Green	0	26	26
						4,170	4,812	642

## Divisional analysis – Prescribing



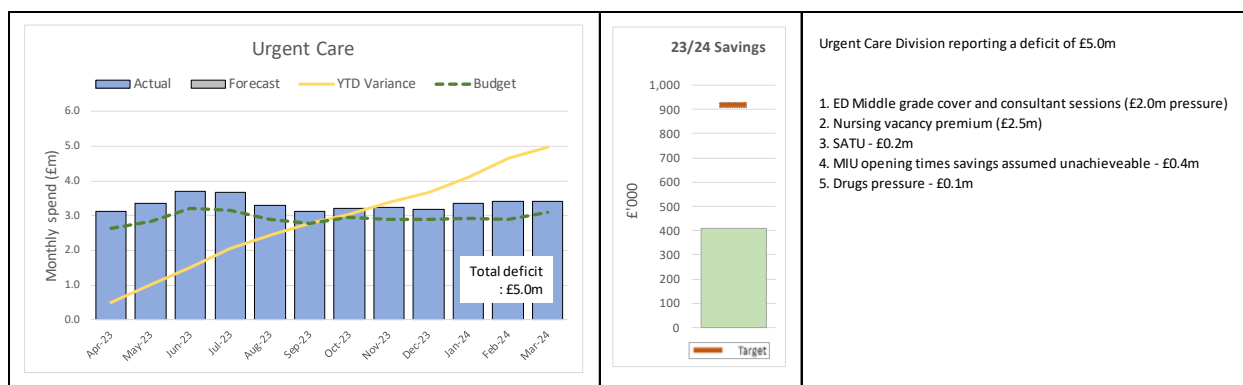
Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Prescribing	PCC-03	Generic CIP - Non-Pay	R	IMTP	Green	435	435	0
Prescribing	PCC-07	Medicines management	R	IMTP	Green	1,125	1,125	0
Prescribing	PCC-09	Medicines management	R	IMTP	Green	650	495	(156)
Prescribing	PCC-11	LOE - Apixaban	R	In Year	Green	0	2,382	2,382
Prescribing	PCC-12	LOE - Sitagliptin	R	In Year	Green	0	225	225
Prescribing	PCCS51	Specials And Liquid Preps Review	NR	In Year	Green	0	5	5
Prescribing	PCCS52	ONPOS/NWOS Expanded To GP Surgeries	NR	In Year	Green	0	12	12
						<b>2,210</b>	<b>4,678</b>	<b>2,468</b>

## Divisional analysis – Scheduled Care



Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Scheduled Care	SCH-01	Generic CIP - Pay	R	IMTP	Red	703	0	(703)
Scheduled Care	SCH-02	BADS	R	IMTP	Red	478	0	(478)
Scheduled Care	SCH-03	RTT WLI	R	IMTP	Green	2,296	1,746	(550)
Scheduled Care	SCH-04	RTT Backfill	R	IMTP	Green	962	91	(871)
Scheduled Care	SCH-05	Outpatient transformation (F2F and Virtual)	R	IMTP	Red	1,490	0	(1,490)
Scheduled Care	SCH-06	Outpatient transformation (New to Follow Up ratio)	R	IMTP	Red	277	0	(277)
Scheduled Care	SCH-07	SAU rostering	R	IMTP	Red	155	0	(155)
Scheduled Care	SCH-08	Procurement	R	IMTP	Red	586	0	(586)
Scheduled Care	SCH-08a	Procurement - Ophthalmology B&L theatre consumables	R	IMTP	Green	38	40	2
Scheduled Care	SCH-08b	Procurement - Stryker Pricing review	R	IMTP	Green	72	40	(32)
Scheduled Care	SCH-09	Rostering Efficiencies	R	IMTP	Green	895	1,243	348
Scheduled Care	SCH-09a	Ortho Geriatric variable pay saving	R	IMTP	Green	48	24	(24)
Scheduled Care	SCH-10	Medicines management	R	IMTP	Green	150	946	796
Scheduled Care	SCH-11	procurement	R	IMTP	Red	166	0	(166)
Scheduled Care	SCH-12	Generic CIP - Non-Pay	R	IMTP	Red	317	0	(317)
Scheduled Care	SCH11	Stop backfill	NR	In Year	Green	0	46	46
Scheduled Care	SCH2	Christmas shutdown of elective activity	NR	In Year	Green	0	57	57
Scheduled Care	SCH23	Retinue accruals hold for 3 months not 6 months	NR	In Year	Green	0	111	111
Scheduled Care	SCH6	Nursing - Reduction of flexible rewards for agency / bank	R	In Year	Green	0	700	700
Scheduled Care	SCH13	Non-uk resident patient spend target	R	In Year	Green	0	48	48
Scheduled Care	SCH12	Purchasing off frameworks	R	In Year	Green	0	33	33
Scheduled Care	SCH22	Switch all patients from originator drugs to biosimilar	R	In Year	Green	0	348	348
Scheduled Care	SCH24	Rationalisation of Uni Knee and removing Zimmer	R	In Year	Green	0	8	8
Scheduled Care	SCH9	Limit value of study leave with a cap	NR	In Year	Green	0	5	5
Scheduled Care	SCH3	Medical staff agency spend reduction	NR	In Year	Green	0	68	68
Scheduled Care	SCH NEW	Specialist Rates ITU / Theatres	NR	In Year	Red	0	0	0
						<b>8,634</b>	<b>5,554</b>	<b>(3,079)</b>

## Divisional analysis – Urgent Care



Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Urgent care	URG-01	Generic CIP - Pay	R	IMTP	Green	198	231	33
Urgent care	URG-02	Procurement	R	IMTP	Red	25	0	(25)
Urgent care	URG-03	Rostering Efficiencies	R	IMTP	Green	170	70	(100)
Urgent care	URG-04	Reduce opening times of MIU	R	IMTP	Red	500	0	(500)
Urgent care	URG-05	procurement	R	IMTP	Green	4	41	37
Urgent care	URG-06	Generic CIP - Non-Pay	R	IMTP	Green	22	16	(6)
Urgent care	MMUC01	Variable Fluids Rate	R	In Year	Green	0	1	1
Urgent care	MMUC02	Monifer	R	In Year	Green	0	7	7
Urgent care	UC-01	Hold Recruiting Assistant PFCs	NR	In Year	Green	0	26	26
Urgent care	UC-02	Hold Flow Centre Manager Recruitment	NR	In Year	Green	0	17	17
						919	410	(509)

# Divisional analysis – External Commissioning / WHSSC / EASC



Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	Full year		
						Plan £'000	Forecast £'000	Variance £'000
Contracting and Commissioning	CON-01	External Contracts	R	IMTP	Green	2,000	2,000	0
Contracting and Commissioning	CON-02	External Contracts	R	In year	Green	0	331	331
Contracting and Commissioning	CON-03	External Contracts	NR	In year	Green	0	207	207
Contracting and Commissioning	CON-04	External Contracts (English)	R	In Year	Green	0	1,350	1,350
WHSSC	WHC-01	WHSSC 1% pathways savings	R	IMTP	Red	1,363	(0)	(1,363)
WHSSC	WHC-01a	WHSSC 1% pathways savings	R	IMTP	Green	138	138	1
WHSSC	WHC-02	WHSSC 10-20-30% savings	NR	In Year	Green	0	554	554
WHSSC	WHC-03	WHSSC Integrated Commissioning Plan Savings	NR	In Year	Green	0	2,434	2,434
						<b>3,500</b>	<b>7,014</b>	<b>3,514</b>

## National Covid-19 Funding Assumptions

The Health Board has received £15.637m of funding relating to Covid-19 schemes. There is no further funding anticipated from Welsh Government during 23/24 for Covid-19.

Type	Covid-19 Specific allocations - March 2024	£'000
HCHS	Nosocomial Covid 19 cases - Investigation and learning	753
HCHS	C19 PPE	1,400
HCHS	C19 Health Protection	6,311
HCHS	C19 Vaccination programme	5,532
GMS	GMS Covid19 Vaccinations (Q2+Q3)	757
HCHS	Adeferiad Programme	884
	<b>Total Confirmed Covid-19 Allocations</b>	<b>15,637</b>

In addition, Estates & Facilities legacy costs for areas such as enhanced cleaning, security, portacabins continue and provide a significant forecast pressure for 2023/24 (forecast c.£7.2m).

## Reserves

### Reserves Delegation:

The final reserves position at 31<sup>st</sup> March 24 is £891k surplus. This consists of the recurrent deficit for 23/24 of £112m, offset in part by specific funding received from Welsh Government to address some of the issues within the deficit (£88.4m), additional allocations received in year which have been retained to support the deficit position, and a number of other in-year movements taken to, and retained within, reserves.

Funding has been reviewed throughout the year to determine whether it was appropriate to delegate to Divisions in the context of the budget setting methodology for 23/24 and the Health Board deficit.

A net total of £2.6m was approved and delegated into 23/24 Divisional positions from reserves in month 12. Significant delegations in-month were:

- **WHSSC Vertex funding Q4 £2.3m** – Delegated to WHSSC in line with spend plan (NR)
- **Regional Ophthalmology £300k** - Delegated to Commissioning and Scheduled Care in line with spend (NR)

### 7769-ALLOCATIONS TO BE DELEGATED

Description	23/24
Regional Planned Care funding-Ophthalmology	160,405
PPE 23-24	662,642
Non-consolidated Consultant Pay award 23-24	87,000
New Medical Training post cohorts (addtl)	331,571
RLW: Additional funding 23-24	2,664,000
SAS Pay award adjustment	16,753
<b>Total</b>	<b>3,922,371</b>

### 7788-COMMITMENTS TO BE DELEGATED

Description	23/24
Innovation and Development Fund (£10m)	219,615
<b>Total</b>	<b>219,615</b>

### 7501-SUPPORTING FINANCIAL POSITION

Description	23/24
Balances at month 11	11,352,037
NWSSP Distribution 23-24 (MG/P12)	197,000
National Imaging Academy underspend 23-24	11,221
ANEHFS 121-Pay award funding tranche 2	648
IT Laptops Revenue to Capital M12	11,373
Further National Pressures	1,000,000
Allocation risks / ULD risks	624,769
Innovation and Development Fund (£10m)	8,000,000
<b>Total</b>	<b>21,197,048</b>

### 7515-IMTP 23/24 DEFICIT

Description	23/24
23/24 recurrent deficit	(112,848,200)
Underlying deficit	28,800,000
Inflationary uplift (conditional recurrent)	35,700,000
Inflationary uplift (non-recurrent)	14,400,000
Energy	9,500,000
<b>Total</b>	<b>(24,448,200)</b>

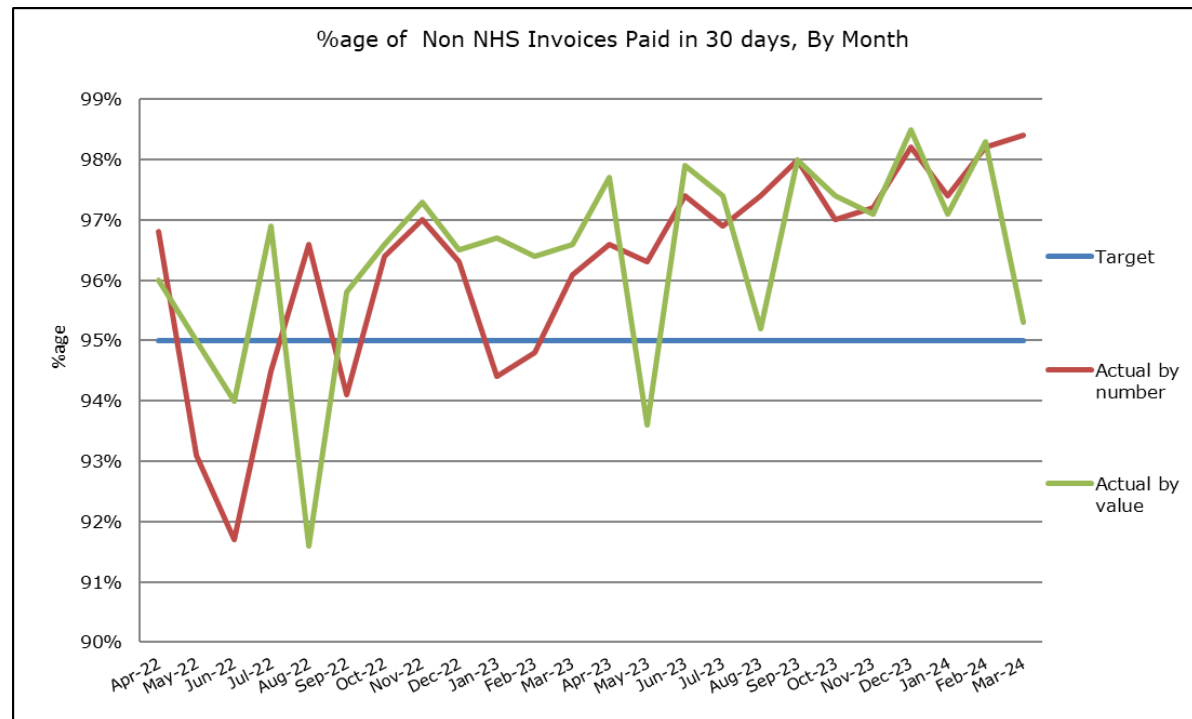
Totals **890,834**

## Cash Position

The cash balance at the 31<sup>st</sup> of March is £4.145m, which is below the advisory figure set by Welsh Government of £6m.

## Public Sector Payment Policy (PSPP)

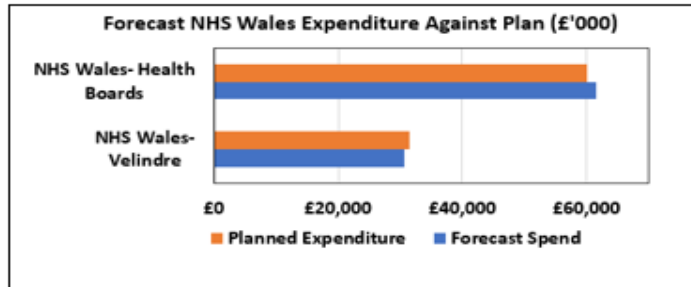
The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in February and cumulatively. There has been a slight decrease in the number & value of NHS invoices paid within 30 days this month. NHS Invoices in breach of the 30 day payment terms have been analysed for months 4-10. Divisional managers are in the process of being contacted to make them aware of the non-compliance with a request to take the appropriate action.



## Contracting & Commissioning – LTA Spend & Income

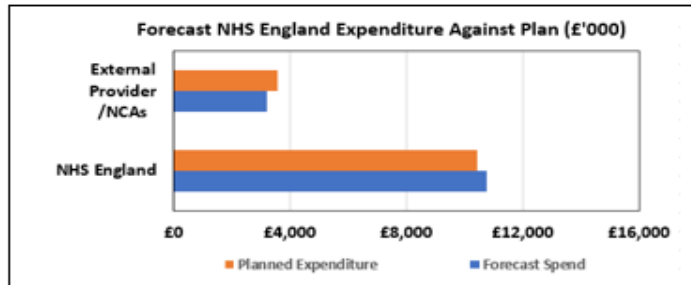
### Month/Financial Year:- Month 12 (March) 2023-24

At Month 12 the financial performance for Contracting and Commissioning is a £536k overspend against the delegated budget  
The key elements contributing to this position at Month 12 are as follows:



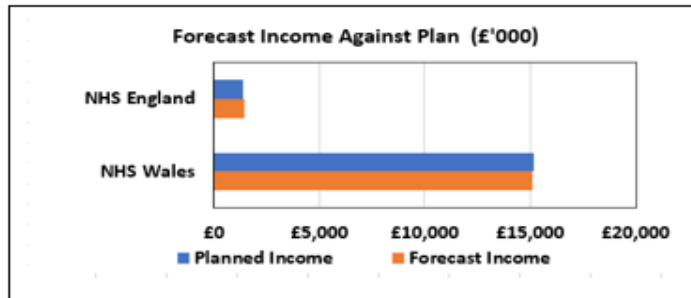
**NHS Wales Expenditure**

ABUHB pursued additional underperformance from Cwm Taf Morgannwg UHB to reflect reduced activity being provided for Gwent residents. WG had to arbitrate on the disputed position and the outcome was a reduction of c£2m compared to the 22-23 LTA.



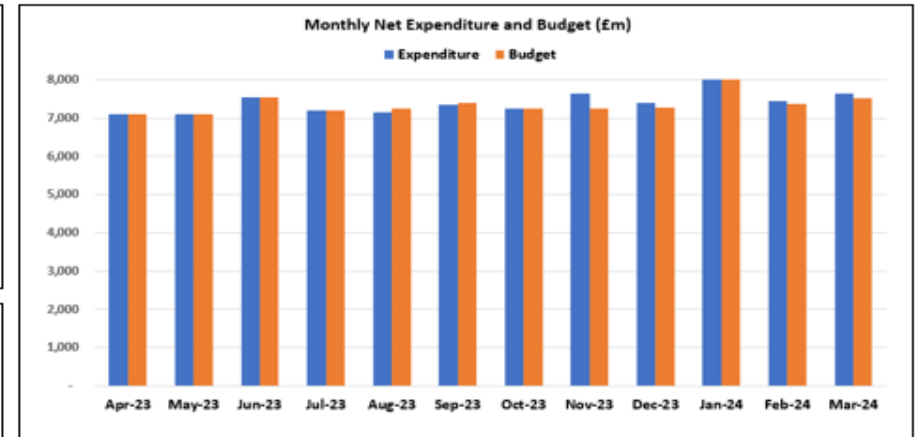
**NHS England Expenditure**

Contract Expenditure with NHS England organisations is expected to be c£12m in 2023/24 and will continue to be monitored and managed regularly.



**Provider Income**

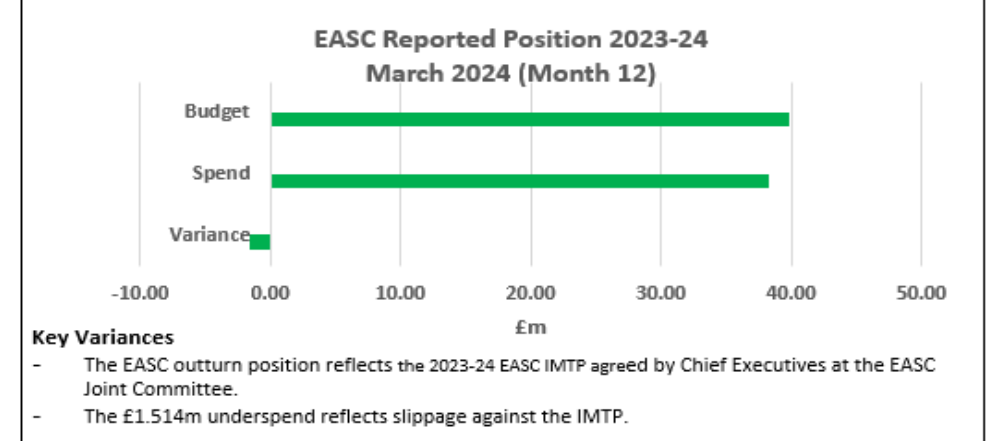
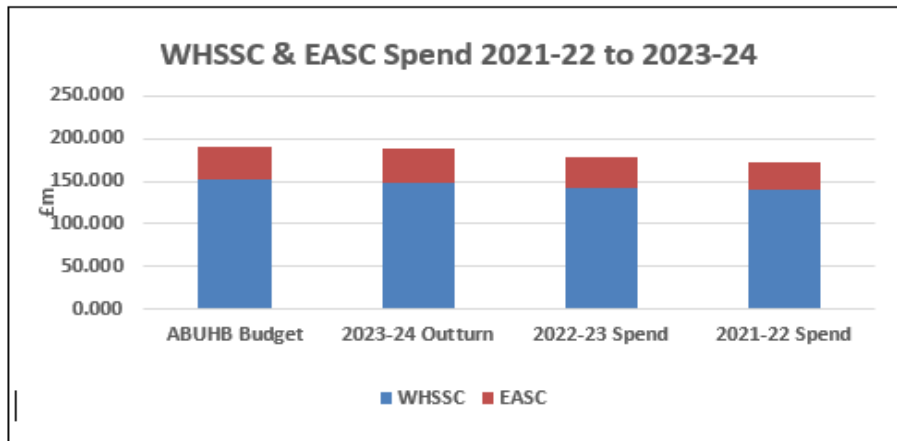
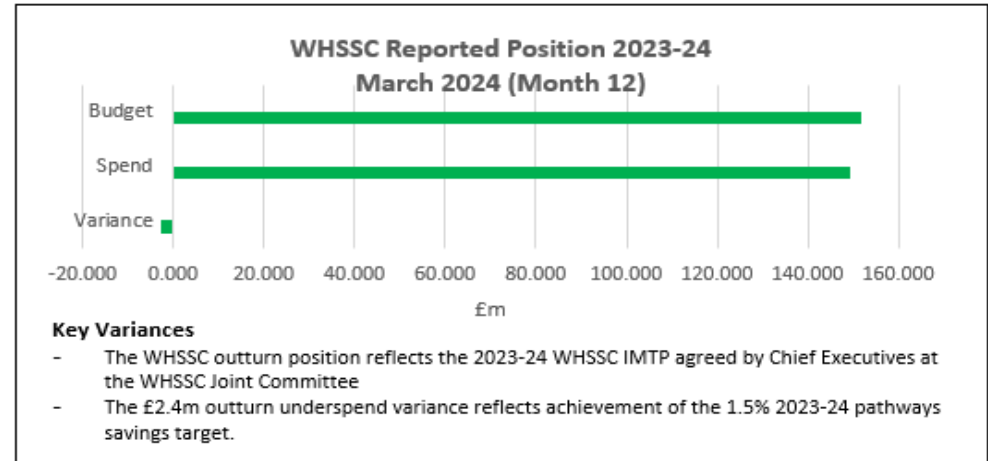
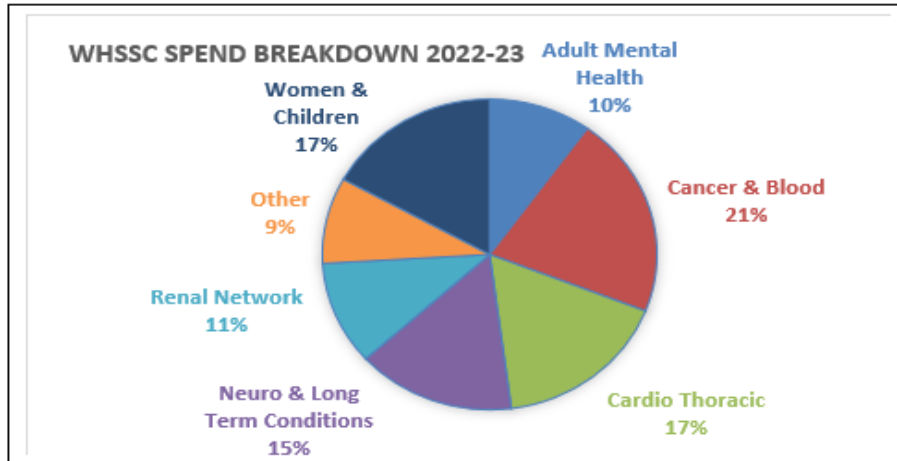
Provider income of c£16m is being planned and forecast in 2023/24 and will continue to be monitored and managed regularly.



- Key Issues 2023-24**
- All LTAs have been signed by the end of June 2023 WG deadline with the exception of the Cwm Taf LTA. A Heads of Agreement has now been signed by both parties reflecting the WG arbitration which resulted in c£2m reduction in expenditure compared to 22-23 terms and conditions.
  - The nationally agreed inflationary uplift of 1.5% has been funded and is reflected in the above position.
  - The forecast spend at Velindre Trust is broadly in line with the provider IMTP however there is a degree of uncertainty around NICE and activity forecasts and the implementation of new service developments.
  - A new saving of £331k was achieved in month 5 from negotiating additional underperformance from the Velindre contract.
  - A cost pressure of c£123k was incurred for increased delivery of pancreatic cancer surgery and thyroid surgery for AB patients at Swansea Bay UHB.
  - The plan and forecast takes into account the full year effect of the regional vascular centralisation project in Cardiff and the phased contract reduction for Powys patients in relation to reduced GUH flows (income).

## WHSSC & EASC Financial Position 2023-24: Month 12

The Month 12 financial performance for WHSSC & EASC is an underspend of £3.929m. The Month 12 position reflects the agreed IMTP with WHSSC and EASC.



## Balance Sheet

Balance sheet as at 31st March 2024			
	2023/24 Opening balance £000s	31st March 2024 £000s	Movement £000s
<b>Fixed Assets</b>	893,408	910,187	16,779
<b>Other Non current assets</b>	83,283	149,418	66,135 *
<b>Current Assets</b>			
Inventories	9,576	9,843	267
Trade and other receivables	152,220	136,632	-15,588 *
Cash	4,704	4,145	-559
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	166,500	150,620	-15,880
<b>Liabilities</b>			
Trade and other payables	242,817	217,281	-25,536
Provisions	168,466	221,474	53,008
	411,283	438,755	27,472
	<b>731,908</b>	<b>771,470</b>	<b>39,562</b>
<b>Financed by:-</b>			
General Fund	552,859	582,146	29,287
Revaluation Reserve	179,049	189,324	10,275
	<b>731,908</b>	<b>771,470</b>	<b>39,562</b>

### Fixed Assets:-

- An increase in net additions of £28.3m in relation to new 2023/24 capital expenditure incurred.
- A reduction of £43.0m for depreciation charges. A reduction of £6.5m for IFRS16 related charges.
- An increase in indexation costs of £37.9m

**Other Non-Current Assets:** This relates to an increase in Welsh Risk Pool claims due in more than one year £66.5m, a decrease in intangible assets of £0.4m, an increase in ICR income due in more than one year of £0.1m and a decrease in Other Financial Assets of £0.1m since the end of 2022/23.

**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 2022/23 relate to:

- A decrease in the value of debts outstanding on the Accounts Receivable system since 2022/23 to the end of March £8.6m
- A decrease in the value of both NHS & Non-NHS accruals of £8.4m, of which £14.0m relates to a decrease of Welsh Risk Pool claims due in less than one year, £5.9m relates to an increase in NHS & Non NHS accruals, £0.1m relates to a decrease in VAT & other debtors and £0.2m relates to an increase in the Bad Debt Provision since the end of 2022/23.
- An increase in the value of prepayments held £1.4m

**Cash:** The cash balance held at the end of March is £4.145m.

### Liabilities, Provisions:

- The movement since the end of 2022/23 relates to a number of issues the most significant of which are:- A decrease in Capital accruals (£0.8m), an increase in NHS Creditor accruals (£7.5m), a decrease in the level of invoices held for payment from the year end (£6.9m), a decrease in non NHS accruals (£18.0m), a decrease in Tax & Superannuation (£0.7m), an increase in other creditors (£0.7m), a decrease in the liability for lease payments (£7.2m), an increase in payments on account (£0.1m)
- Due to the increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £50.4m and a increase in other provisions of £2.6m.

**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 March 2024 (M12 2023/24)	
	£'000
HCHS	1,583,329
GMS	116,441
Pharmacy	34,917
Dental	34,643
<b>Total Confirmed Allocations - March 2024</b>	<b>1,769,330</b>
<b>Plus Anticipated Allocation - March 2024</b>	<b>-</b>
<b>Total Allocations - March 2024</b>	<b>1,769,330</b>

**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 £114m. (£108m for 22/23). 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 £1.88bn (£1.75bn for 22/23).

**WG anticipated allocations: £0.0m**

All anticipated funding has been received by the Health Board for 2023/24.

## Capital Planning & Performance

Summary Capital Plan Month 12 2023/24	2023/24				
	Original Plan £000	Revised Plan £000	Spend to M12 £000	Forecast Outturn £000	Variance £000
<b>Source:</b>					
<b>Discretionary Capital:</b>					
Approved Discretionary Capital Funding Allocation	9,521	9,521		9,521	0
Less EFAB Contribution	-629	-629		-629	0
Less AWCP Brokerage 22/23	-1,472	-2,278		-2,278	0
Plus AWCP Brokerage 23/24	0	1,669		1,669	0
Less DCP Brokerage 23/24	0	-350		-350	0
NBV of Assets Disposed	0	550		550	0
<b>Total Approved Discretionary Funding</b>	<b>7,420</b>	<b>8,483</b>		<b>8,483</b>	<b>0</b>
<b>All Wales Capital Programme Funding:</b>					
AWCP Approved Funding	43,396	50,831		50,831	0
<b>Total Approved AWCP Funding</b>	<b>43,396</b>	<b>50,831</b>		<b>50,831</b>	<b>0</b>
<b>IFRS16 Lease Funding:</b>					
Approved IFRS16 Lease Funding	0	3,259		3,259	0
IFRS16 CRL Reduction for Leased Asset Disposals	0	-5,281		-5,281	0
NBV of IFRS16 Leased Assets Disposed	0	5,281		5,281	0
<b>Total Approved IFRS16 Lease funding</b>	<b>0</b>	<b>3,259</b>		<b>3,259</b>	<b>0</b>
<b>Total Capital Funding / Capital Resource Limit (CRL)</b>	<b>50,816</b>	<b>62,573</b>		<b>62,573</b>	<b>0</b>
<b>Applications:</b>					
<b>Discretionary Capital:</b>					
Commitments B/f From 2022/23	321	277	236	236	-40
Statutory Allocations	576	660	597	597	-63
Divisional Priorities	2,868	4,442	3,831	3,831	-611
Corporate Priorities	300	1,126	1,961	1,961	836
Informatics National Priority & Sustainability	2,170	1,979	1,833	1,833	-146
Remaining DCP Contingency	1,185	0	0	0	0
<b>Total Discretionary Capital</b>	<b>7,420</b>	<b>8,483</b>	<b>8,459</b>	<b>8,459</b>	<b>-24</b>
<b>All Wales Capital Programme:</b>					
Grange University Hospital Remaining works	-3,517	-154	-154	-154	0
Tredegar Health & Wellbeing Centre Development	4,019	3,375	3,475	3,475	100
NHH Satellite Radiotherapy Centre	17,675	14,987	14,987	14,987	0
YYF Breast Centralisation Unit	8,685	8,371	8,371	8,371	0
Newport East Health & Wellbeing Centre Development	10,362	10,046	10,046	10,046	0
RGH Endoscopy Unit	4,004	4,910	4,910	4,910	0
RGH – Block 1 and 2 Demolition and Car Park	404	275	275	275	0
EFAB Schemes	1,764	1,303	1,303	1,303	0
EOY Funding Schemes	0	239	216	216	-23
MH SISU Development	0	10	13	13	3
ICF Schemes	0	8	6	6	-2
Housing with Care Fund - 2022/23 Schemes	0	10	10	10	0
ED Waiting Area Funding	0	201	201	201	1
CAMHS Sanctuary Hub	0	638	638	638	0
National Imaging Programme - 2022/23 Old year schemes	0	55	51	51	-4
Digital Eye Care	0	10	10	10	0
Radiotherapy Satellite Centre NHH Enabling Works	0	9	9	9	0
SDEC Equipment	0	19	22	22	3
Housing with Care Fund - 2023/24 Schemes	0	272	273	273	1
DPIF - RISP, Cyber, End of Year and WNCR Funding	0	1,480	1,491	1,491	11
GUH ED Extension	0	2,937	2,827	2,827	-110
Diagnostics Funding	0	424	424	424	0
Ty Gwent	0	81	81	81	0
EOY Funding 2023/24	0	403	403	403	0
NHH RAAC Funding	0	757	770	770	13
EOY - Imaging Funding	0	404	395	395	-9
VAT Provision release IT AWCP Schemes	0	-239	-239	-239	0
<b>Total AWCP Capital</b>	<b>43,396</b>	<b>50,831</b>	<b>50,815</b>	<b>50,815</b>	<b>-16</b>
<b>Total IFRS16 Lease Expenditure</b>	<b>0</b>	<b>3,259</b>	<b>3,258</b>	<b>3,258</b>	<b>-1</b>
<b>Total Programme Allocation and Expenditure</b>	<b>50,816</b>	<b>62,573</b>	<b>62,532</b>	<b>62,532</b>	<b>-41</b>
<b>Forecast Break Even against Overall Capital Resource Limit</b>					<b>-41</b>
		56,742	WG CRL Figures		

# **Aneurin Bevan University Health Board**

## **Finance Board Report – April 2024 (Month 1 – 2024/25)**

### **Appendix 2 – Welsh Government Monthly Monitoring Return (MMR)**

<b>Section</b>	<b>Page Number(s)</b>
Table A – Movement of Financial Plan to Forecast Outturn	2
Table A1 - Underlying Position	3
Table A2 - Risks and Opportunities	4
Table B - Monthly Position	5
Table B2 - Pay Expenditure Analysis	6-7
Table B3 - COVID-19	8
Table C - Identified Savings Schemes	9
Table D - Welsh NHS Assumptions	10
Table F - Statement of Financial Position – not required in month 1	11
Table G - Monthly Cashflow Forecast – not required in month 1	11
Table H - Prompt Payment of Invoice Performance – not required in month 1	11
Table I - Capital Resource/Expenditure Limit Management	12
Table J - In Year Capital Scheme Profiles – not required in month 1	13
Table K - Capital Disposals	13
Table M - Debtors Schedule	13
Table N - General Medical Services Financial Position – not required in month 1	13
Table O - Dental Services Financial Position – not required in month 1	13
Table P – Ringfenced – not required in month 1	13

**Note: further detail available upon request**



**Table A1 - Underlying Position**

Section A - By Spend Area		IMTP	Full Year Effect of Actions		Subtotal	New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
		Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)			Underlying Position c/f
		£'000	£'000	£'000	£'000	£'000	£'000
1	Pay - Administrative, Clerical & Board Members	(0)		3,334	3,334	(3,334)	(0)
2	Pay - Medical & Dental	(24,293)		8,977	(15,316)	(3,977)	(19,293)
3	Pay - Nursing & Midwifery Registered	(15,638)	4,767		(10,871)		(10,871)
4	Pay - Prof Scientific & Technical	(807)		807	(0)		(0)
5	Pay - Additional Clinical Services	(6,776)	4,767	509	(1,500)		(1,500)
6	Pay - Allied Health Professionals	(0)		850	850	(850)	(0)
7	Pay - Healthcare Scientists	(115)		115	0		0
8	Pay - Estates & Ancillary	(2,841)			(2,841)	(2,159)	(5,000)
9	Pay - Students	0			0		0
10	Non Pay - Supplies and services - clinical	(15,001)	15,001	8,746	8,746	(12,992)	(4,246)
11	Non Pay - Supplies and services - general	(740)	740		(0)		(0)
12	Non Pay - Consultancy Services	0			0		0
13	Non Pay - Establishment	0			0		0
14	Non Pay - Transport	0			0		0
15	Non Pay - Premises	(5,088)	5,088		(0)		(0)
16	Non Pay - External Contractors	0			0	0	0
17	Health Care Provided by other Orgs – Welsh LHBs	(1,000)		7,000	6,000	(6,000)	0
18	Health Care Provided by other Orgs – Welsh Trusts	0			0		0
19	Health Care Provided by other Orgs – JCC	0		12,197	12,197	(13,197)	(1,000)
20	Health Care Provided by other Orgs – English	0			0		0
21	Health Care Provided by other Orgs – Private / Other	(9,110)	7,104	9,295	7,289	(17,289)	(10,000)
22	<b>Total</b>	<b>(81,410)</b>	<b>37,467</b>	<b>51,830</b>	<b>7,887</b>	<b>(59,798)</b>	<b>(51,911)</b>



**Table B– Monthly Summarised Statement of Comprehensive Net Expenditure/Statement of Comprehensive Net Income**

A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD £'000	Forecast year-end position £'000	
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000			
Revenue Resource Limit	Actual/Fcast	140,293	144,111	141,985	141,846	142,132	141,739	142,497	141,188	141,441	141,991	141,988	143,150	140,293	1,704,364
Capital Donation / Government Grant Income (Health Board only)	Actual/Fcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Welsh NHS Local Health Boards & Trusts Income	Actual/Fcast	1,909	1,998	1,998	1,998	1,998	1,998	1,998	1,998	1,998	1,998	1,998	1,998	1,909	23,882
JCC Income	Actual/Fcast	981	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	981	12,851
Welsh Government Income (Non RRL)	Actual/Fcast	2,285	1,103	1,103	1,103	1,103	1,103	1,103	1,103	1,103	1,103	1,103	1,103	2,285	14,419
Other Income	Actual/Fcast	5,072	5,072	5,072	5,072	5,072	5,072	5,072	5,072	5,072	5,072	5,072	5,072	5,072	60,864
<b>Income Total</b>		<b>150,540</b>	<b>153,363</b>	<b>151,237</b>	<b>151,098</b>	<b>151,384</b>	<b>150,991</b>	<b>151,749</b>	<b>150,440</b>	<b>150,693</b>	<b>151,243</b>	<b>151,240</b>	<b>152,402</b>	<b>150,540</b>	<b>1,816,380</b>
Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/Fcast	18,815	18,952	18,782	18,782	18,782	18,782	18,532	18,532	18,532	18,532	18,532	18,532	18,815	224,087
Primary Care - Drugs & Appliances	Actual/Fcast	9,898	9,606	9,606	9,606	9,606	9,606	9,606	9,606	9,606	9,606	9,606	9,606	9,898	115,564
Provided Services - Pay	Actual/Fcast	62,289	63,789	62,789	62,289	62,289	62,289	61,789	60,789	60,789	60,789	62,289	60,789	62,289	742,968
Provider Services - Non Pay (excluding drugs & depreciation)	Actual/Fcast	13,292	14,124	13,346	13,322	13,641	13,846	13,171	13,235	13,261	13,868	13,209	14,493	13,292	162,807
Secondary Care - Drugs	Actual/Fcast	5,708	5,151	5,141	5,145	5,081	5,155	5,425	5,348	5,236	5,126	5,087	5,090	5,708	62,694
Healthcare Services Provided by Other NHS Bodies	Actual/Fcast	27,455	27,200	27,200	27,200	27,200	26,800	26,800	26,800	26,800	26,800	26,800	26,800	27,455	323,855
Non Healthcare Services Provided by Other NHS Bodies	Actual/Fcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuing Care and Funded Nursing Care	Actual/Fcast	10,580	11,092	10,924	11,307	11,338	11,067	11,201	10,907	11,248	11,299	10,497	11,670	10,580	133,131
Other Private & Voluntary Sector	Actual/Fcast	813	1,434	1,434	1,434	1,434	1,434	1,434	1,434	1,434	1,434	1,434	1,434	813	16,588
Joint Financing and Other	Actual/Fcast	2,502	2,765	2,765	2,765	2,765	2,765	2,765	2,765	2,765	2,765	2,765	2,765	2,502	32,920
Losses, Special Payments and Irrecoverable Debts	Actual/Fcast	135	209	209	209	209	209	209	209	209	209	209	209	135	2,430
Exceptional (Income) / Costs - (Trust Only)	Actual/Fcast													0	0
Total Interest Receivable - (Trust Only)	Actual/Fcast													0	0
Total Interest Payable - (Trust Only)	Actual/Fcast													0	0
DEL Depreciation/Accelerated Depreciation/Impairments	Actual/Fcast	3,976	3,984	3,984	3,983	3,983	3,981	3,980	3,980	3,978	3,978	3,975	3,979	3,976	47,762
AME Donated Depreciation/Impairments	Actual/Fcast	37	37	37	36	36	36	36	36	36	36	36	36	37	435
Uncommitted Reserves & Contingencies	Actual/Fcast													0	0
Profit/Loss Disposal of Assets	Actual/Fcast	(0)	0	0	0	0	0	0	0	0	0	0	0	(0)	(0)
<b>Cost - Total</b>		<b>155,499</b>	<b>158,343</b>	<b>156,217</b>	<b>156,078</b>	<b>156,364</b>	<b>155,971</b>	<b>154,949</b>	<b>153,640</b>	<b>153,893</b>	<b>154,443</b>	<b>154,440</b>	<b>155,403</b>	<b>155,499</b>	<b>1,865,241</b>
<b>Net surplus/ (deficit)</b>		<b>(4,959)</b>	<b>(4,980)</b>	<b>(4,980)</b>	<b>(4,980)</b>	<b>(4,980)</b>	<b>(4,980)</b>	<b>(3,200)</b>	<b>(3,200)</b>	<b>(3,200)</b>	<b>(3,200)</b>	<b>(3,200)</b>	<b>(3,001)</b>	<b>(4,959)</b>	<b>(48,860)</b>

**Table B2 - Pay Expenditure Analysis**

A - Pay Expenditure		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	9,760	9,995	9,838	9,760	9,760	9,760	9,682	9,525	9,525	9,525	9,760	9,525	9,760	116,415
2	Medical & Dental	15,120	15,484	15,241	15,120	15,120	15,120	14,999	14,756	14,756	14,756	15,120	14,756	15,120	180,348
3	Nursing & Midwifery Registered	18,828	19,281	18,979	18,828	18,828	18,828	18,677	18,375	18,375	18,375	18,828	18,375	18,828	224,577
4	Prof Scientific & Technical	2,757	2,823	2,779	2,757	2,757	2,757	2,735	2,691	2,691	2,691	2,757	2,691	2,757	32,886
5	Additional Clinical Services	9,372	9,598	9,447	9,372	9,372	9,372	9,297	9,146	9,146	9,146	9,372	9,146	9,372	111,786
6	Allied Health Professionals	3,794	3,885	3,824	3,794	3,794	3,794	3,764	3,703	3,703	3,703	3,794	3,703	3,794	45,255
7	Healthcare Scientists	1,157	1,185	1,166	1,157	1,157	1,157	1,148	1,129	1,129	1,129	1,157	1,129	1,157	13,800
8	Estates & Ancillary	3,431	3,514	3,459	3,431	3,431	3,431	3,403	3,348	3,348	3,348	3,431	3,348	3,431	40,923
9	Students	2	3	4	2	2	2	0	1	1	1	2	1	2	22
10	<b>TOTAL PAY EXPENDITURE</b>	<b>64,221</b>	<b>65,768</b>	<b>64,737</b>	<b>64,221</b>	<b>64,221</b>	<b>64,221</b>	<b>63,705</b>	<b>62,674</b>	<b>62,674</b>	<b>62,674</b>	<b>64,221</b>	<b>62,674</b>	<b>64,221</b>	<b>766,012</b>

B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	28	36	38	39	39	39	37	36	35	35	35	35	28	432
2	Medical & Dental	1,124	1,442	1,529	1,573	1,573	1,573	1,485	1,442	1,398	1,398	1,398	1,398	1,124	17,331
3	Nursing & Midwifery Registered	1,034	1,326	1,407	1,447	1,447	1,447	1,366	1,326	1,286	1,286	1,286	1,286	1,034	15,943
4	Prof Scientific & Technical	27	35	37	38	38	38	36	35	34	34	34	34	27	416
5	Additional Clinical Services	26	33	35	36	36	36	34	33	32	32	32	32	26	401
6	Allied Health Professionals	102	131	139	143	143	143	135	131	127	127	127	127	102	1,573
7	Healthcare Scientists	27	35	37	38	38	38	36	35	34	34	34	34	27	416
8	Estates & Ancillary	205	263	279	287	287	287	271	263	255	255	255	255	205	3,161
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	<b>TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE</b>	<b>2,573</b>	<b>3,300</b>	<b>3,500</b>	<b>3,600</b>	<b>3,600</b>	<b>3,600</b>	<b>3,400</b>	<b>3,300</b>	<b>3,200</b>	<b>3,200</b>	<b>3,200</b>	<b>3,200</b>	<b>2,573</b>	<b>39,673</b>
11	<b>Agency/Locum (premium) % of pay</b>	<b>4.0%</b>	<b>5.0%</b>	<b>5.4%</b>	<b>5.6%</b>	<b>5.6%</b>	<b>5.6%</b>	<b>5.3%</b>	<b>5.3%</b>	<b>5.1%</b>	<b>5.1%</b>	<b>5.0%</b>	<b>5.1%</b>	<b>4.0%</b>	<b>5.2%</b>

C - Agency / Locum (premium) Expenditure - Analysed by Reason for Using Agency/Locum (premium)		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
REF	REASON	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	£'000	£'000
1	Vacancy	1,544	1,980	2,100	2,160	2,160	2,160	2,040	1,980	1,920	1,920	1,920	1,920	1,544	23,804
2	Maternity/Paternity/Adoption Leave	27	35	37	38	38	38	36	35	34	34	34	34	27	417
3	Special Leave (Paid) – inc. compassionate leave, interview	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Special Leave (Unpaid)	39	50	53	54	54	54	51	50	48	48	48	48	39	595
5	Study Leave/Examinations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	Additional Activity (Winter Pressures/Site Pressures)	520	667	707	727	727	727	687	667	646	646	646	646	520	8,014
7	Annual Leave	48	61	65	67	67	67	63	61	59	59	59	59	48	734
8	Sickness	396	508	539	554	554	554	524	508	493	493	493	493	396	6,110
9	Restricted Duties	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	Jury Service	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	WLI	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	Exclusion (Suspension)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	<b>TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE</b>	<b>2,573</b>	<b>3,300</b>	<b>3,500</b>	<b>3,600</b>	<b>3,600</b>	<b>3,600</b>	<b>3,400</b>	<b>3,300</b>	<b>3,200</b>	<b>3,200</b>	<b>3,200</b>	<b>3,200</b>	<b>2,573</b>	<b>39,673</b>

D - Variable Pay Excluding Agency / Locum (premium) Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
REF	TYPE	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	£'000	£'000
1	Administrative, Clerical & Board Members	68	79	78	82	83	84	77	72	68	66	66	65	68	887
2	Medical & Dental	333	385	382	399	408	410	377	354	334	321	322	319	333	4,345
3	Nursing & Midwifery Registered	1,345	1,555	1,543	1,613	1,649	1,657	1,523	1,429	1,350	1,296	1,300	1,288	1,345	17,548
4	Prof Scientific & Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	Additional Clinical Services	1,428	1,651	1,638	1,712	1,751	1,759	1,616	1,518	1,434	1,376	1,380	1,367	1,428	18,631
6	Allied Health Professionals	0	0	0	0	0	0	0	0	0	0	0	0	0	5
7	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Estates & Ancillary	218	252	250	261	267	269	247	232	219	210	211	209	218	2,844
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	5
10	<b>TOTAL VARIABLE PAY</b>	<b>3,393</b>	<b>3,923</b>	<b>3,892</b>	<b>4,068</b>	<b>4,160</b>	<b>4,180</b>	<b>3,841</b>	<b>3,606</b>	<b>3,406</b>	<b>3,270</b>	<b>3,280</b>	<b>3,248</b>	<b>3,393</b>	<b>44,266</b>

**Table B3 - COVID-19**

Overall Covid-19 Position		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
108	Total Planned COVID-19 Expenditure	781	828	986	1,075	1,004	1,007	1,018	1,016	1,230	1,164	1,170	1,137	781	12,416
109	Total Actual/Forecast COVID-19 Expenditure	781	828	986	1,075	1,004	1,007	1,018	1,016	1,230	1,164	1,170	1,137	781	12,416
110	Movement from Planned Expenditure	0	0	0	0	0	0	0	0	0	0	0	0	0	0
111	Total Planned Funding	781	828	986	1,075	1,004	1,007	1,018	1,016	1,230	1,164	1,170	1,137	781	12,416
112	Total Actual/Forecast COVID-19 Funding excluding Virements	781	828	986	1,075	1,004	1,007	1,018	1,016	1,230	1,164	1,170	1,137	781	12,416
113	Total Actual/Forecast COVID-19 Virements	0	0	0	0	0	0	0	0	0	0	0	0	0	0
114	Total Actual/Forecast Funding	781	828	986	1,075	1,004	1,007	1,018	1,016	1,230	1,164	1,170	1,137	781	12,416
115	Movement from Planned Funding	0	0	0	0	0	0	0	0	0	0	0	0	0	0
116	Net Planned Position	0	0	0	0	0	0	0	0	0	0	0	0	0	0
117	Actual / Forecast Net Impact on overall Financial Position due to Covid-1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
118	Net Movement from Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0

**Table C - Identified Expenditure Savings Schemes (Excludes Income Generation and Accountancy Gains)**

		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			YTD variance as %age of YTD	Green	Amber
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000			£'000	£'000	£'000
1	Budget/Plan	622	524	545	709	735	736	1,133	1,136	1,136	1,136	1,136	1,136	622	10,682		0	4,463
2	Pay	622	524	545	709	735	736	1,133	1,136	1,136	1,136	1,136	1,136	622	10,682	5.82%	6,219	4,463
3	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	6,219	0
4	Budget/Plan	226	226	230	451	451	451	451	451	551	451	451	648	226	5,035		2,410	2,625
5	Non-Pay	226	226	230	451	451	451	451	451	551	451	451	648	226	5,035	4.48%	2,410	2,625
6	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0	0
7	Budget/Plan	103	115	125	137	148	160	171	182	194	205	218	229	103	1,987		1,987	0
8	Primary Care - Drugs & Appliances	103	115	125	137	148	160	171	182	194	205	218	229	103	1,987	5.20%	1,987	0
9	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0	0
10	Budget/Plan	15	17	17	17	17	17	17	17	17	17	17	19	15	201		201	0
11	Secondary Care Drugs	15	17	17	17	17	17	17	17	17	17	17	19	15	201	7.49%	201	0
12	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0	0
13	Budget/Plan	35	114	281	353	413	413	656	656	656	656	656	656	35	5,543		3,357	2,186
14	CHC/FNC	35	114	281	353	413	413	656	656	656	656	656	656	35	5,543	0.63%	3,357	2,186
15	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0	0
16	Budget/Plan	221	221	221	232	232	232	237	237	237	237	237	237	221	2,778		2,648	130
17	Primary Care Contractor	221	221	221	232	232	232	237	237	237	237	237	237	221	2,778	7.94%	2,648	130
18	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0	0
19	Budget/Plan	0	0	0	312	312	312	312	312	312	312	312	312	0	2,805		0	2,805
20	Healthcare Services Provided by Other Healthboards	0	0	0	312	312	312	312	312	312	312	312	312	0	2,805	0.00%	0	2,805
21	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%	0	0
22	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
23	Non-healthcare Services Provided by Other Healthboards	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
24	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
25	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
26	Other Private & Voluntary Sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
27	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
28	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
29	Joint Financing & Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
30	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
34	Budget/Plan	1,221	1,216	1,419	2,210	2,307	2,320	2,975	2,989	3,101	3,012	3,025	3,235	1,221	29,031		10,603	2,805
35	Total	1,221	1,216	1,419	2,210	2,307	2,320	2,975	2,989	3,101	3,012	3,025	3,235	1,221	29,031	0.00%	16,822	12,209
36	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		6,219	9,404

**Table D - Welsh NHS Assumptions – Income/Expenditure Assumptions Annual Forecast**

	LHB/Trust	Contracted	Non	Total	Contracted	Non	Total
		Income	Contracted	Income	Expenditure	Contracted	Expenditure
		£'000	£'000	£'000	£'000	£'000	£'000
1	Swansea Bay University	274	880	1,154	1,682	2,080	3,762
2	Aneurin Bevan University	0	0	0	0	0	0
3	Betsi Cadwaladr University	41	97	138	0	1,474	1,474
4	Cardiff & Vale University	1,585	1,614	3,199	37,976	6,327	44,303
5	Cwm Taf Morgannwg University	1,559	1,098	2,657	21,267	847	22,114
6	Hywel Dda University	321	25	346	433	820	1,253
7	Powys	11,348	3,310	14,658	168	205	373
8	Public Health Wales	0	4,253	4,253	0	1,588	1,588
9	Velindre	0	11,055	11,055	30,687	54,670	85,357
10	NWSSP			0			0
11	DHCW	0	1,307	1,307	0	7,549	7,549
12	Welsh Ambulance Services	0	257	257	0	10,305	10,305
13	JCC	11,914	2,034	13,948	209,524	(835)	208,689
14	HEIW	0	14,596	14,596		40	40
15	NHS Executive			0			0
16	<b>Total</b>	<b>27,042</b>	<b>40,526</b>	<b>67,568</b>	<b>301,737</b>	<b>85,070</b>	<b>386,807</b>

**Table F - Statement of Financial Position**

Not required for Month 1

**Table G - Monthly Cashflow Forecast**

Not required for Month 1

**Table H - Prompt Payment of Invoice Performance**

Not required for Month 1

**Table I - Capital Resource/Expenditure Limit Management**

Ref:	Performance against CRL / CEL	Year To Date			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	F'cast £'000	Variance £'000
	<b>Gross expenditure</b>						
	<b>All Wales Capital Programme:</b>						
	<b>Schemes:</b>						
1	Primary Care Fees - Newport East	2,416	2,416	0	12,119	12,525	406
2	Radiotherapy Satellite - Main Scheme	919	919	0	15,570	15,570	0
3	Efab - Infrastructure	340	340	0	2,129	2,129	0
4	Efab - Fire	2	2	0	592	592	0
5	Efab - Decarbonisation	0	0	0	168	168	0
6	Plaid Agreement - Mental Health Sanitary Hubs	128	128	0	251	251	0
7	HCF - St Cadocs Mental Health Unit	0	0	0	975	975	0
8	Grange University Hospital - Brokerage pending VAT reclaim	5	5	0	(3,437)	(3,437)	0
9	Grange University Hospital - Emergency Department - Extension and Reconfiguration	655	655	0	11,355	11,355	0
10	Ty Gwent	1	1	0	1,219	1,219	0
11	RAAC Satellite Unit works	401	401	0	401	401	0
12	Royal Gwent Demolition	0	0	0	279	389	110
13	Breast Centralisation YF	4	4	0	111	111	0
14	RGH Endoscopy Unit	1	1	0	4	4	0
15	Digital Year End Funding - January 2024	1	1	0	20	20	0
16	ICF Pontllanfraith Feasibility	(3)	(3)	0	8	8	0
17	Emergency Department and Minor Injury Unit Improvements	14	14	0	55	57	2
18	HCF - Specialist Children's Beds	0	0	0	6	6	0
19	HCF - Exterior Lighting Serennu Centre	0	0	0	15	15	0
20	Digital Year End Funding - February 2024	0	0	0	53	53	0
21	Diagnostic Equipment	13	13	0	35	35	0
22	Year End Funding - January 2024	6	6	0	49	49	0
23	IRCF - Monmouth Health and Wellbeing Centre and Dixon Surgery	0	0	0	742	742	0
24	IRCF - Aber Valley Health and Wellbeing Centre and Aber Practice Development	0	0	0	742	742	0
25	Tredegar H&WBC	0	102	102	0	822	822
26				0			0
27				0			0
28				0			0
29				0			0
30				0			0
31				0			0
32				0			0
33				0			0
34				0			0
35				0			0
36				0			0
37				0			0
38				0			0
39				0			0
40				0			0
41				0			0
42	<b>Sub Total</b>	<b>4,903</b>	<b>5,005</b>	<b>102</b>	<b>43,461</b>	<b>44,801</b>	<b>1,340</b>

**Table J - In Year Capital Scheme Profiles - not required for month 1**

**Table K - Capital Disposals**

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. Apr 24)	MM/YY (text format, e.g. Apr 24)	MM/YY (text format, e.g. Feb 25)	£'000	£'000	£'000	£'000	
1	Equipment Disposals			April 24	0	0	0	0	

**Table M - Debtors Schedule**

Debtor	Inv #	Inv Date	Orig Inv £	Outstand. Inv £	Valid Entry	>11 weeks but <17 weeks	Over 17 weeks	Arbitration Due Date
CWM TAF MORGANNWG UHB	226160	22 January 2024	4643.82	4,643.82	Yes, valid entry for period	4,643.82		20 May 2024
CWM TAF MORGANNWG UHB	226173	22 January 2024	10833.21	10,833.21	Yes, valid entry for period	10,833.21		20 May 2024
CWM TAF MORGANNWG UHB	226180	22 January 2024	140.00	140.00	Yes, valid entry for period	140.00		20 May 2024
POWYS HEALTH BOARD	225483	16 November 2023	74730.10	74,730.10	Yes, valid entry for period		74,730.10	14 March 2024
POWYS HEALTH BOARD	225654	29 November 2023	15535.78	14,919.78	Yes, valid entry for period		14,919.78	27 March 2024
POWYS HEALTH BOARD	225685	30 November 2023	71252.51	71,252.51	Yes, valid entry for period		71,252.51	28 March 2024
POWYS HEALTH BOARD	225944	08 January 2024	39.10	39.10	Yes, valid entry for period	39.10		06 May 2024
POWYS HEALTH BOARD	226445	31 January 2024	114795.00	0.60	Yes, valid entry for period	0.60		29 May 2024
POWYS HEALTH BOARD	226451	07 February 2024	49704.10	49,704.10	Yes, valid entry for period	49,704.10		05 June 2024
VELINDRE UNIVERSITY NHS TRUST	226361	30 January 2024	22182.18	22,182.18	Yes, valid entry for period	22,182.18		28 May 2024

**Table N - General Medical Services Financial Position - not required in month 1**

**Table O - Dental Services Financial Position - not required in month 1**

**Table P – Ringfenced - not required in month**

## ANEURIN BEVAN UNIVERSITY HEALTH BOARD

### MONITORING RETURN FOR MONTH 1 2024/25

#### Director of Finance Commentary for the Period Ended 30<sup>th</sup> April 2024

##### Introduction

The purpose of this narrative is to provide a commentary on the financial monitoring returns being submitted to the Welsh Government (WG) by the Aneurin Bevan University Health Board (ABUHB) for the period to 30<sup>th</sup> April 2024 (Month 1, 2024/25). This commentary will provide an overview of the financial position and performance of the Health Board as at month one of the 2024/25 financial year. It will also provide a detailed narrative, where required, on each of the tables within the accompanying returns, in the format prescribed by WG.

This commentary will also respond, as far as is possible, to the issues highlighted in the WG response letter, the Health Board's response is recorded in the action log included as an Annex 1 to this commentary.

*As at Month 01, ABUHB is reporting a year to date deficit of £4.959m with a forecast year end deficit of £48.9m in line with the annual plan. There are risks associated with this forecast position, particularly achievement of pipeline opportunities, prescribing and acute drug cost growth, CHC fee uplifts, non-pay inflationary uplifts and operational demand & workforce pressures, more detail is provided in this report.*

For the 2024/25 financial year, the Health Board has received Covid-19 monies in relation to Health Protection, immunisation (Mass Vaccination) and Long Covid (Adferiad) on a recurrent basis. The Health Board has forecast costs within this funding envelope. The Health Board has residual costs which form part of its underlying deficit in relation to the legacy impact for areas such as enhanced cleaning, security and additional facilities above previous baselines. These areas are under continual review in order to minimise and/or increase efficiency where possible.

Pay award costs resulting from the 2023/24 consolidated pay awards have been assumed with anticipated funding for 2024/25. No further pay award costs are included at this time. The Health Board financial plan assumes that any pay award and cost impact from changes to terms and conditions will be fully funded by WG. No estimate is included due to the lack of a current agreement.

Energy costs are based on latest data from NWSSP and will continue to be monitored and updated for revised information from Shared Services. The estimated energy growth for 2024/25 of c.£2.1m which is reflected in these forecasts is based on the All Wales WEG groups figures.

## Actual YTD

The month one reported financial position shows a **£4.959m overspend position**; this is presented as such on the face of **Table B – Monthly Positions**. The table below details the outturn financial position analysed across the Health Board’s organisational structure of Divisions and Corporate Directorates. Funding has been delegated following Board approval and subsequent Chief Executive agreement, further delegation of reserve budgets to services is ongoing: -

Summary Reported position - April 2024 (M01)	Full Year Budget £000s	YTD Reported Variance £000s
<b>Operational Divisions:-</b>		
Primary Care and Community	288,290	206
Prescribing	114,518	354
Community CHC & FNC	72,004	68
Mental Health	124,481	1,335
<b>Total Primary Care, Community and Mental Health</b>	<b>599,293</b>	<b>1,963</b>
Surgery	133,253	1,037
Clinical Support Services	123,176	225
Medicine	148,795	957
Urgent Care	34,514	307
Family & Therapies	129,264	465
Estates and Facilities	86,897	983
Director of Operations	8,283	48
<b>Total Director of Operations</b>	<b>664,180</b>	<b>4,022</b>
<b>Total Operational Divisions</b>	<b>1,263,473</b>	<b>5,985</b>
Corporate Divisions	91,608	627
Specialist Services	188,073	92
External Contracts	89,992	341
Capital Charges	48,197	(0)
<b>Total Delegated Position</b>	<b>1,681,343</b>	<b>7,044</b>
Total Reserves	34,753	(2,085)
Total Allocations	(1,704,364)	0
Other Corporate Income	(11,732)	(0)
<b>Total Reported Position</b>	<b>0</b>	<b>4,959</b>

## Key messages for Month 1

The financial position at the 30<sup>th</sup> of April 2024 shows a £4.959m deficit position, with the key issues in the month being:

Expenditure in the Health Board for pay is reduced in comparison with March 2024 due to notional pension costs in month 12, Managed Practice costs moved to independent contractors and other Primary Care costs in month 12.

Non-pay expenditure has significantly reduced compared with March due to funded expenditure for JCC (WHSSC/EASC) pass through costs, RPB and TEC Cymru/E-system

spend reported in March. Also 111/6 goals cost are now transferred outside of the Health Board for 2024/25.

Variable pay costs reduced significantly compared with March 2024. Some of this relates to funded elements such as RPB and 111/6 goals transferring outside of the Health Board. Managed Practices moving to independent contractors reduced costs as well as reduced industrial action. There was a decrease in the level of variable pay linked to vacancy cover and reduced annual leave taken in April which suggests that the increased availability alongside substantive appointments have reduced costs. The focus remains on minimising variable pay in line with a range of operational and savings plans.

Enhanced care shifts have remained at a similar level compared with the previous 6 months. This is significantly lower than the 2022/23 and early 2023/24 levels. Work continues to review enhanced care including the implementation of a Patient Safety exercise reviewing current usage and configurations across all Health Board sites.

CHC costs for Adult Community Care, Mental Health & Learning Disabilities and Children continue to present an underlying financial pressure. Fee uplifts have been assumed at around 7.7% for Adult and Mental Health packages however there is a risk that these could be higher. Additional specific high-cost packages within Learning Disabilities and Paediatrics may present a further pressure in future months. The real living wage impact from 2022/23 and 2023/24 has been anticipated however this has been reduced in line with the correspondence sent in 2023/24 which reduced the funding by c.£2.8m. No real living wage for 2024/25 has been anticipated at present pending further analysis.

In January 2024 there was a specific very high-cost package of 'emergency' care for a paediatric patient which has been in place since the start of the financial year (23/24) but has only been presented and discussed at the Children's CHC panel in January 2024. Whilst CHC eligibility is not being disputed, the Divisional Director is continuing to dispute the commissioning / governance around the care package process and the level of healthcare provided. Legal advice is currently being obtained, with a date being established for a dispute panel meeting (awaiting confirmation of date in 2024).

Prescribing costs present a financial pressure compared with IMTP financial forecasts. The average cost per item for 2024/25 has increased from £7.29 (Annual Plan) to £7.44 (February PAR). Growth is assumed to be 0.8% for 2024/25 and will be reviewed for March and April PAR data. The current forecast has not been updated for this cost change given the likely effect of 56 day prescribing now being reflected. The forecast for prescribing will be continually monitored.

Energy costs are broadly in line with annual plan estimates which presents an adverse forecast of £2.069m (off-set by reduced costs for non-NWSSP energy). The price and usage are being monitored.

On-going non-pay costs across a number of areas continue including growth in diabetes pumps/consumables, respiratory equipment and hearing aids. Homecare

drugs continue to present an overall cost pressure due to increased activity whilst non-pay inflation impacts across a wide range of provisions and consumables. These are being reviewed in specific service areas to present efficiency opportunities where possible alongside mitigating actions through procurement and Divisions. The national V&SB procurement savings opportunities are being worked through to determine a likely saving forecast deliverable for ABUHB in 24/25.

## 1. Actual YTD and Forecast Under / Overspend (Tables A, B, B2 & B3)

### Table A – Movement of Opening Financial Plan to Outturn

The Board's identified aims for the 2024/25 financial plan are to achieve an improved revenue position compared with 2023/24, a positive movement towards achieving the WG control total and an improved underlying deficit, through achieving at least 2% savings. Additionally a 'road map' to recurrent financial recovery is being developed.

The 2023/24 financial deficit alongside the on-going financial challenges faced by the Health Board meant an annual plan, rather than a 3 year balanced plan, was presented to the Board on the 27<sup>th</sup> March and was subsequently signed off and submitted to WG, this included narrative and the minimum data set.

The annual plan submitted to Welsh Government in March 2024 identified a challenging forecast financial deficit of £48.9m assuming anticipated funding for a range of areas such as Real living wage (22/23 & 23/24), wage awards and Mental Health Service improvement funding.

A break-down of the submitted annual plan for 2024/25 is summarised below:

- Underlying deficit brought forward of +£81.4m
- Cost pressures identified of +£59.8m
- WG discretionary recurrent funding of (£51.8m)
- Identified savings requiring progression of (£29.1m)
- Pipeline opportunities described of (£11.4m)
- **Total deficit forecast £48.9m**

The carry forward underlying deficit for 2025/26 is currently £51.9m in line with the 2024/25 forecast deficit. This is due to non-recurrent savings being off-set with mitigating actions and assumed funding for specific issues.

Annual plan savings plans have been identified at £29.1m, the Health Board Divisions are working to ensure delivery of these plans using the National Value & Sustainability themes. In addition, pipeline opportunities of £11.4m were identified by Divisions as part of internal Divisional annual plan submissions.

The Executives and Board have allocated leads for the National Value & Sustainability themes as part of revised escalation arrangements and have formed the local Value and Sustainability Board to progress savings, mitigations and delivery of core themes:-

- CHC
- Medicines Management
- Non-pay
- Workforce
- Service reconfiguration
- Prevention
- Digital

A more comprehensive breakdown of the annual plan is shown in the table below:-

<b>Financial Plan 2024/25</b>	<b>2024/25 Deficit / (surplus) (£'m)</b>
2023/24 forecast position (as at Month 9)	56.4
WG non-recurrent funding	14.4
Underlying deficit - accounting to reflect recurrent implications	10.6
<b>Underlying deficit going into 2024/25</b>	<b>81.4</b>
National Pressures	14.4
Inflationary Pressures	21.7
Contractual and Unavoidable Pressures	15.7
Local Investment Pressures	8.0
<b>Sub-total 2024/25 including new cost pressures</b>	<b>141.2</b>
Discretionary funding	(51.8)
<b>Sub-total 2024/25 inc. discretionary funding</b>	<b>89.4</b>
2024/25 savings	(29.1)
<b>Total 2024/25 position before further pipeline opportunities</b>	<b>60.3</b>
Additional amber opportunities	(6.9)
<b>Total 2024/25 position before red pipeline opportunities (Likely case)</b>	<b>53.4</b>
Red pipeline opportunities (67% assumption)	(4.5)
<b>ABUHB financial plan 2024/25 total (best case)</b>	<b>48.9</b>
<b>Note</b>	
Additional QIA plans of £6.2m - assumption of 20% achievement would result in c.£47.8m deficit	

### Table B - Monthly Positions

The year to date reported position is a £4.959m deficit position (compared with the annual plan year to date deficit of £3.420m).

Material differences of actual expenditure from the annual plan are as follows:-

- *RRL* – The material difference to plan are in relation to the revenue aspects of Capital, i.e. the depreciation / DEL / AME impairment costs. These elements were excluded in the annual plan whilst the 24/25 figures were being finalised. In addition, allocation adjustments have been actioned for CHC RLW alongside

other anticipated allocations which have reduced the month 1 in comparison with the annual plan.

- *WG income / other income* – this reflects movement in non-cash limited income with equivalent spend implications. Other WG income was higher than forecast but non-cash limited (NCL) adjustments have resulted in the assumed repayment of funding to WG. This was due to prescribing/dispensing off-set by ophthalmic income. These areas have large fluctuations so it is forecast to revert to previous levels throughout 2024/25.
- *Primary Care Contractor* – this is mainly the movement of managed practices to independent contractors which resulted in increased costs in Primary Care Contractor compared with annual plan, with an equivalent decrease in Provider Pay is shown.
- *Primary Care - Drugs & Appliances* – costs are above forecast due to the average price per item forecast currently £7.44 which is above the planned value of £7.29, however, this is only reflected in the year to date position not the full year forecast,
- *Provider Services – Pay* – costs are lower than forecast linked to managed practice movements and the transfer of 111/6 goals outside of the Health Board.
- *Provider Services – Non-Pay* – expenditure is slightly lower than annual plan partly due to energy costs but also due to the changes in 111/6 goals provision.

Further allocations will be anticipated for areas such as Real living wage (24/25) and dispensing Drs (PADM) once WG correspondence has been received.

Section B has not been completed as per guidance and will be assumed to be removed for 2024/25.

The depreciation figures included in Table D are currently based on the baseline DEL depreciation allocation and anticipated allocations for AME Donated Assets and IFRS16 lease depreciation requirements for existing leases. The Health Board needs to work through the forecast indexation and approved 2024/25 capital programme impacts to provide the anticipated baseline shortfall / strategic support required. The overall requirement will be calculated and reported in the Month 2 monitoring return and June Non-Cash return.

AME Impairment estimates have not yet been included. The reversals of impairment funding required is dependent on the effect of indexation. Both will be confirmed in the Month 2 monitoring return and June non-cash return. The anticipated allocations included at Month 1 are detailed in the table below:

	<b>Reported to WG</b>
<b>Allocations</b>	<b>£000</b>
DEL - Baseline Depreciation Shortfall	TBC
DEL Strategic depreciation Support	TBC
DEL Accelerated Depreciation	TBC
DEL IFRS16 Leases Depreciation	3,690
DEL Impairment Funding	TBC
<b>Total DEL Funding</b>	<b>3,690</b>
AME Donated Asset Depreciation	326
AME Impairment Funding	TBC
AME Reversals of Impairment Funding	TBC
AME IFRS16 Leases Depreciation	109
<b>Total AME Funding</b>	<b>435</b>
<b>Donated &amp; Granted Assets Credit</b>	<b>TBC</b>
<b>Total Allocations (excluding DEL Baseline)</b>	<b>4,125</b>

Section F describes the 2024/25 energy costs forecast, the breakdown of the full year energy cost forecast is as follows:-

- Shared service contract element - £18.961m
- Other gas and electricity costs - £0.447m
- Total forecast energy costs in section F - £19.408m

It should be noted that this forecast does not include energy management related contracts, water, sewage, staffing and other fuel costs which are part of the utilities directorate within the Health Board.

#### **Table B2 – Pay & Agency (Section A)**

This table has been completed in line with the guidance.

#### **Table B3 – Covid-19**

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 profile is reflective of the Health Protection 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
- Covid Public Inquiry

## **2. Underlying Position (Tables A1)**

The Underlying (U/L) position is a brought forward value of £81.4m with a carry forward deficit into 2025/26 of £51.9m reflective of the annual plan submission.

## **3. Risk Management (Table A2)**

There are significant challenges to the financial forecast for 2024/25, which include:

- Ensuring full delivery of the savings plans identified in the annual plan including the pipeline opportunity values,
- Identifying savings to mitigate any further financial pressures identified outside of the annual plan,
- Receipt of all anticipated allocations,
- Workforce absence / vacancies, availability of staff for priority areas,
- Delayed transfers of care due to LA service challenges,
- Funding for any wage award or change in terms and conditions,
- Prescribing growth in items and average cost per item,
- Further CHC fee uplifts above forecast levels,
- Impact of any further strike action,
- Impact on service delivery and performance on waiting times because of savings required.
- Long Term agreements sign off, possible arbitration on financial quantum and how the 3.67% pass through should be used,
- Establishment increases relating to patient safety issues,
- Covid legacy costs to adhere to specific guidelines, e.g. enhanced cleaning costs, additional leases and security,
- Inflationary impacts including provisions and supplies,
- Impact of any further strike action,
- Additional revenue costs due to IFRS 16,
- Specific economic factors such as supply chain issues and non-pay inflation including travel expense costs,
- H&S fines,
- VAT rebate opportunities
- Re-review of previously 'discounted' and other savings ideas, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.

#### **4. Ring Fenced Allocations (Tables N, O & P)**

This table is not required for month 1.

Tables N (GMS) and O (Dental) will be completed from month 6.

#### **5. Agency / Locum (Premium) Expenditure (Tables B2 Sections B & C)**

Variable and agency expenditure continues at the high level of previous months, albeit reduced compared to March.

Variable and agency expenditure across nursing and additional clinical services is predominantly to cover vacancies as well as enhanced care. Medical agency expenditure has remained high due to on-going elective activity, vacancies and service pressures. The impact of managed practices converting to independent contractors have resulted in some reduction in variable pay in-month.

#### **6. Savings (inc Accountancy Gains & Income Generation) (Tables C, C1, C2 & C3)**

As part of the annual plan submitted by the Board to Welsh Government (March 2024), the financial plan for 2024/25 identified 2 elements to the savings plans for 2024/25:-

- Divisional plans alongside Corporate schemes and targets - £29.1m
- Pipeline opportunities - £11.4m

The Divisional plans of £29.1m are progressing with savings forecast for this section reported as delivering £29.1m with some re-profiling.

The pipeline opportunities of £11.4m are currently assumed to be delivered from October. There will inevitably be some risk to this plan and further mitigating actions are being reviewed.

The month 1 delivery of savings plans is £1.221m. Planned savings for month 1 in the annual plan were £2.2m these had been profiled on a straight-line basis, these have now been re-profiled.

The UHB continue to operate a Value & Sustainability Board to identify and monitor savings delivery & new opportunities.

#### **7. Income Assumptions 2023/24 (Tables D, E & E1)**

##### **Table D – Welsh NHS Assumptions**

This table has been completed in line with the guidance.

## **Table E - Revenue Resource Limit**

This table has been completed in line with the guidance. The Month 01 financial position is based on total allocations of £1,704.4m, of which £1,636.6m are received and £67.8m are anticipated.

Allocations are anticipated on receipt of a notification from WG, including Policy Leads and finance colleagues. A list of anticipated allocations is included in Table E.

The Capital MMR table shows the outturn capital charges position for the Health Board. The position confirms the DEL and AME outturn positions which includes the allocation adjustments agreed with WG colleagues. All figures are subject to change.

Further allocations will be anticipated for areas such as CHC Real living wage 2024/25, outpatient transformation and Mental Capacity Act costs once WG correspondence has been agreed.

## **8. Healthcare Agreements and Major Contracts**

ABUHB is commissioning services based on patient need and forecast activity, recognising the 3.67% funding uplift will be applied for agreements to recognise cost inflation and service developments. ABUHB is currently finalising LTA agreements with most provider and commissioner organisations. Velindre NHS Trust and CTMUHB agreements will require greater focus to finalise.

## **9. Statement of Financial Position and Aged Welsh NHS Debtors (Tables F & M)**

### **Table F – Statement of Financial Position**

This table is not required for month 1.

### **Table M - AGED WELSH NHS DEBTORS**

At the end of April 2024, the Health Board had 10 invoices outstanding with other Welsh Health Bodies totalling £248,445.

Cwm Taf Morgannwg University Health Board – 3 invoices outstanding totalling £15,617. The invoices were agreed as part of the month 12 agreement of balances process. We have requested a confirmed payment date regarding these outstanding invoices.

Powys Teaching Local Health Board – 6 invoices outstanding totalling £210,646. One invoice for £71,253 has since been paid. Out of the remaining 5 invoices 2 are in excess of 17 weeks. All 5 outstanding invoices were agreed as part of the month 12 agreement of balances process. We have not been made aware of any issues with these invoices. The HB has requested urgent payment of all 5 outstanding invoices.

Velindre NHS Trust – 1 invoice totalling £22,182. This invoice was agreed as part of the month 12 agreement of balances process. We have requested confirmed payment date regarding this outstanding invoice.

#### **10. Cash Flow Forecast (Table G)**

This table is not required for month 1.

#### **11. Public Sector Payment Compliance (Table H)**

This table is not required for month 1.

#### **12. Capital Schemes & Other Developments (Tables I, J & K)**

Table I has been completed in line with the latest CRL issued on 2nd May 2024.

The approved Capital Resource Limit (CRL) as at Month 1 totalled £53.551m. A forecast over spend of £1.340m against All-Wales Capital Programme (AWCP) schemes (detailed further below) is being offset by a corresponding under spend against the Discretionary Capital Programme (DCP). The forecast year-end outturn at Month 1 is breakeven.

#### **AWCP Schemes**

##### **Newport East HWBC**

Works on Newport East H&WBC continue with scheme completion expected to be April 2025. The overall project budget remains under pressure due to additional asbestos and utility costs. There is a forecast overspend of £0.406m on the project overall which will impact on the 2024/25 DCP unless mitigated by additional funding and / or value engineering savings.

##### **NHH Satellite Radiotherapy Centre (including RAAC works)**

Works at NHH Satellite Radiotherapy Centre are progressing well with planned completion currently forecast to be 30th January 2025. The overall scheme is currently forecast to be £0.523m under budget largely as a result of additional VAT recovery savings. The impact on the 2024/25 allocation will be worked through in May and reported at Month 2.

##### **EFAB – National Programmes: Infrastructure / Fire / Decarbonisation**

A number of the larger EFAB schemes that commenced in 2023/24 continue into 2024/25 including Glan Usk roof replacement, St Cadoc's Hospital Ducts safety upgrades, and the Fire alarm replacements at RGH and St Cadoc's. All schemes are due to complete during 2024/25.

### **CAMHS – Sanctuary Hub (Plaid agreement and HCF Funding)**

Works are on-going on the CAMHS Sanctuary Hub scheme with scheme completion currently anticipated to be August 2025.

### **Grange University Hospital – VAT Reclaim**

The final VAT recovery claim for the main scheme was submitted to HMRC in September 2023. The Health Board is currently responding to Information requests from HMRC and anticipate the final claim will be agreed in 2024/25.

### **GUH Emergency Department Extension**

The GUH Emergency Department extension scheme is underway with completion of the extension currently estimated to be January 2025. The scheme is forecast to be in line with budget.

### **Ty Gwent**

The building lease was signed in early March following WG approval. The initial set up works and IT infrastructure requirements are being progressed with full spend expected to be achieved this financial year.

### **RGH Blocks 1 & 2 Demolition and Car Park**

A forecast over spend of £0.110m is being reported against the RGH Blocks 1 & 2 Demolitions and Car Park scheme as a result of additional asbestos and delays due to nesting birds. This overspend is being funded via the DCP. Plans for the new car park are expected in the next month. The programme will be confirmed once these plans have been received and agreed.

### **YYF Unified Breast Unit**

The final account is being agreed for the new Unified Breast Unit at YYF. Once agreed, the final VAT recovery claim can be made to HMRC. The allocation of £0.111m confirmed for 2024/25 is being used to support additional equipment / IT requirements for the unit.

### **RGH Endoscopy**

RGH Endoscopy unit was opened on the 6<sup>th</sup> November. The small carry forward into 2024/25 relates to an outstanding IT cost which is expected to be spent in quarter one.

### **DPIF – Digital Year End Funding – January 2024**

The slippage amount of £20k is expected to be spent in quarter one of 2024/25.

### **ICF – Pontllanfraith Feasibility**

This scheme is now complete. The funding remaining will need to be repaid via the RPB process.

### **Emergency Department Improvements – 2023/24**

The slippage amount of £55k is expected to be spent in quarter one of 2024/25.

### **Housing with Care Fund**

The slippage amounts totalling £21k are expected to be spent in quarter one of 2024/25.

#### **DPIF – Digital Year End Funding – February 2024**

The slippage amount of £53k is expected to be spent in quarter one of 2024/25.

#### **Diagnostic Equipment**

The slippage amount of £35k is expected to be spent in quarter one of 2024/25.

#### **Year End funding – January 2024**

The slippage amount of £49k is expected to be spent in quarter one of 2024/25.

#### **IRCF - Monmouth Health and Wellbeing Centre and Dixton Surgery**

The external team has been appointed for this project and work is commencing. A cashflow profile is awaited to confirm the 2024/25 spend profile.

#### **IRCF - Aber Valley Health and Wellbeing Centre and Aber Practice Development**

The external team has been appointed for this project and work is commencing. A cashflow profile is awaited to confirm the 2024/25 spend profile.

#### **Tredegar HWBC**

Phase 2 of Bevan Health and Well-being Centre (demolition of the existing Health Centre and car-parking) is continuing and is anticipated to complete in October 2024. The scheme is forecasting an overspend of £0.822m in 2024/25 which is being offset by the DCP. Discussions continue with the contractor in relation to the resolution of a number of disputed compensation events. An additional funding bid to WG is also planned to be made in 2024/25 for unfunded costs in relation to inflation allowances on works and fees, EV charging and other required changes. These currently total circa £1.2m plus VAT.

#### **Discretionary Capital Programme**

The Health Board Discretionary Capital Programme (DCP) funding available for 2024/25 is £8.770m 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

The opening DCP for 2023/24 was approved at the January 2024 Board meeting. The current forecast spend for approved DCP schemes is £7.430m. This equates to an under spend of £1.340m that is required to offset the overspends on AWCP schemes. The DCP contingency remaining as at Month 1 is £0.735m.

## **Other Issues**

### Risk Management

Claims submitted to the Welsh Risk Pool at the end of April 2024 total £3.679m. No significant claims have been reimbursed up to the end of April 2024 leaving a total £3.679m to be reimbursed.

The total payments made by the HB equate to £28,978m of which we have submitted reimbursement claims for £3.679m leaving a balance of £25.299m relating to claims not yet reimbursed.

### CREDITORS

Attached to the returns is a separate file containing the following information in relation to outstanding creditors: -

- All outstanding creditors we currently have identified with other Welsh Health bodies as at 10<sup>th</sup> May 2024.
- Response to the month 12 list of creditors circulated as part of the monthly reply letter.

## **13. Authorisation**

Financial Performance is reported consistently in Board papers and external reporting including the MMR, however, internally these are presented in a more user-friendly way. The MMR Narrative and key tables are submitted for review to Finance and Performance Committee, as a sub-committee of the Board.

The dates for future Board meetings are as follows:-

- Wednesday 22<sup>nd</sup> May 2024
- Wednesday 17<sup>th</sup> July 2024
- Wednesday 25<sup>th</sup> September 2024

The dates for future Finance and Performance Committee meetings are as follows:-

- Monday 17<sup>th</sup> June 2024
- Monday 9<sup>th</sup> September 2024
- Monday 16<sup>th</sup> December 2024
- Monday 17<sup>th</sup> February 2025

In accordance with the MMR guidance, the Health Board will endeavour to ensure that the MMR submission is agreed, and the narrative signed by two parties, by the Chief

Executive and the Director of Finance. Where timescales and availability prevent this the Deputy Chief Executive will sign on behalf of the Chief Executive and the Deputy / Assistant Director of Finance (Financial Planning) will sign on behalf of the Director of Finance.



**Robert Holcombe**  
Director of Finance, Procurement and Value  
Cyfarwyddwr cyllid a chaffael



**Nicola Prygodzic**  
Chief Executive Officer  
Prif Weithredwr

Submitted with this report are:

- Monthly Monitoring return Tables
- All outstanding creditors we currently have identified with other Welsh Health bodies as of 10<sup>th</sup> May 2024, and the
- Response to the month 12 list of creditors circulated as part of the monthly reply letter.

## Appendix 1

### Aneurin Bevan Health Board

#### Monthly Monitoring Returns – Current Period Action Points 2024/25

Month	Action Point	How responded to
2023/24 Month 12	No action-points	



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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	<b>Integrated Medium Term Plan (IMTP) 2023/26 Quarter 4 Progress Report</b>
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Hannah Evans (Director of Strategy, Planning and Partnerships)
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Marie-Claire Griffiths (Head of Strategic Planning) Jennifer Keyte (Senior Corporate Planning & Service Improvement Manager)

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

Sefyllfa / Situation

The purpose of this paper is to provide the Board with a progress report against the Aneurin Bevan University Health Board’s Integrated Medium-Term Plan (IMTP) 2023/26. This report summarises the Health Board’s progress during Quarter 4, through the lens of the following chapters:

- Outcomes Framework through Life Course approach
- Priority Programme and Ministerial priorities progress
- A review of the planning scenario

A complementary Performance report has been developed to provide assurances to committee and Board in the intervening months between full outcome reports.

The Board is asked to:

- Note the progressed achieved during Quarter 4

Cefndir / Background

The IMTP for 2022/2026 sets out the vision for the organisation, that is to improve population health and reduce health inequalities experienced by our communities. In order to achieve this vision, the IMTP focusses on 5 life course priorities.

## **Outcomes and Performance Framework**

Aligned to the five life course priorities the Health Board has developed a set of supporting outcomes and associated indicators that helped focus understanding of how well they were doing in these areas. Indicators have been included that cover the full spectrum of what the organisation understand the health system to be, and what can be realistically measured at the moment.

The aim is to provide information and measurement at a system and population level to support the understanding of progress against the IMTP. Alongside this, the report provides a high-level overview of activity and performance at the Quarter 4 of 2023/4, with a focus on delivery against key national targets included within the performance dashboard. This section of the report also includes improvement actions against those indicators where there has been deterioration.

## **Progress on Priorities: Ministerial Priorities and Clinical Futures Programmes**

Through the templates underpinning the IMTP in 2023/24, the health board made a number of commitments in response to the Minister's priorities for delivery. Progress in delivering against these commitments is set out in this chapter. Additionally, the IMTP set out key priority programmes, which, based on the understanding of the system, will deliver the biggest impact and improve the sustainability of the health and care system. By their very nature, these key strategic priorities are complex, system wide and the programmes of work are designing to implement these changes during the course of the IMTP. This report provides an update against the key milestones and progress made against each of the key programme areas, aligned to the relevant ministerial priority.

## **IMTP Planning Scenario**

The report provides an update against the dynamic modelling and forecasting that was included in the IMTP, what was planned, what took place and forward projections.

This information has supported refreshed profiles included in the updated Minimum Data Set for Quarter 4, this is required to be submitted to Welsh Government as part of the IMTP process.

## **Asesiad / Assessment**

In Quarter 4 there has been mixed performance in line with the forecasted activity levels, with increases in activity coupled with increasing demand preventing progress in some areas. Our planning assumptions, in aggregate form, largely followed as predicted by the services as set out in the IMTP and they are in line with expected delivery.

## **Outcomes and Performance Framework**

- Of the 41 indicators included in the Outcomes Framework, 21 have newly available data to be reported upon during this quarter. 14 of the 21 measures have either improved or are statistically similar and 7 indicators have deteriorated since the last reporting period.
- Outcome measures for 'Every child has the best start in life' demonstrates all indicators sustaining performance levels. Getting it right for children and

young adults have two measures that have improved included achieving 100% compliance with Child and Adolescent mental health choice referrals.

- There is mixed progress across the adult life course outcomes with 4 indicators having deteriorated across three areas. 2 of these are within the 'maximising an individual's time' outcomes, 1 in the 'adults living healthily and aging well' outcome measure and 1 in maximising cancer outcomes.
- For Older People two outcomes are similar and two have deteriorated. The two deteriorating indicators are reduction in number of emergency admissions over 65 years of age and increase in accepted referrals to Rapid Response Services. Across the Dying well as part of life priority area mixed progress with deteriorated performance in inpatient mortality rate, improved performance for increase in referrals to Palliative Care services and similar performance for proportion of Palliative Care referrals assessed within two days.
- Under each life course section, clarity is provided on improvement actions initiated to recover performance where required.

### **Progress on Priorities: Ministerial Priorities and Clinical Futures Programmes**

- Variable progress continues to be made across the Ministerial priorities and priority programmes with some notable achievements that deliver system change as well as some service areas with persistent challenges. The current financial context has limited progression of service developments in some areas.
- There continues to be high demand on services. Within Primary Care, there has been an increase in NHS Dental Care and Community Dental services units of activity and new patients. Additionally, the number of new patients accessing NHS Optometry services has increased. Both areas are exceeding forecasted levels Quarter 4.
- Cancer demand continues to increase, despite prioritisation of capacity, performance against the forecast in reduction in backlog of cancer patients waiting over 62 days and percentage of patients starting definitive cancer treatment within 62 days from point of suspicion has not been achieved.
- The Health Board is ahead of trajectory in eliminating waits of over 156 weeks for treatment, with 10 patients waiting at the end of March 2024 compared to the March 2023 position of 553.
- Improvements have been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,430 at the end of March 2024. Despite this reduction, the Health Board remains off track to meet the Quarter 4 104-week treatment trajectories by 1,184.
- An area of concern remains the growth in the total waiting list, largely driven by the outpatient (stage 1) component. At the end of March 2024, there were 2,169 patients waiting over 104 weeks for a first outpatient appointment. There is mixed progress across specialities with ENT, Orthopaedics and Ophthalmology currently behind trajectory.
- Challenges remain in timely provision of mental health interventions. The provision of assessment by mental health service within 28 days from referral is currently 17.1% (Feb 24) and interventions less than 28 days from assessment which is currently 7.3%. Both of these areas are significantly below target and a 90-day action plan to improve performance is in place and being monitored by Executive Committee.
- The performance of our Urgent & Emergency Care system remains a priority due to its fragility. The number and rate of patients waiting over 60 minutes to be transferred to the Emergency Department from an Ambulance increased

during the winter period and peaked in January 2024 (1,537 – 44.7%). However, this has since reduced significantly during March 2024 (1,107 – 36.7%) to the lowest levels seen over the last two financial years. Whilst this remains high, as a result of poor flow through the system, there has been a concerted effort to decrease the number of delayed ambulance handovers.

### **IMTP Planning Scenario**

The planning scenario has, in aggregate form, largely followed as predicted by the services and is in line with the pressures on the availability of capacity due to delayed discharges and length of stay. Outpatient and inpatient treatments were ahead of projections, reflecting the priority that services are placing on addressing the longest waiting patients and managing demand.

The Health Board continues to make progress reducing the number of the longest waiting patients for planned care treatments. With the rate of referrals and current focus on treat in turn, there is a risk of greater waiting list growth due to the profile and will mean the Year 2 position may become more challenging without changes in activity. The Quarter 4 forecasts were in line with the actual activity for ED attendances with a total of 45,620 attendances during the quarter across all sites. The bed plan has continued to follow the overall expected occupancy levels and demand patterns with Medicine Division running at 99% occupancy against their bed plan and the Community Division at 107%.

This Quarter 4 assessment sets out the organisation’s understanding of its system. The plan remains robust and the priority decisions made in the IMTP remain valid areas of focus of the 2024/25 annual plan.

### **Argymhelliad / Recommendation**

The Board is asked to:

- NOTE the position against IMTP 2023/24 commitments as at Quarter 4 and the mitigating and improvement actions in place.

<b>Amcanion: (rhaid cwblhau)</b>	
<b>Objectives: (must be completed)</b>	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate 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  <a href="#">Link to IMTP</a>	Choose an item. Choose an item. This is a Quarterly report against the Integrated Medium-Term Plan and the key organisational

	priorities informed by our detailed understanding of how our system operates.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives <a href="#">Strategic Equality Objectives 2020-24</a>	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

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

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Resource Assessment:</b>	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:
• <b>Workforce</b>	Choose an item.
• <b>Service Activity &amp; Performance</b>	Choose an item.
• <b>Financial</b>	Choose an item.
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<b>No does not meet requirements</b> 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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a>

**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.

## Priority Indicator Summary

### Quarter 4

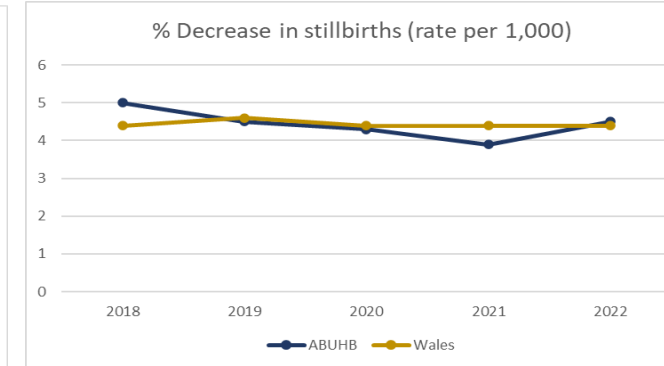
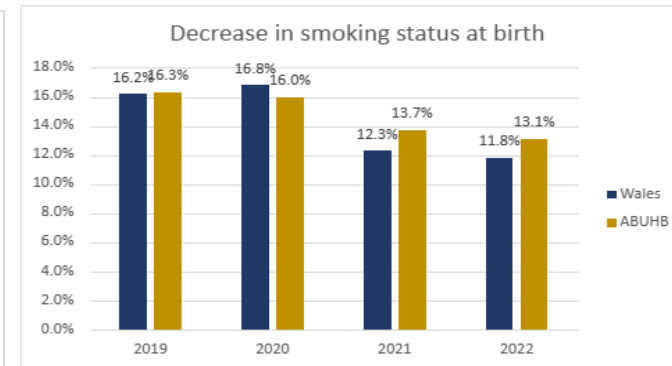
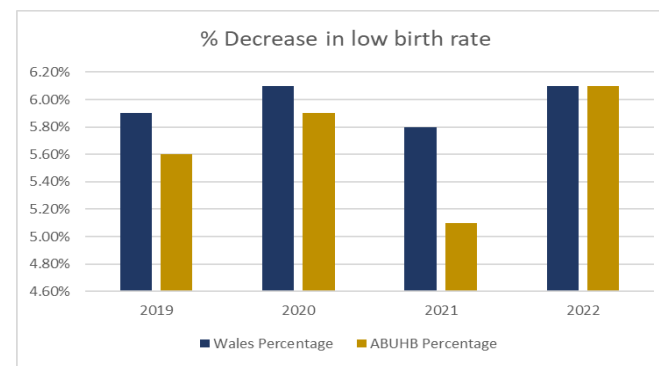
Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. The 'No Data' category is used where the indicator is in development.

Type of change	P1 - Every child has the best start in life	P2 - Getting it right for children and young adults	P3 - Adults living healthily and aging well	P4 - Older adults are supported to live well and independently	P5 - Dying well as part of life	Total
Improved	3	2	7	2	1	<b>15</b>
Similar	3	3	4	2	2	<b>14</b>
Deteriorated	2	0	5	3	2	<b>12</b>
<b>Total indicators</b>	<b>8</b>	<b>5</b>	<b>16</b>	<b>7</b>	<b>5</b>	<b>41</b>

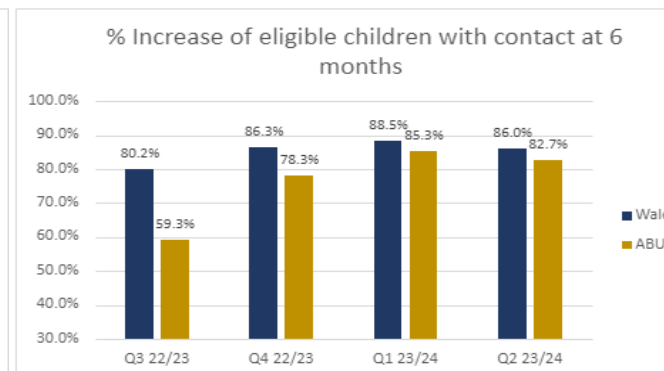
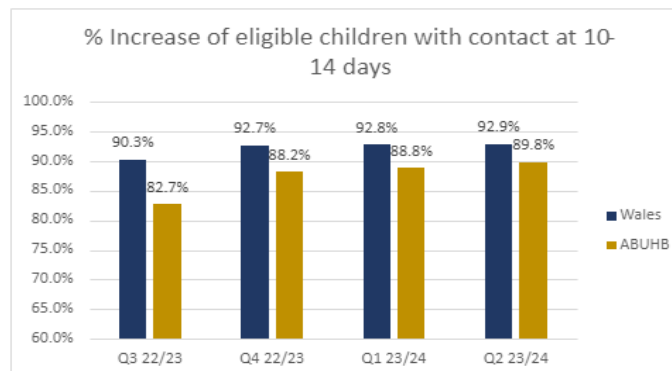
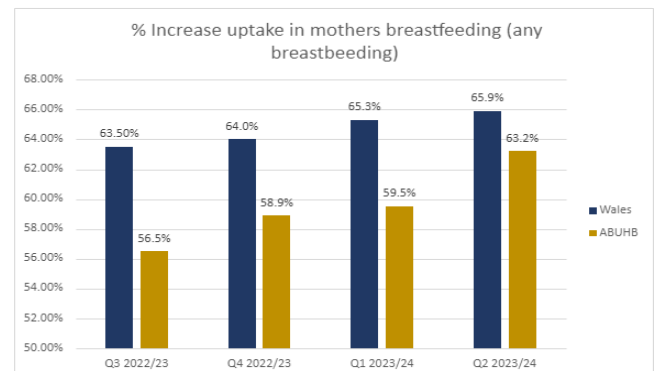
Priority 1 - Every Child has the best start in life

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 1 - Every child has the best start in life	Improving Good Health in Pregnancy	Decrease in low birth weight rates	5.6%	4%			2022	6.1%	Deteriorated	Increase in indicator between 2021 and 2022. In line with the All Wales average. Next update due June 2024 (provisional).
		Decrease in smoking status at birth	16%	10%			2022	13.1%	Improved	Significant decrease between 2021 and 2022, however remains above the all Wales average. Next update due June 2024 (provisional).
		Decrease in stillbirths	4.8	3.0			2022	4.5	Deteriorated	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	59.2%	65%			Q2 2023/24	63.2%	Improved	Indicator value has improved by 7.3% between Q4 22/23 and Q2 23/24.
		Increase of eligible children with contact at 10-14 days	88.2%	95%			Q2 2023/24	89.8%	Similar	Improvement in indicator between Q4 22/23 and Q2 23/24 by 1.8%
		Increase of eligible children with contact at 6 months	78.3%	95%			Q2 2023/24	82.7%	Improved	Significant improvement in indicator between Q4 22/23 and Q2 23/24 by 5.6%
	Increasing childhood immunisation and preventing outbreaks	Percentage of children who received 2 doses of the MMR vaccine by age 5	91%	95%	Q2 2023/24	89.7%	Q3 2023/24	89.3%	Similar	Indicator value has remained stable.
		Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	96%	95%	Q2 2023/24	95%	Q3 2023/24	94.5%	Similar	Indicator value has remained stable.

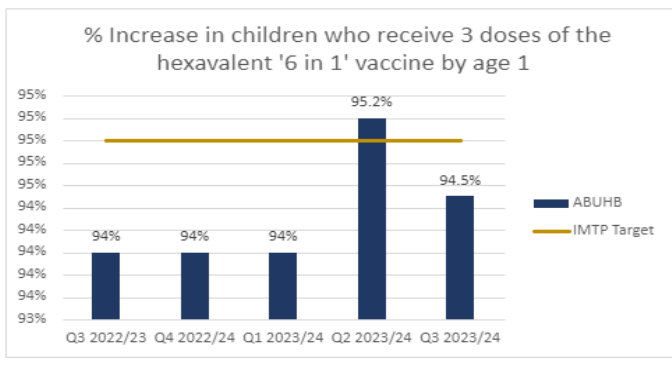
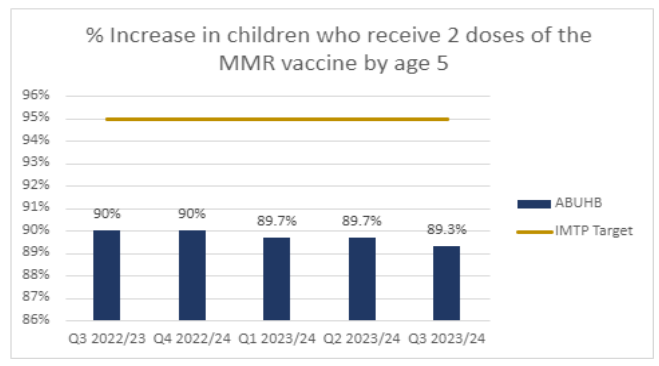
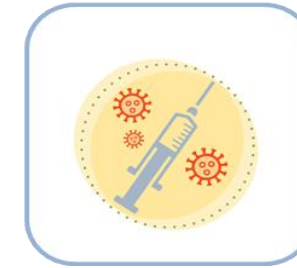
Improving Good Health in Pregnancy



Optimising a child's long term potential



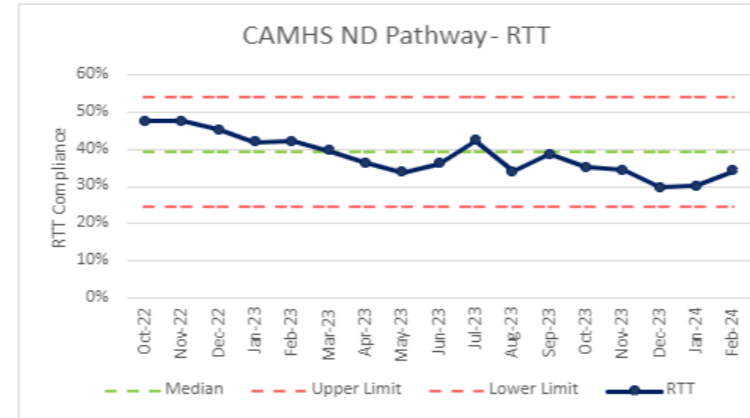
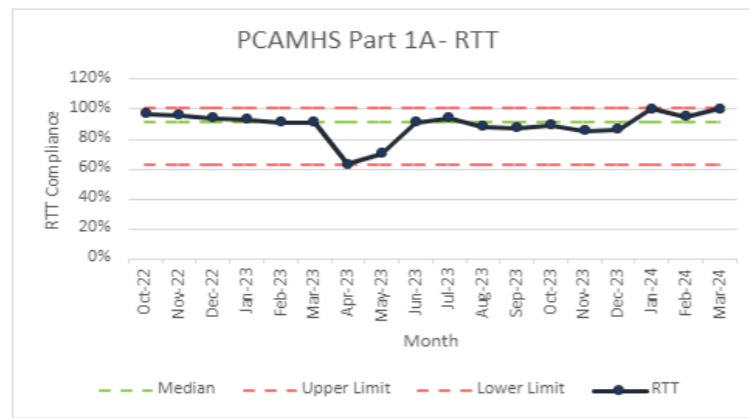
Increasing childhood immunisation



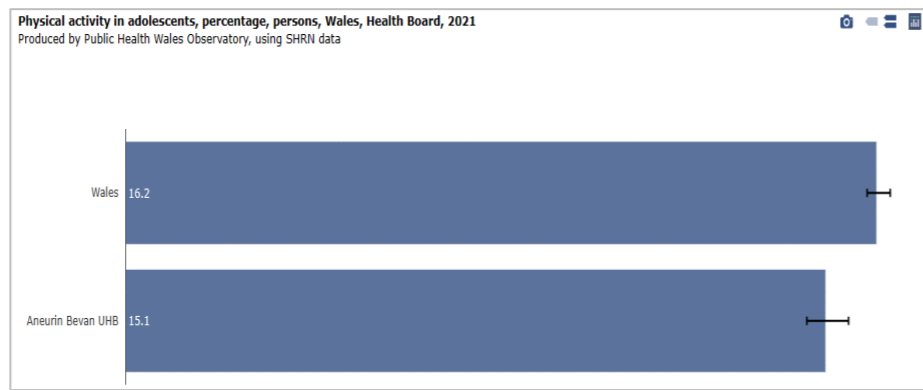
Priority 2 - Getting it right for children and young adults

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 2 - Getting it right for children and young adults	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	95%	80%	Dec-23	86.2%	Mar-24	100.0%	Improved	Indicator has improved significantly since last reporting period. National target of 80% remains achieved at 100% compliance.
		Decrease in neurodevelopmental (SCAN) waiting list	80%	80%	Dec-23	29.9%	Feb-24	34.3%	Improved	Indicator has gradually improved over the last 3 months by 14.7%. However, this remains below the IMTP target.
	Support being a healthy weight	Increase in physical activity (for at least 60 minutes a day) in adolescents	15.1%	20%			2021	15.1%	Similar	Indicator is lower than the welsh average of 16.2%. Please note, trend data is not yet available.
	Improve healthy lifestyle behaviours	Decrease in adolescents using alcohol	40.9%	30%			2021	40.9%	Similar	Indicator is higher than the welsh average of 40.2%. Please note, trend data is not yet available.
		Decrease in adolescents drinking sugary drinks once a day or more	18.5%	10%			2021	18.5%	Similar	Indicator is higher than the all welsh average of 16.4%. Please note, trend data is not yet available.

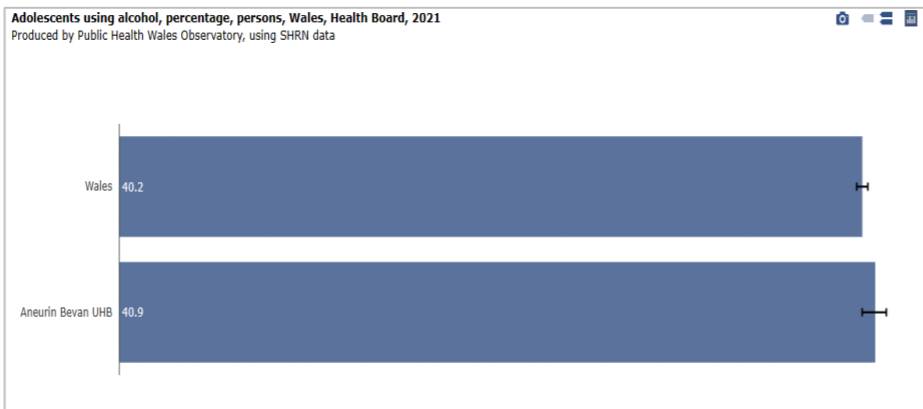
Improve mental health resilience



Support being a healthy weight



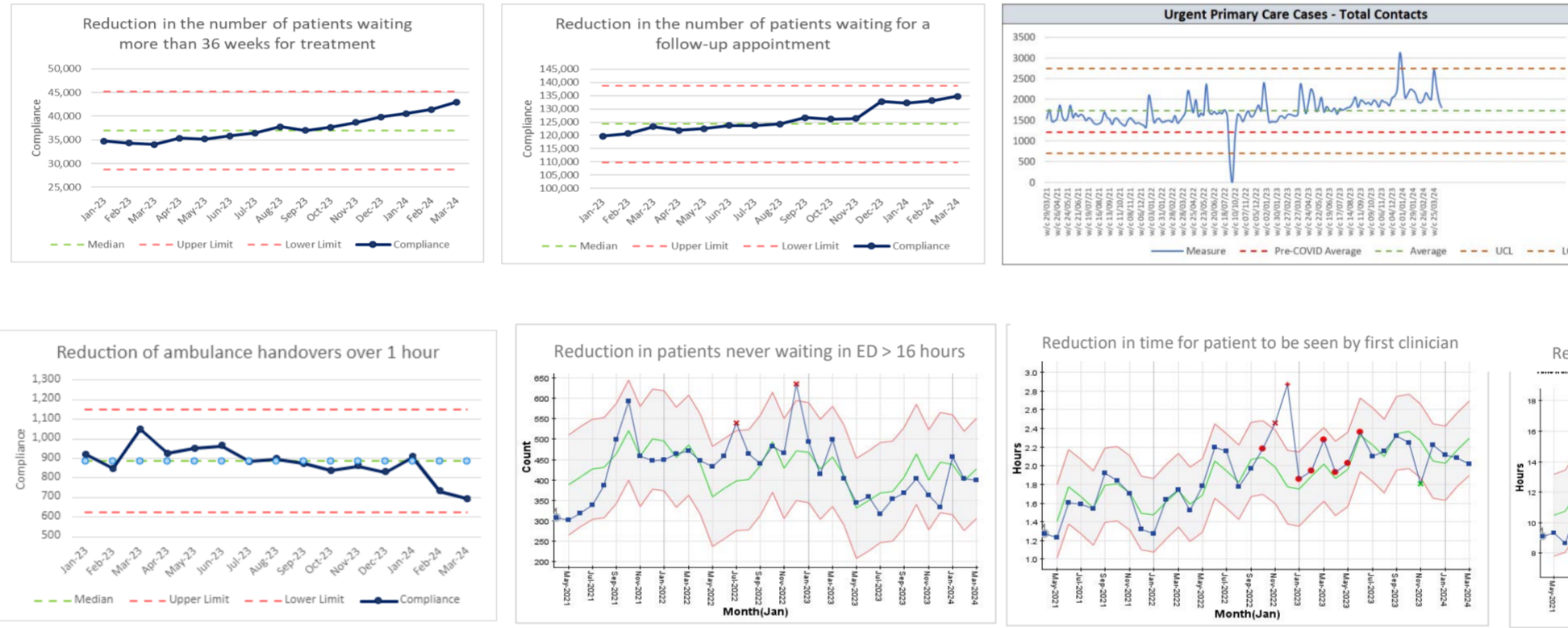
Improve healthy lifestyle behaviours



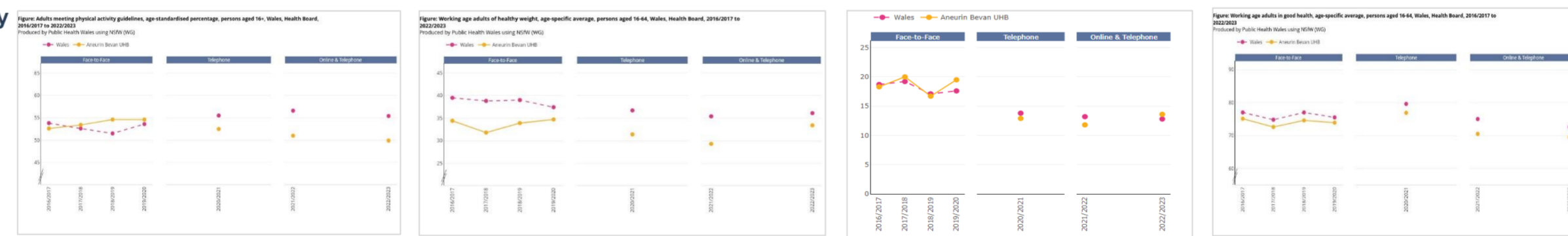
Priority 3 - Adults living healthily and aging well

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings	
					Data Available	Indicator value	Data Available	Indicator value			
Priority 3 - Adults living healthily and aging well	Maximising an individuals time	Reduction in the number of patients waiting more than 36 weeks for treatment	32,202	32,168	Jan-24	40,576	Mar-24	42,980	Deteriorated	Indicator value has increased since Jan 24 and Mar 24 by 5.9%	
		Reduction in the number of patients waiting for a follow-up outpatient appointment	113,107	69,268	Jan-24	132,230	Mar-24	134,784	Deteriorated	Indicator value has increased by 1.9% between Jan 24 and Mar 24.	
		Increase in Urgent Primary Care Contacts	5,336	8,000	Dec-23	9,469	Mar-24	9,916	Improved	Increase in the number of UPCC contacts between Dec 23 and Mar 24 by 447.	
		Reduction of ambulance handovers over 1 hour	737	0	Jan-24	906	Mar-24	691	Improved	Overall improving trend over the last 12 months.	
		Reduction in patients never waiting in ED over 16 hours	417	0	Jan-24	457	Mar-24	399	Improved	Decrease in indicator value between Jan 24 and Mar 24.	
		Reduction in time for patients to be seen by first clinician	1.6 hours	2 hours	Jan-24	2.1 hours	Mar-24	2.0 hours	Improved	Improvement from 2.1 hours in Jan 24 to 2.0 hours in Mar 24. Improving trend has been overseved since Sep 23.	
	Adults living healthily and aging well	Adults living healthily and aging well	Increase in adults meeting physical activity guidelines	53.8%	60%			2022/23	49.9%	Deteriorated	Since Covid-19, there has been a decrease in physical activity from 54.6% (19/20) to 49.9% (22/23).
			Decrease in the % of adults smoking	19%	15%	2021/22	11.8%	2022/23	13.6%	Deteriorated	IMTP target met, however there is an observed increase in the percentage of adults smoking between 21/22 and 22/23 and rates are higher than the national average.
			Increase in working age adults of healthy weight	34.4%	50%			2022/23	33.4%	Improved	For the first time since Covid-19, there has been a 14% increase in the number of working age adults of healthy weight. However, this does remain below the all wales average of 36.1%.
			Increase in working age adults in good or very good health	69%	80%			2022/23	69.5%	Similar	Whilst indicator remains statistically similar, both the ABUHB and All Wales average have seen a decreasing trend in the indicator since Covid-19.
	Improved mental health resilience in adults	Improved mental health resilience in adults	Increase uptake of National Screening Programmes	64.2%	80%			2020/21	70.2%	Improved	Improvements in indicator value observed. Next update scheduled Quarter 4 (provisional).
			Increase in life satisfaction among working age adults	76.4%	55			2022/23	79.2%	Similar	Indicator remains statistically similar during 21/22 and 22/23.
	Maximising cancer outcomes	Maximising cancer outcomes	Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	80%	90%	Dec-23	68.3%	Feb-24	67.7%	Similar	Measure has been sustained at similar level, with a slight decrease, between reporting periods.
			Increase in compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	56.9%	75%	Dec-23	62.9%	Feb-24	56.5%	Deteriorated	Deterioration in indicator value from 62.9% (Dec 23) to 56.5% (Feb 24)
Maximising cancer outcomes	Maximising cancer outcomes	Increase in 5 year cancer survival	49.1%	60%			2016-20	58.6%	Similar	Indicator value is similar, however a slight decrease has of 0.8% has been observed and remains below the welsh averages for the third year. Next update scheduled May 2024 (provisional).	

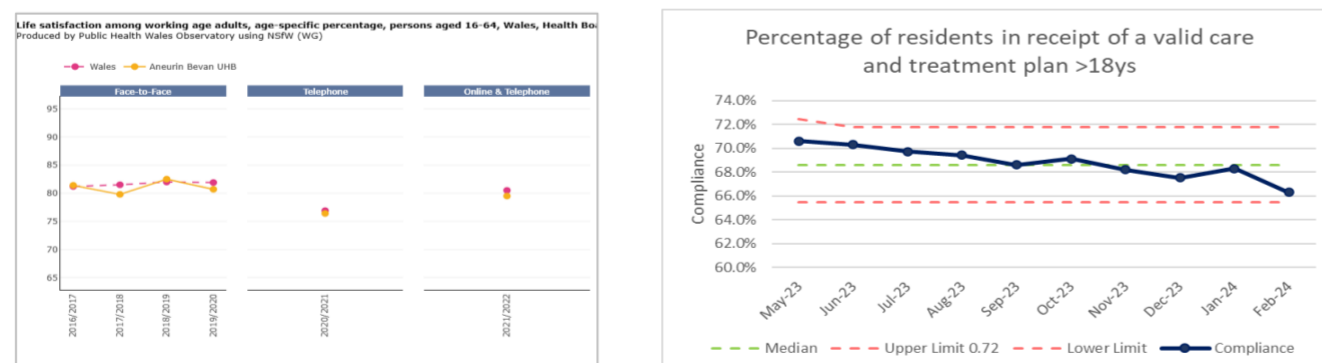
Maximise an individuals time



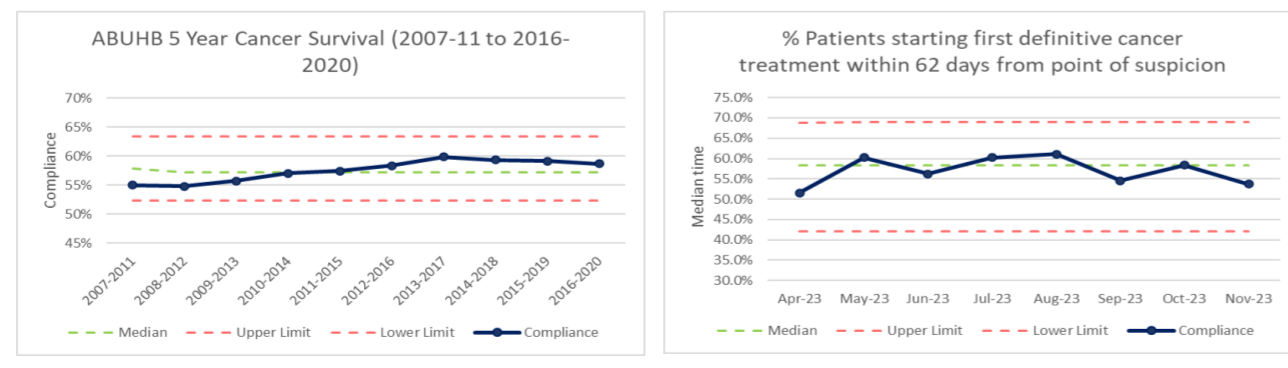
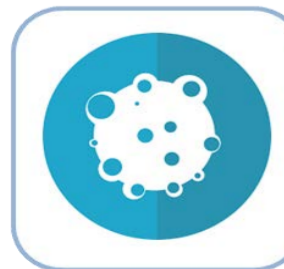
Adults living healthily and aging well



Improve mental health resilience



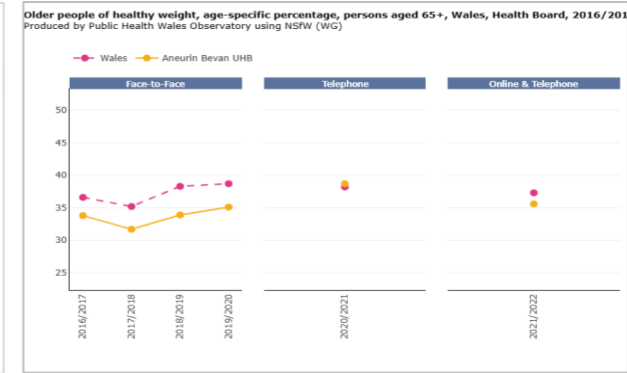
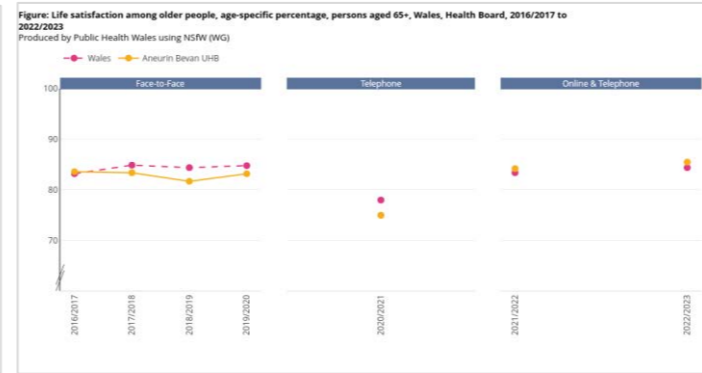
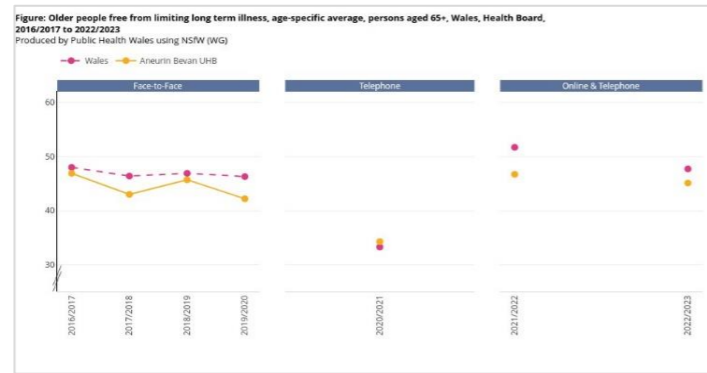
Maximise cancer outcomes



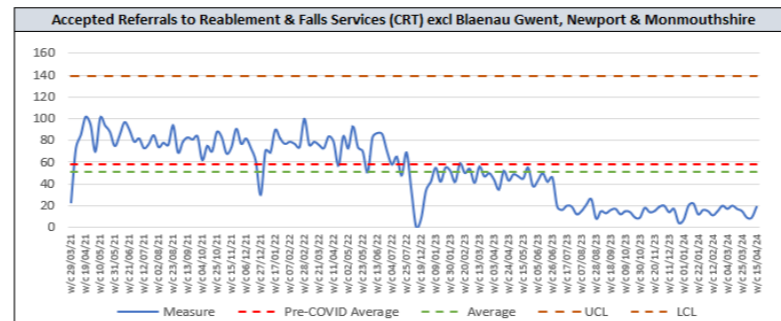
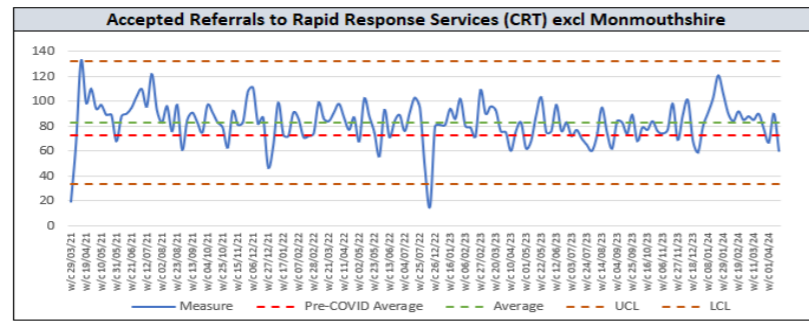
Priority 4 - Older adults are supported to live well and independently

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 4 - Older adults are supported to live well and independently	Prevention and keeping older adults well	Increase in older people free from limiting long term illness	43.3%				2022/23	45.1%	Deteriorated	Deterioration in indicator from 46.7% (2021/22) to 45.1% (2022/23) and remains below the all Wales average of 47.7%
		Increase in life satisfaction among older people	75.0%				2022/23	85.5%	Improved	Increase in indicator over the last 3 financial years and remains above the all wales average of 84.4%
		Increase in older people of healthy weight	38.7%				2022/23	41.2%	Improved	Increase in indicator from 35.6% (21/22) to 41.2% (22/23), surpassing the all wales average of 39.6%.
	Delivering Care Closer to Home	Increase in accepted referrals to Rapid Response Services (CRT)	343	375	Jan-24	392	Mar-24	377	Deteriorated	Deterioration in indicator during Quarter 4 by 3.8%, however IMTP target remains met.
		Increase in accepted referrals to Reablement & Falls Services (CRT)	331	375	Jan-24	71	Mar-24	76	Similar	Sustained levels in the number of accepted referrals between Jan 24 (71) and Mar 24 (76).
	Reducing admissions and time spent in hospital	Reduction in the number of Emergency Admissions >65 years of age	1297	1000	Jan-24	1539	Mar-24	1738	Deteriorated	Significant increase in the number of emergency admissions by 12.9% between Jan 24 and Mar 24.
			Decrease (from 65 - 55%) in LOS over 21 days	65%	55%	Q3 2023/24	55%	Q4 2023/24	55%	Similar

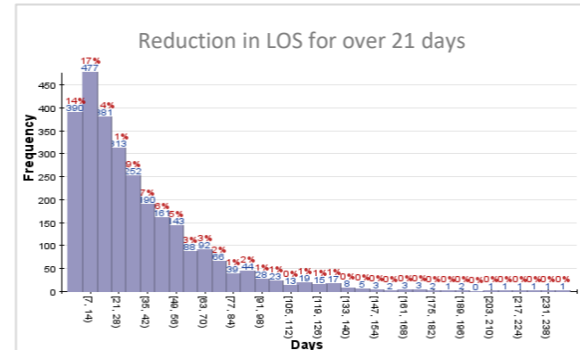
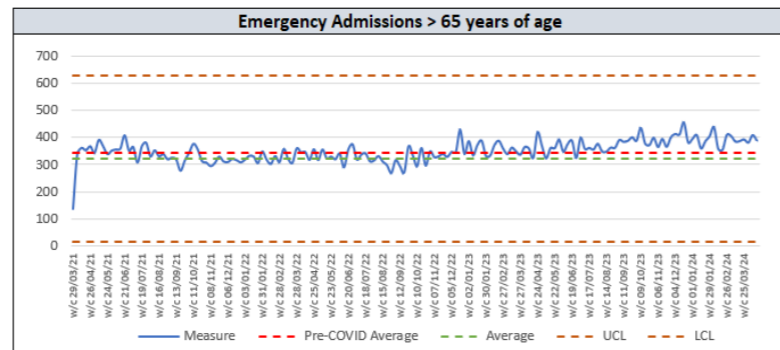
Prevention and keeping older adults well



Delivering care closer to home



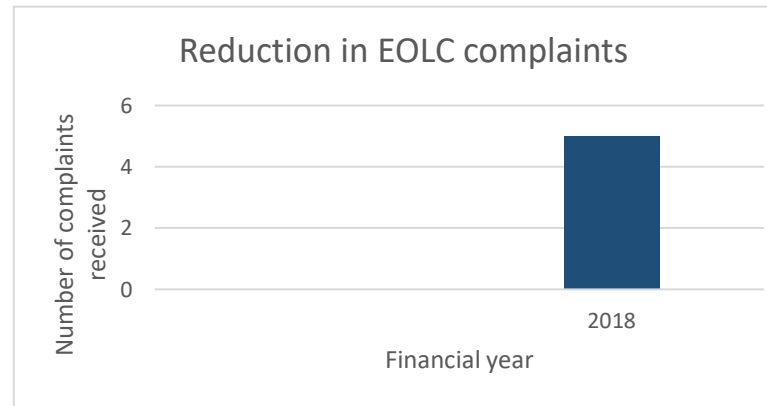
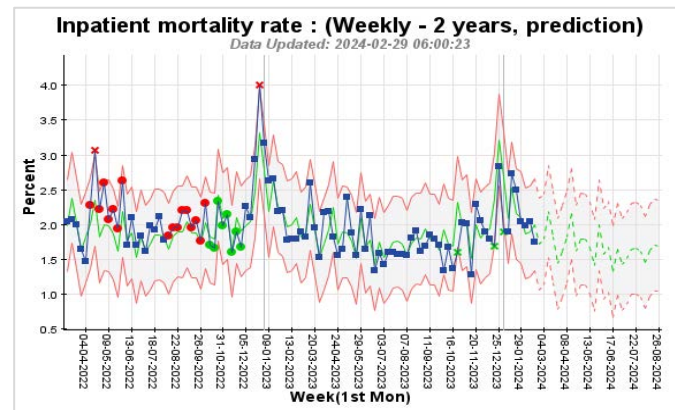
Reducing admissions and time spent in hospital



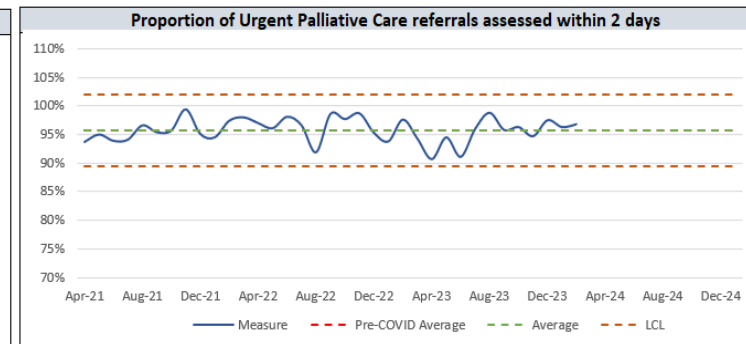
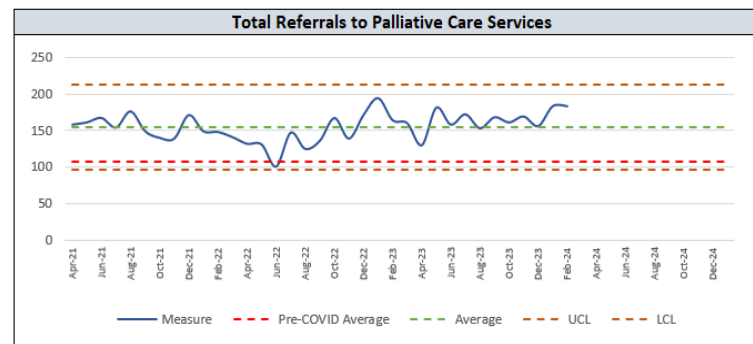
Priority 5 - Dying well as part of life

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 5 - Dying well as part of life	Improve care at end of life	Decrease in inpatient mortality rate	2.0%	1.5%	Q3 2023/24	1.8%	Q4 2023/24	2.1%	Deteriorated	Increase in inpatient mortality rate from 1.8% in Q3 23/24 to 2.1% in Q4 23/24.
		Reduction in compliants	11	0			2022/23	21	Deteriorated	Deterioration in indicator from 11 complaints received during 2021/22 to 21 during 2022/23.
	Improved planning and provision of end of life care	Increase in referrals to Palliative Care Services	141	200.0%	Dec-23	156	Feb-24	183	Improved	Indicator has increased significantly by 17% between reporting periods.
		Increase in propotion of Urgent Palliative Care referrals assessed within 2 days	91%	95%	Dec-23	97%	Feb-24	97%	Similar	Despite significant increase in referrals, the propotion of Urgent Palliative Care referrals assessed within 2 days has been sustain and compliance with target remains.
	Minimising avoidable ill health	Reduction in the number of deaths from non communicable diseases	324.8	300			2020-22	329.9	Similar	The rate of deaths from non communicable diseases has remained statistically similar over the reporting period.

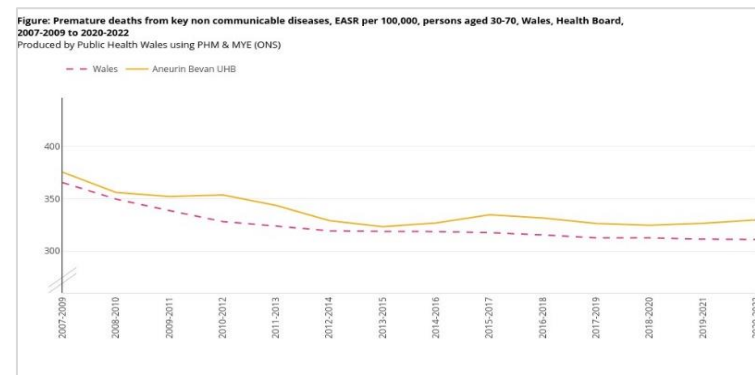
Improved end of life care experience



Improved planning and provision of end of life care



Minimising avoidable ill health



# IMTP 23/26

## Integrated Medium-Term Plan

### Quarter 4

### Outcomes and Performance Report



# 1. INTRODUCTION

This report summarises the Health Board’s progress for Quarter 4 of 2023/24 against the commitments set out in the Integrated Medium-Term Plan (IMTP), bringing together reporting on outcomes, performance, priority programmes, Ministerial Priorities and a review of the underpinning planning scenarios.

Key achievements from Quarter 4 include:

- ✓ Welcoming our first patients into the Breast Care Unit at Ysbyty Ystrad Fawr,
- ✓ Good progress towards eliminating waits of over 156 weeks for treatment, with 10 patients waiting at the end of March 2024 compared to the March 2023 position of 553,
- ✓ Outpatient Did Not Attend (DNA) rate has sustained its performance from January to March at 6.1% (4,682),
- ✓ Child and Adolescent Mental Health Services choice referrals have achieved 100% in March 24 compared to 87.5% December 2023 exceeding the national target,
- ✓ Sustained compliance with national target of 95% of children receiving 3 doses of the hexavalent ‘6 in 1’ vaccine by age 1,
- ✓ Community Pharmacy have achieved 4,866 claims under common ailment scheme during 23/24, compared to 2,962 during 22/23,
- ✓ Opening of new Endoscopy suite at Royal Gwent Hospital at the start of November. The impact of this investment has resulted in the number of people waiting over 8 weeks at the end of March 2024 reducing to 1,368 compared to 1,890 (Nov 23),
- ✓ Same Day Emergency Care: volume sustained during Q4 with weekly average of 138 attendances at GUH and 49 at YF.

Risks across a number of pathways have endured into Quarter 4 with the addition of slightly deteriorated performance against the single cancer pathway measures. Addressing underlying capacity constraints and

sustained urgency profiles across these pathways will result in continued challenges around reducing the numbers of patients waiting:

- Compliance against the 62-day target for definitive cancer treatment has decreased from 62.9% at the end of December 2023, to 60.8% in March 2024,
- Number of patients waiting more than 104 weeks for treatment in planned care, predominantly in the specialities of Orthopaedics (mainly spines), Ear Nose and Throat and Ophthalmology,
- Delivery of Mental Health interventions in a timely way with concerns on the provision of assessment by mental health service within 28 days from referral which is currently at 17.1% (Feb 24) and interventions less than 28 days from assessment which is currently 7.3%,
- The proportion of Child and Adolescents Mental Health waiting on the neurodevelopmental waiting list has increased to 34.3% from 29% but still significantly below national target of 80%.

The actions to improve the position and risk-level have been included in our plans set out later in this document.

## Structure

This report is structured across four sections as follows:

CHAPTER	PAGE
<a href="#">Outcomes Framework and Performance Summary</a> – This section reports against the life cycle priority outcome measures.	3
<a href="#">Progress of Priorities</a> – This section reports on the key milestones and actions against the Ministerial and Clinical Futures priorities as set out in the IMTP	15
<a href="#">IMTP Planning Scenarios</a> - This section reports against the planning scenarios as set out in the Minimum Data Set of the IMTP.	23

## 2. OUTCOMES FRAMEWORK & PERFORMANCE SUMMARY

The vision set out in the IMTP 2023-2026 is to:

Improve population health and reduce the health inequalities experienced by our communities.

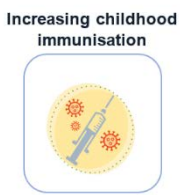
In order to achieve this vision, the IMTP focuses on five life course priorities. The Outcomes Framework is updated quarterly and, depending on data availability, the latest data is reported for each indicator. For the 2023/26 IMTP, the Outcomes Framework was reviewed and aligned, where appropriate, with the newly published [Public Health Outcomes Framework](#). The timescales for indicators vary according to the data source. Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. The 'No Data' category is used where the indicator is in development.

Of the 41 indicators included in the Outcomes Framework, 21 have newly available data to be reported upon during this quarter. 14 of the 21 measures have either improved or are statistically similar and 7 indicators have deteriorated since the last reporting period. The full Outcomes Framework can be found in Appendix 1 and a breakdown of the type of change by priority between Quarter 3 and 4 can be seen in the table below:

Type of change	P1 - Every child has the best start in life	P2 - Getting it right for children and young adults	P3 - Adults living healthily and aging well	P4 - Older adults are supported to live well and independently	P5 - Dying well as part of life	Total
Improved	0	2	5	0	1	<b>8</b>
Similar	2	0	1	2	1	<b>6</b>
Deteriorated	0	0	4	2	1	<b>7</b>
<b>Total indicators</b>	<b>2</b>	<b>2</b>	<b>10</b>	<b>4</b>	<b>3</b>	<b>21</b>

**Priority 1**  
Every child has the best start in life

**Our Outcomes:**



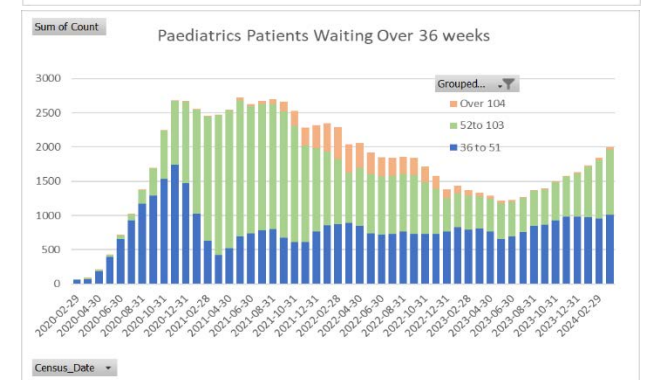
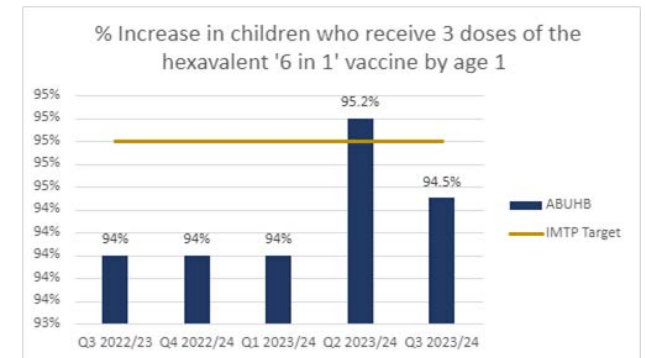
Early childhood experiences, including before birth, are key to ensuring improved health outcomes. The Health Board’s IMTP committed to working with partners to take forward actions and activities that have a positive impact on the first 1,000 days of life. The table below sets out three core outcomes to be achieved in this area. Alongside identified measures, this information is used to target actions and identify priorities for the organisation.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 1 - Every child has the best start in life	Increasing childhood immunisation and preventing outbreaks	Percentage of children who received 2 doses of the MMR vaccine by age 5	91%	95%	Q2 2023/24	89.7%	Q3 2023/24	89.3%	Similar	Indicator value has remained stable.
		Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	96%	95%	Q2 2023/24	95%	Q3 2023/24	94.5%	Similar	Indicator value has remained stable.

The position in the reported indicators in the outcome ‘**Increasing childhood immunisation and preventing outbreaks**’ has remained broadly stable. Uptake of the complete three-dose course of the hexavalent ‘6 in 1’ vaccination by age 1 is reported at just below 95% during Quarter 4, demonstrating strong sustained performance levels and is consistent with national levels. Torfaen and Monmouthshire have the lowest uptake within Gwent with an uptake rate of 90.9%. Blaenau Gwent had the highest uptake rate of 95.1%.

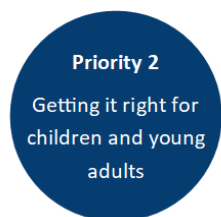
The MMR vaccine protects against three infections – measles, mumps and rubella. The uptake rate in Gwent of the MMR 2 dose vaccine (age 5 years) was below the uptake for Wales between 2019 and 2021. From 2022 the uptake rate in Gwent and Wales have fallen, with Gwent now sharing the same uptake rate of 89.3% as Wales in quarter 4. Newport has the lowest uptake within Gwent, with a rate of 86.7%. Caerphilly had the highest uptake rate of 92.5%.

The number of children on the Health Board’s waiting lists who have been waiting over 36 weeks increased during the pandemic and peaked during the summer of 2021. As of March 2024, there were 495 children waiting over 52 weeks for a new outpatient appointment. There continues to be focused efforts to reduce



paediatric waiting times and consequently, intensive plans have been developed to reduce and maintain the waiting time for first outpatient appointments across all specialities.

Priority 1 Improvement Actions		
Indicator	Improvement Action	Monitoring Arrangement
Children who received who received 2 doses of the MMR vaccine by age 5:	School Health Nurses undertaking robust vaccination plan coupled with dedicated MMR catch up clinics are being delivered using a combination of Vaccination Centre appointments and pop-up clinics in areas of low uptake.	Divisional Assurance meetings
Children who received three doses of the hexavalent '6 in 1' vaccine by age 1:	Referral pathways being embedded to ensure that professionals within Health Visiting are able to directly refer to the Vaccination Service to allow vaccinations or immunisations to be delivered outside the usual route.	Divisional Assurance meetings
Children waiting over 52 weeks for a new outpatient appointment:	<ul style="list-style-type: none"> <li>Service improvement developments including referral triage team and advice letters as an alternative to consultation where appropriate.</li> <li>Continued use of GP triage.</li> </ul>	Divisional Assurance meetings



Our Outcomes:

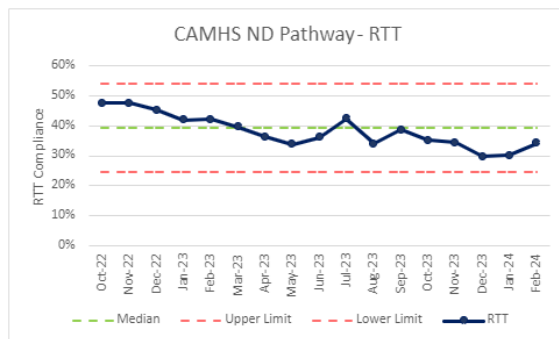
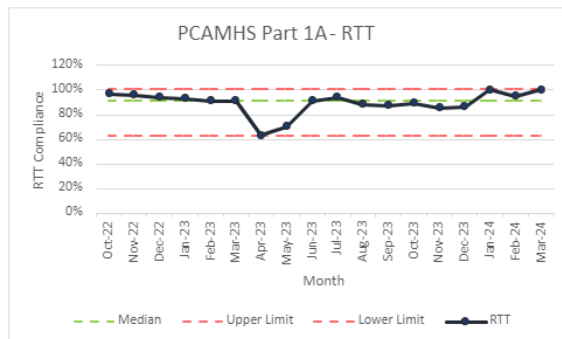


Nurturing future generations is essential for our communities. There is strong evidence that healthy behaviours in childhood impact throughout life; therefore, targeting actions to improve outcomes in these areas has a long-lasting impact on delivery. Young adult mental health is a Ministerial Priority area with CAMHS a focus in the national performance framework.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 2 - Getting it right for children and young adults	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	95%	80%	Dec-23	86.2%	Mar-24	100.0%	Improved	Indicator has improved significantly since last reporting period. National target of 80% remains achieved at 100% compliance.
		Decrease in neurodevelopmental (SCAN) waiting list	80%	80%	Dec-23	29.9%	Feb-24	34.3%	Improved	Indicator has gradually improved over the last 3 months by 14.7%. However, this remains below the IMTP target.

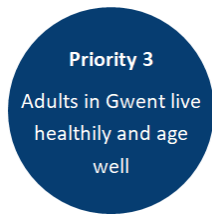
Progress within the 'Improve Mental health Resilience in Children and Young Adults' outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% target of completing ND assessments within 26 weeks. Quarter 4 of 2023/24 has seen a continued demand of referrals requesting consideration of an ND assessment. There are on average 220 new referrals a month which is a 200% increase on the monthly average for 2019/20

and this challenge has resulted in an RTT compliance for the end of February 2023 of 34.3%. A recovery plan was implemented in April 2023 to be able to support the current waiting lists across the 0-18 years pathway by separating the cohorts of 0-5 years and the 5-18 years.



PCAMHS 1a performance against the ministerial target of 80% compliance has remained steady since 2022. As of March 2024, the reported position increased significantly to 100%, surpassing the ministerial target. However Part 1b remains significantly off track at 7.5% compliance (March 2024). Despite workforce constraints, the waiting list is reducing. CAMHS Part 2 RTT has seen increased compliance since April 2023, however there is a slight decrease in the reported March 2024 position at 72.4%.

Priority 2 Improvement Actions		
Indicator	Improvement Action	Monitoring Arrangement
PCAMHS Part 1a and 1b compliance	<ul style="list-style-type: none"> <li>Following additional funding, undertake procurement of private provider to support with 80 Children and Young People currently on the waiting list (1b);</li> <li>Scope of CAMHS workforce take up offer of overtime/ additional hours – Saturday clinics proposed (1b);</li> <li>Continued weekly performance meetings and validation of CHOICE assessment and waiting times demand and capacity;</li> <li>Expressions of interest sought for Clinical CTP Lead for Care and Treatment planning to ensure the quality of CTPs and completion in a timely manner.</li> </ul>	Divisional Assurance meetings / PCAMHS performance meeting
CAMHS Neuro-developmental (ND) Service 80% target of completing ND assessments within 26 weeks	<p>Continued implementation of the CAMHS recovery plan with a particular focus on:</p> <ul style="list-style-type: none"> <li>Workforce plan – including recruitment of assistant psychologists during, Speech and Language Therapists, and additional community Paediatrician sessions to increase capacity;</li> <li>Pan-Gwent pathway to be developed and merged into one multi-disciplinary group including the membership from a community paediatrician, speech and language therapist and psychologist with training and experience in working with ND children and young people. This will provide a single point of access for referrals to the autism team.</li> </ul>	Divisional Assurance meetings



Our Outcomes:

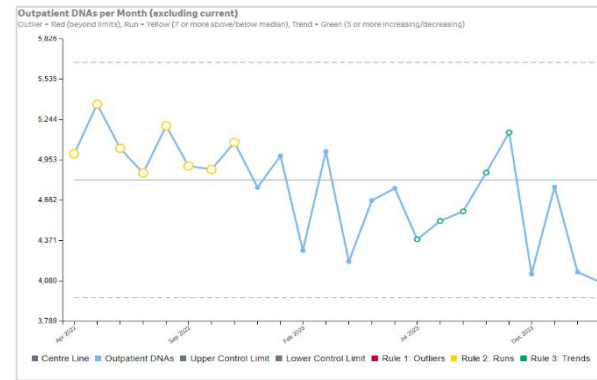
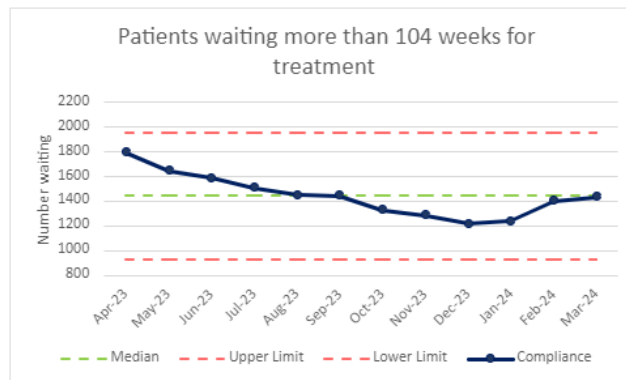
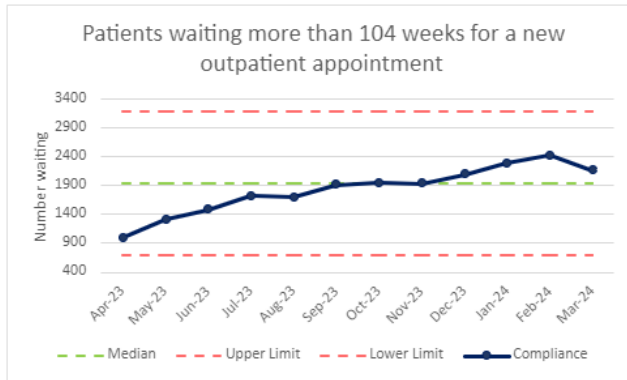


Our ambition is for citizens to enjoy a high quality of life and to be empowered to take responsibility for their own health and care. A significant number of measures fall within this area, particularly in relation to maximising an individual's time. The outcomes and performance set out below underpin the work of the priority programmes and in particular the work of the Six Goals for Urgent and Emergency Care, Planned Care and Mental Health.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings	
					Data Available	Indicator value	Data Available	Indicator value			
Priority 3 - Adults living healthily and aging well	Maximising an individual's time	Reduction in the number of patients waiting more than 36 weeks for treatment	32,202	32,168	Jan-24	40,576	Mar-24	42,980	Deteriorated	Indicator value has increased since Jan 24 and Mar 24 by 5.9%	
		Reduction in the number of patients waiting for a follow-up outpatient appointment	113,107	69,268	Jan-24	132,230	Mar-24	134,784	Deteriorated	Indicator value has increased by 1.9% between Jan 24 and Mar 24.	
		Increase in Urgent Primary Care Contacts	5,336	8,000	Dec-23	9,469	Mar-24	9,916	Improved	Increase in the number of UPCC contacts between Dec 23 and Mar 24 by 447.	
		Reduction of ambulance handovers over 1 hour	737	0	Jan-24	906	Mar-24	691	Improved	Overall improving trend over the last 12 months.	
		Reduction in patients never waiting in ED over 16 hours	417	0	Jan-24	457	Mar-24	399	Improved	Decrease in indicator value between Jan 24 and Mar 24.	
		Reduction in time for patients to be seen by first clinician	1.6 hours	2 hours	Jan-24	2.1 hours	Mar-24	2.0 hours	Improved	Improvement from 2.1 hours in Jan 24 to 2.0 hours in Mar 24. Improving trend has been overseved since Sep 23.	
		Reduction in time for bed allocation from request	11.5 hours	8 hours	Jan-24	13.6 hours	Jan-24	12.3 hours	Improved	Improving trend overseved over the last 12 months.	
		Adults living healthily and aging well	Decrease in the % of adults smoking	19%	15%	2021/22	11.8%	2022/23	13.6%	Deteriorated	IMTP target met, however there is an observed increase in the percentage of adults smoking between 21/22 and 22/23 and rates are higher than the national average.
		Improved mental health resilience in adults	Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	80%	90%	Dec-23	68.3%	Feb-24	67.7%	Similar	Measure has been sustained at similar level, with a slight decrease, between reporting periods.
		Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	56.9%	75%	Dec-23	62.9%	Mar-24	60.8%	Deteriorated	Deterioration in indicator value from 62.9% (Dec 23) to 60.8% (Mar 24)

**Maximising an Individual's Time-Planned Care**

Maximising an individual's time is a core element of planned care. During the Junior Doctor Industrial Action on the 25<sup>th</sup>-29<sup>th</sup> March 2024, a total of 1,361 outpatient appointments and 152 treatments were cancelled and this loss of capacity has had an impact upon performance levels. The Health Board has made good progress towards eliminating waits of over 156 weeks for treatment, with 10 patients waiting at the end of March 2024 compared to the March 2023 position of 553. Improvements have also been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,430 at the end of March 2024. Despite this reduction, the Health Board remains off track to meet the Quarter 4 104-week treatment trajectories by 1,184.



There is a particular challenge within ENT where demand has outstripped capacity, along with reduced outpatient capacity. A 'GP gatekeeper model' has been introduced and is being piloted to review demand with the purpose of managing demand in the most appropriate way, and early indicators show that the additions to the waiting list have reduced. Ophthalmology have launched a new technician diagnostic hub to address the backlog of Glaucoma patients on the follow-up waiting list, with a particular focus on those waiting over 100% past their follow-up target date.

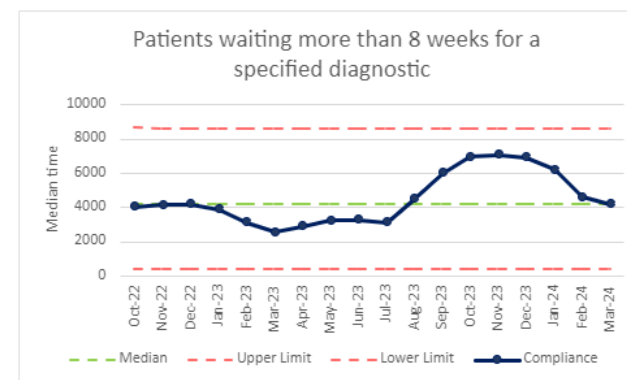
Improvement in outpatient performance remains essential to make the most of an individual's time and is a core focus of the Planned Care Programme. At the end of March 2024, there were 2,169 patients waiting over 104 weeks for a first outpatient appointment. There is mixed progress across specialities with ENT, Orthopaedics and Ophthalmology currently behind trajectory. There are extensive recovery plans in place across ENT and Urology including a clinical review of patients on the waiting list along with other solutions (e.g. audiology) supporting ENT and a focus on improving treat in turn prioritisation across all specialities. However, despite plans being implemented it is likely to take time to recover the 104-week position, although significant improvements have been noted within the ENT 52-week position due to the implementation of the recovery plan.

The outpatient transformation programme is focussing on the outpatient Did Not Attend (DNA) plan, of which the current rate for new outpatient appointments has been sustained at 6.1% (4,070) in March 2024. Additionally, the programme is continuing to work alongside finance and divisional teams, with a particular focus to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment.

### Maximising an Individual's Time - Diagnostics

The overall eight week diagnostic breach position has seen an improvement since November 2023. Key areas in diagnostics include:

- Royal Gwent Hospital endoscopy unit opened in November 2023, with the purpose to sustain services and reduce backlog of those waiting. The impact of this investments has resulted in the number of people waiting at the end of March 2024 reducing to 1,368, compared to 1,890 (Nov 23);



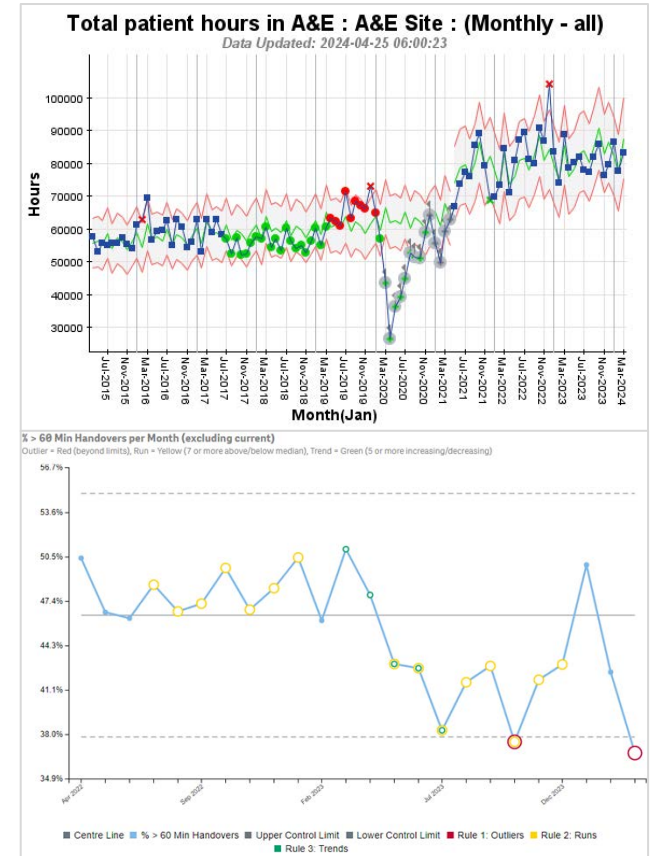
- Radiology diagnostics patients waiting over 8 weeks has decreased from 3,802 (November 2023) to 1,600 (March 2024);
- Cardiology position has been maintained at 206 breaches in March 2024.

### Maximising an Individual's Time- Urgent Care

Urgent Care services continue to be under significant pressure both nationally, regionally and locally, making delivering timely care challenging. There has been increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and Minor Injury Units, increased acuity, increased bed occupancy for emergency care and high levels of delayed discharges linked with significant social care workforce challenges.

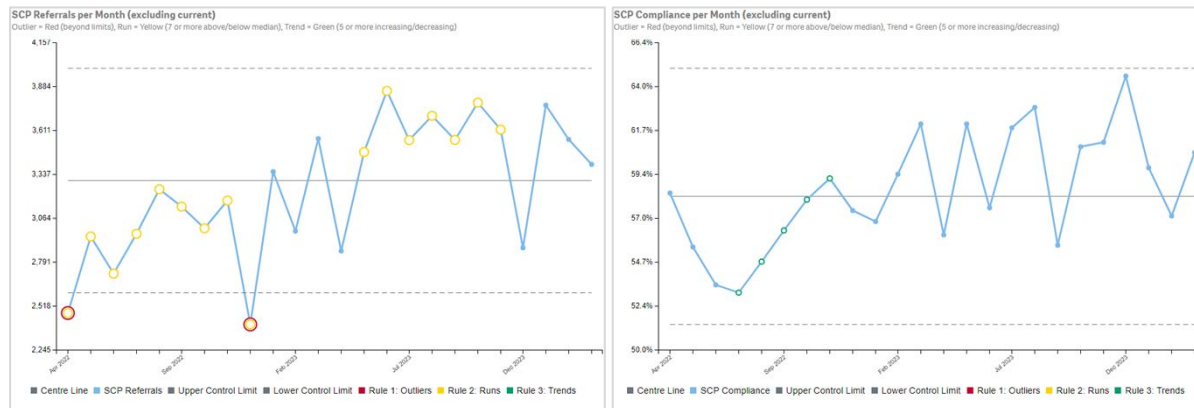
Over the last three months, there have been on average 501 daily attendances to the Emergency Department or a Minor Injury Unit, compared to 422 during the previous quarter, and the pressure on the urgent care system has resulted in patients staying in hospital for longer. The average time from arrival to departure in the GUH Emergency Department continues to be above target, with the total number of patient hours spent in A&E increasing significantly above pre-covid levels as the chart on the right demonstrates. The number and rate of patients waiting over 60 minutes to be transferred to the Emergency Department from an Ambulance increased during the winter period and peaked in January 2024 (1,537 – 44.7%). However, this has since reduced significantly during March 2024 (1,107 – 36.7%) to the lowest levels seen over the last two financial years. Whilst this remains high, as a result of poor flow through the system, there has been a concerted effort to decrease the number of delayed ambulance handovers.

Despite the extreme pressures upon the urgent care system, the performance measures of patients waiting fewer than four hours in ED has been maintained during the winter period and last quarter, and is currently reported at 73.8% (March 24) against a target of 73%. The most recent national performance data reports that the Health Board's performance is higher than the Welsh average of 68%. Patients waiting over 12 hours in Emergency Departments was 1,477 in March 2024, compared to 1,588 in January 2024.

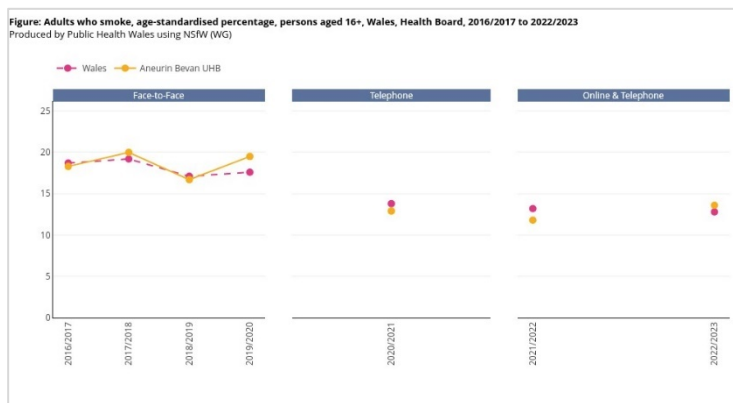


## Maximising cancer outcomes

Compliance against the 62-day target for definitive cancer treatment has decreased from 62.9% at the end of December 2023, to 60.8% in Jan 2024. This is behind the performance ambition set in the IMTP. Drivers for this include the significant increase in demand alongside the focus on reducing the over 62 day waits, which will affect compliance. Significant increases in demand relating to the suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500.



The number of SCP treatments undertaken has increased by 5.5% over the last 12 months and is continuing to increase month by month. Despite the pressures of increased demand and capacity challenges, there has been an improving position in the number of patients waiting over 62 days over the last 6 months, with 388 waiting over 62 days at the end of September 2023 compared to 346 at the end of March 2024.



## Adults living healthily and aging well.

Lifestyle factors such as diet and physical activity are closely associated with chronic health conditions such as cancer, diabetes, obesity and cardiovascular disease. The outcome 'Adults living healthily and aging well' has seen a deterioration in the measure of the percentage of adults smoking. The rate has increased to 13.6% in 2022/23 compared to 11.8% in 2021/22 and is higher than the national average.

Over the next year the Health Board will be developing a cardiovascular disease risk assessment programme to tackle preventable cardiovascular disease focusing on behavioural risk factors including smoking which is the second highest risk factor following hypertension. This will be a holistic assessment and support model deployed across the neighbour care networks in Gwent.

## Mental Health in Working Adults

Mental wellbeing and life satisfaction result in better subsequent health outcomes on some physical health indicators, health behaviours and psychosocial indications, including depressive symptoms. Mental wellbeing remains a key priority for the organisation and sustained performance levels have been observed in the 'improved mental health resilience in adults' outcome. As of Feb 2024, 68% of Health Board residents over 18 in receipt of secondary mental health services have a valid care and treatment plan. There are concerns on the provision of assessment by mental health service within 28 days from referral which

is currently at 17.1% (Feb 24) and interventions less than 28 days from assessment which is currently 7.3% both areas are being addressed in a 90 day action plan monitored by Executive Committee to ensure targeted assurance.

Priority 3 Improvement Actions		
Indicator	Improvement Action	Monitoring Arrangement
Reduction in the number of patients waiting more than 156 weeks for treatment	<ul style="list-style-type: none"> <li>Targeted approach for T&amp;O and ENT to maintain improvements in December 2023 position.</li> <li>85% theatre utilisation in Max Fax and Ophthalmology drive for 24/25;</li> <li>Treat in turn – speciality specific targets to deliver improvements necessary for stage 1 and 4 to achieve a significantly improved 104 position.</li> <li>ENT - agreed funding for additional activity to support longest waiters (treatments and outpatients)</li> </ul>	Divisional Assurance meetings
Patients waiting over 104 weeks for a first outpatient appointment	<p>Actions in the challenged services include:</p> <ul style="list-style-type: none"> <li>ENT – joint model with audiology, GP review of lists, treat in turn rates;</li> <li>Ophthalmology – progress with regional solution to increase capacity for cataract outpatient and inpatient stages;</li> <li>Spines - a lower backpain pathway is in development between MSK therapy and orthopaedic services. This work has already redirected patients from the spinal waiting list to the physio waiting list;</li> <li>Increased volume lists (colorectal UGI) and increase productivity;</li> <li>Continuation of outsourcing of Ophthalmology patients during Quarter 1 through spa medica and Vanguard.</li> </ul>	Divisional Assurance meetings
Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	<ul style="list-style-type: none"> <li>Optimal pathway work to reduce volume of breaching patients through reviewing capacity scheduled with specialities, with a particular focus on Urology, Gynaecology, Head &amp; Neck and Lower GI.</li> <li>Close working with Radiology regarding Accelerated Imaging and Pathology regarding turnaround times.</li> <li>Continued rollout of Did Not Attend (DNA) reduction pilot schemes</li> <li>Joint working with tertiary centres on shared pathways</li> </ul>	Divisional Cancer Weekly Assurance meeting
Maximising and Individual's Time-Diagnostics	<ul style="list-style-type: none"> <li>Radiology continue to prioritise clinically urgent cases and maternity ultrasound</li> </ul>	Divisional Assurance meetings
Maximising and Individual's Time- Urgent and Emergency Care	<ul style="list-style-type: none"> <li>Enhanced monitoring improvement plan in place focusing on: <ul style="list-style-type: none"> <li>ED actions on triage time and wait to see a clinician,</li> <li>Assessment models to facilitate timely ambulance handover</li> </ul> </li> </ul>	Enhanced monitoring arrangements

	<ul style="list-style-type: none"> <li>○ Actions in the 6 goals programme including Acute Frailty model</li> </ul>	
Assessment by mental health service within 28 days from referral	<ul style="list-style-type: none"> <li>● 90-day improvement plan in place with targeted actions to address part 1 performance.</li> </ul>	Executive Committee via escalation arrangements
Interventions <28 days following assessment by mental health service	<ul style="list-style-type: none"> <li>● Embedding of mental health services in Neighbourhood care networks continues in piloted areas with a view to expand across all boroughs.</li> <li>● Further progress matched care model and implementation of therapy pathways.</li> </ul>	Executive Committee via escalation arrangements

**Priority 4**  
Older adults are supported to live well and independently

**Our Outcomes:**

Prevention and keeping older adults well



Delivering care closer to home



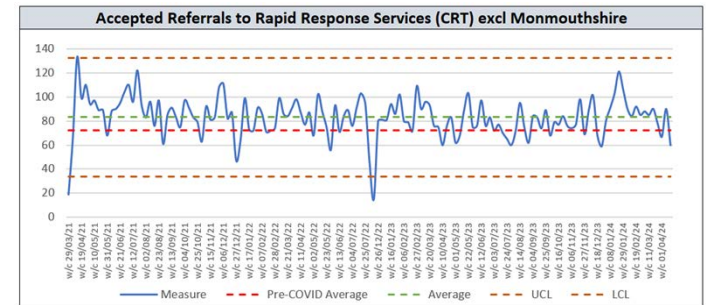
Reducing admissions and time spent in hospital



Supporting older adults to live well and independently is a core component of the Health Boards' plan for a sustainable health and care system. We know we need to deliver improvement for this section of our population in our service offer. Within the Urgent and Emergency Care 6 Goals programme there is prioritisation in Goals 1 and 2 for redesigning services for older people.

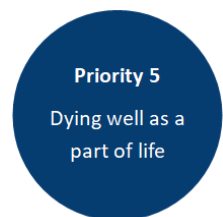
Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 4 - Older adults are supported to live well and independently	Delivering Care Closer to Home	Increase in accepted referrals to Rapid Response Services (CRT)	343	375	Jan-24	392	Mar-24	377	Deteriorated	Deterioration in indicator during Quarter 4 by 3.8%, however IMTP target remains met.
		Increase in accepted referrals to Reablement & Falls Services (CRT)	331	375	Jan-24	71	Mar-24	76	Similar	Sustained levels in the number of accepted referrals between Jan 24 (71) and Mar 24 (76).
	Reducing admissions and time spent in hospital	Reduction in the number of Emergency Admissions >65 years of age	1297	1000	Jan-24	1539	Mar-24	1738	Deteriorated	Significant increase in the number of emergency admissions by 12.9% between Jan 24 and Mar 24.
		Decrease (from 65 - 55%) in LOS over 21 days	65%	55%	Q3 2023/24	55%	Q4 2023/24	55%	Similar	Statistically similar to last reported position.

The indicator values for 'Delivering Care Closer to Home' outcome are mixed. As of March 2024, there were 377 accepted referrals to the Rapid Response Services and 76 to the Reablement & Falls Services. Goal 1 of the Urgent & Emergency Care Transformation programme has progressed the development of redesign of frailty services, including a Nurse-led Acute Frailty Response team at the Grange University Hospital (GUH) front door and the expansion and capacity build across Community Resource Teams via RPB funding to enable people to remain at (or close to) home, where this is safe and appropriate.



The outcome ‘Reducing admissions and time spent in hospital’ has seen mixed progress, with the number of emergency admissions for over 65 years of age increasing during Quarter 4 and currently reported at 1,738 at the end of March 2024. The indicator ‘decrease in the length of stay over 21 days’ has remained statistically similar to the previous reported position of 55% in March 2024, which has resulted in the IMTP target of 55% being met.

Priority 4 Improvement Actions		
Indicator	Improvement Action	Monitoring Arrangement
Increase in accepted referrals to Rapid Response Services (CRT)	Infrastructure in place to commence the implementation of findings of CRT review (principles work) that aims to optimise and standardise offer across ABUHB footprint.	Divisional Assurance meetings Six Goals for Urgent & Emergency Care
Increase in accepted referrals to Reablement & Falls Services (CRT)	Redesign of services for older people programme taking forward actions to increase referrals to reablement and falls. Development of a consistent offer across Gwent monitoring service availability across the Health Board and relevant Local Authorities.	Divisional Assurance meetings Six Goals for Urgent & Emergency Care
Reduction in the number of Emergency Admissions >65 years of age	Plan to implement an Acute Frailty Unit (AFU) are underway with appropriate stakeholders. Realigning resource to provide daytime Urgent Primary Care support and utilisation of HCSWs to support keeping patients at home.	Divisional Assurance meetings Six Goals for Urgent & Emergency Care



Our Outcomes:

Improved end of life care experience



Improved planning and provision of end of life care

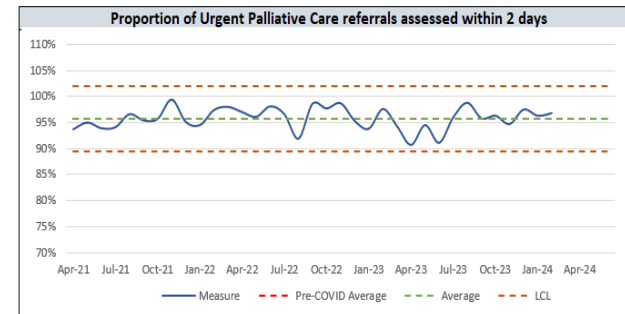


The IMTP sets out the commitment to continuously improve what we do to meet the need of people of all ages who are at the end of life. The measures represent indicators to support the organisation’s understanding of how it is delivering in this area to support the population to die in their place of choice and have access to good care.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Jan 24)		Current reported position (Mar 24)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 5 - Dying well as part of life	Improve care at end of life	Decrease in inpatient mortality rate	2.0%	1.5%	Q3 2023/24	1.8%	Q4 2023/24	2.1%	Deteriorated	Increase in inpatient mortality rate from 1.8% in Q3 23/24 to 2.1% in Q4 23/24.
	Improved planning and provision of end of life care	Increase in referrals to Palliative Care Services	141	200.0%	Dec-23	156	Feb-24	183	Improved	Indicator has increased significantly by 17% between reporting periods.
		Increase in proportion of Urgent Palliative Care referrals assessed within 2 days	91%	95%	Dec-23	97%	Feb-24	97%	Similar	Despite significant increase in referrals, the proportion of Urgent Palliative Care referrals assessed within 2 days has been sustain and compliance with target remains.

Progress against all two of the outcomes of this life course priority vary. For the outcome measure **‘Improve care at the end of life’**, it is recognised that the relationship between mortality rates and the quality of patient care is a complex one. For this reason, the indicator ‘decrease inpatient mortality rate’ is used as a measure and trigger for further investigation, understanding that it may not indicate any deficiency in the quality of care. The rate in inpatient mortality increased slightly from 1.8% during Quarter 3 to 2.1% during Quarter 4.

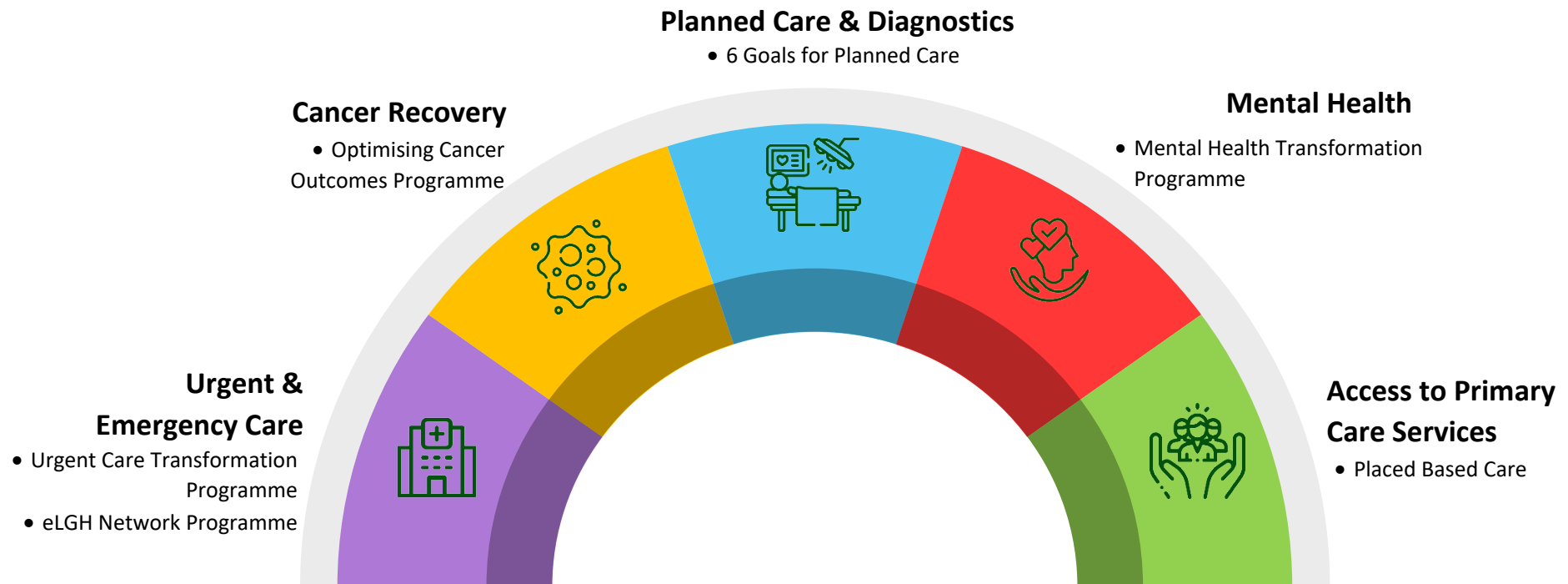
Good progress has been made within the outcome **‘Improved planning and provision of end-of-life care’**, with the number of referrals to palliative care services increasing significantly from 156 (Dec 2023) to 183 (Feb 2024). Despite this increase, the proportion of urgent palliative care referrals assessed within 2 days has been sustained at 97% and the IMTP target remains met. Over the next year we will implement the National Bereavement Pathway for Wales, including the development of a single point of contact for death and offer surveys to bereaved people to obtain feedback on the quality of support received.



Priority 5 Improvement Actions		
Indicator	Improvement Action	Monitoring Arrangement
Increase in referrals to Palliative Care Services	Continued collaborative approach to advanced care planning programme working with primary care, secondary care, care homes and voluntary sectors, driven by the End of Life Care delivery plan to raise awareness.	Divisional Assurance meetings

### 3. PROGRESS OF PRIORITIES

This chapter of the report updates on delivery against the Ministerial Priorities and Clinical Futures programmes. There is a high degree of synergy between the Ministerial Priorities for 2023/24 that are designed to support a swift recovery of business as usual and to reduce growing waiting lists and waiting times. All priorities are underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services. This chapter provides a quarterly update on progress made against key milestones, planned actions for the next quarter and measurement against trajectories.



### 3.1 URGENT AND EMERGENCY CARE

**Why is this a priority?** Prior to the pandemic, the situation in Emergency Departments was increasingly difficult, with demand soaring and the percentage of people being seen within the four-hour target reaching an all-time low over the 2019/20 winter. Since the start of the pandemic, ED attendance decreased significantly which led to performance improvements. Since lockdown eased, demand has steadily risen, and a greater number of people with serious problems are presenting themselves in our urgent and emergency care system.



#### Ministerial key focus should be on delivering:

- Honour commitments that have been made to reduce handover waits.
- Reduction in backlog of delays transfers of care (Pathways of Care).
- Implementation of Same Day Emergency Care services.

#### Where we are now:

- ⇒ **Ambulance Handovers:** Ambulance handovers over 1 hour at 1,107 in March 24 compared to 1,537 in Jan 24.
- ⇒ **Delayed Transfers of Care (DTOC):** DTOCs reduced from 264 in Nov 23 compared to 232 in Mar 24.
- ⇒ **Same Day Emergency Care:** volume sustained during Q4 with weekly average of 138 attendances at GUH and 49 at YFF.

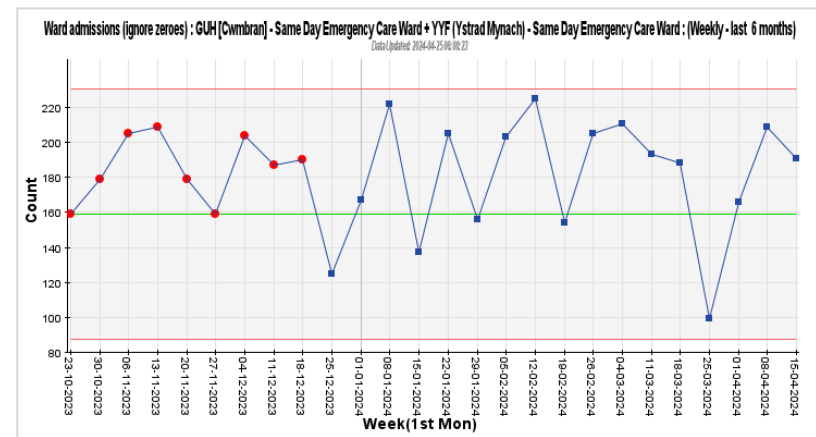
### Quarter 4 update against actions & milestones

#### Goal 1:

- **Acute Frailty Response (AFR)** Team launched and substantive staff recruitment underway.
- **Community Response Team (CRT)** Work commenced to bring together GUH front door teams including service delivery and evaluation (AFR, CAATT, Home First, AMU SAS Dr).
- **Care Home** workstream established and Luscii technology pilot in care homes agreed (pending start date).

#### Goals 2, 3 and 4:

- **Same Day Emergency Care** patient volume sustained at an average of 138 weekly attendances at GUH and 49 at YFF.



- **Reducing Conveyance** Collaborative Workshop with WAST held on 19<sup>th</sup> February 2024 to discuss opportunities including strengthening falls response in community and a 111 first pathway.
- **Urgent Primary Care Demand:** Analysis completed to understand the increase in demand from Primary Care at start of 2024. Single phone number for Urgent Care launched February 2024.
- **Flow Centre** Transitioning to a Nurse led model.
- **Fracture Liaison Service** development funding received.

#### Goals 5 & 6:

- **Step Down Improvement** Optimising Hospital Flow Framework Refresher training being delivered as part of a development programme. Patient Safety Events continue at GUH with a specific focus on patients planned for step down.
- **Hospital 2 Home** team now fully appointed, working with Monmouthshire and Newport Localities.
- **Discharge/Transfer Lounge** Royal Gwent Hospital (RGH) Discharge Lounge Capital works complete and leadership role appointed. NHH Discharge Lounge now operating under new pull model. Modelling undertaken for GUH Discharge Lounge
- **Optimising Patient Flow** Discharge to Assess digital solution piloted across three wards, wider roll out now underway. Two Future Flow Design workshops delivered, and two areas of work identified – bed allocation and workforce model.

#### Enhanced Local General Hospital Configuration:

- Relocation of two wards and repurpose of one ward at St Woolos Hospital (SWH) to RGH, end of February 2024.
- NHH Clinical Service Model, series of workshops planned for Q1.
- Medical Model Workshop held on 15 April 2024, to scope the optimal clinical model for acute emergency admissions.
- Joint clinical and operational workshop with Velindre to scope opportunities and model for SACT outreach services (critical to inform NHH future size and scope)

#### **Planned actions & milestones for next quarter**

##### Goal 1:

- **AFR Team** to undertake a formal 3-month evaluation, complete recruitment and agree Phase 2 plans (including plans to further draw together front door teams).

- **CRT acceptance of referrals to 5pm** to undertake additional data interrogation and consider implications for staffing cohorts e.g., changes to demand on Therapies. Further engagement with referrers to encourage increase in referrals planned.
- **Care Homes** Formally commence of Luscii Technology Pilot.

##### Goals 2, 3 and 4:

- **Same Day Emergency Care/Ambulatory Care** to hold a workshop with stakeholders to agree an approach to strategy design. Bring together project teams from across six goals to improve service offer for older people.
- **ED Main Wait and e-Triage** pilot re-start at a slower pace over 3 weeks. Complete GUH ED attendances re-audit for Primary Care for appropriateness of referral.
- **Flow Centre Development** to develop proposals following WAST Collaborative. Review advanced paramedic practitioner models in other Health Boards to explore if such model could enhance our existing structure of navigation.

##### Goals 5 & 6:

- **Patient Safety Team** to roll out weekly Patient Safety deep dives in RGH and agree new format for future GUH step down events.
- **Discharge/Transfer Lounge** to implement changes to performance and function of RGH/NHH Discharge Lounges. 'Road map' for delivery of proposed GUH Discharge Lounge extension. Develop business case, workforce model and metrics to inform decision.
- **Step Down Improvement** to submit revised transfer/hand over document for sign off by the Executive Committee.
- **Hospital to Home** to work with all Localities to spread and scale Hospital 2 Home service.
- **Ready to Go Unit** to be opened at RGH.
- **Data and Digital** to complete the Discharge to Assess digital solution roll out and finalise reporting arrangements.

### Enhanced Local General Hospital:

- NHH Clinical Service Model – Scheduled Care and Family and Therapies workshops to be held in May and June 2024
- Plan for further bed reductions across sites, aligned to the Clinical Futures model.

### 3.2 CANCER RECOVERY

**Why is this a priority?** Cancer outcomes need to be improved. The Single Cancer Pathway, supported by Optimal Cancer Pathways for individual tumour sites, provides the roadmap to shorten diagnostic and treatment pathways once a person is suspected as having cancer. The Cancer Strategy, Delivering a Vision 2020-25, sets out the broader context with prevention, early detection, patient experience, living and dying with cancer, cancer research and access to novel therapies also key components to transforming cancer services for our population.

#### **Ministerial key focus should be on delivering:**

- Reduction in backlog of patients waiting over 62 days, to enable delivery of 75% of patients starting their first definitive cancer treatments 62 days.
- Implement the agreed national cancer pathways within the national target, demonstrating annual improvement towards achieving target by March 2026.

#### Where we are now:

⇒ **62 days:** 60.8% achieved in Mar 24 against forecasted target of 75%.

#### Quarter 4 update against actions & milestones

- **YYF Breast Centre** on Monday 5th February 2024, the brand-new Breast Care Unit at Ysbyty Ystrad Fawr welcomed Gwent patients for the very

first time. This resulted in an improvement of the single cancer pathway compliance for Breast in March treating a total of 47 patients.

- **Acute Oncology Service** Bevan Commission project between VCC treatment helpline and ABUHB Acute Oncology Service and SDEC teams has been completed and the report and poster submitted
- **Public Health Inequalities** Workshop was held in January and subsequent paper and Inequalities Action Plan have been produced and agreed by Cancer Board in March 2024.
- **SACT Outreach Partnership** A SACT Outreach Workshop was held between with Velindre Cancer Centre in February 2024.
- **Enhanced Psychological Programme for those living with and beyond cancer/person** successfully recruited a Clinical Psychology Lead in March 2024.
- **Radiotherapy Satellite Centre** Estates and Facilities meeting between the Health Board and VCC to discuss operational modelling held.

#### Planned actions & milestones for next quarter

- **SACT Outreach Partnership** to develop Project Initiation Documentation and workstream model.
- **Public Health Inequalities** reducing Cancer Inequalities Group inaugural meeting to be held in April 2024. Patient website development continues in readiness for launch.
- Workstreams for pathway improvements, including National Optimal Pathways, Task and Finish Groups continue.
- Continued development of Regional Cancer Work, in particular around data.

### 3.3 PLANNED CARE AND DIAGNOSTICS

**Why is this a priority?** During the pandemic, services had to be paused to respond to the immediate demands and challenges of COVID-19 and capacity has been reduced by infection prevention and control requirements. As a result, the number of people waiting – and the time people are waiting – for planned care services are now longer than ever. This position is further exacerbated by those who did not access health care during the pandemic and in addition to the backlog of patients known to the services there is a potentially significant cohort of ‘unreferred demand’.

#### Ministerial key focus should be on delivering:

- Implementation of regional diagnostic hubs, to reduce waiting times and meet waiting time ambition in Spring 2024.
- Implement pathway redesign – adopting ‘straight to test model’ and onward referral as necessary.
- 52 week Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT.
- Address capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025.

#### Where we are now:

- ⇒ **Straight to test:** implementation of bladder cancer STT service in progress.
- ⇒ **52 Week Outpatients:** 14,846 against a target of 9,802.
- ⇒ **104 weeks treatment:** 1,430 against a target of 0.
- ⇒ **Capacity Gaps:** Improvement in job planning of junior doctors to increase capacity.

- **Health Pathways - Health Pathways** launch date of 19<sup>th</sup> April 2024 agreed with first 50 pathways. Phase 2 pathways allocated, to be reviewed against national and local priorities. Project manager commenced in post.
- **Patient Access and Activation** Welsh Government funding confirmed for 2024/25. Recruitment of Call Handlers ongoing, along with communication to raise awareness of the service.
- **Outpatients** Welsh Government part-funded RGH OP Treatment Unit until March 2024. Business case drafted for full funding of the unit. Work ongoing with DHCW to progress Automated Clinical Booking System on MS Teams App.
- **Diagnostics** Continuing to engage in regional diagnostic developments e.g. CDH, Path and Endoscopy.
- **Theatres** Embedding new dashboard through scheduling meetings and performance reporting. Draft data pack from GIRFT shared, and work progressing on data quality issues.
- **Planned Care Academy** 3 workstreams are progressing objectives (e.g. draft training plan has been developed)

#### Planned actions & milestones for next quarter

- **Health Pathways** continue to develop pathways and launch is planned for 19<sup>th</sup> April 2024. Workplans being finalised for 2024-25. Delivery of Comms & Engagement plan continues to realise opportunities for embedding Health Pathways across the Health Board
- **Patient Access and Activation** Engagement sessions being planned and engagement awareness sessions e.g. LMC, Outpatients Steering Group are ongoing.
- **Outpatients** – Business Case for Outpatient Treatment Unit developed and going through governance in March for Executive Committee approval.
- **Theatres** developing project document to outline scope of work and support delivery of key milestones over the next year.

- **Planned Care Academy** – Develop and agree training plans for forthcoming year including the development of planned care career pathway in more detail.
- **Deep Dives** into three challenged surgical specialities of ENT, orthopaedics and ophthalmology

### 3.4 MENTAL HEALTH AND CAMHS

**Why is this a priority?** The detrimental impact of COVID-19 on the mental health and wellbeing of our population has been significant. Demand is likely to exceed capacity threefold over the next three to five years. Demand for mental health and CAMHS services is sharply increasing and we need to find ways of supporting people earlier to better support crisis prevention and recovery.

#### Ministerial key focus should be on delivering:

- Implement 111 press 2 for urgent mental health issues (24/7)
- Recover waiting time performance to performance framework standards of 18+ LPMHSS assessment and intervention.
- Recover waiting time performance to performance framework standards for Specialist CAMHS.
- Recover waiting time performance to performance framework standards of under 18 LPMHSS assessment and intervention.

#### Where we are now:

- ⇒ **18+ LPMHSS:** Sustained position of 68% in Mar 24.
- ⇒ **CAMHS:** 100% in Mar 24 CAMHS choice referrals compared to 87.5% Dec 23.
- ⇒ **Under 18 LPMHSS:** 74.8% in Mar 24 compared to 63.2% in Apr 23.

### Quarter 4 update against actions & milestones

- All planned quarter 4 milestones for **implementation of 111 press 2** are off track due to capacity constraints impacting on delivery of service improvements. Emergency funding from Welsh Government is being used to deliver core service. The move of the service into new accommodation is being considered as part of wider organisational work on estates.
- **Hub based model** operating across Neighbourhood Care Network (NCN) areas is significantly off track as funding constraints impacted estates availability. At present this is on hold until other avenues that require less investment can be agreed.
- The Welsh Community Care Information Systems (WCCIS) backlog continues to be reduced.
- Further progressed is being made regarding the **Matched Care Model**.
- Weekly performance meetings continue and are responsive to the demand ensuring effective use of capacity.
- CAMHS have surpassed 80% compliance for **CHOICE (New referrals) to assessment within 28 days** for Quarter 4 at 100% compliance. Monthly demand and capacity review undertaken to ensure that job plans have sufficient capacity to meet CHOICE demand. Continued implementation of workforce plans including efficient recruitment into vacancies.
- PCAMHS is continuing to flex capacity to meet the **Initial Assessment Part 1A 80% target** with March 24 position 78.12% despite significant vacancies and workforce deficits.
- **Under 18s Initial Assessment Part 1B recovery plan** continues to be implemented making reasonable progress.

## Planned actions & milestones for next quarter

- **Initial Assessment and Intervention by LPMHSS** continued implementation of recovery plan towards Welsh Government targets.
- Explore funding options for **hub-based model** across Neighbourhood Care Network areas.
- To maintain over **80% RTT Target Compliance for New Choice referrals to assessment within 28 days** - CORE CAMHS and CET ED Teams
- **CCIH** to continue to work closely with Gwent wide SPACE Wellbeing partners and continue to hold weekly performance meetings to review capacity and demand and expedite potential breachers.
- **PCAMHS Initial Assessment Part 1A** maintain steady state RTT 80% Target and **PCAMHS Initial Intervention Part 1B Recovery**.



melo

## 3.5 ACCESS TO PRIMARY CARE SERVICES

**Why is this a priority?** The Primary Care Model for Wales set out how primary and community health services will work within the whole Public sector system to deliver Place-Based Care. Collaborative work is at the core of this bringing together local health and care services to ensure care is better coordinated to provide care closest to home and promote the wellbeing of people and communities.



## Quarter 4 update against actions & milestones

### Ministerial key focus should be on delivering:

- Improved use of community pharmacy.
- Increase access to dental services.
- Improved access to GP and Community Services.
- Improved use of optometry services.

### Where we are now:

- ⇒ **Community Pharmacy:** 4,866 claims under common ailment scheme during 23/24, compared to 2,962 during 22/23.
- ⇒ **Dental Services:** Weekly average of 688 community dental attendances during 23/24, compared to 644 during 22/23.
- ⇒ **UPCC:** 9,916 contacts in Mar 24 compared to 9,469 in Dec 23.
- ⇒ **Optometry Services:** Monthly average of 4,090 claims for Eye Health Examinations Wales during 23/24, compared to 3,416 in 22/23.

- **Professional Collaboratives** formalised governance arrangements for professional collaborative leads and agreed priorities for each professional collaborate.
- **Access Standard** – 100% of GP practices have reported access standards quarterly.
- **Community Pharmacies** has demonstrated continued success achieving a 46% increase in common ailment consultations over this year.
- Continuing to progress the units and levels of patients accessing NHS and **Community Dental Services**- over this year 325,904 patients have received dental care of which 24,182 were new Patients. Development of new dental contract as part of Tredegar Development is currently in progress and on track to open on 1<sup>st</sup> April 2024.
- Supported the roll out of Wales National Workforce and Reporting System (WNWRS).

- Development of a **Palliative Care** Medical Champions Programme
- **Pharmacy** career pathways defined and scheduling of phase 1 undergraduate MPharm student placement scheme
- **Urgent Primary Care** contacts increased by 22% from 2022-23 to 2023-24
- All Managed **GP practices** transferred to independent providers from 1<sup>st</sup> April 2024
- Wellbeing collaboratives continues to be developed alongside **NCNs**.
- Implementation of the contract requirements for **Wales General Ophthalmic Services (WGOS)** in 2024/25 and Contract monitoring to ensure all Optometry practices are meeting performance standards (including WGOS activity)
- Scoping remote care service for patients with uncontrolled hypertension for 2024/25

#### Planned actions & milestones for next quarter

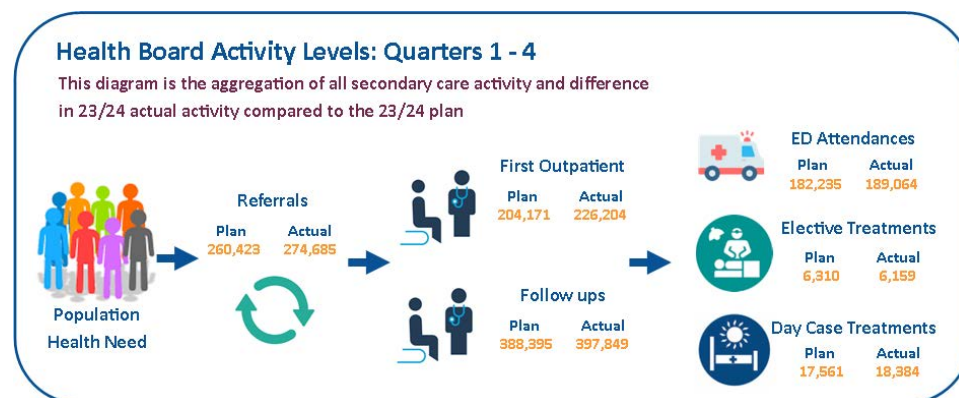
- Development of **Professional Collaboratives** induction toolkit.
- Commence implementation of 2024/25 localised delivery projects
- Engagement and delivery of **NCN** workforce planning programme
- Develop a plan to establish a range of services identified as best delivered at a NCN level or for a pan- NCN population.
- Increase number of Pharmacy Independent Prescribing Service (PIPS) in **Pharmacy**.
- Continue to progress the units and levels of patients accessing NHS and **Community Dental Services** and Contract monitoring to ensure all Dental practices are meeting standards.
- Continue development of information resources / service directories to facilitate collaborative working between GP Practices with Urgent Care Teams, Frailty Consultants, Allied Health professionals, Nursing Teams and other services.

## 4. IMTP PLANNING SCENARIO

In line with Welsh Government IMTP requirements, the organisation submitted a Minimum Data Set (MDS) outlining a profile of activity for the year alongside forecast performance and workforce information and this information is reviewed quarterly.

The planning scenario has, in aggregate form, largely followed as predicted by the services and is in line with the pressures on the availability of capacity due to delayed discharges and length of stay. Outpatient and inpatient treatments were ahead of projections, reflecting the priority that services are placing on addressing the longest waiting patients and managing demand. During 2023/24:

- Referrals were slightly higher than forecasted.
- Both new and follow-up outpatient levels have been operating significantly above forecasted levels. This is particularly noted in a number of specialties including: Cardiology, Dermatology, Gynaecology, Neurology, Rheumatology, T&O and Urology.
- In its totality, treatment activity is operating above the forecasted scenario, despite staffing challenges and urgent pressures. This is attributed to the significant drive to increase activity levels to meet demand and reduce waiting times.



Waiting Lists	Urgent Care	Primary Care	Bed Plan
<p>The Health Board continues to make progress reducing the number of the longest waiting patients for planned care treatments and outpatient appointments.</p> <p>With the rate of referrals and current focus on treat in turn, there is a risk of greater waiting list growth due to the profile and will mean the Year 2 position may become more challenging without changes in activity.</p>	<p>Overall, the Quarter 4 forecasts were aligned with the actual activity for ED attendances with a total of 45,620 attendances during the quarter across all sites.</p> <p>Emergency attendances are the same as the forecasted position and therefore forward projections will not be amended.</p>	<p>GMS activity levels have gradually started to decrease from April with more face-to-face activity and is currently ranging between 17,000 – 20,000 a week. Increased demand is reported by practices.</p> <p>GP referrals for urgent assessments via Rapid Response, Emergency Departments or Assessment Units have increased against pre-covid level.</p>	<p>The bed plan has continued to follow the overall expected occupancy levels and demand patterns. Medicine Division have running at 99% occupancy against their bed plan and the Community Division at 107%.</p> <p>Beds occupied by patients cared for by Care of the Elderly was in line with the forecast and continues to drive the need for additional inpatient capacity which presents associated workforce challenges.</p>

## 5. SUMMARY

Of the 41 indicators included in the Outcomes Framework, 21 have newly available data to be reported upon during this quarter. 14 of the 21 measures have either improved or are statistically similar and 7 indicators have deteriorated since the last reporting period. The outcome measures for every child has the best start in life are broadly stable since quarter 3. Progress in improving Mental health Resilience in Children and Young Adults remains mixed. Improvements have been observed in Primary Care CAMHS 1a performance significantly to 100%, surpassing the ministerial target of 80%.

In relation to our adult population, progress is mixed. In longer term outcomes, we are sustaining progress in improved Mental Health resilience. Our compliance in the number of patients starting cancer treatment within 62 days has slightly deteriorated since quarter 3. For making the best use of an individual's time, we have improved our position for the urgent and emergency care system metrics however we still have a considerable number of patients waiting for planned care procedures and this position has deteriorated since quarter 3. This demonstrates the importance of the Ministerial priorities and Clinical Futures programmes in focussing upon urgent care, planned care and services for older people. Similarly, in relation to supporting people to live well in the community, the system is holding too many patients in hospitals, and this is a key focus area for our population.

Across both the Ministerial and Clinical Futures there are noted key achievements that deliver system change coupled with enabling actions to improve service delivery and ultimately patient outcomes. There continues to be high demand on service which is evidenced in performance against forecast in areas. We continue to work in partnership to deliver regional solutions for planned care and cancer. Our six goals and E-LGH programme continue to embed system change that to deliver the right care in the right place at the right time. Performance remains challenging within our Mental Health services with enhanced governance and scrutiny in place to ensure we deliver against the agreed quality improvement plan. Within Primary Care, there has been an increase in NHS Dental Care and Community Dental services units of activity and new patients. Additionally, the number new patients accessing NHS Optometry services has increased.

This Quarter 4 assessment sets out the organisation's understanding of its system. The plan remains robust and the priority decisions made in the IMTP remain valid areas of focus of the 2024/25 annual plan.





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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	22 May 2024
<b>CYFARFOD O: MEETING OF:</b>	Board
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Quality Outcome Framework - Quarter 4 2023/24
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Jennifer Winslade, Executive Director of Nursing
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Leeanne Lewis – Assistant Director for Quality and 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**

**Sefyllfa / Situation**

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;

We have been clear on our aims to continuously improve and learn. Our quality strategy supports the new legislative requirements and has recently been updated (included in Appendix).

The reporting of patient safety and quality metrics is maturing via our Quality Outcomes Framework (QOF) and the quality narrative report. The Health Board is continuing to develop our Quality Management System to routinely set meaningful targets, monitor, measure and report performance. This ensures we provide excellent standards of care and set quality goals to continuously improve the services we provide.



## Cefndir / Background

Following the launch of the Quality Strategy and Patient Experience & Involvement Strategy we continue to develop and report quality metrics as part of our Quality Outcomes Framework (QOF). This has been an iterative framework, under constant development throughout year one. The development of the QOF recognises some of the measures as we bring online new ways of reporting and capturing what is important for our patients, their families and the Public. This QOF will continue to be refined by working with planning and the digital, data and technology team with aspirations to automate reporting.

This current report combines both the quality metrics as part of the QOF and the quality narrative report. As mapped in the quality strategy, there is a focus on patient safety, patient experience, health and safety and infection prevention and control activity. Data is available for Quarter Four (time period January to March 2024).

## Asesiad / Assessment

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. Our Quality Outcomes Framework (QOF) is mapped to ensure we develop and deliver our services around the six domains of quality and the six quality enablers. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

The quality outcomes framework 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. Providing data across these Pillars of Quality will enable us to review our performance. The pillars are 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.

## **Areas of Improvement**

- PQSOC approved the Health Board's first Listening and Learning Framework with the aim of promoting greater learning from incidents, feedback and concerns to reduce harm and prevent reoccurrence



- RAMI - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator with a focus on Learning from Deaths reporting based on the English model.
- The PALS service launched in November with around 700 referrals a month with almost all issues being resolved at an informal stage. There are considerations as to how the service can support and work into the PTR process
- Civica has been successfully implemented with a satisfaction rate over the 85% benchmark albeit the digital solution is required to increase take up.
- There have been no new Never Events since November, there remains focused work on Human Factors training within theatres
- A renewed focus on clinical audit strengthening reporting and governance
- Improved uptake of Level 1 and Level 2 Safeguarding training
- Improved bereavement offer including improved access to information and support and with co-design of the service with families and the Public
- Improved Health and Safety assurance
- The Health Board continues to support a number of nationally recognised quality improvement projects which are significantly improving patient safety and patient experience this includes, amongst others, projects within Theatres to address Human Factors, improvement in acute deterioration, referral to memory assessment services, discharge improvement through an integrated model and a number of collaboratives to address concerns for example Hospital Acquired Pressure Ulcers

### Areas of Focus

There are a number of issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. The report details the analysis, actions and assurance. For Board consideration the areas are summarised below.

- Infection rates for C.Difficile have risen over the last 12 months, which is a picture seen across Wales. The reasons for this are complex with rates impacted by community prevalence, the number of people with complex co-morbidities, anti-microbial prescribing and poly pharmacy as well as a need post pandemic to refresh basic good IPC practice
- Continued focus on the quality of care within Mental health and Learning Disability Services as evidenced through the 30,60, 90 day improvement plan and recent HIW inspections
- Quality outcomes and timeliness of care within urgent care. This relates to a number of metrics including Ambulance Handover times, 12 and 24 hour waits in ED and system flow.
- Avoidable pressure damage to skin, the Health Board has seen a rise in Healthcare Acquired Pressure Ulcers over the Winter however there has been improvement in recent months. A focused review and improvement collaborative continue to focus on reducing avoidable harm
- Falls the Health Board has seen variation in the number of inpatient Falls and in Quarter 4 has received a Regulation 28 from the coroner in relation to an inpatient fall.
- Safeguarding Level 3 training remains an area for improvement, in order to be complaint with the intercollegiate guidance Level 3 training is required for clinical staff.



- Themes from incidents continues to include the deteriorating patient, which is part of the safer care collaborative.
- Putting Things Right (PTR) the compliance with closure of PTR concerns within 30 days remains of concern. There has been steady improvement in aged complaints over 12 months however the Health Board has developed a plan to return to the required level of compliance which will be 75% of PTR concerns closed within 30 days.

This report demonstrates not all measures have been feasible to collect throughout the year. As part of updating the QOF for 2024/25 a workshop has been held to collectively discuss each of the measures, refine the indicator and review how the data is being accessed. For those indicators that are blank, this will be reviewed.

For the Health and Care Quality Standards that are limited in reporting e.g. Equitable, these will be reviewed to establish what else is being reported that can be inserted into the QOF and what additional measures should be included (i.e. more data is required in relation to Safeguarding & domestic violence and children and young people's outcomes).

The QOF needs to encompass a whole system approach and primary care and communities and public health data is an area for development. Working with data, digital and technology the report will become automated and mirror the updated reporting for Board with the use of iconography.

Combining these reports into one document demonstrates the hard work and commitment from the Health Board to develop the quality strategy and our reporting obligation under the Duty of Quality. The report demonstrates how the Health Board is striving to better understand our systems of care and continues to mature our Quality Management System and refining the QOF to enable us to set meaningful targets to monitor, measure and report our performance.

This report illustrates how we are improving our insight of data and developing our understanding of insights from multiple sources of information throughout our entire system. We have delivered the key objectives outlined for the first year in the strategy, and on target to publish our annual quality report. Our quality reporting structure sets out progressive implementation plans. Plans can be adapted based on experiences and learning, and monitoring progress against our strategic goals.

The Health Board has formed a learning and improvement forum which highlights our creativity, passion, expertise, and our commitment to learn from experiences. The listening and learning framework was approved at Patient Quality and Safety Outcomes Committee in April and an implementation plan is underway (see Appendix).

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

This report is to provide assurance to the Board on the ongoing work to deliver the Duty of Quality and Duty of Candour, through implementing the Quality Strategy and Patient Experience & Involvement Strategy.

### Amcanion: (rhaid cwblhau)

### Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.
Blaenoriaethau CTCI IMTP Priorities  <a href="#">Link to IMTP</a>	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  <a href="#">Strategic Equality Objectives 2020-24</a>	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:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau: Glossary of Terms:	N/A
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee Patient Quality, Safety & Outcomes Committee



**Effaith: (rhaid cwblhau)**  
**Impact: (must be completed)**

	<b>Is EIA Required and included with this paper</b>
<p><b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b></p>	<p>Choose an item.</p> <p>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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b></p> <p><a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a></p>	<p>Choose an item.</p> <p>Choose an item.</p>





**PERSON  
CENTRED**



**SAFE**



**TIMELY**



**EFFECTIVE**



**EFFICIENT**



**EQUITABLE**

# Quality Outcomes Framework

## Quarter 4 2023/24



**LEADERSHIP**



**WORKFORCE**



**CULTURE**



**INFORMATION**



**LEARNING,  
IMPROVEMENT &  
RESEARCH**



**WHOLE SYSTEMS  
APPROACH**

# Overview

This is a combined report that includes the measures within quality outcomes framework (QOF) and a narrative on the data. 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 ABUHB quality priorities including the Quality and Safety Pillars, as included in the Quality Strategy and has ensured that the Patient Experience and Involvement Strategy has been embedded throughout the report.

This includes:

- Areas for escalation
- The QOF as aligned to Health and Care Quality Standards
  - Person Centred Care
  - Safe Care
  - Timely Care
  - Effective Care
  - Efficient Care
  - Equitable Care
- Additional information is available in the report to provide assurance against these standards

# Priority 1: Person Centred Care



Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
<b>Priority 1 - Person Centred</b>	Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations	General experience rating of episode of care	Q3 2023.24	87%	Q4 2024	88%	Improved	Overall satisfaction score at 88% (benchmark is 85%). Total surveys completed is 594 (previously reported as 570). Paper surveys submitted after month end.
		Number of complaints closed	Q3 2023.24	410	Q4 2024	406	No Change	Slight decrease in number of complaints closed
		Complaints backlog	Q1 2023.24	773	Q4 2024	859	Deteriorated	Across Q3 & Q4 2023/24 the HB have managed to ensure more than half of the complaints received are being completed within the 30-working day target, compared with under 50% across the same quarters in 2022/23. There has been a 16% increase in the number of complaints received by ABUHB in Q4 2023/24. Includes early resolution and managed under PTR
		Compliments – total number of written compliments	Q3 2023.24	114	Q4 2023	132	Improved	Data to be pulled from CIVICA going forward. Themes identified by compliments are: Beyond duty of care, Communication, Understanding.
	Increased patient, public and staff involvement.	Increase in number of responses in Civica	Q3 2023.24	282	Q4 2024	594	Improved	Q4 594 (Q1/2/3 = 749 previously reported as 728. Total 1343 responses. CIVICA is live on all inpatient wards excluding maternity at present. CIVICA is live in 190 areas across the Health Board. Significant increase in Q4 feedback and also training attendance by ward/department teams
	Learning from complaints is implemented	Qualitative feedback use of the learning section in Datix						Measure being refined
		Increase in the number of actions plans completed						Measure being refined

# Volunteering – Key Highlights

The Health Board is publishing our Volunteering Annual Report during Volunteer Week 3<sup>rd</sup>-9<sup>th</sup> June. The report highlights the benefits of volunteering for those who volunteer, those who are supported and for wider social connections. With over 20 role profiles, people are afforded an opportunity to volunteer in areas of interest and through our Volunteer to Career pathway, an increasing number of volunteers are now gaining skills to enable them to seek meaningful employment.

Some of the key highlights are demonstrated here.

Our volunteers have provided <b>over 8183</b> unpaid volunteer hours.	Our Welcomer volunteers at NHHS and YYF have supported over <b>3651</b> people since August 2023.	We have <b>20</b> spoken languages by <b>34</b> volunteers, including <b>9</b> Welsh speaking volunteers and <b>1</b> BSL volunteer.	WE have <b>27</b> Telephone Befrienders supporting <b>32</b> patients, mostly on a weekly basis.
We recruited <b>92</b> new volunteers in <b>2023</b> .	We have launched our <b>Volunteer to Career</b> Programme and are the first Health in Wales to do so.	<b>7</b> volunteers have gained paid employment through out <b>Volunteer to Career</b> programme.	Listening to patients, staff and volunteers, we have created <b>7 new</b> volunteers role profiles during 2023.
We have support <b>5</b> people to become experts by experience (Mental Health, Gastroenterology and Stroke).	We have provided <b>49</b> training sessions for volunteers.	We have provided volunteer and work experience opportunities for <b>3</b> people with additional needs.	We held an annual volunteer <b>celebration event</b> in June 2023.
We have attended <b>37</b> volunteer promotion events across the geographical area.	We now have <b>130</b> Hospital Befrienders and End of Life Companions. With our team supporting <b>321</b> volunteer inductions during 2023.	We have worked closely with Therapy teams to create <b>Stroke Peer Support</b> Volunteers.	We have worked closely with <b>Cancer Services</b> and created new volunteer roles including Befrienders, Welcomers and Peer Support.
We have worked closely with the <b>Alcohol Care Team</b> and are creating a volunteer led dedicated alcohol support group.	Through our partnership with Cardiff University, over <b>75 pharmacy students</b> will have gained patient experience volunteering opportunities.	<b>52</b> volunteers have supported the <b>Ukraine Resettlement</b> and <b>Mass Vaccination Centres</b> .	We have developed <b>9</b> personal wellbeing sessions with over <b>51</b> volunteers attending.
We have presented our volunteering model at local and <b>national</b> events.	<b>Helpforce Cymru</b> and <b>The Bevan Commission</b> have published a national case study on our Volunteer to Career model.	<b>Volunteer Long Service:</b> <b>26</b> completed <b>50 hours</b> <b>18</b> completed <b>100 hours</b> <b>12</b> completed <b>200 hours</b> <b>7</b> completed <b>300 hours</b> <b>4</b> completed <b>400 hours</b> <b>1</b> completed <b>500 hours</b> <b>1</b> completed <b>700 hours</b> <b>1</b> completed <b>800 hours</b>	In 2023, the Volunteer Service has won a <b>Volunteer Award</b> and have been finalists in <b>3</b> other award.

## Top 3 Themes from PCC Survey

Positive Themes	Negative Themes
<p><b>Compassion (98)</b></p> <p>reassurance empathetic considerate thoughtful <b>compassion</b> reassure kindly <b>supportive</b> angels reassured <b>caring</b> reassuring empathy "very patient" kind sympathetic "was patient" <b>understanding</b> consideration <b>compassionate</b> thoughtfulness</p>	<p><b>Waiting (27)</b></p> <p>"another 5 hours" "for many hours" "after an hour" "for 17 hours" "for 185 hours" "finally" waited "for 10 hours" "wait" "delays eventually" "for hours" "for 10 hours" "took too long" "after 245 hours" "took another 5 hours"</p>
<p><b>Friendliness (75)</b></p> <p>approachable friendliness <b>warm</b> cheerful <b>friendly</b> personable <b>pleasant</b> welcoming relaxed <b>chatty</b> "open manner"</p>	<p><b>Comfort (19)</b></p> <p>"not always sleep" "i felt very cold" "ward was cold" "too dark" "blaring" "no sleep" "kept awake" <b>uncomfortable</b> "the heating" loud "hard to sleep" louder freezing "room is cold" "extra blankets" "room freezing cold"</p>
<p><b>Emotional and Physical Support (75)</b></p> <p>helpfulstaff "excellent support" "help and support" <b>"care and support"</b> reassuring <b>helping</b> "put at ease" "great support" <b>helpful</b> reassured assisted <b>supportive</b> supported "put me at ease" <b>helped</b> helpfulpeople <b>"support me"</b> "lots of support" helpfulnice "given excellent support"</p>	<p><b>Food &amp; Beverages (17)</b></p> <p>"wasnt offered a hot drink" "food this was not" "dont like the food" "any food" "no coffee" "food choice" <b>"better food"</b> "food choices" "or food" "more tea" "food isnt" "any drink" "food not" "choice of food"</p>



## Positive

on a busy acute ward you showed kindness and compassion to us as a family when we had so many questions and concerns

lovely staff always pleasant and chatty to me

all care and support was given and all staff were positive and engaging

## Not So Positive

i had no bed and had to wait in an uncomfortable chair attached to drips for many hours. then when i had a bed i was left at the end of a ward corridor with just a screen for privacy up

i felt very cold until staff turned the heating on

the food isnt very good it`s always coldthe ward is coldcheck on me more often

# Bereavement: The Big Conversation

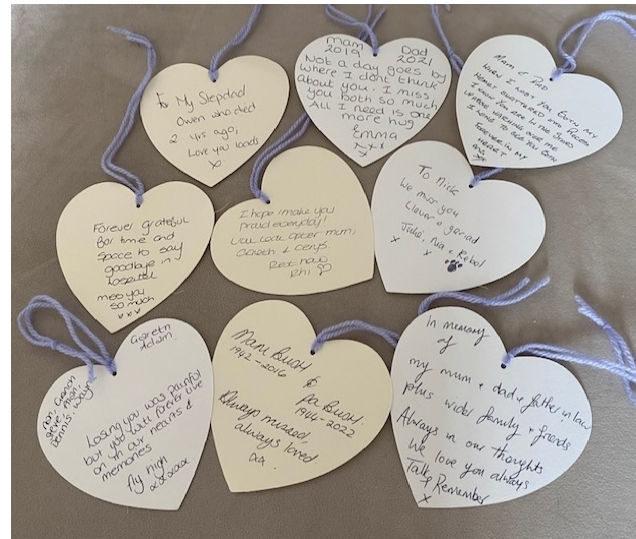
Developing our Bereavement Model is a key priority for the Health Board, the Big Conversation has been the launch of our new approach



## Morning Programme

<b>9:00am</b>	<b>Arrival, Registration and Refreshments</b>
9:25am	Chair's Welcome Carol Taplin, Specialist Chaplain, Aneurin Bevan University Health Board
9:30am	Opening Remarks Jenny Winslade, Executive Director of Nursing/Executive Lead for End-of-life Care and Bereavement, Aneurin Bevan University Health Board.
9:40am	Opening Address Nicola Prygodzicz, Chief Executive Officer, Aneurin Bevan University Health Board
9:50am	Improving bereavement support in Wales: The new national framework for the delivery of bereavement care and the research which informed it Dr Emily Harrop, Marie Curie Research Fellow, Cardiff University
10:10am	Advance and Future Care Planning: Making your wishes known Dr Clifford Jones, Assistant Medical Director, Aneurin Bevan University Health Board
10:25am	Living with Loss and Post Traumatic Growth Rhian Mannings, Chief Executive Officer 2 Wish
10:40am	The 'Hard to Reach' Myth Chris Dunn, Chief Executive Officer, Diverse Cymru
10:55am	Bereavement Support for People Affected by a Death by Suicide Bethan Bowden, Consultant in Public Health, Aneurin Bevan Gwent Local Public Health Team
<b>11:10am</b>	<b>Refreshments</b>
11:30am	Bereavement Support for People with Sensory Loss Non Ellis, Equality, Diversity, and Inclusion Specialist, Aneurin Bevan University Health Board
11:45am	Religion, Spirituality and Pastoral Care Alan Tyler, Senior Chaplain and Farid Khan, Imam, Aneurin Bevan University Health Board
12:00pm	The Impact of the New Death Certification Reforms Dr Jason Shannon, Lead Medical Examiner for Wales
12:15pm	The Local Vision for Improved Bereavement Services Tanya Strange, Head of Nursing, Patient Experience and Involvement and Louise Jones, Bereavement Lead Nurse, Aneurin Bevan University Health Board
<b>12:30pm</b>	<b>Lunch and Networking</b>

- 🌈 20<sup>th</sup> March 2024
- 🌈 **170** attendees (public, staff, partners, stakeholders)
- 🌈 **9** round table discussions
- 🌈 **51** Messages to loved ones
- 🌈 Bereavement Collaborative- **50** expressions of interest
- 🌈 **Evaluation Report**
- 🌈 **5** borough Big Conversation events in May 2024
- 🌈 **Peoples feedback** will inform the new Bereavement Model



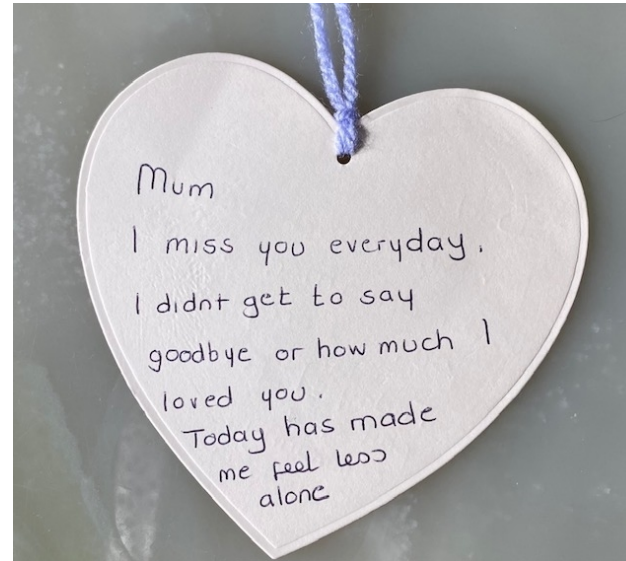
## Afternoon Programme

<b>Please see Room/Table Numbers in Main Foyer</b>	
<b>1:15pm</b>	<b>Round Table Conversations - Preparing for loss and bereavement support for:</b>
	<ul style="list-style-type: none"> <li>• People with sensory loss and disabilities</li> <li>• People from Black, Asian and Minority Ethnic Communities</li> <li>• People who have lost a child or young person</li> <li>• People who have lost someone under traumatic circumstances (including suicide)</li> <li>• People whose loved ones have died in hospital/inpatient setting</li> <li>• People who have lost loved ones in the community</li> <li>• People with identified religious and spiritual, and pastoral support at end of life</li> <li>• End of life care and bereavement support for people with cognitive impairment (including dementia)</li> <li>• Advance and Future Care Planning: Making your wishes known</li> </ul>
<b>2:15pm</b>	<b>The Big Conversation - Attendees to return to Main Hall</b>
2:15pm	Feedback from all discussion groups to inform the Big Conversation Chairs: Grant Usmar, CEO Hospice of the Valleys; Carol Taplin, Specialist Chaplain; Tanya Strange, Head of Nursing, Patient Experience and Involvement
3:15pm	Closing Remarks John Moss, National Bereavement Framework Programme Manager, NHS Wales Executive
<b>3:30pm</b>	<b>Event Close</b>

# Bereavement: The Big Conversation Feedback

## FEEDBACK: WHAT DID YOU FIND MOST USEFUL ABOUT TODAY (COMMON THEMES)

<b>To know I am not alone in my grief</b>	Having honest conversations-ability to speak freely	<b>Power of personal stories (numerous mentions)</b>	Learning that there is an obvious need to talk about bereavement. Lack of support can result in <b>negative grief</b> . Sensory loss and bereavement- <b>opened my mind</b> . <b>Round table</b> conversations. <b>Need to learn</b> so other families don't go through what we did Knowing <b>you are not alone</b> . Ability to <b>share experiences</b> . Everyone now knows that <b>change is needed</b> . Presentations highlighted the fact that <b>grief is widespread</b> <b>Emotional day</b> but very worthwhile. <b>Information</b> available. That <b>grief can affect all ages</b> .
<b>Networking and variation of attendees in conversation groups</b>	Variety of presentations and round table discussions	<b>Learning about the changes of the new Death Reform process</b>	
<b>'Eye opening' informative presentations</b>	<b>AFCP (numerous mentions)</b>	<b>Awareness of what's available</b>	
<b>Really good programme, various contributors</b>	Hearing about the lived experience of participants (numerous mentions)	<b>That change is coming- we need to listen to people's experience</b>	<b>" Today, my voice was heard".</b>



## FEEDBACK: STAYING CONNECTED AND BEREAVEMENT COLLABORATION

We asked: *Would you be interested in helping us **shape** the bereavement model?*



58 people provided written feedback. Of those, 50 people said they wanted to work with us to develop the new bereavement model.



Including the people already engaged, and those who have asked to be involved through social media, this means we will have around **80 people** engaged through our **bereavement collaborative**.



It is likely that **more people** will come forward as we engage in Big Conversations across all 5 boroughs.



## FEEDBACK: DO YOU THINK WE NEED TO HAVE MORE CONVERSATIONS ABOUT BEREAVEMENT

**100% of feedback received supported the need for more conversations**

"Absolutely more conversations"

"Yes, and allow people to know what's available"

"We need more Big Conversations as it raises important issues from all the public including diverse groups"

"Yes, death is feared and not talked about enough"

"Yes- could have a rolling conference focussing on different themes?"

"Yes, if points raised are listened to and acted upon and not just a tick box."

"Definitely- more conversations should be encouraged to normalise death and dying"

"Yes. We also need more education across the sector to help bereaved people."

"Yes, specifically around pregnancy/baby loss."

"Absolutely! Bereavement still feels like a taboo topic despite everyone experiencing it."

"Yes. Need a broader range of people's experiences with bereavement services."

"Yes, the more the better."

"Absolutely necessary."

"Yes, sharing people's stories to implement change is vital."

"Yes, this is just the start."

"Yes, so people know they are not alone."

"Need to have these discussions across Wales!"

## COMMENTS AND SUGGESTIONS

"Maybe, once someone loses a loved one in hospital, let staff take them into another room and talk to them, and explain what services are available and maybe tell them you will be in touch with them to arrange a meeting with a bereavement councillor within the Health Board to see how the family are doing?"

"Pregnancy loss under 20 weeks' gestation needs to be made as important as those pregnancies over 20 weeks. Maternity has protected bed status and 1:1 care. Gynaecology staff deal with baby loss daily, but no protected beds. All baby loss matters, to support our women, we need to be supported to protect them and give the best care possible".

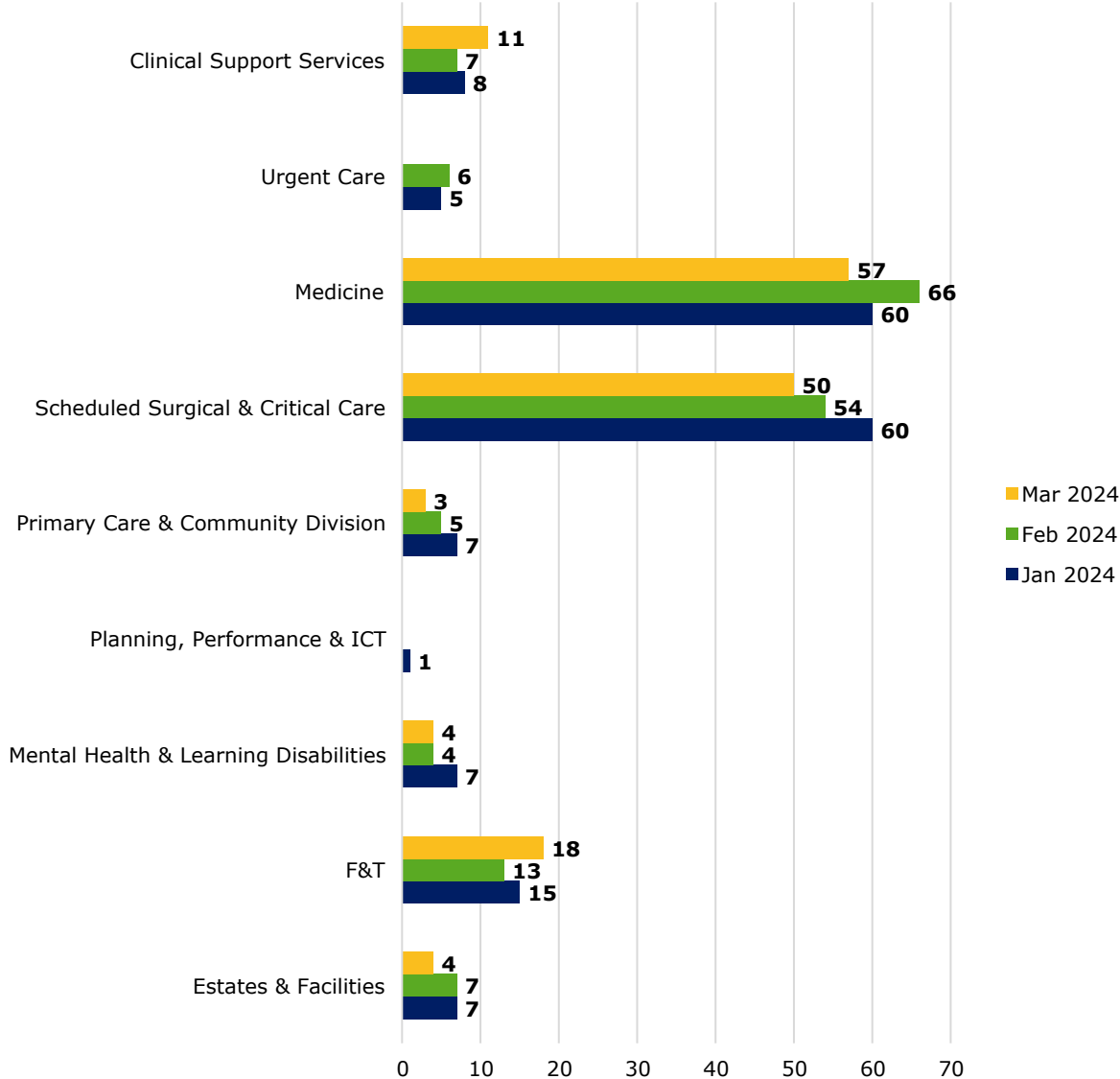
"We need to be confident we can meet strict funeral timelines depending on culture".

"Look at allocating 'Bereavement Champions' like Dementia Champions across the Health Board to raise awareness and improve education".

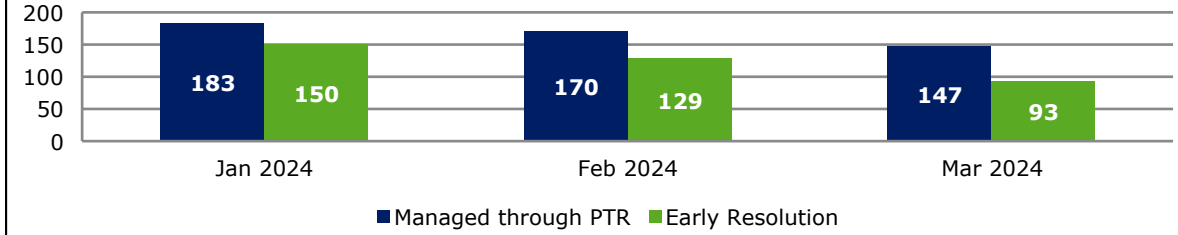
"Could the model follow a model similar to the 6 principles of trauma informed practice as this follows a lot of what has been missing".

# Complaints and Compliments

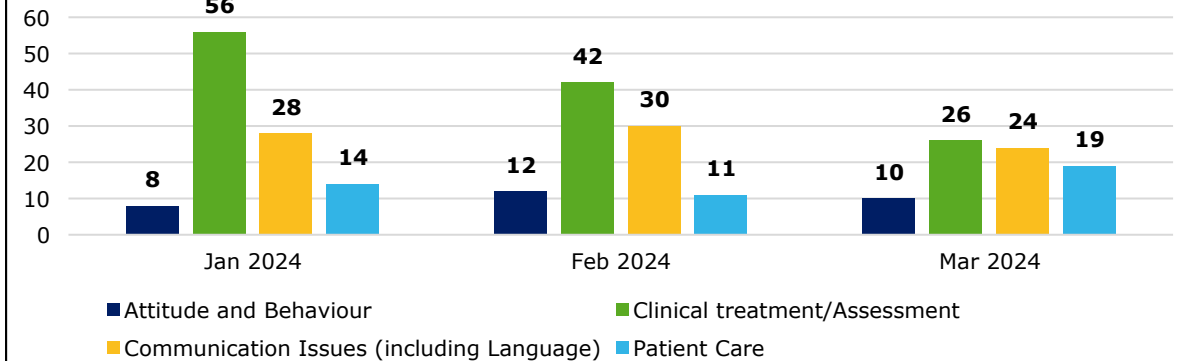
### Received Complaints Managed under PTR by Division Q4 Jan - Mar 2024



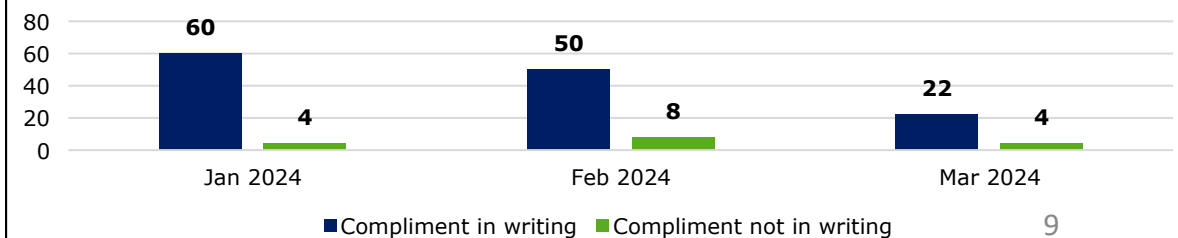
### Complaints Received by Type Q4 - Jan - Mar 2024



### Complaints Managed under PTR by Theme (Top 4) Q4 Jan - Mar 2024

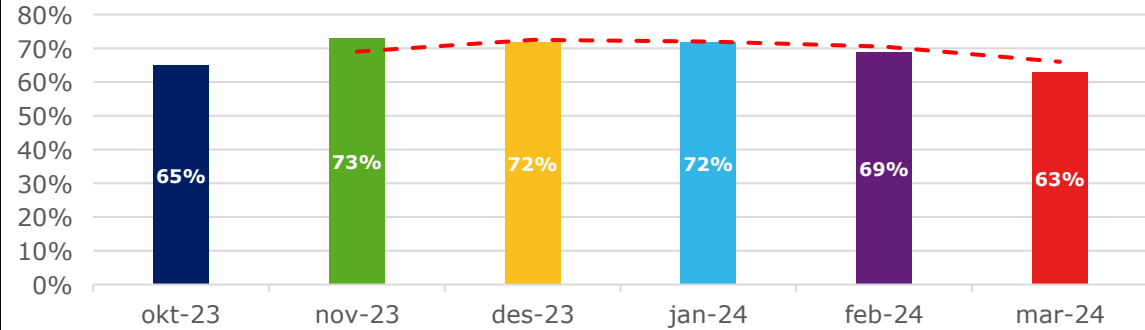


### Compliments Received Q4 Jan - Mar 2024

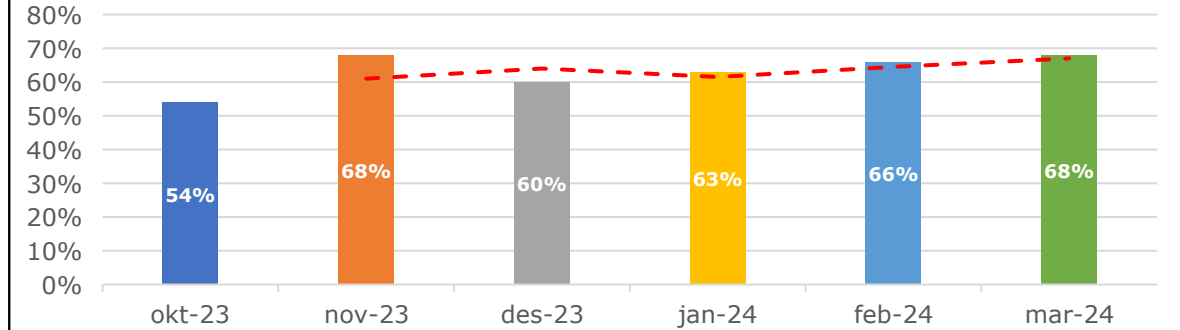


# Complaints and Compliments

**6 Monthly Early Resolution Performance**



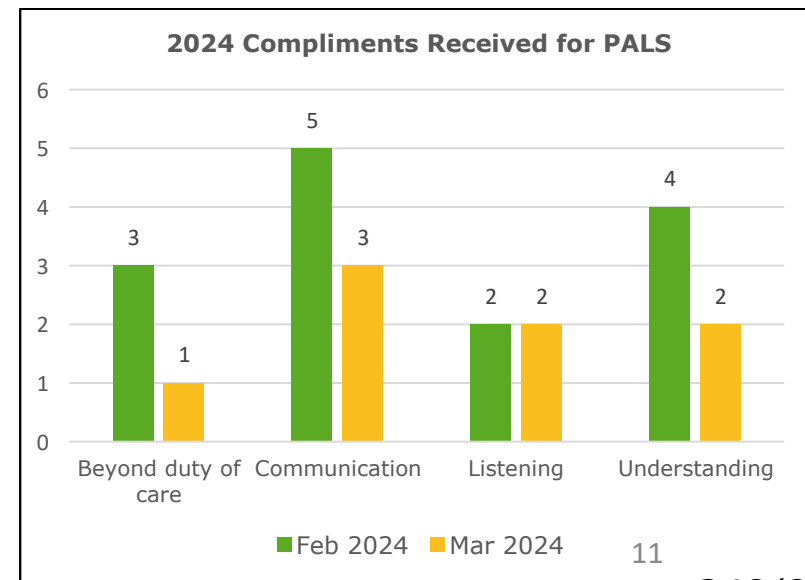
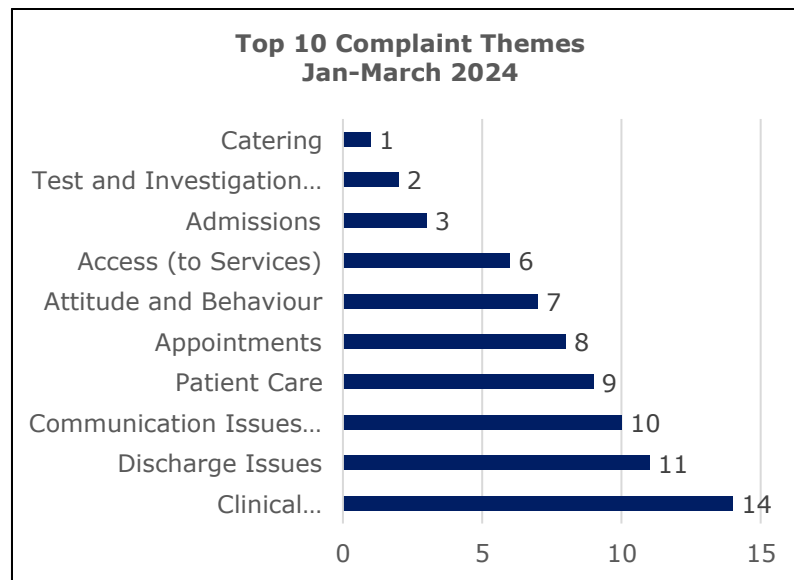
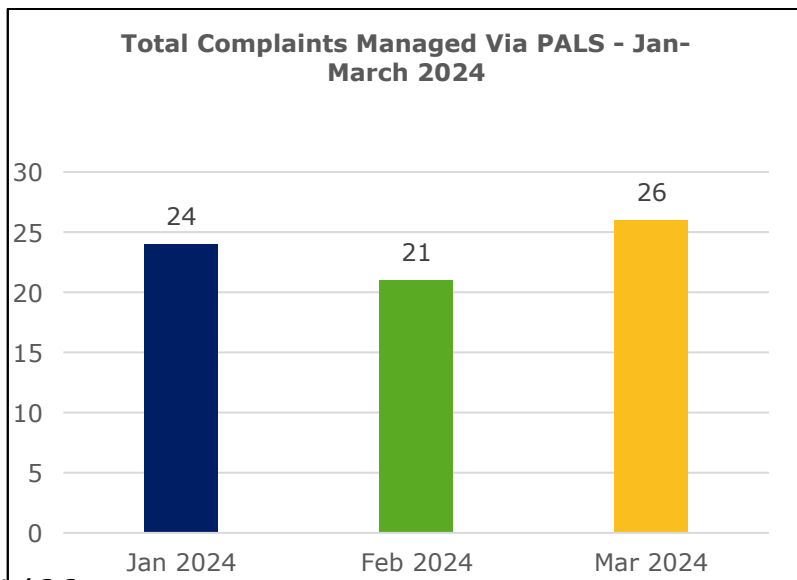
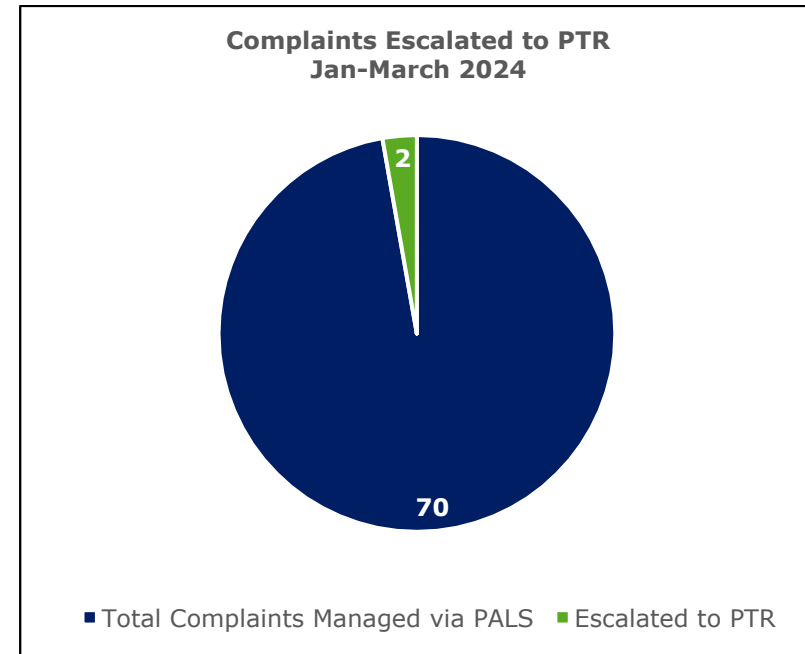
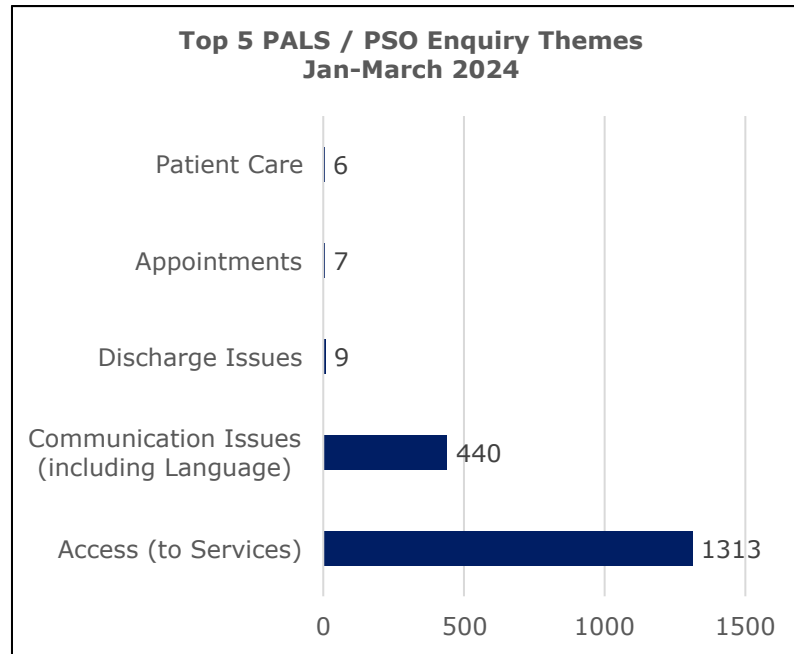
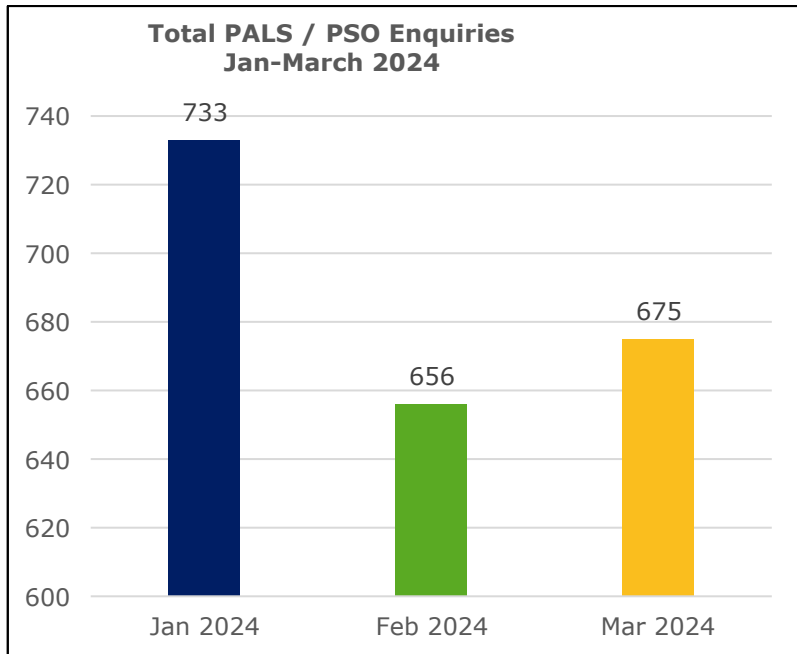
**6 Monthly Managed Via PTR Responded to Within 30-day target**



The target of 75% of PTR issues managed within 30 days indicates a positive improvement month on month for the upcoming financial year. In some areas compliance is already exceeding the proposed trajectory.

Trajectory for Improvement by Division/ Directorate	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
01 Family & Therapy Services	60%	63%	65%	68%	72%	75%
02 Scheduled Surgical & Critical Care	60%	63%	65%	68%	72%	75%
03 Primary Care & Community	45%	50%	54%	62%	69%	75%
04 Mental Health & Learning Disabilities	45%	50%	54%	62%	69%	75%
05 Urgent Care	55%	60%	65%	68%	71%	75%
06 Medicine	45%	50%	54%	62%	69%	75%
07 Estates & Facilities	90%	90%	90%	75%	75%	75%
08 Complex Care	75%	75%	75%	75%	75%	75%
09 Other	75%	75%	75%	75%	75%	75%
10 Clinical Support Services	60%	63%	65%	68%	75%	75%
Health Board	55%	59%	65%	68%	72%	75%

# Patient Advice and Liaison Service (PALS)



# Listening and Learning Framework

- A framework has been developed and approved which demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.
- This framework will compliment and build on divisional and directorate assurance arrangements by adding a strategic approach to support the Health Board to learn lessons from a range of internal and external sources. This will form part of our learning repository, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.
- The framework provides roles and responsibilities and details our systemic approach to learning, ensuring learning is continually captured within an accessible Learning Repository and builds an Organisational Memory.
- Next steps will involve presenting at the Learning Forum to produce an implementation plan.

# Priority 2: Safe Care

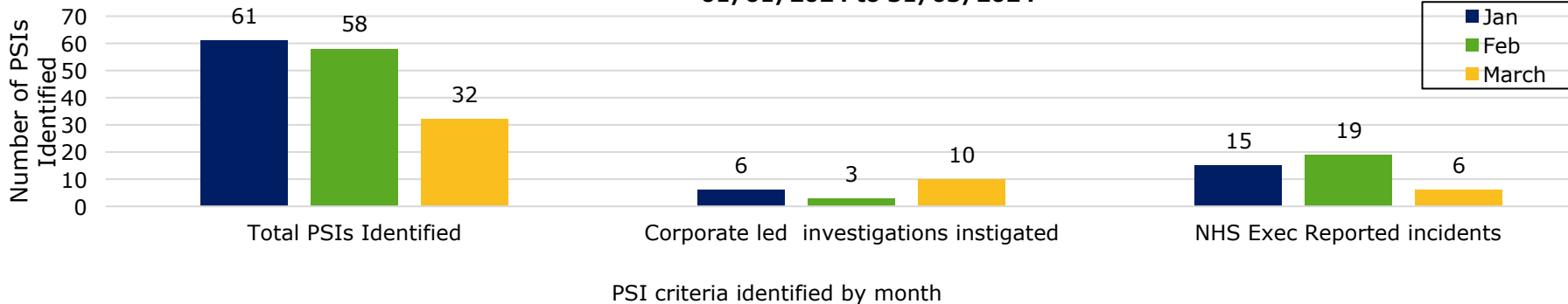


Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings	
			Latest data available	Indicator value	Latest data available	Indicator value			
<b>Priority 2 – Safe Care</b>	Fewer repetitive incidents in the priority areas and across the Health Board	Reduction in the number of SI's, by harm category	Q3 2023.24	68	Q4 2024	75	Increased	As of 31st March 2024, the PSI team were managing 75 live Serious Incident investigations (moderate/ severe), with 30 in meeting stages, and so an upward trend in the overall numbers of Corporate PSI investigations being held, but a decrease in the number still in the meeting stage.	
		Reduction in the number of National Reportable Incidents	Q3 2023.24	45	Q4 2024	40	Decreased	The Health Board reported 15 NRIs in January, 19 during February, with a significant decrease to 6 during March 2024.	
		Reduction in the number of Never Events	Q3 2023.24	4	Q4 2024	0	Decreased	0 Never Events reported during January, February and March 2024.	
		Improvement in the time to respond and close incidents (average time to closure – all incidents)	Q3 2023.24	83 days	Q4 2024	72 days	Decreased	There has been decreasing trend for the time taken to close incidents, and an increase in the number of incidents reported in line with an increased use of the DATIX system.	
		Decrease in the number of reportable IPAC incidents	Q3 2023.24	29/week	Q4 2024	See table	Increased	We would anticipate an upward trend in the winter due to the prevalence of respiratory infections, with RGH and NHH having the most outbreaks due to the layout of the ward environments, the table shows specific infection rates	
		The number of incidents with no harm themes identified							Refining measure
		Increase in the compliance of Health and Safety Statutory and Mandatory Training	Q3 2023.24	86%	Q4 2024	87%	Improved	There has been an increase in all the health and safety areas compared with the previous report. H&S 87%, fire safety 83%, manual handling 55% and V&A 85%.	

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
<b>Priority 2 – Safe Care</b>	Improved clinical outcomes	Decrease in the time to complete safety alerts	Q3 2023.24	4 days	Q4 2024	4 days	No Change	The average time to report has stabilised however the data is highly variable with regular peaks above four days.
		Severity of harm following a fall in hospital (moderate and above)	Q3 2023.24	44	Q4 2024	49	Increased	Q1 79, Q2 42 Q2 – Q4 number of falls with moderate harm or above remains consistent.
		Decrease in the number of Falls by 1,000 occupied IP Bed days	Q3 2023.24	7.24	Q4 2024	7.35	Increased	Q1 6.95, Q2 7.43 – falls data remains broadly consistent
		Decrease in the number of falls treated in ED which have had a previous admission - reattendance	No Data	No Data			No Data	Measure to be refined
		Improved RAMI Score	Q3 2023.24	114	Q4 2024	110	Decreased	There has been a decrease in RAMI from Q3 – Q4. The Health Board is currently outperforming the Welsh Peer Group Average of 113.46. Positioned as 3 <sup>rd</sup> best RAMI out of Welsh peer group.
		Improved Crude mortality by hospital	Q3 2023.24	4.3	Q4 2024	5.07	Increased	Increase in Deaths per 1000 bed days of 0.77 between Q2 and Q4 of 2023/24. A process is being defined to review deaths, looking at coding and deep dive SOP for reviewing notes.
		Decrease in the number of HA pressure ulcers by grade	Q3 2023.24	25%	Q4 2024	20%	Decreased	Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty. Reduction of 5% over the quarter
		Decrease in the number of HA pressure ulcers	Q3 2023.24	23/week	Q4 2024	23 /week	Unchanged	Work underway with improvement collaborative which has shown a decrease in reported PU of 2,3,4 grade 1 remain static.
		Decrease in the severity of medication incidents	Q3 2023.24	469	Q4 2024	448	Severe category consistent	Total incidents: Q1 304, Q2 389, Q3 469, Q4 448 Moderate-severe: Q1 28, Q2 67, Q3 85, Q4 69 Catastrophic: 0 reported Q1-Q4
		Decrease in the number of incidents under - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Q3 2023.24	21	Q4 2024	19	Decreased	Q3 -21 incidents reported to the HSE in accordance with RIDDOR, 61.9% of these cases were reported within the legal timeframes within the legislation. Q4- 19 incidents reported within 73.6%. This is an increase in compliance with legal timeframe.
		Reviewed Cardiac Arrest calls by 10,000 bed days	No Data	No Data			No Data	Measure to be refined
		Decrease in Preventable Hospital Acquired Thrombosis (HAT) incidents	Q2 2023.24	0	Q3 2023.24	0	Maintained	Non preventable HAT incidents – Q1 72, Q2 70, Q3 –62. Data is consistent. There is a 3–6-month delay on data and requires case notes review.
		Increase in the number of PREM Audit and actions						Measure to be refined.

# Patient Safety Incidents

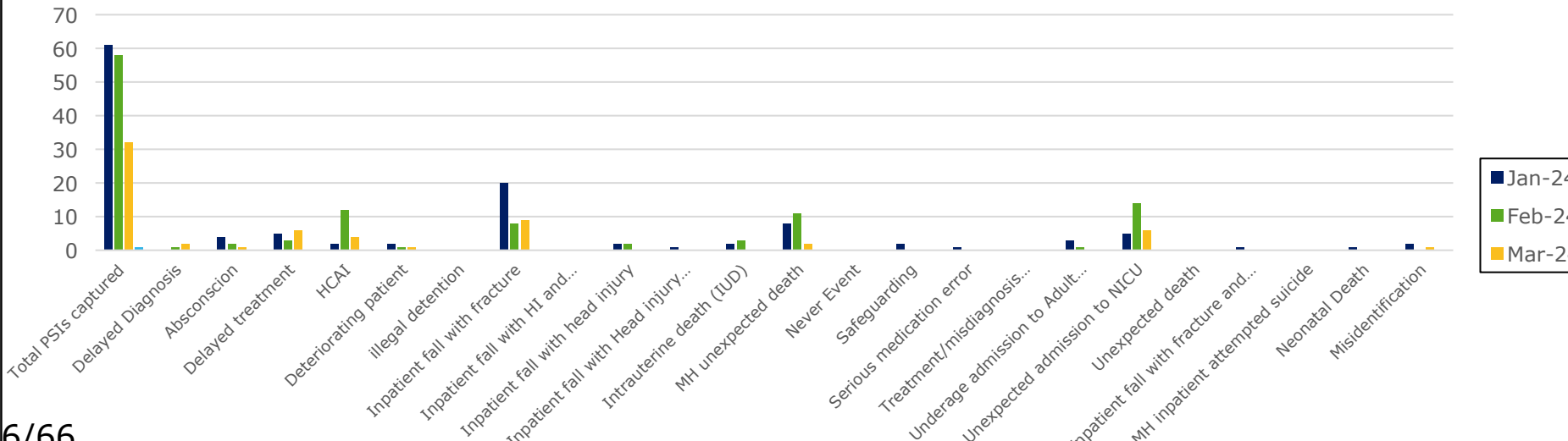
**Patient Safety Incidents Identified highlighting Corporate led investigations, and NHS Exec reported incidents 01/01/2024 to 31/03/2024**



A total of 210 Patient Safety Incidents were identified during January, February and March 2024. 61, 58 and 32 respectively. MH Unexpected Death, Unexpected Admission to NICU and Inpatient fall with # were the top themes.

There were 30 EWNs reported to WG during this period, 13 in January 12 in February and 5 in March. Themes included varied safeguarding issues, absconsions, misidentification of patients and PRUDiCs.

**PSIs captured from 1st January 2024 and 31st March 2024**



## Themes

### Ophthalmology Delays

Ophthalmology report incidents of glaucoma patients lost or delayed to follow up. Each case assessed for harm. Currently one completed PSI, one in progress and a further 7 awaiting review. Currently, 5437 glaucoma patients awaiting a follow-up appointment. Of which 3882 are now past their target date. Diagnostic hub and risk stratification tool are now in place. Further capacity for virtual reviews is being sought. Ongoing discussion with primary care re contract reform due to commence in April and may impact ODT capacity.

### Missed Cancers

The Health Board continues to receive incidents of missed cancer diagnosis via a number of avenues, including patients lost to follow-up appointments, or missed on radiological reporting. There have been three new PSIs in this quarter.

### PSI Team

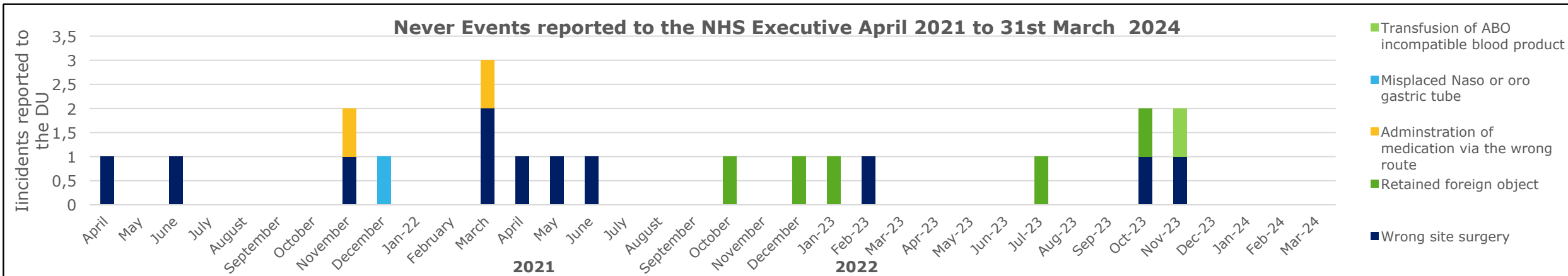
The PSI team have developed a new Patient Safety Incident Report template with guidance notes, drawing on best practice, human factors methodology/ tools and from feedback received from staff, patients, families and HM Coroner. This is currently out for consultation and feedback from key Health Board stakeholders.

# Review of Patient Safety Incident Process

Issue	Cause	Remedial Action	Who	When
<p>SI process currently sub-optimal to meet needs of organisation.</p>	<p>Historic process no longer fit for purpose</p>	<p>Presentation of all Serious incidents to weekly Executive Huddle for decision regarding level of investigation.</p>	<p>Head of Putting Things Right</p>	<p>Ongoing</p>
	<p>Varying processes across Corporate and Divisions</p>	<p>Weekly pre- Executive Huddle meeting to form a decision panel.</p>	<p>Deputy Director of Nursing</p>	<p>Complete</p>
	<p>Lack of organisational learning shared</p>	<p>Ongoing meetings with EDoN and Corporate PSI Team to identify barriers to effectiveness</p>	<p>Director of Nursing/ PSI team</p>	<p>Ongoing</p>
		<p>Divisional engagement and 1-2-1's undertaken. Outcomes to be communicated.</p>	<p>Assistant Director of Nursing</p>	<p>Complete January 2024</p>
		<p>QPSOG is being reconfigured in line with the Learning Framework.</p>	<p>Assistant Director of Nursing/Assistant Director for Quality and Patient Safety</p>	<p>Ongoing</p>

# Never Events

- 0 Never Events reported during January, February and March 2024.
- The PSI team are currently engaging with the NHS England Never Events consultation in conjunction with NHS Wales colleagues.



Never Event Workstreams	Improvement Work
2 NE SI's closed in period	Key safety themes identified and prioritised as a key area of improvement focus. Patient Safety Incidents Team supporting ongoing Never Event investigation using a systems approach and methodology (fishbone diagrams) to ensure high quality reviews.
	<b>There will be changes to the All-Wales Transfusion Policy</b> to ensure a standardised approach to the checking procedure across the wards for blood components and products. This will include the process for checking barrier-nursed patients.
	<b>'Back to Basics' programme of training and education for Theatre staff</b> (Scrub, Anaesthetic and Recovery staff) has been commenced. Run on a monthly basis since January 2024, each month focuses on a key topic such as swab counting, standardisation of practice, diathermy practice, and safe handling of medication in theatre for example. This has been incredibly successful and now is being scaled and spread to other areas such as Cardiac Catheter Lab (GUH) and Endoscopy(RGH) where topics can be made bespoke to staff training needs.
	<b>Standardisation of the World Health Organisation (WHO) Safety Checklist</b> is being currently reviewed across Theatres.
	<b>Tackling Safer Culture sessions</b> have been rolled out, the QPS Scheduled Care Team, focusing on 'Pause for the Gauze' locally in advance of the national roll out of NatSIPPs 2. This has been extended across all sites.
	<b>Theatre Safety Bulletins</b> have been developed to improve overall theatre engagement across Theatre Teams. Bulletins contain information on ongoing Theatre Safety Improvement Work and any training updates or information around incidents in theatre. Each Theatre department produces their own Bulletin, and these are shared with other Theatre areas.
	QPS/Theatres have been working alongside the Communications Team to develop an Intranet Page to raise the profile of the Operating Department Practitioner (ODP) role and Theatre Nurse role.

# Wider Learning on Incidents

Issue	Cause	Remedial Action	Who	When
<p>There has been an increased awareness and education around systems thinking and Human factors has been highlighted in ongoing Patient Safety Incident investigations to move away from linear Root Cause Analysis (RCA) methodologies and towards a systems-based lens. This will benefit clinical teams, investigating officers and support QPS in patient safety priorities.</p>	<p>Apart from the current provision of 'Introduction to Human Factors', there is currently no formal Human Factors training available in NHS Wales or ABUHB.</p>	<p>The Health Board to scope the potential for formal training provision from external providers as per below;</p> <ul style="list-style-type: none"> <li>• <a href="#">Creating Patient Safety eLearning   CHFG - Clinical Human Factors Group</a></li> <li>• <a href="#">Health Services Safety Investigations Body - Education Prospectus (NHS) (turtl.co)</a></li> <li>• <a href="#">Training Courses   CIEHF (ergonomics.org.uk)</a></li> </ul>	<p>Head of PSI</p>	<p>30 June 2024</p>
<p>PSI documents no longer align with recording actions on RL Datix</p>	<p>Updating of PSI Policy and move over to RL Datix.</p>	<p>Update and circulate for consultation new Report template and Guidance. Amend as per comments. Launch April 2024.</p>	<p>PSI Manager</p>	<p>22 April 2024</p>

# Infection Prevention & Control

## All Wales comparison – WG Goals

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	38.55	1.52	20.29	59.35	22.66	4.23
Betsi Cadwaladr UHB	41.7	1.16	24.99	79.63	22.67	4.65
Cardiff and Vale UHB	22.35	2.57	28.88	68.24	23.74	3.56
Cwm Taf Morgannwg UHB	28.38	2.03	29.05	85.13	26.57	4.73
Hywel Dda UHB	47.26	2.6	25.97	100.49	28.05	7.53
Powys THB	18.67	0	0.75	1.49	0	0
Swansea Bay UHB	65.2	1.83	34.95	67.02	24.51	5.22
Velindre NHST						
<b>Wales</b>	<b>38.89</b>	<b>1.82</b>	<b>25.61</b>	<b>72.61</b>	<b>23.5</b>	<b>4.63</b>

- < than same period last FY
- = same period last FY
- > than same period last FY

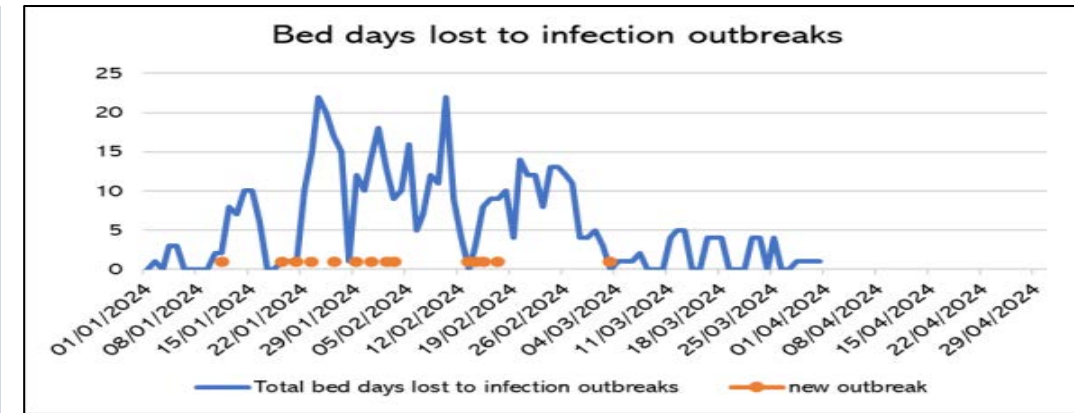
Issue	Cause	Remedial Action	Who	When
3 wards closed at Nevill Hall due to increase of C difficile infection 4/3, 3/1 & 3/4	<ul style="list-style-type: none"> <li>Antibiotics prescribed without Microbiology advice</li> <li>Antibiotics prescribed out of guidance</li> <li>Failing to withhold PPI while on antibiotics</li> <li>Isolation</li> <li>Lapse with mattress checking</li> <li>Cleaning and ownership of shared equipment</li> <li>Soiled commode</li> <li>Gaps with cleaning schedules due to low staffing establishment</li> <li>Low compliance with hand hygiene</li> </ul>	<ul style="list-style-type: none"> <li>Antibiotic audits feedback to medical teams</li> <li>Geno sequencing indicates no onward hospital transmission</li> <li>Staff reminded to isolate patients when symptoms commence if suspecting infection</li> <li>Staff reminded to check mattresses at least weekly. Ensure shared equipment is cleaned/wiped down between use. Use "I am Clean" stickers</li> <li>Decant HPV clean implemented</li> <li>Visit ward with hand decontamination unit</li> </ul>	Antibiotic Pharmacist Ward Manager/ Senior Nurse Infection Prevention	Completed
Increase in gram negatives blood cultures in comparison to previous financial year.  One area (community ward) identified 2 cases of Klebsiella associated with urinary catheter antimicrobial sensitives different strain  Below all Wales rate for all areas of measurement.	<ul style="list-style-type: none"> <li>Majority of cases identified on admission</li> <li>Increased antimicrobial resistance</li> <li>Poor documentation compliance with device management</li> <li>Associated with secondary respiratory</li> </ul>	<ul style="list-style-type: none"> <li>RCA meeting for all BSI associated with urinary catheter and line infection</li> <li>Promotion of ANTT</li> <li>Promotion of procedure packs for blood culture collection and insertion of medical devices</li> <li>Monitoring of medical device care bundles via AMAT</li> </ul>	Antibiotic pharmacist Ward Manager/Senior Nurse Infection Prevention	Ongoing

# Infection Prevention & Control

An increase of diarrhoea & vomiting outbreaks coupled with Covid and Influenza circulating resulted in **528** bed days lost due to infections. Three wards at Nevill Hall experienced lost beds due to an increase of C difficile infection. Beds closed to allow deep clean to take place.

Impact of prolonged bed closures managed promptly by: -

- ✓ Risk assessment of patient movement
- ✓ Ensuring patients with same illness cohorted
- ✓ Compliance with fundamental infection prevention measures
- ✓ Correct use of appropriate PPE
- ✓ Public Comms to restrict visiting



Issue	Cause	Remedial Action	Who	When
Suspected Pertussis (whooping cough)	Index case in ED for 12 hours on 22 <sup>nd</sup> – 23 <sup>rd</sup> January 2024	<ul style="list-style-type: none"> <li>• Contact tracing exercise undertaken to identify patients exposed for at least one hour</li> <li>• Warn &amp; Inform letter sent to 51 parent's and GP</li> </ul>	Infection Prevention	Completed 09/02/24
Suspected Pertussis (whooping cough NHH & GUH)	Index case presented at GP out of hours on 11 <sup>th</sup> Feb & 12 <sup>th</sup> Feb, transferred to GUH on 12 <sup>th</sup> Feb	<ul style="list-style-type: none"> <li>• 2 patient contacts – checked for vaccination status</li> <li>• Staff contacts wearing PPE</li> </ul>		
Shingles exposure	Patient with confirmed shingles on care of the elderly community ward	<ul style="list-style-type: none"> <li>• Contact tracing exercise undertaken to identify staff and patient immune status</li> </ul>	Infection Prevention	Completed 25/01/24
4 wards closed due to Covid outbreak 11 wards closed due to D&V outbreaks 1 ward closed due to influenza	<ul style="list-style-type: none"> <li>• Lapse with PPE – staff, visitors &amp; patients</li> <li>• Sub standard cleaning</li> <li>• Staff knowledge of IP measures</li> <li>• Visitors attended with known symptoms</li> <li>• Additional capacity &amp; boarding</li> </ul>	<ul style="list-style-type: none"> <li>• Encouraged correct use of appropriate PPE</li> <li>• Enhance cleaning and recording</li> <li>• Bespoke ward based practical training</li> <li>• Restricted access posters displayed at ward entrance</li> <li>• Comms circulated for visiting</li> </ul>	Infection Prevention Ward Manager/ Senior Nurse	At time of outbreak
Patient with healthcare associated invasive group A strep	<ul style="list-style-type: none"> <li>• Possible staff member working with symptoms of sore throat</li> </ul>	<ul style="list-style-type: none"> <li>• Staff and patient contacts risk assessed for signs of infection- sore throat, skin soft tissue infection or concerns about infection at any site</li> <li>• Staff member visited GP for treatment</li> <li>• 4 patient contacts received prophylaxis antibiotics</li> <li>• Ward and inform letters sent to patient contacts</li> </ul>	Infection Prevention Ward Manager Senior Nurse	Completed February 2024
Invasive group A strep identified on admission	<ul style="list-style-type: none"> <li>• Patient admitted with worsening skin rash for 2 days prior to admission. Considered vasculitic rash secondary to bacteraemia.</li> </ul>	<ul style="list-style-type: none"> <li>• Patient commenced antibiotic treatment</li> <li>• Patient isolated</li> <li>• No patient or staff contacts</li> </ul>	Infection Prevention	March 2024
Measles exposure within GP OOH and GUH resulting in three further cases identified measles positive.	<ul style="list-style-type: none"> <li>• Patient not isolated on presentation to the department</li> </ul>	<ul style="list-style-type: none"> <li>• Contact tracing of patients and staff (71)</li> <li>• Incident Management Team held via Public Health</li> <li>• Under 6 month children offered HNIG</li> <li>• Warn and inform letters sent</li> <li>• Increased comms</li> <li>• Review MMR status</li> <li>• Promote mask fit testing</li> </ul>	Incident Management Team	March 2024

# Measles Outbreak Update

9 confirmed cases of which 7 onward transmission from exposure in waiting area all unvaccinated  
Contact tracing a total of 213 children, MMR history and direct exposure reviewed resulting in:-

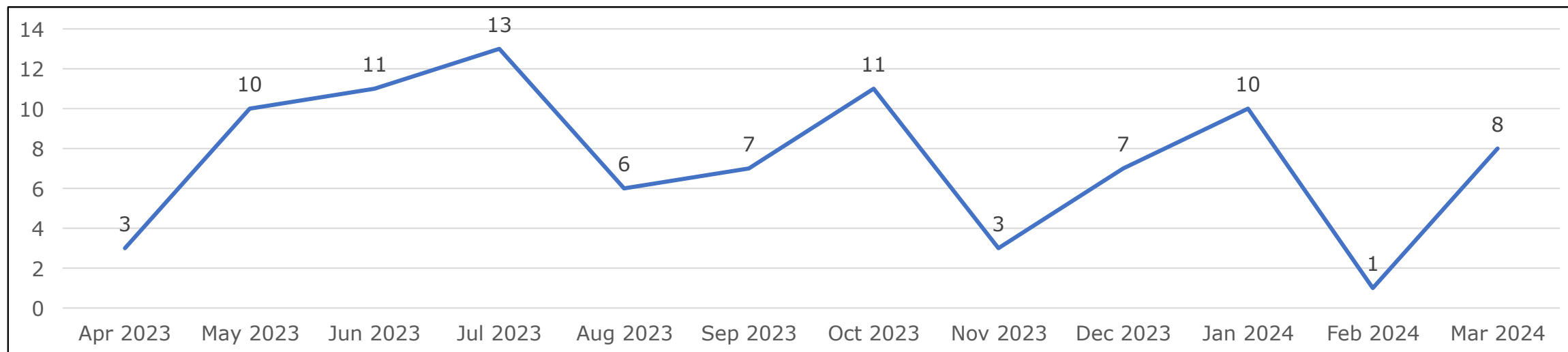
- 2 clinics for under 6 months resulting in 15 babies receiving HNIG, everyone received warn and inform letters, and exclusion advice dependant on MMR history advocated, medical alerts placed on children for the incubation and infectious period
- 8 staff members medically excluded

## Actions:-

- Revisited patient pathways, screening questions amended, hub relocated outside ED, enhanced cleaning, declutter of environment, air changes checked, promotion of mask fit testing and vaccination
- Primary care reviewed action card to formalise the process developed re the management for:-
  - Identified contacts, staff working in practice, and unvaccinated patients

## Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period Jan 2024 to the end of March 2024 the Health Board have reported **19 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). This is the lowest reported quarter in 23/24



**67.7%** of these cases were reported within the legal timeframes within the legislation.

# Health, Safety & Security – Statutory & Mandatory Training

At end of March 2024 training compliance for the Health Board was reported as:

Health & Safety	87%
Violence & Aggression	85%
Manual Handling	55%

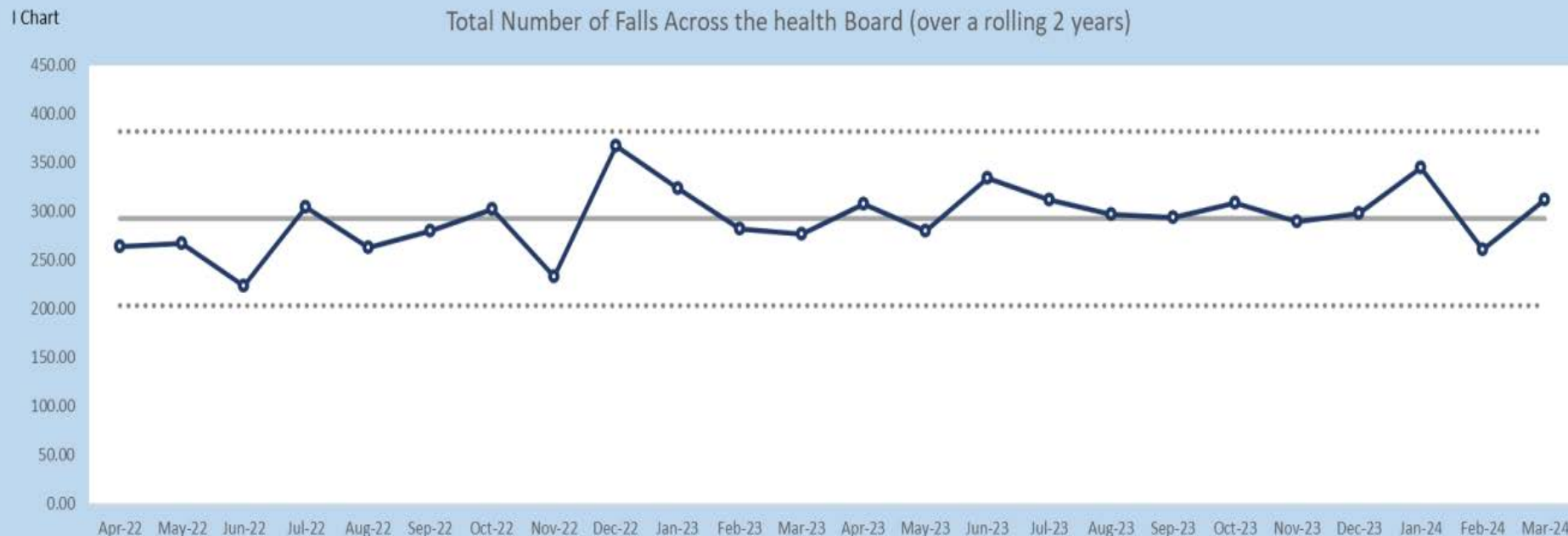
There has been **no change** in the compliance with Violence & Aggression compared with the previous report, however, the compliance with Health & Safety, Fire Safety and Manual Handling have all **increased by 1%**.

## Health, Safety & Security – Improvement Plan 2023/24

Seven areas for focus have been identified for improvement in 2023/24. These are:

- 1) Manual handling training compliance
- 2) Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
- 3) Lack of proactive health and safety monitoring plan
- 4) The quality and standard of health and safety risk assessments
- 5) Compliance with the review of fire risk assessments
- 6) Adequacy of fire alarm systems
- 7) Compliance with the management of fire barriers (compartmentation)

# Total Number of Inpatient Falls



## April 2024 - Context

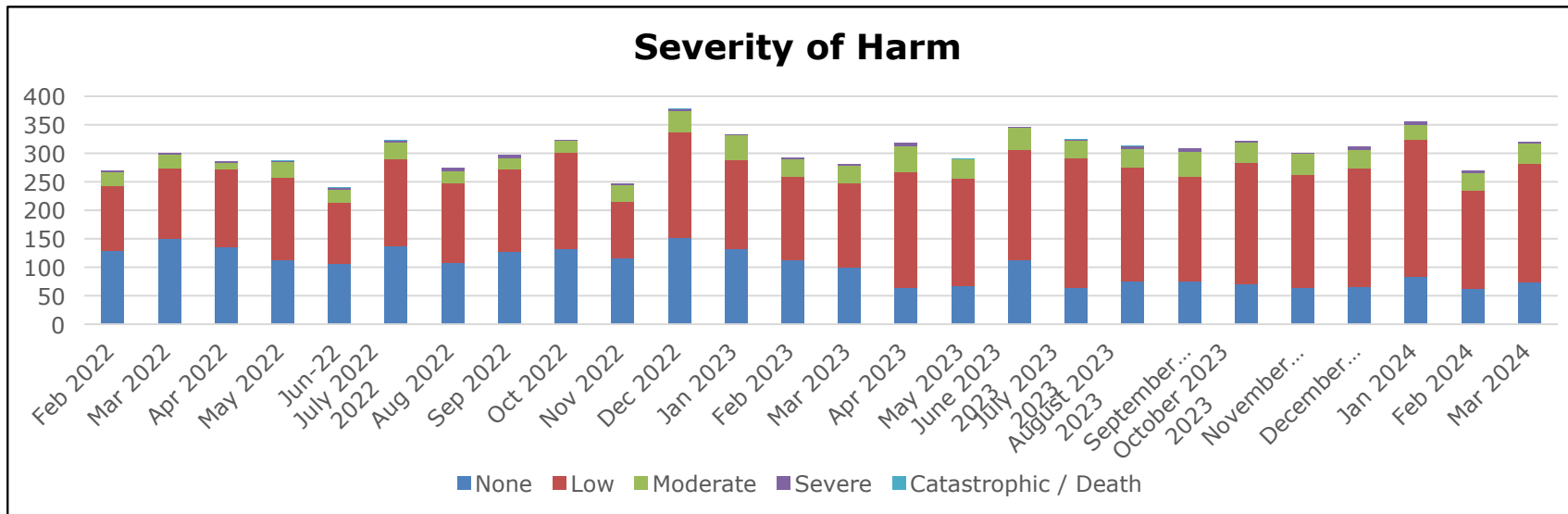
The data used in this chart has been retrieved from RLDatix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period February 2022-24.

With the information available for Q4 2023-24, 44 patients have experienced more than 2 falls with an average of 3.6 per patient. Further work is being undertaken to sub categorise the falls incidents aligned to RLDatix definitions to further enhance the data collection information.

Definitions	What the chart tells us	Variation
<p>Reported fall incidents in Aneurin Bevan University Health Board (ABUHB).</p> <p>This data was retrieved from RLDatix as the information source.</p>	<ul style="list-style-type: none"> <li>For the given period of analysis, the mean average fall of fall incidents is 290.</li> <li>Following the period August –December 2023 in which the numbers of falls incidents remained on a steady trajectory along the centreline January 2024, saw a rise to a value more closely aligned to the upper control limit. A subsequent decrease in incidents has been seen in February 2024.</li> </ul>	<p>January 2024 saw the second highest value of reported incidents for the period of analysis whilst February 2024 represents the lowest value for reported incidents since November 2022.</p>

# Inpatient Falls Data by Severity of Harm



## April 2024 - Context

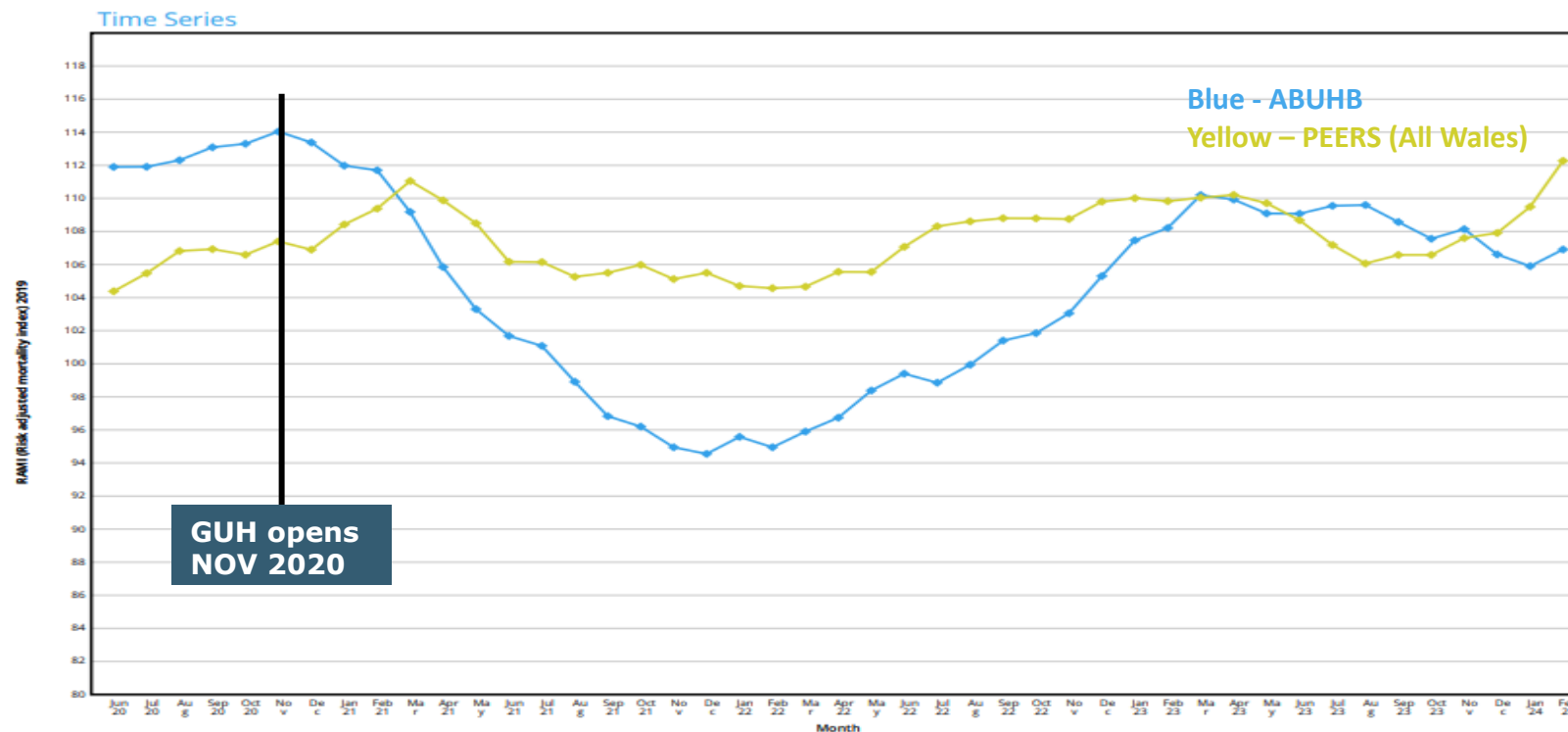
The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period February 2022- March 2024.

The severity data is reflective of the identified level of harm recorded at the time of reporting and may be subject to change following investigation.

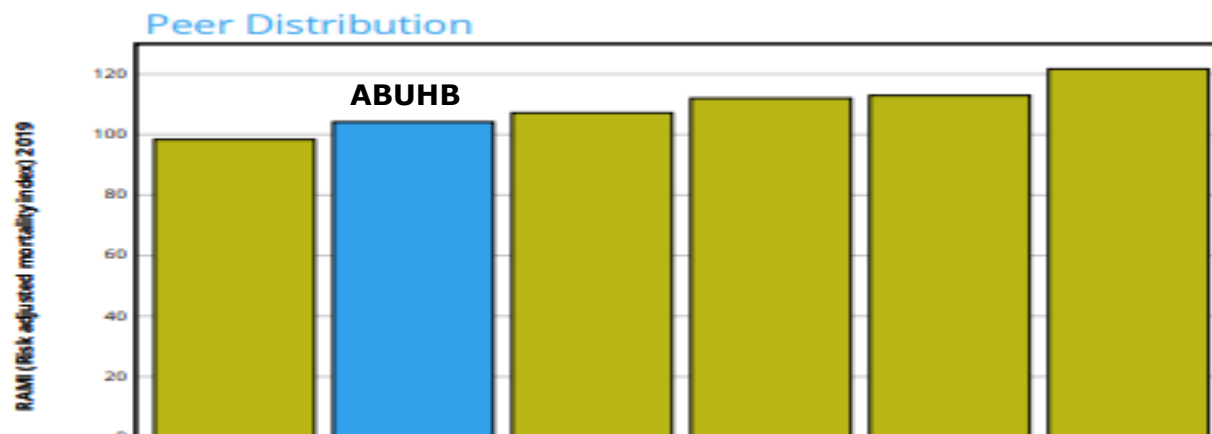
Definitions	What the chart tells us	Variation
<p>Reported fall incidents in Aneurin Bevan University Health Board (ABUHB).</p> <p>This data was retrieved from RLDatix as the information source.</p>	<p>Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 7916. Of this figure the following is identified.</p> <ul style="list-style-type: none"> <li>• 89% No or low harm</li> <li>• 10% - Moderate harm</li> <li>• 0.9% Severe harm</li> <li>• 0.1% Catastrophic</li> </ul>	<p>For 2024 to date no incidents were reported as catastrophic at the time compiling this report with no change post investigation.</p>

# RAMI (Risk Adjusted Mortality Index)

RAMI is a mortality index which is a ratio of an observed number of deaths to an expected number of deaths in a particular population. The index is simply the number of observed events divided by the number of expected events.

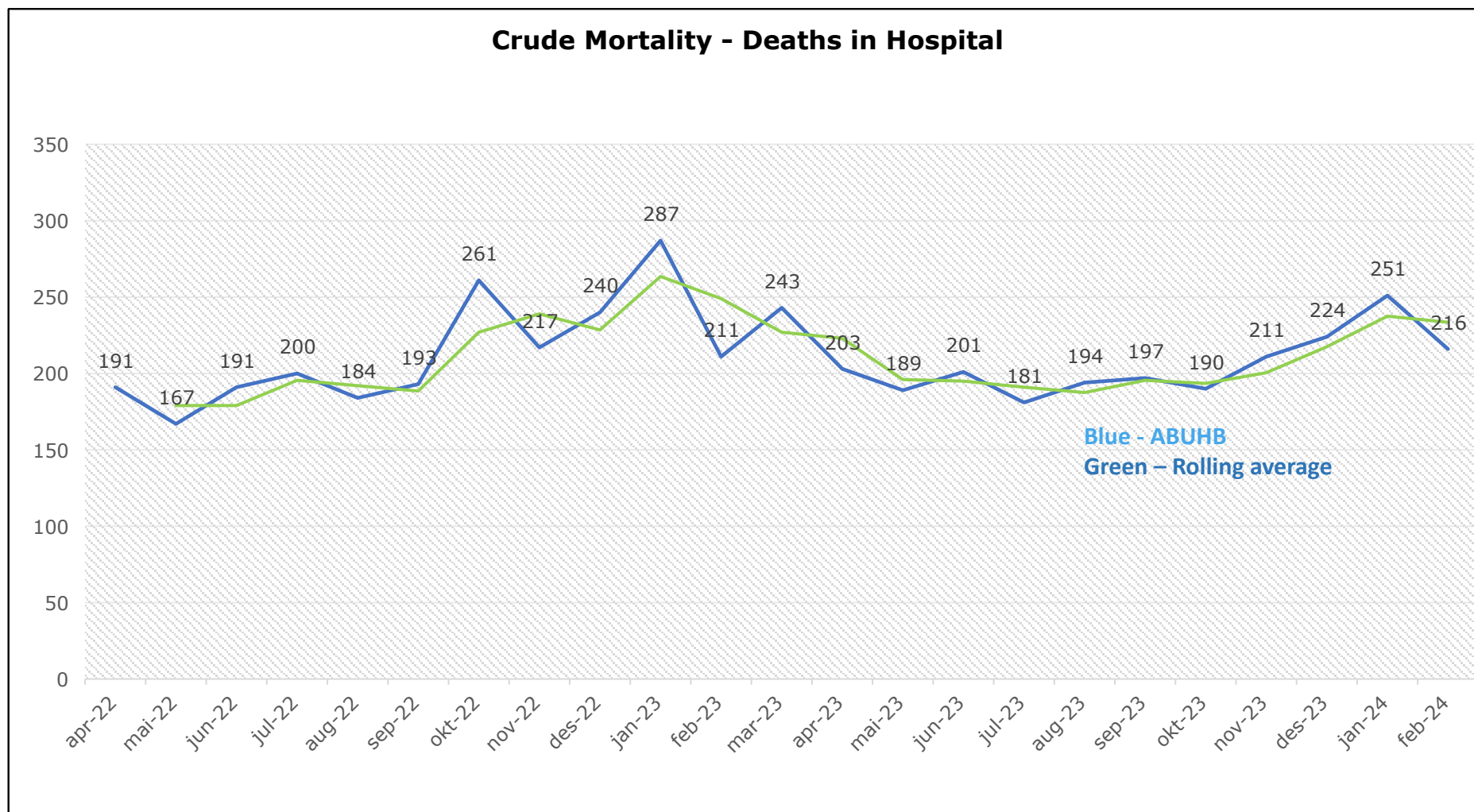


**Feb 2024 RAMI is 107**



**Currently performing 2<sup>nd</sup> of 6 within All Wales peer group**

# Crude Mortality in Hospital



Whilst the Health Board RAMI has varied significantly, the crude mortality and mortality rate are flat and consistent.

This emphasises the need for an individual mortality report to undertake deep dives in high mortality specialties.

# Mortality Actions

Issue	Cause	Remedial Action	Who	When
Understanding mortality data and how we implement learning from mortality	<p>There is a need to understand what is reported to PQSOC and to Board for mortality.</p> <p>England produce a Learning from Death framework which enables a standardised mortality report.</p>	Mortality report completed. Learning from Death Framework under development and progressing to first draft. This will include learning from the Medical Examiner service and the mortality review screening panel. We are reviewing our end to end mortality process.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistency of mortality reporting and data.	Mortality report available for this PQSOC, proposing a framework for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports crude mortality. We are part of the All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	Ongoing
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 80% because of increasing activity.	Work with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	On-going
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHLD deaths and suicide.		
	Mortality indicators not available to all	Once mortality indicators are agreed, the team will develop as a QLIK app to provide instant access to data.		

# Pressure Ulcer Faculty – Introduction and Aims

Following the COVID-19 Pandemic, the Health Board reported increased numbers of unstageable and grade 3&4 Health Acquired Pressure Ulcers (HAPU's). Divisions report data via the HAPU Steering Group and the Quality and Patient Safety Operational Group.

The Director of Nursing requested a new focus on reduction and prevention of HAPU's within ABUHB to meet the Welsh Government standard of 0% avoidable Health Acquired Pressure Ulcers. With the success of the previous pressure ulcer prevention and reduction collaborative in July 2018, the Pressure Ulcer Faculty 2023 has been developed, led by the Nursing Directorate and Senior Nurses from Medicine, Unscheduled Care, Urgent Care and Community Care nursing; with support from ABCi.

## Aim of the Faculty

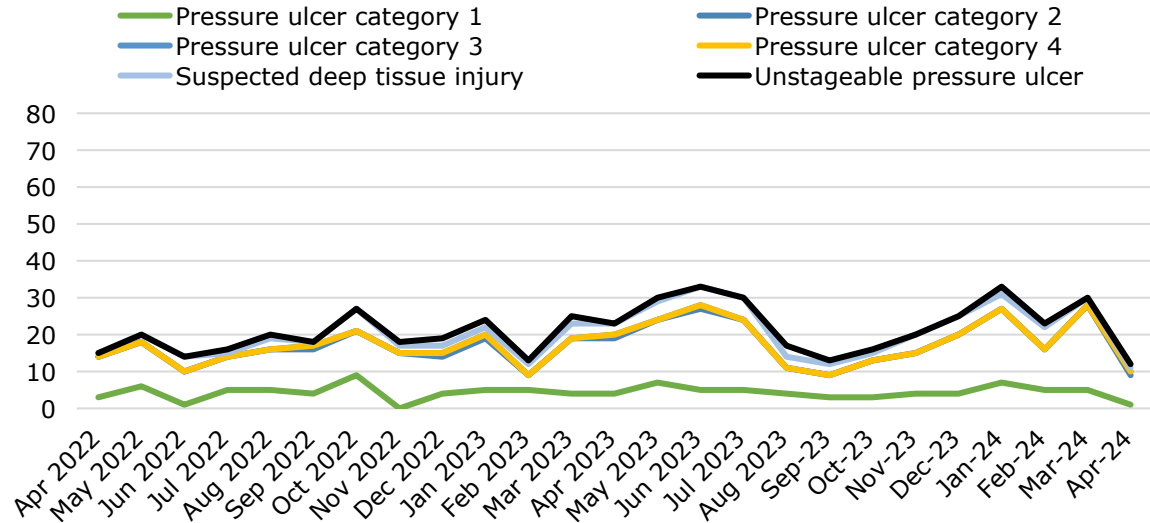
- Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty.
- Eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty.

# Pressure Ulcer Faculty – Aims and Progress

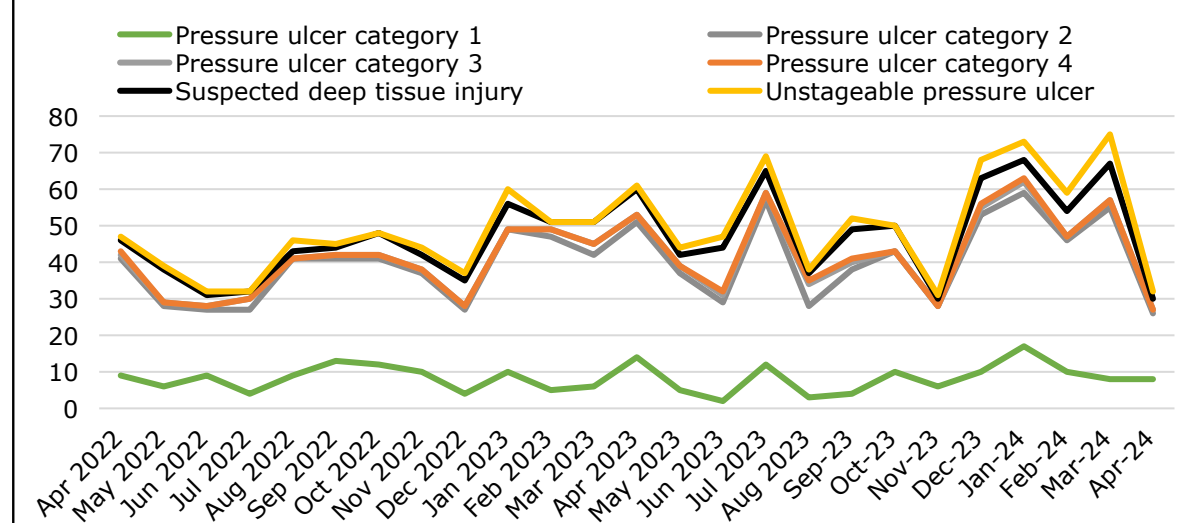
- Downward trend noted from January to April 2024
- TVNs to develop a pre-recorded PowerPoint teaching package
- PANDO APP to be used to support timely wound review and timely treatment
- PDSA Cycle in progress to support test for change across all sites within ABUHB
- PDSA cycle to be agreed at faculty meeting February 2024
- SharePoint file set up to share all resources
- Sharing of developed Posters across Divisions
- Driver diagram updated
- Pressure Ulcer Pilot commenced February 2024
- Next steps evaluate data collected at April meeting so signs of improvement

# Health Acquired Pressure Ulcer Incidents by Division

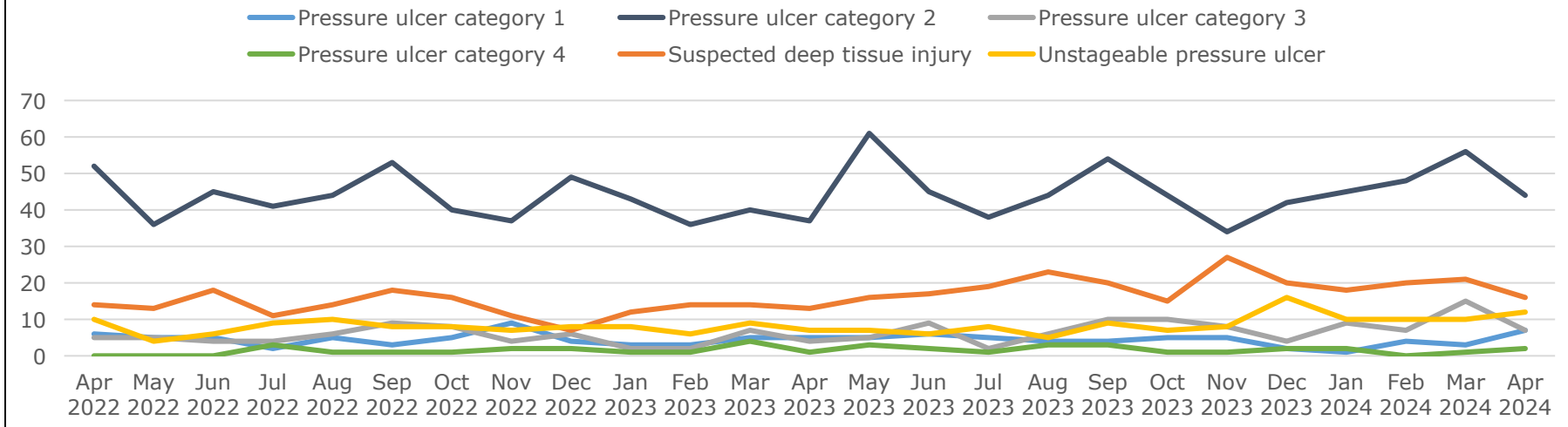
## Scheduled Care



## Medicine

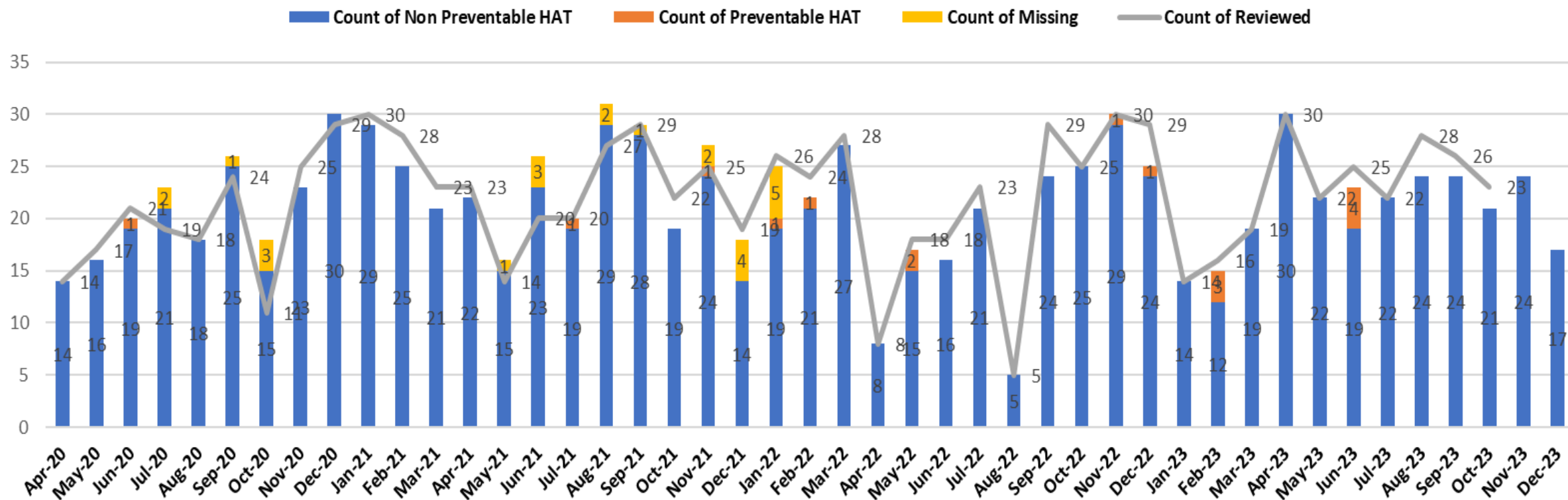


## Primary & Community Care



# Hospital Acquired Thrombosis (HAT)

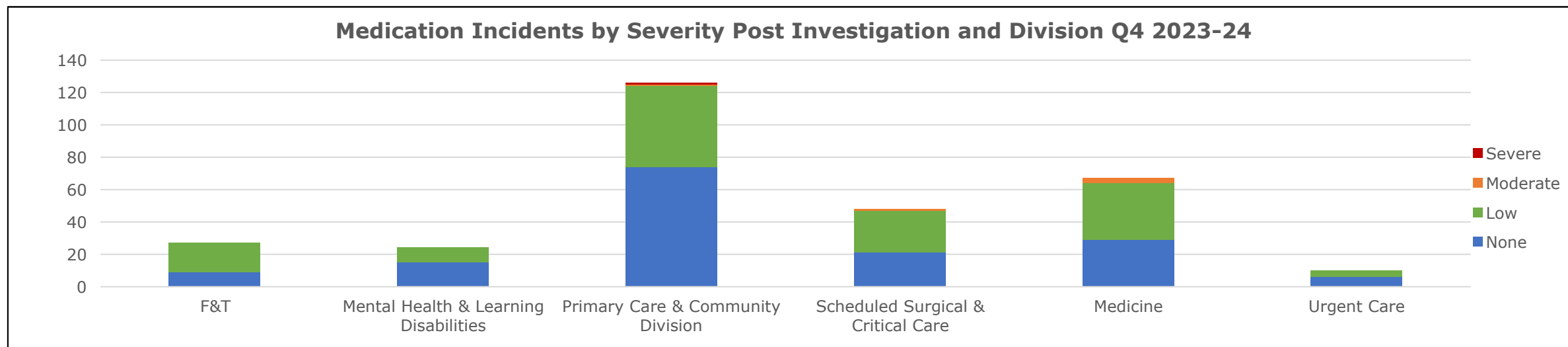
Hospital Acquired Thrombosis (HAT)  
April 2021 - December 2023



All suspected cases of HAT will ensure a review of the case notes has taken place to define if this was prevented. The process and learning for preventable HATs is being reviewed to ensure they are captured as an incident on Datix and the learning is documented.

Meetings are currently taking place with Divisions to share the HAT data by speciality and to ensure there are points of contact within directorates to discuss best practice of thromboprophylaxis and appropriate risk assessment.

# Medical Safety Group (MSG)



Reporters View on Levels of Harm				
	Q1	Q2	Q3	Q4
None	188	194	187	174
Low	88	128	197	205
Moderate	21	60	77	57
Severe	7	7	8	12
Catastrophic	0	0	0	0
<b>Total</b>	<b>304</b>	<b>389</b>	<b>469</b>	<b>448</b>

- Data for Q4 was scrutinised in terms of type of incidents, themes and areas of concern.
  - Total 448 incident reported January to March 2023. Total 306 incidents reviewed and investigated.
- Focused Outcomes**
- Continue to deliver on the corporate action plan for anticoagulant incident review e.g., pharmacy intervention report, thematic review, SOP update.
  - Support DICE with teaching session on insulin/ VRIII in areas requiring support e.g., ED.
  - Develop and issue an Internal Alert on Desmopressin following a trend of missed doses of this critical medication.
  - Continue to support Mental Health and Neurology to deliver on the Sodium Valproate action plan as per MHRA.

# Medical Safety Group – Action Plan

Issue	Cause	Remedial Action	Who	When
Anticoagulation incidents consistent and high-risk potential	Multifactorial as per thematic review	As per corporate action plan	MSG	July 2024
Insulin incidents consistently reported	Multifactorial, but lack of knowledge/ confidence a strong theme.	Continue to support DICE to identify areas requiring Insulin education.	MSG	Ongoing
Desmopressin – multiple incidents of missed doses of this critical medication	Lack of knowledge about drug and risks of omitted doses.	Internal Alert – pending sign off	MSG	April 2024

# All Wales Patient Safety Solutions: Compliance Status

Alert	Compliance Deadline	Action to achieve compliance	Status
<b>PSA008 NG Tube misplacement: continuing risk of death &amp; severe harm Compliance deadline: 30/11/2017, updated to 29/09/2023</b>	29-Sep-23	Safe use of NG tubes remains on on-going concern, however ABUHB has now declared compliance with this alert. This will report through the Nutrition and Hydration Group and the QPS Clinical Audit team will be undertaking an audit in due course.	Compliant
<b>PSA016 Potential risk of underdosing with calcium gluconate in severe hyperkalaemia</b>	15-Dec-23	Work underway. The ABUHB policy for AKI and treatment of hyperkalaemia has been revised, approved by CSPG and added to intranet. ABUHB declared compliance with this in Jan 24.	Compliant
<b>PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients</b>	29-Sep-23	Project led by Peggy Edwards. Health Board working group and meeting every 8 weeks to progress. Work is still on-going.	In-progress
<b>NatPSA 2023 013 Valproate- Compliance deadline: 31/01/2024</b>	31-Jan-24	Organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients.  This is being progressed within neurology and MHLD and a gap analysis and SBAR of outstanding actions needed to comply is being developed. Risks are being escalated within the Division.	In-progress
<b>PSA017 Identified Safety Risks with the Euroking Maternity System. Compliance deadline: 28/06/2024</b>	28-Jun-24	This PSA being led by Peggy Edwards. Important to note the Health Board does not use this system. However, all organisations need to review actions 5 and 6, therefore the focus is on these actions and in progress.	In-progress

# Priority 3: Timely Care

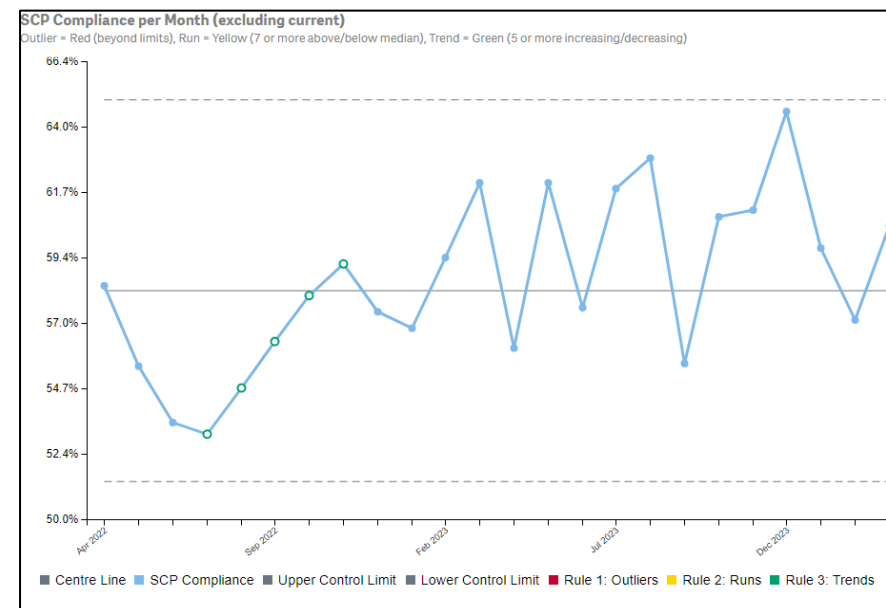
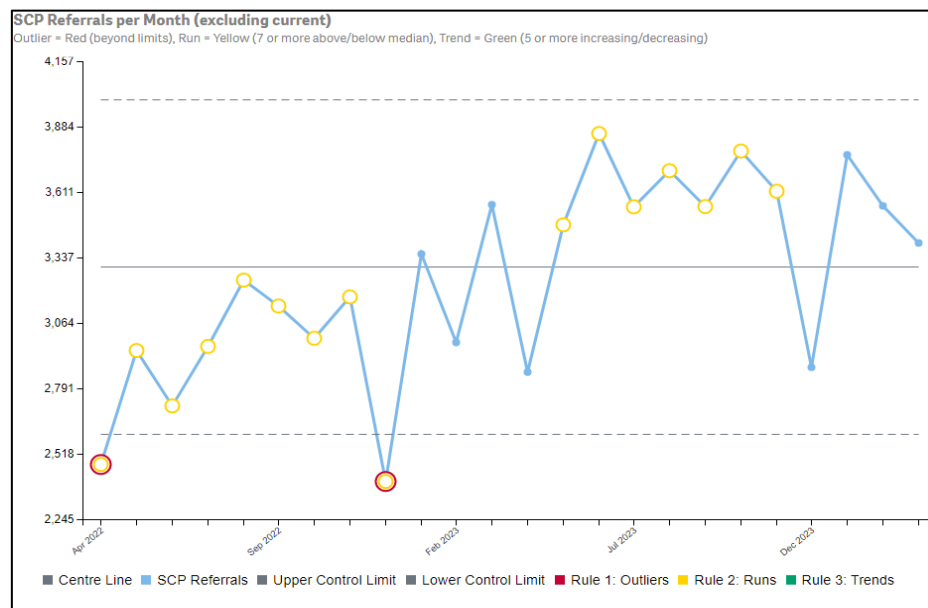


# The detailed narrative is included within the Performance Report

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 3 Timely	Maximising and individuals time and outcomes	Decrease in the time from admission to surgery for emergency admissions	Q3 2023.24	30 hours	Q4 2024	34 hours	No change	Average time to theatre from Arrival/Admission continues generally around 30 hours aside from a period in October/November of 32-42 hours.
		Decrease in the time from surgery to discharge	Q3 2023.24	2.6 hours	Q4 2024	3 hours	No Change	Average time from leaving theatre to discharge has been mostly stable around 3 hours
		Decrease in time spent on a waiting lists	Q3 2023.24	34.16	Q4 2024	10	Improved	The Health Board has made good progress towards eliminating waits of over 156 weeks, with 10 patients waiting at the end of March 2024 compared to the March 2023 position of 553.
		Decrease in the number of handovers >1 hour, monthly	Q3 2023.24	3353	Q4 2024	3549	Deteriorated	Number increased during the period
		Decrease in the time for patients to be seen by first clinician	Q3 2023.24	4.2 hours	Q4 2024	3.8 hours	Deteriorated	Trend has stabilised since Q2. Was improved in November but returned to normal in December.
		Decrease in the time for bed allocation from request	Q3 2023.24	7.5 hours	Q4 2024	8.4 hours	Deteriorated	Increase from September to November
		Decrease in ED waits >12hrs, weekly	Q3 2023.24	265	Q4 2024	241	Improved	Improved slightly over the quarter
		Increase in discharges before midday;	Q3 2023.24	32%	Q4 2024	32%	No change	No improvement in indicator value, expected to see further improvement in Q1
		Decrease in the number of patients with a LoS over 21days	Q3 2023.24	563	Q4 2024	549	Improved	>21 days Occupancy is below normal trends
		Time from Flow Centre call to discharge/ admission from assessment?					No Data	Refine measure
		Number of emergency admissions in hospital over 7 days	Q3 2023.24	354	Q4 2024	354	No Change	Preciously increasing trend since Q1 2023, mainly patients moving from assessment units
		Decrease in the time from request to step up/down to a different site					No Data	Refine measure
		Decrease Overnight bed moves and patient transfers	Q3 2023.24	37.90%	Q4 2024	38.70%	Deteriorated	Increasing trend since Q1 2023, mainly patients moving from assessment units
		Reducing time spent in hospital					No Data	Reviewing measure

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 3 - Timely	Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	Q3 2023.24	60.10%	Q4 2024	62.20%	Improved	Stable around 60%
		Increase in 5 year cancer survival rates	Q2 2023	0.54	Not available	Not available	No data	Reviewing measure
	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	Q3 2023.24	86.2%	Q4 2024	100%	Improved	Indicator has improved significantly since last reporting period. National target of 80% remains achieved at 100% compliance.
		Decrease in neurodevelopmental (SCAN) waiting list	Q3 2023.24	29.9%	Q4 2024	34.3%	Improved	Indicator has gradually improved over the last 3 months by 4.1%. However, this remains below the IMTP target.
	Improved mental health resilience in adults	Increase in life satisfaction among working age adults	2022/23	85.5%	2022/23	85.5%	Improved	Increase in indicator over the last 3 financial years and remains above the all Wales average of 84.4%
		Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	Q3 2023.24	68.3%	Q4 2024	67.7%	Deteriorated slightly	Measure has been sustained at similar level, with a slight decrease, between reporting periods.
		Increase in life satisfaction among older people			2022/23	85.50%	Improved	Increase in indicator over the last 3 financial years and remains above the all Wales average of 84.4%

# Maximising Cancer Outcomes - Summary



- Compliance against the 62-day target for definitive cancer treatment has decreased from 62.9% at the end of December 2023, to 56.5% in February 2024, behind the performance ambition set in the IMTP. There has been a significant increase in demand alongside the focus on reducing the over 62 day waits, affecting compliance. Increases in demand relating to the suspected cancer referrals continue to exceed 3,500 referrals per month compared to pre-covid levels of 2,500.
- SCP treatments undertaken increased by 5.5% over 12 months and increases monthly. Improved position in number of patients waiting > 62 days over the last 6 months, 388 waiting over 62 days (September 2023) compared to 346 at the end of March 2024. SCP demand has levelled off but remains high.
- 62 day cancer performance, January 58.8%, February 56.2%, which was as predicted.
- 14 day compliance has deteriorated in both January and February as a result of reduced capacity.
- Cancer backlog - reducing the active patients waiting over 62 and 104 days remains the priority laid out at the March 2023 ministerial cancer summit.

# Cancer - Concerns

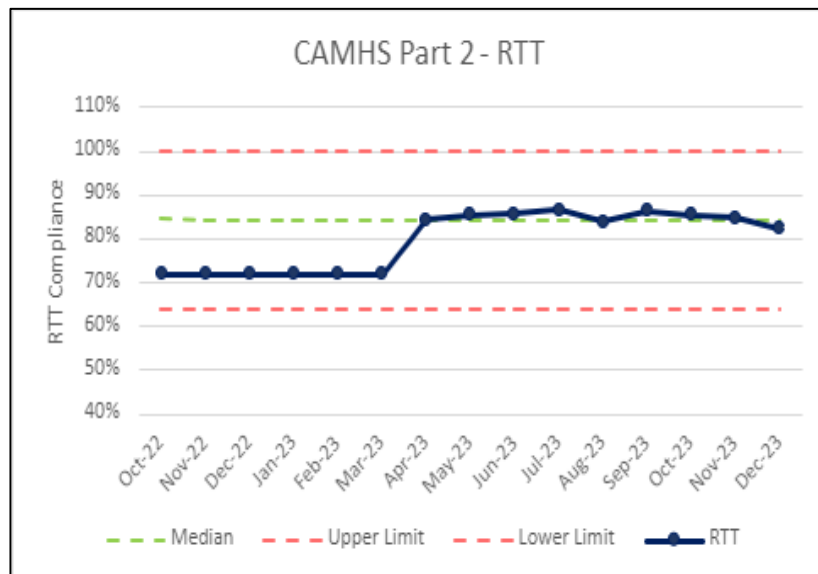
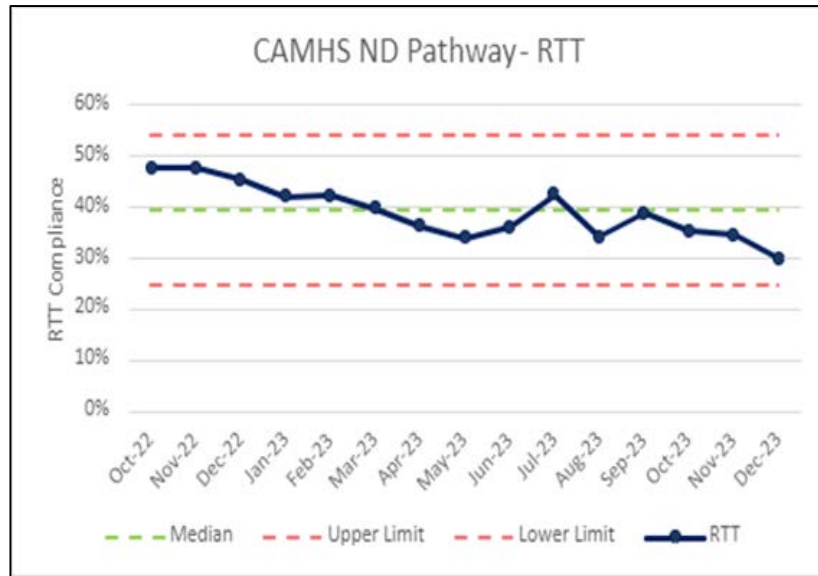
Issue	Cause	Remedial Action	Who	When
Significant delays to FOA for suspected gynae-oncology patients.	Junior doctor industrial action during Q4 2023/24.  Consultant backfill/WLI payment rates dispute resulting in loss of capacity	Directorate continues to explore solutions	Division Management staff	Anticipate evidence of improvement during Q1 2024/25
Cancer pathways not meeting 62 day SCP compliance (exception is skin)	Referral demand remains high.  Lack of sufficient timely access to diagnostic capacity	Planned Improvement Task and Finish groups have been attended by all disciplines involved in urology, gynae and H&N pathways. Lower GI group will meet for the first time in May 2024.  The programme of work makes use of the learning from Toyota training and inclusion of National Optimal Pathway mapping against milestones.	Macmillan National Optimal Pathway Manager  Divisional General Managers	Progress will be ongoing.  Anticipate incremental improvement by the end of Q2 2024/25
Significant loss of Endoscopy capacity in January, February and March	Junior doctor industrial action during Q4 2023/24.  Backfill/WLI payment disputes resulting in loss of activity	Services will mitigate as much loss as possible during IA.	Divisional General Managers & Clinical Directors	End of Q4 2023/24
Loss of breast OPA capacity	Breast Unit opened in YYF in February 2024.  Introduction of new one stop model for patients to have all diagnostic tests at one visit. Loss of capacity as the new model embeds.	Service plan to limit capacity loss by providing additional clinics post move as appropriate	Directorate Manager	Q1 2024/25

# Mental Health in Working Adults

Mental wellbeing and life satisfaction result in better subsequent health outcomes on some physical health indicators, health behaviours and psychosocial indications, including depressive symptoms. Mental wellbeing remains a key priority for the organisation and sustained performance levels have been observed in the 'improved mental health resilience in adults' outcome.

As of February 2024, 68% of Health Board residents over 18 in receipt of secondary mental health services have a valid care and treatment plan. There are concerns on the provision of assessment by mental health service within 28 days from referral which is currently at 17.1% (Feb 24) and interventions less than 28 days from assessment which is currently 7.3% both areas are being addressed in a 90 day action plan monitored by Executive Committee to ensure targeted assurance.

# Improving mental health resilience in Children and Young adults



Nurturing future generations is essential for our communities. There is strong evidence that healthy behaviours in childhood impact throughout life; therefore, targeting actions to improve outcomes in these areas has a long-lasting impact on delivery. Young adult mental health is a Ministerial Priority area with CAMHS a focus in the national performance framework.

Progress within the **'Improve Mental health Resilience in Children and Young Adults'** outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% target of completing ND assessments within 26 weeks. Quarter 4 of 2023/24 has seen a continued demand of referrals requesting consideration of an ND assessment. There are on average 220 new referrals a month which is a 200% increase on the monthly average for 2019/20 and this challenge has resulted in an RTT compliance for the end of February 2023 of 34.3%. A recovery plan was implemented in April 2023 to be able to support the current waiting lists across the 0-18 years pathway by separating the cohorts of 0-5 years and the 5-18 years.

# Priority 4: Effective Care



Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 4 Effective	Reduced variation in Care	Increased Get It Right First Time (GIRFT) implementation plans by area						Reviewing measure
		Insert ward accreditation measures – to be confirmed						Ward accreditation is still being rolled out
	Increased understanding of variation to focus Improvements	Increase in the SMART action plans with accountability in National Clinical Audit						Reviewing measure- see Clinical Audit slides
		Increase in the numbers of wards participating in accreditation (Audits via AMaT)						Reviewing measure- see Clinical Audit slides
		Increase in the actionable audit recommendations by National Clinical Audits						Reviewing measure- see Clinical Audit slides
	Improvement is part of the AB way	Staff Survey – increase in the score for staff being able to raise concerns						Reviewing measure
		Compliance the number of incidents triggering Duty of Candour within 5 days	No Data	No Data	No Data	No Data	No Data	Reviewing measure
		QI projects outcomes (Non SCC)	No Data	No Data	No Data	No Data	No Data	Reviewing measure
		Outcomes of the SCP teams	No Data	No Data	No Data	No Data	No Data	Reviewing measure
	Improving Good Health in Pregnancy	Decrease in low birth weight rates	2021	5.10%	2022	6.10%	Decreased	Increase in indicator between 2021 and 2022. In line with the All Wales average. Next update due June 2024 (provisional). 2023 data being validated.
		Decrease in stillbirths	2021	3.9	2022	4.5	Decreased	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years. 2023 data being validated.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	Q3 2023/24	63.2%	Q4 2024	55%	Decreased	Indicator value for 2023 was 57%. Q4 has decreased.
		Increase of eligible children measured and weighed at 8 weeks	Q3 2022/23	39.70%	No Data	No Data	Improved	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average. 2023 data being validated.

# Safe Care Collaborative: January – March 2024

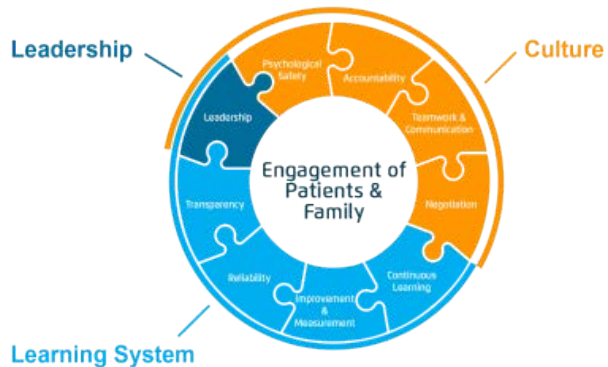
## Organisational Update: Stage-Action Period 8

- **Learning Session 5, March 20th**– Face to Face Learning Session held at the ICC with a focus on building Learning Systems. Teams presented storyboards of their work.
- **SCC Close** - Final Celebration event being held on 14<sup>th</sup> May 2024
- **ABUHB Deteriorating Patients Collaborative** – planning phase
- **ABUHB Deteriorating Patients Collaborative** – Local day in February & April was cancelled due to Industrial Action.
- **Leadership programme of work** – schedule of executive Safety Walkarounds Programme set up until March 2024.
- **Quality Outcomes Framework**– Working to refine QOF in conjunction with Public Health. Quarter 3 report completed reported to the executive team. Information team to develop a Qlik dashboard based on 'Making Data Count' format already used for the ABUHB Performance Dashboard
- **QI Skills Development**– Improvement in Practice training with Improvement Cymru for staff from Primary Care, Mental Health and Collaborative work has been completed. Quality Coach training completed in March with additional 9 coaches
- **OCP – QPS & QI Teams to Nursing Directorate** – QPS staff moved over, focus now on integrating QI Unit
- **Improvement Advisor – Theatres** scoping and initiating work

## Team Update:

- **Project Outcomes** – potential to generate Safety Culture outcomes for all teams
- **Storyboards** - Updated for Learning session 5
- **Ward C0** –Up until the end of March, there hasn't been a Cardiac Arrest for 125 days. Next stage of visual management, screen accessible for full MDT at handover between shifts.
- **Monmouthshire** – Reduction in Package of Care hours for medically optimised patients. Sustained reduction in median LOS. Deep dive identifying ALOS increase due to inability to discharge outlying patients
- **AMU** – Implemented 4 hourly observations. Will be testing visual management of Careflow data. Stickers being used in medical notes to highlight outcome of board round discussions
- **OT Early Intervention** – 30-60 minute saving for each patient during 3 month telephone evaluation rather than face to face adopted as common practice. Testing memory strategy information provision to patients waiting.
- **Theatres** – Improvement Advisor in post, scoping work to reduce Never Events. Testing Safety Culture survey as part of Human Factors. Q Exchange funding bid submitted to Q Community.

Framework for Safe & Reliable Care



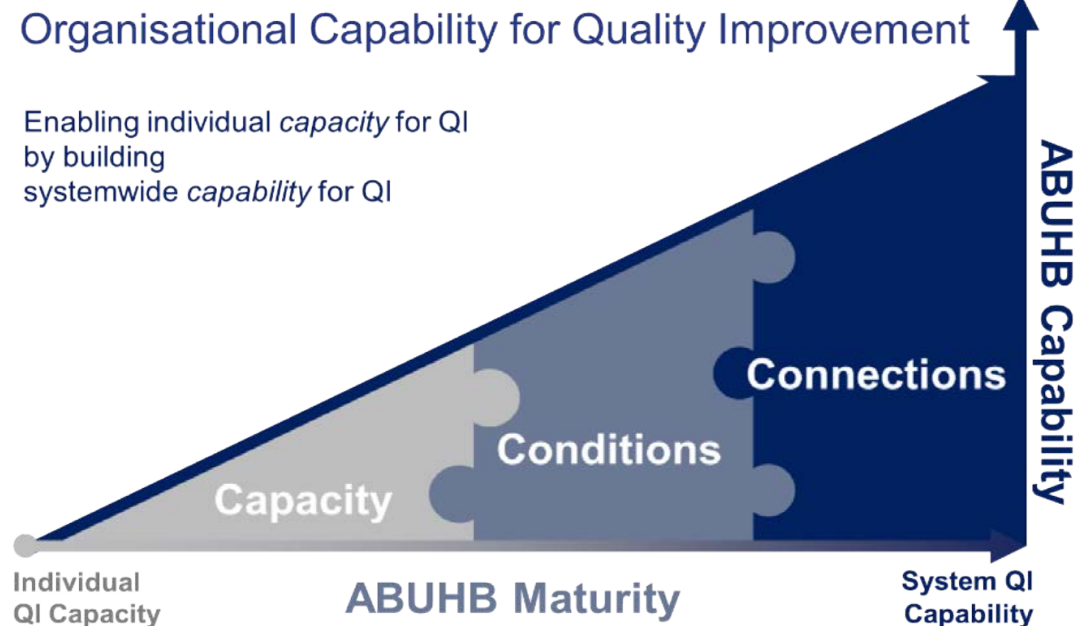
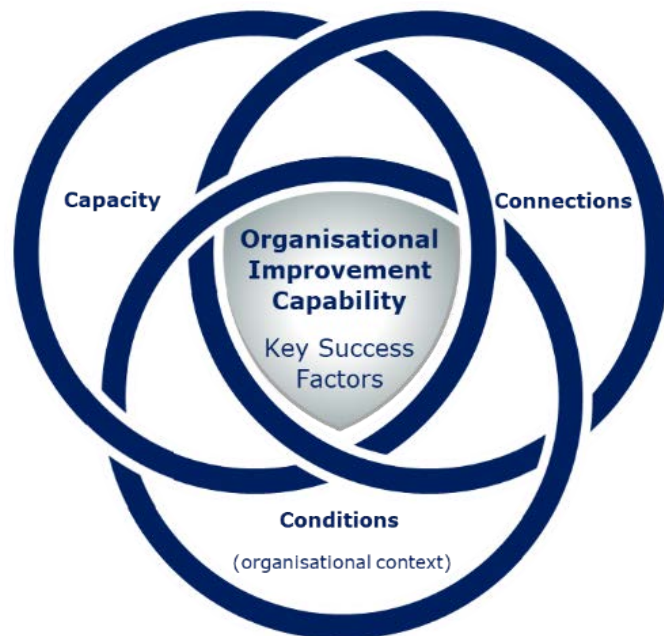
Based on <https://www.safeandrelievablecare.com/blog/2016/11/29/s-s-sociotechnical-framework-ihl-mimicourse>

Workstream	ABUHB Team	Score
<b>Acute</b>	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	3.5
	Theatres – Human Factors	1
<b>Ambulatory</b>	North Monmouthshire Integrated Team	3.5
<b>Community</b>	OT/MH Early Intervention for Cognitive Impairment Team	3
<b>Leadership</b>	Executives, Leaders for Safety, Faculty	3.5

Score	IHI - Stage of Project Scoring
<b>0.5</b>	Intent to participate
<b>1.0</b>	Forming team
<b>1.5</b>	Project plan begun
<b>2</b>	Activity but no changes
<b>2.5</b>	Changes tested but no improvement
<b>3</b>	Modest improvement
<b>3.5</b>	Improvement
<b>4</b>	Significant improvement
<b>4.5</b>	Sustainable improvement
<b>5.0</b>	Outstanding sustainable improvement

# Quality Improvement - Direction

- “Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement.”
- Organisational QI Capability is “the organisational ability to intentionally and systematically use improvement approaches, methods and practices, to change processes and products/services to generate improved performance”.
- Quality Improvement forms part of the ABUHB Quality Strategy. Our plan is to grow and mature our organisational capability for Quality Improvement (QI), by building capacity, conditions and connections which will enable staff to use QI methodology for solving complex problems, and in so doing provide a consistent approach to testing change ideas, learning and informing our decisions.



# Clinical Audit - Reflections

With the introduction of AMaT (Audit Management and Tracking system) in June 2022 there has been a focus on training staff to utilise the system. Currently there are more than 1,300 users across the Health Board. AMaT is used to build the audit proforma, capture data and produce results with an action plan. This license has been extended for a further two years.

There has been improved engagement with Clinical Leads throughout the audit process to discuss results. This has enabled the development, monitoring and completion of improve (SMART) action plans. These are discussed at the Clinical Standards and Effectiveness Group (CSEG). Actions are logged on AMaT and actions are tracked by progress and date.

A standardised Clinical Audit Activity reporting template has been developed in AMaT. This supports review of audit results by CSEG and is used for onward ratification at the Patient Quality and Safety Outcomes Committee (PQSOC). The template ensures risks are discussed and can be escalated to PQSOC, once they have been raised within the Division and placed on the risk register.

Divisional teams have been asked to identify clinical audits as part of their local audit plans. This allows scrutiny and assurance of issues arising from quality and safety risks identified from Datix, complaints and outcomes of care.

Future audit work will include reviewing how the learning from audit is triangulated. This will include working with the Value-Based Health Care team and consider how patient experience is being captured and how this can be linked to audit results.

# Clinical Audit – Effective Commitments 2023-2026

<p>Results of clinical audit forms part of our wider Quality Management System in development in the Health Board since Implementation of the Duty of Quality in April 2023.</p> <p>Audit outputs and activity contribute to the "effectiveness" domain of the Duty of Quality.</p>	<p><b>To deliver care that is effective, reliable, and based upon the best evidence available. To increase the proportion of patients who receive evidence-based care. To reduce variations in the quality of care. To identify and implement evidence-based best practice guidance. Deliver consistently effective and reliable care.</b></p>	
	Aim	Objective
	Provide effective care	<ul style="list-style-type: none"> <li>Deliver consistently effective and reliable care, based on best practice which is delivered as part of a culture that encourages and enables innovation to Improve outcomes.</li> <li>To ensure that the care delivered to patients is effective and based upon the best evidence available.</li> <li>Support Divisions to drive improvement priorities from learning.</li> </ul>
	Implement the mandatory National Audit Programme	<ul style="list-style-type: none"> <li>Participate in the relevant national audits to provide assurance of effective care delivery. Use the findings from the relevant national audits to support the continued improvement of quality outcomes by sharing learning and good practice across the organisation.</li> <li>Produce action plans to monitor the actions needed from audits, ensuring these are measurable and achievable.</li> </ul>
	Building audit capability across the organisation through skills development	<ul style="list-style-type: none"> <li>Developing an organisational training offer covering all staff groups.</li> <li>Build audit capability across the organisation through the implementation of the web-based Audit Management and Tracking System (AMaT).</li> <li>Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives.</li> </ul>
	To increase engagement with audit and effectiveness work	<ul style="list-style-type: none"> <li>To improve the visibility of Clinical Audit Results by implementing the Clinical Audit Strategy, including developing an internal registry</li> <li>Develop and embed GIRFT processes within the central team, supporting the Divisions to drive improvement priorities from learning.</li> </ul>
Implement NICE Guidance and adoption of Health Technology Wales guidance	<ul style="list-style-type: none"> <li>Ensure the relevant NICE (National Institute for Health and Care Excellence), and specialist national guidance are regularly assessed and implemented to deliver interventions based upon the best possible evidence.</li> <li>Utilise best practice evidence and benchmark data to improve outcomes.</li> </ul>	

AMaT is an innovative system designed to make auditing easier, faster, and more effective. Data can be input and accessed in real time on a smartphone, tablet, laptop or desktop computer, giving healthcare staff increased flexibility and mobility - and more time to spend with patients.

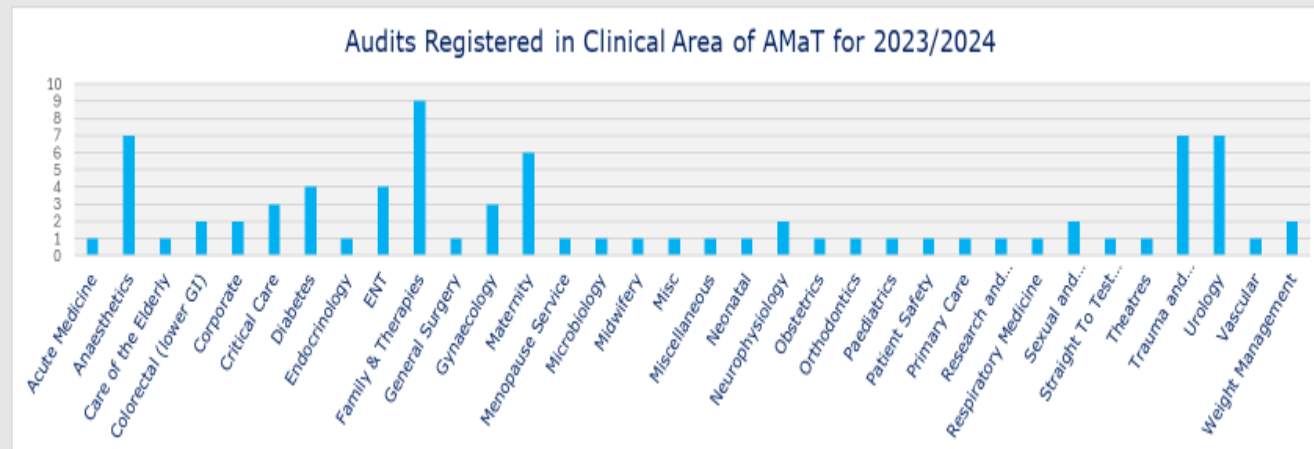
During 2023/2024, 80 projects were added to AMaT.

Project Type	Count
Clinical Audit Project	45
Other	1
Patient Questionnaire (feedback, satisfaction, etc.)	3
Quality Improvement Project	21
Service Evaluation	9
Staff Questionnaire (feedback, satisfaction, etc.)	1
<b>Total</b>	<b>80</b>

National Audits do not capture data within AMaT, however the audit process is managed in the system, using various section:

- Audit results and criteria
- Guidance (NICE, HTW, HIW, AWMSG)
- Conclusions and assurance (inc Risk)
- Key success and key concerns
- Recommendations
- Action plans

Projects were recorded under many specialties, and this will grow as the Health Board expands its use of AMaT. Recommendations can be documented, and actions given with timelines.



The Health Board action status within the clinical area shows:

Action Status	Count
Fully Complete	17
New	27
Overdue	3
Partially complete	1
Partially complete (Overdue)	1
<b>Total</b>	<b>49</b>

It is difficult to give a forward plan of projects within the Clinical Area as these usually are registered at the time of commencing the audit, even if this a retrospective audit.

# Clinical Audit and AMaT – Ward Area Audits

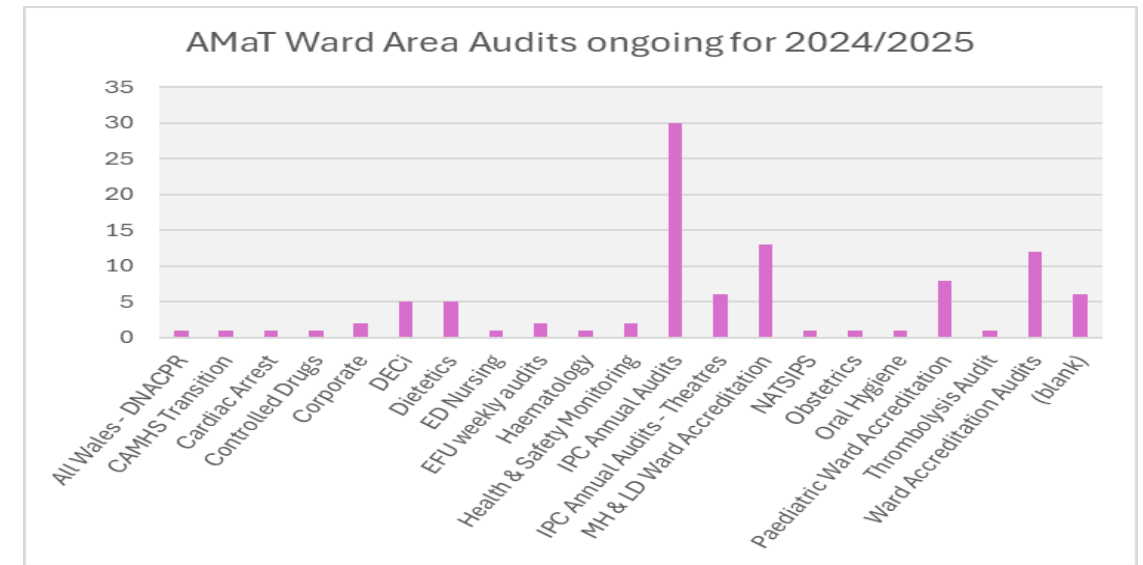
Ward Area is the area in AMaT which will display all audits being undertaken at ward/theatre level. These can be set within projects and the results can be viewed in the dashboard area. Action can be allocated and audited within each audit.

There are a total of 101 audits currently registered and active in Ward Areas. An audit can be linked to one ward, 10 wards or all wards across the sites/Health Board.

These have generated 2,318 actions with 1,335 being fully completed to date.

Of the 101 audits registered a number are still active and included in the plan for 2024/2025. Action status for completed 2023/2024 audits are:

Action Status	Count
Action no longer relevant	24
Fully Complete	1335
New	284
Overdue	608
Partially complete	12
Partially complete (Overdue)	41
Unable to Complete	14
<b>Total</b>	<b>2318</b>



# National Clinical Audits

## **Participation in the following NCAs, all results and SMART actions available in Annual Audit Activity Report:**

National Lung Cancer Audit Annual Report (NLCA)

National Heart Failure Audit (NHFA)

Management of Heart Attack: analyses from the Myocardial Ischaemia 2023 Summary Report (MINAP)

National Audit of Percutaneous Coronary Intervention (NAPCI)

National Paediatric Diabetes Audit (NPDA)

Fracture Liaison Service Database (FLS-DB) Annual Report

National Pregnancy in Diabetes Audit 2021 and 2022 (NPDA)

National Diabetes Audit 2021-22, Type 1 Diabetes (NDA)

National Diabetes Audit: Care Processes and Treatment Targets 2021-22 (Primary Care)

National Neonatal Audit Programme (NNAP) Summary Report 2022

National Early Inflammatory Arthritis Audit (NEIAA) Year 5 State of the Nation Report 2023

National Vascular Registry State of the Nation Report 2023

National Prostate Cancer Audit (NPCA) State of the Nation report

National Bowel Cancer Audit – NBoCA

HQIP Planned Activity list for 2023/2024

# Priority 5: Efficient Care

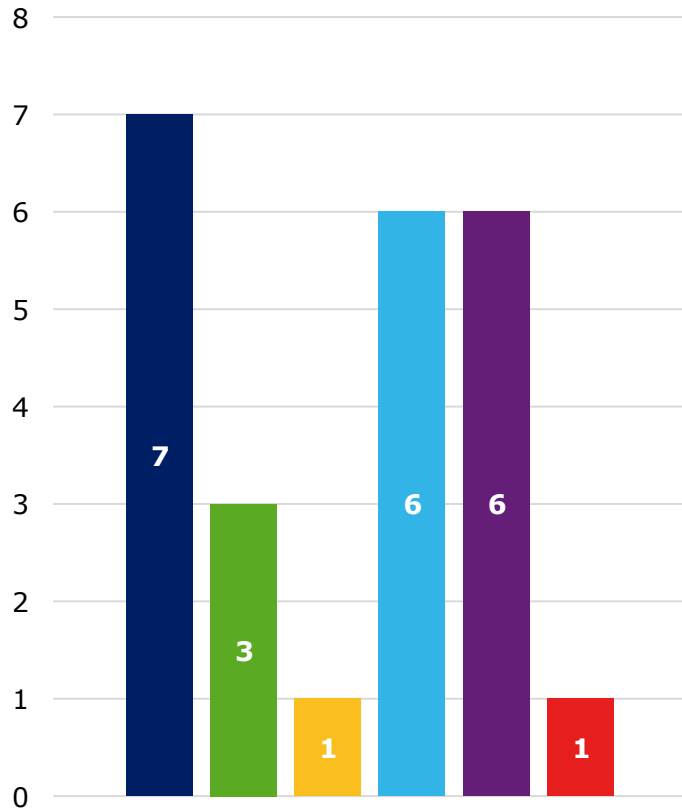


Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		

Priority 5 Efficient	Patient experiences are visible and acted on	Decrease in the number of open personal injury claims	Q3 2023.24	76	Q4 2024	69	Decreased	No financial Penalties at Jan or March 2024 WRP Committee
		Decrease in the number of open clinical negligence claims	Q3 2023.24	657	Q4 2024	676	Increased	Increased but no financial Penalties at Jan or March 2024 WRP Committee
		Decrease in the number of open Coroner inquests	Q3 2023.24	188	Q4 2024	205	Increased	Increase for Q4
		Decrease in the DNA's and CNA'S	Q3 2023.24	6.6%	Q4 2024	6.8%	Decreased	Overall DNA rate for 2023-2024 was 5.7%, for 2022-2023 was 6.6%. Work in progress with Gastroenterology and Public Health focusing on Hepatology, to understand patterns for DNA's and potential reasons, inclu analysis of secondary care activity following DNA to understand impact. Patient contact has commenced in May to further explore reasons. This is to support service planning and redesign to maximise clinic attendance. This approach will be rolled out in other areas with High DNA rates if pilot successful.
		Response time to Public Services Ombudsman for Wales( PSOW)	Q3 2023.24	4 days	Q4 2024	3 days	Improved	Reporting 3-4 days earlier than PSOW target
		Number of INNUS's being completed	Q2 2022	518	Q3 2022	457	Decreased	There is a national piece of work to review every INNU across Wales, ensuring clinical evidence is up to date, and coding is correct. As a result, the clinical criteria for many of the INNUS will change.
		Decrease in the number of outliers by Specialty	New Measure					New Measure
		Decrease in the number of medically fit for discharge patients	Q2 2023	280	No Data	No Data	No data	No longer valid – measure requires further development
		Decrease in the number of patients cancelled on the day of surgery	Q1 2023	130	Q2 2023	110	Decreased	There has been a decreasing trend in the numbers cancelled in the day of surgery the numbers over the past quarter remain circa 110 per week
		Decrease in the % of hospital as a place of death	Q3 2023	3.00%	Q4 2024	3.00%	No change	Hospital as a place of death has remained static at 3% from Q3 to Q4.
	Improve care at the end of life	Increase in compliance of issuing of Medical Certificates within 5 days	No Data	No Data	No Data	No Data	No Data	Reviewing measure

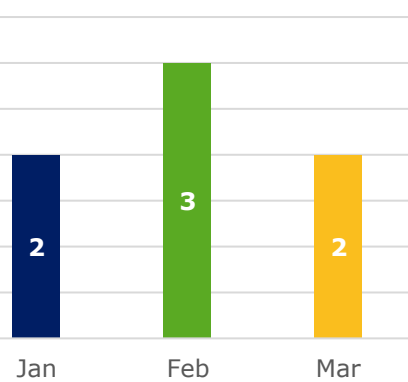
# Ombudsman (PSOW)

**Complaints referred to PSOW by Division Q4 Jan - Mar 2024**

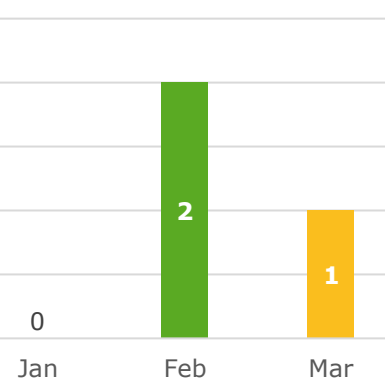


- F&T
- Mental Health & Learning Disabilities
- Primary Care & Community Division
- Scheduled Surgical & Critical Care
- Medicine
- Clinical Support Services

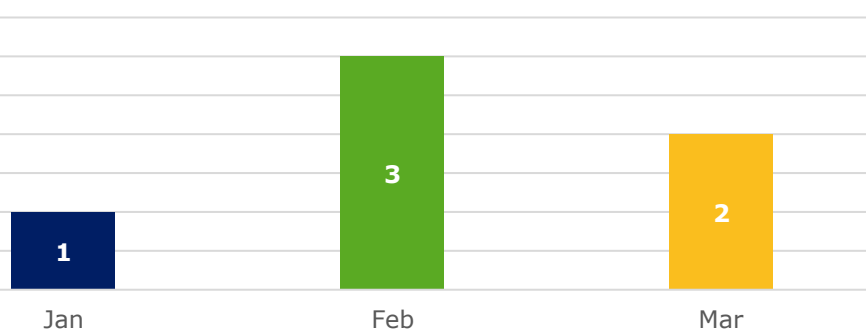
**PSOW Final Reports Upheld Q4**



**PSOW Final Reports not Upheld Q4**



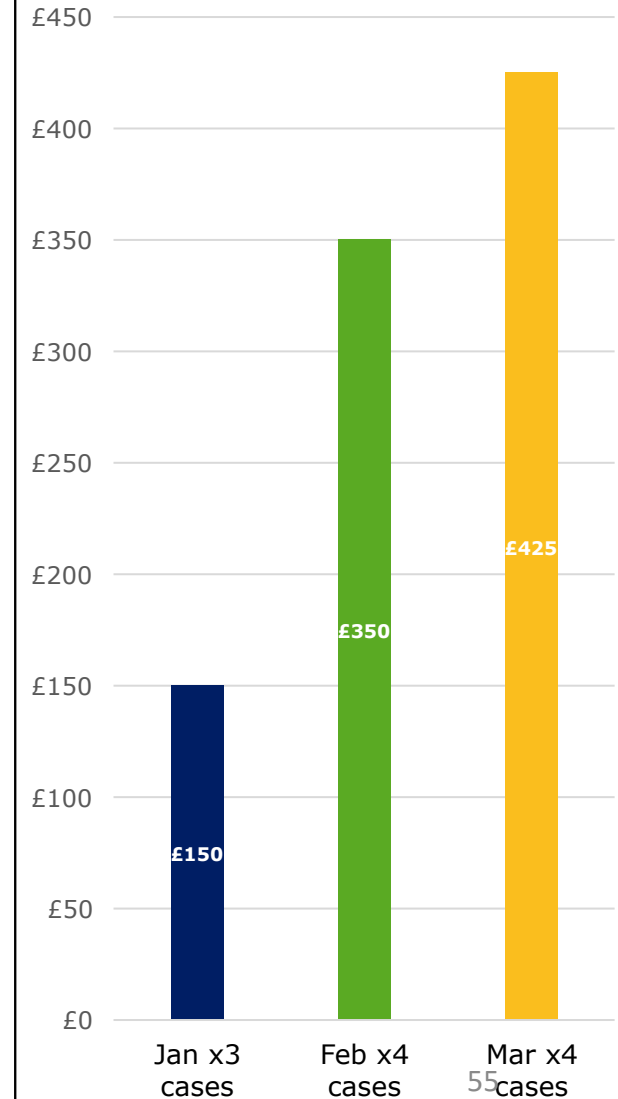
**PSOW Cases not to Investigate Q4**



The top 3 subject areas whereby PSOW have been involved relate to:

1. Clinical Treatment/Assessment
2. Communication Issues
3. Complaints Handling

**PSOW Total Settlements per Month Q4**



# Priority 6: Equitable Care



Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 6 Equitable	Improving quality of life and equitable access	Increase in the access to Safeguarding Training	Q3 2023.24	<b>Level 1</b> Adult 79% Children 85% <b>Level 2</b> Adult 88% Children 86%	Q4 2024	<b>Level 1</b> Adult 87% Children 86% <b>Level 2</b> Adult 90% Children 88%	Improving	Compliance with training has improved (with tolerance of 85%)
		Narrowing of the life expectancy Gap across our Health Board	Q4 2020	Women 20 years Men 13 years	Q4 2020	Women 20 years Men 13 years	N/A	The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities
		Timely closure of Safeguarding incidents		Measure in development		4 Child Practice Reviews 1 Adult Practice Review 5 Domestic Homicide Reviews		Reviewing measure
		Number of incidents of violence and aggression towards staff (per 1,000 staff)	Q3 2023.24	35.7	Q4 2024	28.3	Improved	Number of incidents for violence and aggression towards staff has continued to decrease, with Q4 being the lowest to date. (Incidents per 1,000 staff) Q1 - 36.6 and Q2-31.7.

# Safeguarding: Training and Development

There is a national requirement for staff groups within the Health Board to undertake safeguarding training appropriate for their role. The following shows our current levels of compliance in five of the seven areas. At this current time ESR does not permit recording of compliance at Level 3 for either Child or Adult Safeguarding, with work ongoing to remedy this. However, it is noted that there has been a slow uptake of the Level 3 Training, which is face-to-face, due to staff not being able to be released for training.

Training Module	Compliance %
Adult Safeguarding Level 1	79%
Children Safeguarding Level 1	89%
Adult Safeguarding Level 2	86%
Children Safeguarding Level 2	88%
Ask and Act Training	73%

It is noted some improvement in compliance is required with Level 1 Safeguarding Adults and Ask and Act, to achieve our target of 85%. This has been escalated to Divisional Leadership Teams via the Safeguarding Committee.

# Safeguarding: Activity

Safeguarding activity data must be used with caution when being utilised as a marker of quality improvement. However, the current data available for 2023/24 highlights there has been a substantial number of safeguarding referrals made, or responded to, by the ABUHB Safeguarding Team in 2023/24. This is influenced by a number of potentially negative factors (increased harm) over which we have no control, but is also testimony to the effectiveness of the workforce in being aware of neglect and abuse within our population.

	2022/23	2023/24	Increase
<b>Safeguarding Children Strategy Discussion</b>	451 (01/11/22 - 31/03/23)	1932	79%
<b>Adult Duty to Report</b>	263	362	38%
<b>Child Duty to Report</b>	1944	3736	92%

It should be noted that the duty to report figures represent those that were generated by the Health Board.

# Safeguarding: MARAC/Sexual Safety/Serious Violence

## Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

In QTR 4 2023/24, the Corporate Safeguarding Team attended 33 MARAC, providing information and contributing to safety plans for 432 survivors of Domestic Abuse. It is noted that in this period the number of individuals discussed in MARAC has increased by 87%. This has been noted by the Gwent MARAC Steering Group, with current work on MARAC sustainability being a focus of the Gwent VAWDASV work for the current year.

## Sexual Safety

The 2023 the Women's Rights Network published a national report in regard of the volume of sexual assaults that have taken place in hospital settings. A recent report, generated at the request of the National Safeguarding Team, highlights that there have been 48 incidents, in the period 1 August 2023 to 31 January 2024. Analysis of this data has highlighted that most of the incidents related to inappropriate behaviour by patients towards staff, followed by patent on patient and only two incidents where the allegation was made towards a member of staff. In addition, it is noted that none of the incidents resulted in physical harm or fulfilled the national definition of serious sexual assault.

There is work ongoing within the Health Board to develop a Chaperone Policy, refresh the pathway for referral to the Sexual Abuse Referral Centre (SARC) and to develop an overarching sexual safety policy which will provide guidance on risk assessment, recording of sexual safety incidents and timely escalation.

## Serious Violence

The Serious Violence Duty 2022 sets an expectation on Health Boards to actively engage with the development of a regional strategy to tackle serious violence. As such, ABUHB has produced a data set which is provided to the OPCC as lead agency and which enables us to actively participate in the strategic needs assessment and production of the strategy.

In addition, funding has been made available for 2023/24 to support work in violence reduction via our urgent care areas. This funding will commission a Violence Reduction Worker to in reach to our emergency areas and minor injury units, with a focus on staff training, improving data collection and early intervention with individuals that may be involved in serious violence and potentially organised crime or exploitation.

# Safeguarding: Current Concerns

Issue	Cause	Remedial Action	Who	When
Safeguarding Level 3 Training Non Compliance	Delays in being mandated via ESR	Safeguarding Team working with Divisional leads to establish how this training can be "prioritised" and "delivered" to such a large cohort.	Head of Safeguarding	Q1 2024/25
Decommissioning of Specialist Domestic Abuse Service in General Practice	Funding is not sustainable for 2024/25 to enable the continuation of the IRIS Programme	Public Health, Primary Care, Safeguarding and VAWDASV working collaboratively on a transition programme to ensure that the work previously provided by a commissioned service is supported through exiting services.	Public Health	Q2 2024/25
Non compliance with MAPPA Statutory Duties	There is no dedicated Strategic Lead for MAPPA and no specific resources to support operational responsibilities	Safeguarding and Public Health to work collaboratively to scope whether this duty can be supported from existing resources.	Head of Safeguarding	Q1 2024/25
Statements and Court Reports for Child protection are not being prepared in a timely manner	Absence of a SoP or process for Development/Approval of Statements and Reports	Identification of the Safeguarding Hub as the SPOC and development of a SoP in regard of how requests are managed.	Deputy Head of Safeguarding	Q1 2024/25

# Areas of Escalation



# C.Difficile



Averaging 22 cases per month since September.

April Total = 25

HAI = 13

Community acquired, relapses and indeterminate cases = 12

During April, 3 wards affected due to period of increased incidence of healthcare associated C difficile: Ebbw Ward, C4E and A3

Lessons learned from outbreak control meetings:-

- Microbiology tests i.e. MSU, blood culture to support diagnostically and guide antibiotic choice
- Contacting Microbiology on weekend for test results and any concerns with treatment to avoid delay
- Appropriate escalation for some antibiotic choices
- Sustaining compliance with cleaning schedules and hand hygiene audits
- Drs to record rationale for all treatment
- Notify nurse in charge if sample being collected
- Discuss AMR linked to renal failure with medical team
- Improve correct use of PPE with Facilities
- Improve hand hygiene compliance with Medics & Therapies

## C.diff – update as of March 2024 and actions

**228 cases in total for the year ending March 2024 representing a 19% increase in cases**

- **159 cases are healthcare associated (HAI) or 'indeterminate' (i.e. HAI / Community acquired infections)**
  - Whole genome sequencing (WGS) identified that 16 (13%) of the definite HAI cases where WGS was available (Total 117) acquired their infection from another patient whilst in hospital
  - Root cause analysis of all CDI cases indicate that compliance with hand hygiene and environmental cleanliness are risk factors.
  - 23% of HAI / Indeterminate cases received sub-optimal antibiotics prior to their C. difficile infection
  - Identified priorities: -
    - Medicine Division Reducing C. difficile Quality Improvement Faculty
    - Organisational Action Plan
    - Ward based CDI training
    - Promotion of proactive HPV programme (challenges in completion of programme 2023-24)
    - Audits to identify areas of sub-optimal antibiotic prescribing
- **69 are community acquired infections (CAI)**
  - Root cause analysis information requested from GP's. Return rate currently around 58%
  - Of the returned RCA's 14% of cases were linked to suboptimal prescribing of antibiotics
  - All suboptimal prescribing is fed back to GP practices via the Antimicrobial Pharmacist Team

# Mental Health & Learning Disabilities Escalation

Overall Status Summary	Progress/Achievements What went well this period and upcoming Deliverables	Challenges
<ul style="list-style-type: none"> <li>• Since July 2023 the MH&amp;LD Division has been subject to internal escalation</li> <li>• A number of quality improvement actions were identified, and these were prioritised into a 30, 60, and 90-day improvement plan.</li> <li>• The Plan has also addressed broader efforts in workforce modelling, leadership, clinical engagement, performance, risk management, and service transformation.</li> <li>• NHS Exec Oversight has been in place</li> <li>• Appointment of an Improvement Director - in post (currently acting Divisional Director)</li> <li>• Appointment of a Divisional Director – who starts in May</li> <li>• Progress on quality, safety, and governance in MHLD has been routinely reported through the Executive Committee, Patient Quality Safety &amp; Oversight Committee the Board, and externally through IQPD.</li> <li>• NHS Exec will continue to monitor delivery of improvements through IQPD and JET meetings</li> <li>• Feedback from the NHS Executive on the improvement plan has been addressed, and there is a commitment to aligning better with the Health Board's Quality Strategy and the new accountability/escalation framework.</li> </ul>	<p><b><u>Progress/Achievements:</u></b></p> <ul style="list-style-type: none"> <li>• Setting The Scene workshop to engage with staff on the setting the vision and ideas for service improvement.</li> <li>• Ongoing support from the QPS team to better align the division with the Health Board Quality Strategy and embed processes.</li> <li>• A strong focus on improved safety governance in line with HB processes from the Nursing Team</li> <li>• Multi-professional clinical leadership opportunities developing</li> <li>• Wider Team support to Implement a process to systematically assess workforce risks and incorporate them into the risk register and the IMTP process.</li> <li>• Models of care: The teams are keen to look at doing things differently and will start having discussions with the directorates.</li> <li>• Increased corporate divisional governance in place – fortnightly</li> <li>• Improved learning from deaths processes</li> </ul> <p><b><u>Deliverables and Focussed pieces of work</u></b></p> <ul style="list-style-type: none"> <li>• Thematic review process</li> <li>• Ward accreditation in line with HB processes</li> <li>• Audit strategy</li> <li>• Daily briefings and escalation processes further embedded at BAU</li> <li>• A review of serious incidents is ongoing, and the Executive Director for Nursing and Chief Operating Officer continue to monitor safeguarding processes, serious incident reporting, and disciplinary processes</li> <li>• Embed Right Care right person and the new rolling out the new model of police and health partnership for mental health crisis response.</li> </ul>	<ul style="list-style-type: none"> <li>• Interim Senior Leadership Team currently in place.</li> <li>• Embeddedness of governance and assurance in relation to the quality and safety of care.</li> <li>• Structures to support strong clinical professional leadership</li> <li>• Additional support and focus on patient safety and safeguarding, staff engagement, cultural and improvement initiatives.</li> <li>• Some of these actions require a longer-term cultural improvement programme to sustain the change.</li> <li>• Ongoing issues with WCCIS (patient information system) and the necessary work arounds for validated information.</li> <li>• Continued focus on 1A/1B performance and the necessary actions to address the waiting list issues, such as validation, triage and rules.</li> <li>• Continue to review staff engagement and communication across the Division.</li> </ul>



# Next steps

- The QOF framework was developed during Quarter 2 and has been refined as the year has progressed. Throughout the year, more of the outcome measures have been reported and the outcome measures have been updated iteratively.
- This report demonstrates not all measures have been feasible to collect. As part of updating the QOF for the new financial year a workshop has been held to collectively discuss each of the measures, refine the indicator and review how the data is being accessed. For those indicators that are blank, this will be reviewed.
- For the Health and Care Quality Standards that are limited in reporting e.g. Equitable, these will be reviewed to establish what else is being reported that can be inserted into the QOF and what additional measures should be included.
- Working with data, digital and technology the report will become automated and mirror the updated reporting for Board with the use of iconography.