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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Executive Commttee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jenny Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kelly Downes - Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Board is required to consider and have due regard for the duty on them, under Section 25A of the Act, to provide sufficient nurses to allow time to care for patients sensitively wherever they are receiving nursing services. The report, therefore, outlines the actions taken to comply with Section 25A of the Nurse Staffing (Wales) Act.

This report covers the period April 6th, 2023, to April 5th, 2024, and summaries the outcomes of the Bi-annual Spring and Autumn nurse staffing re-calculations, as well as the exceptional re-calculations following the reconfiguration of Stroke services.

Cefndir / Background

The Nurse Staffing (Wales) Act (NSLWA) became law in 2016. The Act sets out the Health Board's overarching responsibility to ensure robust workforce plans are in place to make provision for appropriate nurse staffing levels and ensure sufficient nurses are provided to allow nurse's time to care (Section 25A). This requirement extends to all care environments whereby NHS Wales provides or commission a third party to provide nurses.

Further duties, Sections 25B and 25C, came into effect from April 2018. The responsibility for meeting the requirements of the Act applies to staff at all levels with the Board and the Chief Executive being ultimately responsible for ensuring compliance with the Act.

Section 25E of 'the Act' requires Health Boards to report their compliance in maintaining the nurse staffing levels for each acute medical, surgical, and paediatric in-patient ward. The report provides ongoing assurances on the approach, mechanisms, monitoring, and management of risks relating to Nurse Staffing Levels and the overall compliance with the requirements of 'the Act' over the past 12-month period.

Asesiad / Assessment

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses required and staff to whom nursing duties have been delegated by a registered nurse to deliver the planned roster. It is acknowledged there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment; however, these staff are not included within the data for this report.

Themes from the Spring re-calculations, identified high acuity, and enhanced care needs of patients on the Care of the Elderly wards. A need to increase HCSW by night was identified on four medical wards, but changes were put on hold in view of the reconfiguration of the Stroke service. However, the Executive Committee agreed planned roster amendments on D2W RGH and Bedwas Ward YYF.

Following the Autumn re-calculations, the planned rosters to most wards were deemed appropriate to meet the needs of patients. The Scheduled Care division made cost neutral adjustments to rosters by reallocating the nurse pool resource to the wards and small savings were made to an elective surgery ward (D2E) by reducing HCSW's by night.

Exceptional re-calculations were undertaken on four wards in January /February 2024 on completion of the Stroke service re-configuration. As a result, the only changes to planned rosters involved cost neutral transition to the Core Care model on Oakdale, a newly designated Stroke rehabilitation ward.

The information below outlines the work that has been completed over the past 12-month reporting period; 6th April 2023 to 5th April 2024:

Date	Position	Status
March/ April 2023	Spring recalculations based on January Acuity Audit and challenge and support meeting held with the Nurse Director on January acuity recalculation	Completed
May 2023	Annual Assurance Report 2022-23 on compliance with the Nurse Staffing Levels (Wales) Act 2016 presented to Board	Completed
June 2023	June Acuity Audit Undertaken	Completed
October/ September 2023	The Autumn re-calculations undertaken based on June Acuity audit and challenge and support meetings held with Nurse Director.	Completed
November 2023	Mandatory Annual Presentation 2022-23 report on compliance with the Nurse Staffing Levels (Wales) Act 2016; paper taken to Board	Completed

January /February 2024	Exceptional re-calculations were undertaken on four wards on completion of the Stroke service re-configuration.	Completed

Argymhelliad / Recommendation

The Board is asked to formally receive and **NOTE** the information contained within the Nurse Staffing Levels (Wales) Act 2016 Annual Assurance Report 2023-24.

This report does not come with an additional financial request and is for Assurance only.

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):	2. Safe Care 5. Timely Care 3.1 Safe and Clinically Effective Care 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Nurse Staffing Levels (Wales) Act 2016
Rhestr Termau: Glossary of Terms:	• 25A Duty to have regard to providing sufficient nurses. • 25B Duty to calculate and take steps to maintain nurse staffing levels. • 25C Nurse staffing levels: method of calculation • 25D Nurse staffing levels: guidance

	• 25E Nurse staffing levels: report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well, Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Aneurin Bevan University Health Board (ABUHB)		
Date annual assurance report is presented to Board	Presented to Board 29 May 2024 This report includes data from April 6th, 2023- April 5th, 2024. *This annual report refers only to year 2023/ 2024* but this report forms part of the 3 yearly assurance report that will be presented to Welsh Government in October 2024 for the *reporting period from April 2021- April 2024.*		
	Adult acute <u>medical</u> inpatient wards	**Adult acute <u>surgical</u> inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Lowest 21 Highest 21	Lowest 13 Highest 13	Lowest 1 Highest 1
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	4 wards in the Division of Medicine required re-calculations, following reconfiguration of the stroke service. (January/February 2024)	0	0

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Date approved by All Wales Nurse Staffing Group: 25/09/2023.

The process and methodology used to calculate the nurse staffing level.	In accordance with the Nurse Staffing Levels Wales Act 2016 (NSLWA), a systematic and well embedded triangulated approach to review and recalculate the nurse staffing levels on all 25B wards (Adult and Paediatric) has been applied as stipulated in legislation. The Spring and Autumn recalculations include in-depth discussions with the Divisional/Deputy Nurse, Senior Nurse, Ward Manager, Nurse Staffing Act Programme Lead as well as representation from the e-rostering and finance teams. Professional judgement is at the forefront of decisions in regards recalculation to ensure sufficient staffing levels and resources are deployed for each individual ward. **Discussions include:** • Ward speciality, bed base, planned roster. • Funded establishment and aligned budget. • E-roster housekeeping and Safecare compliance. • Patient acuity levels from the January and June audits are scrutinised alongside patient flow and activity data. • Staffing levels deployed, including bank and agency usage and variable pay figures. • Additional roles to support the ward but not included in the template, such as ward clerk, ward assistant, activities coordinator, discharge coordinator. • Care quality indicators-which include incidences of hospital acquired pressure ulcers, patient falls with harm, medication errors, Serious Incidences (SI's), infection rates, complaints, and incidences of infiltration/extravasation on the paediatric ward. • All learning taken from the incidences is shared. • Staff related data including PADR and mandatory training compliance and sickness percentage/management. • Ward managers are given the opportunity to discuss ward initiatives and improvement projects. An agreed All-Wales template for each 25B ward is subsequently completed and presented to the Designated Person, (Executive Director of Nursing), Deputy Director of Nursing and Nurse Staffing

	Act Programme Lead by way of challenge and support meetings held in June and October respectively. In line with the requirements of the Act assurance is sought that: • All Section 25B wards have a 26.9% uplift applied to the Registered Nurse workforce within their calculated establishments to allow for annual, sick and study leave. • Ward Managers are supernumerary to the planned rosters. The 26.9% uplift has also been applied to the Ward Manager establishment to cover sick leave, study leave and to enable the continuing provision of the supervisory role in the ward manager's absence. Following completion of the Spring and Autumn calculations for 2023, the annual presentation of the nurse staffing levels was presented to board on 22 November 2023. **Spring 2023 Calculations:** Themes during the calculation processes continued to identify high dependency on Care of the Elderly wards and the need to provide enhanced care to cognitively impaired patients who pose a risk to themselves and others. The Medical Division discussed new and innovative ways of working to improve the patient experience for this cohort of patients. Evidence shows, providing increased mental and physical stimulation prevents deconditioning, therefore, the introduction of an "Activity Coordinator" role is being trialled to further improve and enhance the patient experience. On completion of the Spring recalculations, six wards in total were identified as requiring amendments to previously agreed rosters, these recalculations were presented to the Executive Committee in August 2023. However, the Spring recalculations were undertaken shortly before the decision to re-configure stroke services. It was, therefore, recommended alterations to staffing rosters on the affected wards be put on hold. The requirement to continue to staff these wards to

the proposed new establishments with temporary staffing in the interim was recognised, with a plan to undertake additional recalculations on the wards once the reconfiguration is complete.

In August, the Executive Committee approved the proposed planned roster amendments for:

- D2W Royal Gwent Hospital, (professional discussions and acuity data confirmed the ward did not require a Health Care Support worker by night).
- Bedwas ward Ysbyty Ystrad Fawr, the budget and roster template were aligned to reflect 1WTE supernumerary ward manager.

Autumn 2023 Calculations:

Following the recalculation processes, the planned rosters to most wards were deemed appropriate to meet the needs of patients. As a result, no alterations were required to rosters on the medical wards apart from those awaiting the outcome of the stroke reconfiguration service. The Scheduled Care division made cost neutral adjustments to rosters by reallocating the nurse pool resource to the wards and small savings were made to an elective surgery ward (D2E) by reducing HCSW's by night.

The Below Table demonstrates the required amendments to the 3 Wards within Scheduled Care following the Autumn recalculations:

Scheduled Care						
Ward	**Pre-Calculation**			**Post-Calculation**		
	RN WTE	**HCSW WTE**	**Total WTE**	**RN WTE**	**HCSW WTE**	**Total WTE**
A0 GUH	25.85	25.20	**51.05**	25.85	27.99	**53.84**
B0 GUH	25.85	25.20	**51.05**	25.85	27.99	**53.84**
D2W RGH	12.65	03.59	**16.24**	11.23	03.59	**14.82**

	There were no required changes to the paediatric ward or the gynaecological ward at the Grange University Hospital in the Spring and Autumn Calculations. **Stroke ward re-calculations January/February 2024:** On completion of the re-configuration of Stroke rehabilitation services to Ysbyty Ystrad Fawr (YYF) the following wards were repurposed and underwent a re-calculation: • Elderly Frail Unit known previously as Oakdale ward, relocated to ward 1-1 in YYF. Outcome- no change to planned roster. • Bargoed Ward YYF- Previously a combined Care of the Elderly (COTE)/Stroke rehabilitation ward, repurposed to a 30 bedded Stroke rehabilitation ward. Outcome - core care model established no change to planned roster. • Oakdale Ward YYF (previously known as Bedwas ward), relocated to Oakdale ward and repurposed to a 30 bedded Stroke rehabilitation ward. Outcome - convert to core care model, cost neutral. • Ward 3-4 NHH previously Stroke rehabilitation ward, repurposed to 24-28 bedded COTE ward. Core care model established. Outcome - no change to planned roster at this time.
Informing Patients	In compliance with the 2016 Act following the six-monthly calculations cycle, the All Wales bi-lingual templates displayed at the entrance to each 25B ward are updated to confirm the date and roster changes agreed by the Health Board.

	Information leaflets in English and Welsh detailing frequently asked questions on the Act and how to raise concerns regarding staffing levels are available on each ward and under patient information on the Health Board website. Ensuring this information is displayed can pose a challenge for the Health Board when wards are re-purposed or temporarily relocated for deep cleaning. The recently introduced ward accreditation programme requiring monthly ward audits will provide additional assurance this information is accurately displayed on 25B wards.

Section 25E (2a) Extent to which the nurse staffing level has been maintained.

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2022 following January audit Second cycle: autumn 2022: following June audit		**Period Covered 6th April 2023-5th April 2024**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	34	601.1	713.85
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	34	595.47	700.46
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	34	599.6	720.22
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle	34	594.05	706.24
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE**: 34		

Accompanying narrative:

The staffing rosters on Ward B4 Acute Stroke in GUH have been aligned to reflect the eight medical beds funded by the Medical Division.

There remains a discrepancy between the required and funded establishments following the Spring and Autumn calculations, until the stroke reconfiguration is complete.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Vacancy Position:

Workforce sustainability continues to be considered the greatest corporate risk in the delivery of safe, efficient, and sustainable patient care and experience, this is not unique to ABUHB, with all Health Boards across Wales facing similar recruitment and retention challenges. The Registered Nurse vacancies for the Health Board for the end of January 2024 was 290 WTE. This is an improved position from the previous year where there were circa 376 WTE Registered Nurse vacancies.

Recruitment and Retention:

The Health Board is now one year into the three-year Midwifery and SCPHN Workforce Strategy 2023-2026. In recognition of the competitive market and a similar position across Wales, ABUHB

	aims to deliver its People Plan ambition of being an employer of choice and for nursing to be the career of choice. The Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026 focuses on: • Recruitment Effectiveness • Recruitment Experience • Brand and Marketing • Career Development and Educational Opportunities – Growing-our-Own • Attraction and Retention

Extent to which the required establishment has been maintained within <u>paediatric inpatient wards</u> NB: First cycle: spring 2022 following January audit Second cycle: autumn 2022: following June audit		**Period Covered 6th April 2023-5th April 2024**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May)	1	70.22	17.06
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) calculation cycle	1	70.22	17.06
	Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during second calculation cycle (Nov)	1	70.22.	17.06
	WTE of required establishment of paediatric inpatient wards <u>funded</u> following second (Nov) calculation cycle	1	70.22	17.06

	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE**: 1

Accompanying narrative:

Spring calculations:

Ward C1 an acute 50 bedded paediatric inpatient area inclusive of 2 funded HDU beds. The spring calculations included discussions centred on acuity and bed occupancy, with an average daily occupancy of 32 patients.

The Acuity data recorded daily at 9a.m. does not guarantee an accurate capture of workload and activity but does allow capture of HDU level 4 patients, of which there were fifteen during January. Most patients (67%) were assessed at level 2.

Bank staff usage of 6.63% which were predominantly substantive staff and therefore does not compromise the standard of care provided.

Autumn Calculations:

The Autumn calculations noted a small rise in the average bed occupancy and patient acuity when compared to January figures. Discussions acknowledged high RN vacancies (19.4 WTE), a junior workforce and continued usage of Bank staff to maintain patient safety.

Professional discussions concluded despite holding vacancies, both the Spring and Autumn calculations did not require adjustments to the planned rosters.

Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards and Paediatric wards</u>	To date the Health Board has been unable to accurately report the extent to which the planned staff roster has been maintained within 25B wards due to the lack of appropriate digital capability.
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	NHS Wales is committed to using a national informatics system to enable health boards/trusts to provide consistent reporting on the extent to which nurse staffing levels have been maintained as per the requirements of the Act. All Health Boards/Trusts are committed to implementing the Allocate Safecare system prioritising 25B wards. Further developments are necessary to the Safecare system to enable HB/Trust to extract the necessary data to report on the extent to which rosters have been maintained on 25Bwards. We anticipate these developments will be completed by April/May 2024, which will enable us to include this data in future reports. The Safecare system (an add on to E-roster) was rolled out to all 25B wards in the Health Board by June 2023, and most wards have embedded the twice daily acuity census. Insight from the professional judgement report extracted from Safecare for the month of June 2023 are set out below. **Reasons recorded for raising red flags in the system included:** • High patient Acuity. • Surge beds Open. • Boarding of Patients. • Unforeseen short notice sickness. • Last minute cancellation of bank and agency staff.

	• High levels of enhanced care patients' level 4 and 5. • Deficits not covered by bank and agency. • RN shortfall. • **Themes around mitigation and escalation of red flags raised include:** • Escalation to senior nurse/site teams. • Re-deployment of staff from other wards. • Ward manger stepped into the numbers to fill the deficit. • Cohorting of enhanced care level 4 patients with increased observation. • Patients on the ward divided equally between available RN's. • Staffing appropriate to manage patients on the ward. • Block booked agency nurse who is familiar with the ward. The e-rostering team monitor Safecare and present each 25B ward with monthly compliance reports. Additional support is provided to areas below 90% compliance. During the Bi-annual recalculation meetings ward managers are reminded of the importance of raising a red flag for individual issues of concern. Consequently, professional judgement must be noted against each red flag to escalate or mitigate the risk.
Process for maintaining the Nurse staffing level	Processes to manage and escalate nurse staffing deficits is now well established to ensure all reasonable steps have been followed to maintain nurse staffing levels, which includes: • A ratified Nurse Staffing Operational Policy, to standardise and inform staff groups of their responsibilities to ensure all areas where nurses are deployed are staffed appropriately to meet the needs of patients.

	• A weekly reporting and escalation process by which staffing deficits across the Health Board are reported include: ➢ Filled and unfilled Registered Nurse (RN) shifts against planned rosters ➢ Filled and unfilled Health Care Support Worker (HCSW) shifts against planned rosters ➢ Percentage of substantive staff versus agency staff populating rosters to gauge quality, safety, and continuity of care. ➢ Serious incidents considered to have been attributed to a deviation from the planned ward nursing roster. • A workforce tracker is presented to the Executive Team detailing progress on recruitment, bank, and agency usage, turnover and absenteeism. • A monthly Strategic Workforce (NSLWA) meeting is held with representation from all clinical Divisions, with the purpose of overseeing the implementation of the Act and monitoring key workforce and staffing metrics. • Daily review of nurse staffing levels by all divisions – to manage and mitigate risk. • Unfilled shifts escalated to bank/agency at the earliest opportunity to give best opportunity of securing staff. • Clear Divisional escalation procedures to ensure and manage timely escalation of unfilled shifts. • The development of new and innovative roles has been crucial in maintaining nurse staffing levels across the Health Board.

	• The deployment of staff between wards and across sites to fill short notice deficits. • Senior nurses and site teams are encouraged to use the sunburst view in the Safecare system to assess staffing levels, staffing deficits and patient acuity. Red flags and professional judgements assigned to 25B wards help inform decision making when considering the deployment of staff.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
	TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	3	6	0	44
Total number of incidents/ complaints not closed and to be reported on/during the next year	3	1	0	43

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Date approved by All Wales Nurse Staffing Group: 25/09/2023.

Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	2	0	0	23
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	1	1	0	7

Accompanying Narrative:

Based on a review of the health boards/trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Directors of Nursing & Midwifery and the Chief Nursing Officer for Wales in 2021 requesting a review of the current reporting process. A sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process; standardise reporting in line with the Duty of Candour set out in the Health and Social Care (Quality & Engagement Act) (Wales) Act 2020 and to broaden the reporting scope of incidences of harm to provide more meaningful data.

The findings and recommendations of the Reporting Sub-Group were presented to the Executive Nurse Directors in August 2023 who approved the recommendations to take effect from the next reporting period i.e. 6th April 2024 – 5th April 2027.

The quality indicators for the adult in-patient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm, or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).

- Any complaints received about nursing care (complaints refer to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR).

The measures going forward will include:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents / complaints not closed and to be reported on /during the next year.
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained.
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor.
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained.
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

Following the Executive Nurse Directors agreeing the recommendations in August 2023 it became apparent that the Duty of Candour (DoC), which came into force on 1st April 2023, would impact the reporting metrics.

Previous reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. This change to reporting is not specific to ABUHB but will impact on reporting from all Health Boards.

Therefore, to align with patient safety incident reporting to Welsh Government from 6th April 2023 this report, and all future reports, will report on closed patient safety incidents which have been validated with a reportable level of harm (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.

Consequently, despite the afore mentioned broadening of reporting criteria, the number of incidents reported within this annual assurance reports may be lower than those in previous years.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards					
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Hospital acquired pressure damage (grade 3, 4 and unstageable)**	**Falls resulting in serious harm or death (i.e. 4 and 5 incidents).**	**Medication errors never events**	**infiltration and extravasation injuries**	**Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)**
	TOTAL	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	0	0	0	1	1
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	0	0	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was <u>not</u> maintained	0	0	0	0	0

Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0	0

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.

The quality indicators for the paediatric inpatient wards will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm or death (i.e., level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)

The data to be reported for each of the above will be:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year.
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained.

• Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor. • Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained. • Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)
Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies.	By way of assurance, the Health Board has in place: • Well embedded process to investigate all Health Care Acquired Pressure Ulcers (HAPU's) through root cause analysis (RCA) which considers a range of variables which may have contributed to the incident. Any HAPU's considered to have been deemed avoidable are reported to Welsh Government and are reviewed at the Redress Panel, enabling a process of reflection and learning. • A Falls Review Panel is well established, where all variables are considered. Falls that meet the duty of Candour as moderate level of harm or above are reviewed at the Redress Panel. Organisational shared learning events have taken place in relation to falls. • Complaints is a complex metric to capture due to the multi-faceted nature of complaints. • Never event medication errors will be investigated as a serious incident and reported to the Delivery Unit. A small number of outstanding incidents requiring root cause analyses, will be included in the next reporting period.

	• **Hospital Acquired pressure ulcers (HAPU) Grade 3,4 and unstageable.** There have been 3 HAPUs deemed avoidable (2 carried over from last year and 1 from this reporting period) staffing levels were a contributary factor in one incident. There were 23 closed HAPUs, deemed unavoidable and 3 awaiting root cause analyses which will be carried over to the next reporting period. • **Patient Falls** There has been a total of 7 falls closed on DATIX as severe or catastrophic, the planned roster was met on all occasions. Staffing levels were deemed a contributing factor in 1 incident as enhanced care needs were not met. • **Infiltration/Extravasation** There has been 1 incidence of extravasation/infiltration injury on the paediatric ward, with no serious harm.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned,	In accordance with the NSLWA the Health Board is required to ensure there are sufficient nurses (including those to whom registered nurses delegate the delivery of care) to allow nurses time to care for patients sensitively wherever nursing care is provided and/ or commissioned. **District Nursing:** • In line with the National and Strategic direction, and National Community Nursing Specification, positive progress has been made against 3 of the 7 key milestones, whilst on target to complete all 7 within the desired timeframe.

not only wards where section 25B applies)	• CNO / WG funding allocated for the implementation of the Band 4 Assistant Practitioner Model, supported by a robust training / mentoring programme. • Full implementation of the CIVICA Scheduling Tool has enabled the Division to adopt a capacity v demand model. This will be formally evaluated to inform full implementation across all 5 boroughs within 2024. This will help inform future workforce modelling. • ABUHB has participated in the National NHS Benchmarking Programme which has provided useful data to support the ongoing District Nursing Service workforce review. **Medical Assessment Units:** A review has been completed using the principles of the re-calculations deep dives used in 25B wards. The Division is finalising an SBAR to take to SMT for approval. **Maternity Services:** Maternity Services within the Health Board use Birthrate Plus. Birthrate Plus is a midwifery-specific, national tool that provides intelligence and insight needed to be able to model midwifery numbers, skill mix and deployment. This also supports decision making when planning safe and sustainable services. Birth Rate Plus recommends, the ratio of midwives to band 3 maternity support workers is discretionary to meet the needs of the service. In our Health Board the ratio equates to 94/6% split. If Band 4 practitioners were to be included in this ratio it would demonstrate a 93%/7% split.

	In view of significant workforce challenges maternity services were centralised in September 2023 to ensure the safety of mothers and babies. There has subsequently been a pro-active and targeted approach to recruitment, maternity services have seen a significant reduction in vacancies to those reported in July 2022. **July 2022 Midwife Vacancies:** • 25.4 WTE band 6/5 Midwife • 1.1 WTE band 7 Midwife • Further 5.2 WTE band 6 Midwives about to leave the service. **February 2024:** • 5.6WTE vacancies **Emergency Departments:** Urgent Care constantly review ED staffing to ensure the models are correct in line with the RCN Nursing Workforce Standards for Type 1 Emergency Departments. A review of all minor injury Units has been undertaken in terms of operating hours, number of attendances and the staffing profile to ensure equity across all sites. Deep dives are undertaken of all areas using the same principles as the 25B wards and the establishment templates are agreed using the same principles of triangulating acuity, attendances, staffing and professional judgement.

	Mental Health & Learning Disabilities: The MH & LD Division has undertaken a review of all staffing models, using 5 of the Safe Staffing Principles which are directly workforce related. • The ward manager should be supervisory and supernumerary. • Each ward must have a minimum of 1WTE administrative support. • There should be a registered nurse to patient ratio of 1:5 per day shift and 1:8 per night shift. • Each ward should have access to 3 staff on duty per shift who are trained in the use of restraint. • Each ward should have 24 hours, 7 days a week, band 6 cover within their establishment to provide clinical leadership to the nursing team. There is a plan to invest in Health Care Support Workers (HCSW's) by providing education/training and development opportunities, with a view of ensuring band 4's are incorporated into all units. The Division aims to increase the Advanced Nurse Practitioner workforce to encourage a focus on high quality nursing care.
	Conclusion & Recommendations
	• The Health Board has a well-developed process embedded in practice for calculating nurse staffing levels in 25B wards with the principles being applied in all service areas where nurses are deployed.

- Established processes are in place to scrutinize quality indicators and determine if nurse staffing levels were a contributing factor.
- Robust re-calculation processes confirmed nurse staffing levels in the majority of 25B wards were appropriate to meet the needs of patients, requiring minimal changes to planned rosters and establishments.
- The Nursing, Midwifery and SCPHN Workforce Strategy has been implemented.
- Safecare has been rolled out to all 25B wards with a plan to extend to other areas.
- Anticipated development in digital informatic systems will improve the quality and accuracy of future reporting on nurse staffing levels on 25B wards.

Recommendations:

- Ensure compliance in displaying planned versus actual rosters on 25B wards as well as information informing the public of the Nurse Staffing Act.
- Future reports to include new quality Metrix agreed by the All-Wales Nurse Staffing Group (AWNSG).
- Future reports to include the extent to which the planned roster has been maintained on 25B wards.

Appendix: Annual Assurance Report

Health board/trust:	ABUHB
Period of the report	6th April 2023-5th 204
adult acute medical wards	21

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Medical Inpatient wards

		Required Establishment at the start of this report (Spring calculation cycle) including uplift 26.9%			Required Establishment at the end of the period of this report (autumn calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Name of Ward	**TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse**	**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**	**TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse**	**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
A2 GUH	1WTE	20.16	16.78	1WTE	20.16	16.78	Yes	No	Deemed Appropriate	No			
A4 GUH	1WTE	25.86	22.38	1WTE	25.86	22.38	Yes	No	Deemed Appropriate	No			
B4 GUH	1WTE	17.32 (23.01) on hold	16.77 (22.37) on hold	1WTE	23.01	22.37	Yes	Changed foolowing Autumn recalulation	Needed to include the establishment and funding for 8 medical beds	No			
C4 GUH	1WTE	40.07	27.97	1WTE	40.07	27.97	Yes	No	Deemed Appropriate				
C4 GUH	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No	Deemed Appropriate	No			
C5E RGH	1WTE	14.48	16.48 (19.56) on hold	1WTE	14.48	16.48 (19.56) on hold	Yes	On Hold	Awaiting completion of stroke reconfiguration	No- plans to close			
C5W RGH	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No	Deemed Appropriate	No-plans to close			
C6E RGH	1WTE	14.48	22.42	1WTE	14.48	22.42	Yes	No	Deemed Appropriate	No			
C6W RGH	1WTE	17.48	22.42	1WTE	17.48	22.42	Yes	No	Deemed Appropriate	No			
D4E RGH	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No	Deemed Appropriate	No			
D4W RGH	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No	Deemed Appropriate	No			
3.1 NHH	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No	Deemed Appropriate	No			
3.2 NHH	1WTE	14.48	22.42 (25.2) on hold	1WTE	14.48	22.24 (25.2) on hold	Yes	On Hold	Awaiting completion of stroke reconfiguration	No- need more acuity data			
3.3 NHH	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No	Deemed Appropriate				
3.4 NHH	1WTE	14.48	22.24 (25.2) on hold	1WTE	14.48	22.24 (25.2) on hold	Yes	On Hold	Awaiting completion of stroke reconfiguration	Yes	29/01/2024	Awaiting challenge & support	ward repurposed to COTE, staff adjusting. Increased EC needs
4.3 NHH	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No	Deemed Appropriate	No			
4.4 NHH	1WTE	20.16	13.98	1WTE	20.16	13.98	Yes		Deemed Appropriate	No			
Bedwas YYF(Moved to Oakdale- in November 2023 renamed Oakdale stroke rehab)	0.5 budget 1WTE in place	17.32	22.36	1WTE	17.32	22.36	Yes	Yes	Budget and roster aligned to reflect 1WTE Wm	Yes	01/02/2024	Awaiting challenge & support	Ward moved location and changed name and repurposed- stroke rehab
Oakdale YYF (Moved to 1st floor renamed EFU)	1WTE	17.32	22.36	1WTE	17.32	22.36	Yes	No	Awaiting completion of stroke reconfiguration	Yes	01/02/2024	Awaiting challenge & support	Ward moved location and repurposed to full ward EFU
Bargoed YYF	1WTE	14.48	25.2	1WTE	14.48	25.2	Yes	No		Yes	01/02/2024	Awaiting challenge & support	Al beds now stroke rehab.
Risca YYF	1WTE	17.32	22.36	1WTE	17.32	22.36	Yes	No	Deemed Appropriate	No			

Appendix: Annual Assurance Report

Health board/trust:	ABUHB
Period of the report	6th April 2023-5th April 2024
adult acute surgical wards	13

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Surgical Inpatient wards

	TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the start of this report (Spring calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the end of the period of this report (autumn calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Name of Ward		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
A0 GUH	1WTE	25.85	25.2	1WTE	25.85	27.99	Yes	Yes	Pool resourse moved to ward budget	No			
B0 GUH	1WTE	25.85	25.2	1WTE	25.85	27.99	Yes	Yes	Pool resourse moved to ward budget	No			
C0 GUH	1WTE	25.85	25.2	1WTE	25.85	27.99	Yes	No	Deemed Appropriate	No			
A3 GUH	1WTE	20.16	13.98	1WTE	20.16	13.98	Yes	No	Deemed Appropriate	No			
C7E RGH	1WTE	14.48	22.4	1WTE	14.48	22.4	Yes	No	Deemed Appropriate	No			
C7W RGH	1WTE	14.48	19.61	1WTE	14.48	19.61	Yes	No	Deemed Appropriate	No			
D2E RGH	1WTE	14.48	8.38	1WTE	14.48	8.38	Yes	No	Deemed Appropriate	No			
D2W RGH	1WTE	12.65	2.8	1WTE	12.23	3.59	Yes	Yes	Cost Saving- Spring recalculation-reduction of HCSW by night Mon-Fri Autumn recalculation -RN reduced to 1WTE from Sat pm- Mon am	No			
D3E RGH	1WTE	17.32	19.61	1WTE	17.32	19.61	Yes	No	Deemed Appropriate	No			
D3W (formerly D5W)	1WTE	14.48	22.46	1WTE	14.48	22.46	Yes	No	Deemed Apprpriate	No			
D7E RGH	1WTE	11.64	11.22	1WTE	11.64	11.22	Yes	No	Deemed Appropriate	No			
OSU SWH	1WTE	16.91	8.39	1WTE	16.91	8.39	Yes	No	Deemed Appropriate	No			
4.2 NHH	1WTE	14.48	22.4	1WTE	14.48	22.4	Yes	No	Deemed Appropriate	No			

Appendix: Annual Assurance Report

Health board/trust:	ABUHB
Period of the report	6th April 2023-5th April 2024
paediatric inpatient wards	1

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Paediatric Inpatient wards

	TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the start of this report (Spring calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the end of the period of this report (autumn calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Name of Ward		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
C1 GUH	1WTE	70.22	17.06	1WTE	70.22	17.06	Yes	No	Deemed Appropriate				

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Six Goals for Urgent & Emergency Care Programme Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Simon Roberts, Programme Lead, Urgent & Emergency Care

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

Er Gwybodaeth/For Information

The purpose of this report is to provide an update on progress to date in respect of the Six Goals for Urgent and Emergency Care Programme.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This is an executive summary of the Six Goals Programme update with supporting information included as an Appendix.
The purpose of the Executive Summary is to:

- Outline the Programme Structure and workstreams
- Provide an update on Key achievements for 2023/2024 , priorities for 2024/2025 and intended benefits of the Programme

The Six Goals Programme is one of the priority programmes for the Health Board. The Programme brings together Six goals for Urgent and Emergency Care in line with Welsh Government's national programme. The programme focuses on the transformational changes required across Urgent and Emergency Care. Positive progress is being made in all workstreams, and this paper summarises this work.

The National Six Goals are as Follows:

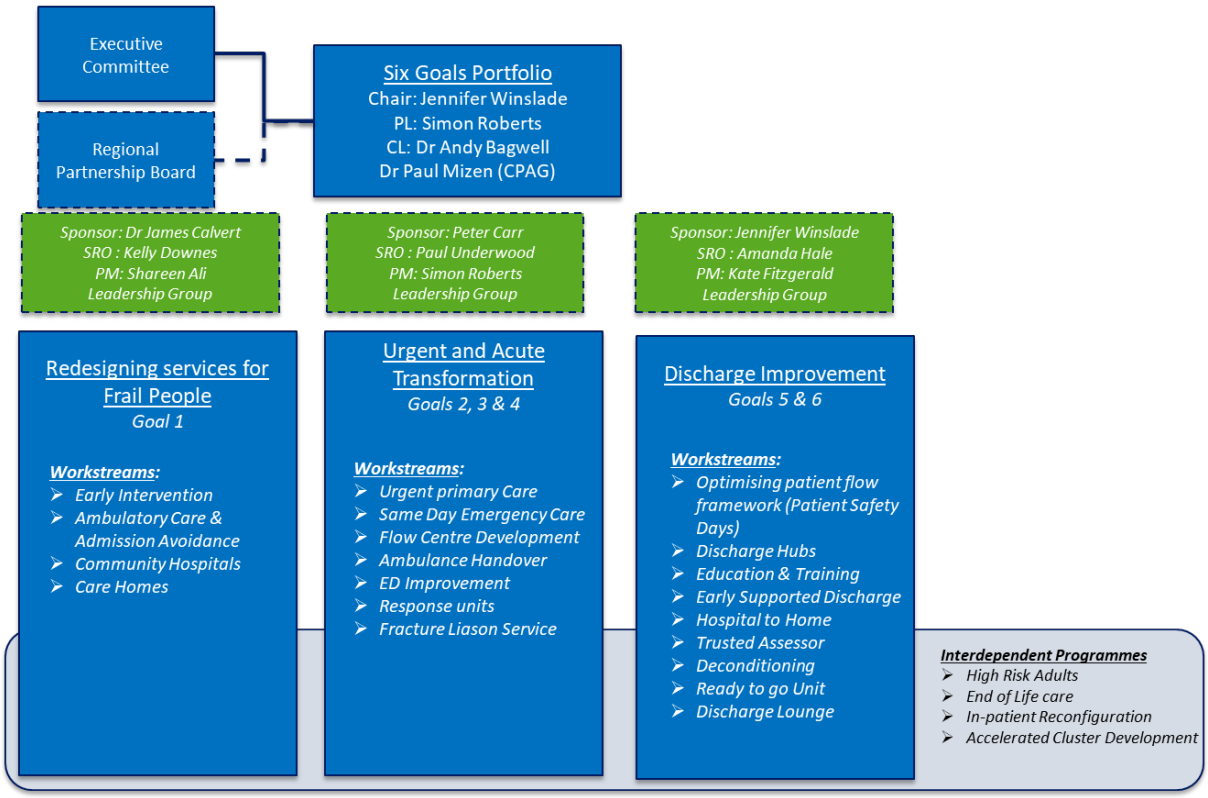
- **Goal 1**: Co-ordination planning and support for populations at greater risk of needing urgent or emergency care

- **Goal 2**: Signposting people with urgent care needs to the right place, first time
- **Goal 3**: Clinically safe alternatives to admission to hospital
- **Goal 4**: Rapid response in physical or mental health crisis
- **Goal 5**: Optimal hospital care and discharge practice from the point of admission
- **Goal 6**: Home First approach and reduce risk of readmission.

Cefndir / Background

The purpose of the programme is to provide strategic oversight of a sustainable, whole system approach to improving patient experience and outcomes within urgent and emergency care by delivering on multiple programmes of improvement.

The Programme is structured into three overarching workstreams each with an SRO, Programme Manager and Executive lead. The Programme has an Executive Chair, Programme Lead and Clinical Lead.



Each workstream consists of various projects that are at differing stages of maturity. The Programme is underpinned by an improvement ethos and tests of change are actively encouraged through a 'Plan, Do, Study, Act' (PDSA) methodology.

Workstream	Scope
Goal 1 - Redesigning Services for Older People	Improving access to care and support for older and/or frail people in order for them to remain at, or as close to, home as possible and avoid unnecessary hospital admissions and lengths of stay by redesigning, optimising and building appropriate capacity within community services.
Goals 2, 3 & 4 - Urgent & Acute Needs	Improving core Emergency Department KPIs, ambulance handover times, patient experience and outcomes in Urgent and Emergency Care, developing alternative admission pathways
Goals 5 & 6 – Return & Stay Well at Home	Delivering optimal hospital care and discharge practice from the point of admission, delivering a home first approach to reduce risk of readmission

Asesiad / Assessment

There is a positive momentum through each of the goals in the context of significant operational pressure. Engagement with partners and support organisations continues to be positive with National Programme, Local Authority , Welsh Ambulance Services Trust and NHS Executive representation at programme board level.

This section provides an overview of the key achievements by workstream through 2023/2024 followed by key priorities for 2024/2025.

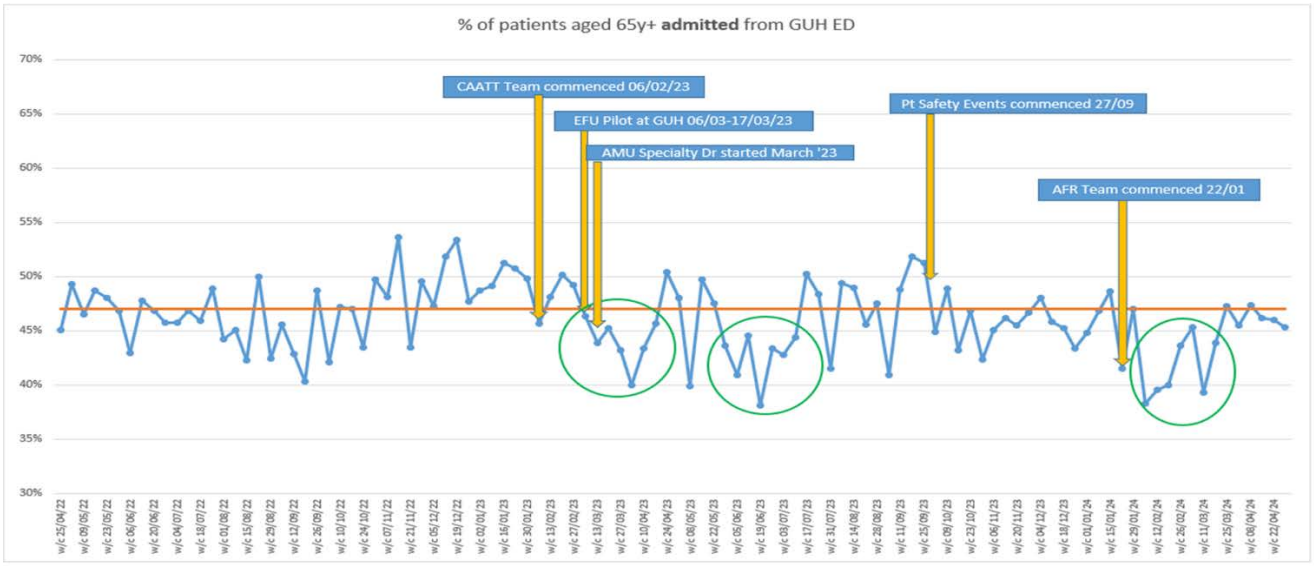
Key Achievements :

Goal One: Redesigning Services for Older and/or Frail People (RSfOFP)

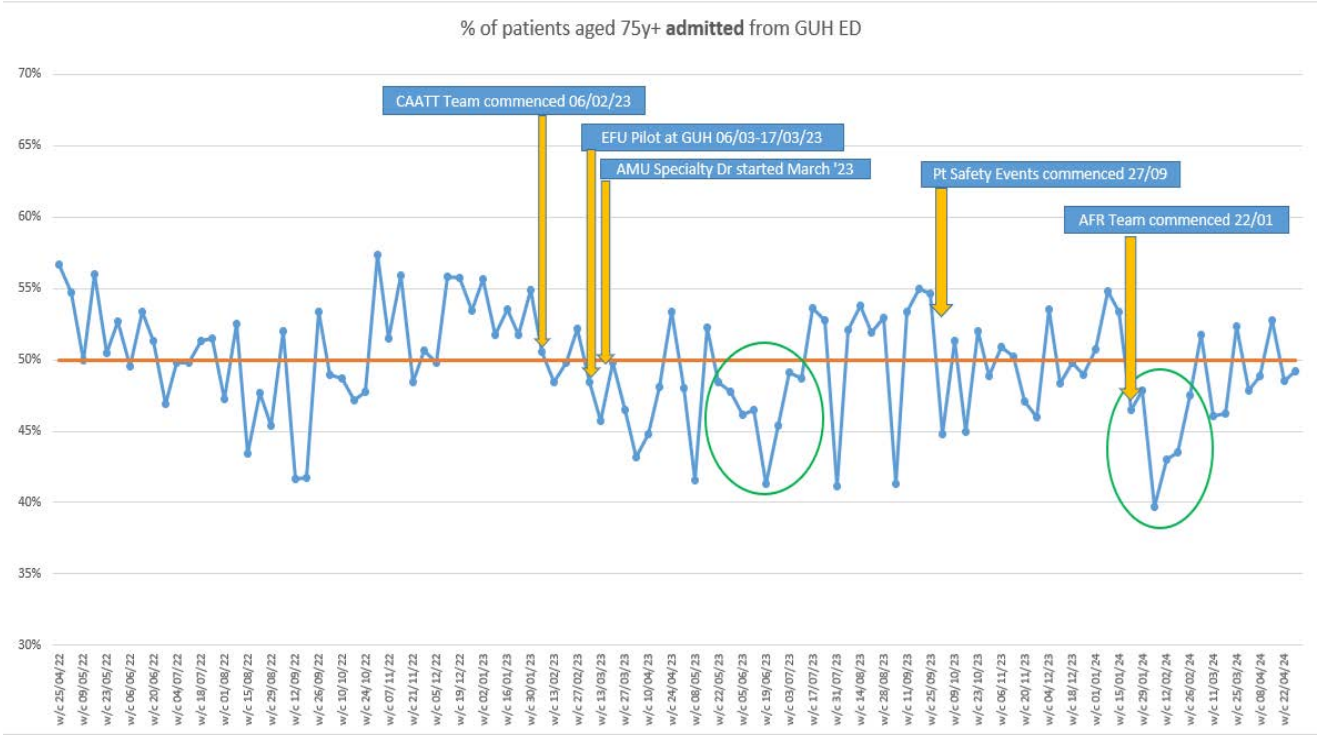
- **Nurse led Acute Frailty Response** (AFR) phase one commenced on 22nd January 2024; providing in-reach into the GUH front door Monday-Friday 8.30am-4.30pm to identify, assess and transfer patients to community services to avoid inappropriate acute admissions and/or an unnecessary length of stay following an acute episode. Recruitment to permanent posts as part of phase two commenced and an evaluation of the service is ongoing. This includes the commencement of a joint approach to evaluation between the AFR team, CAATT and Home First to report outputs and outcomes and mitigate the risk of 'double counting'.
- **Professional Hub** phase one pilot planning underway, informed by pre-pilot that commenced in January 2024. Aim is to provide CRT clinician capacity at the Flow Centre to support clinician to clinician conversations and triage of identified frail/older patients, including care home residents, to offer an appropriate alternative to acute admission.
- Funding secured to enable the **extension of CRT rapids provision**.
- Phase one and two of **proactive frailty approach complete**; this constitutes an appraisal of evidence and best practice and the development of a guidance document for the Gwent model. This approach enables the identification of frail patients in the community and will enable proactive interventions to reduce risk for those patients requiring secondary care. This will be integrated into the High Risk Adult Cohort (HRAC) work.

Initiative Evaluation : Nurse Led Acute Frailty Response

Commenced : 22nd January 2024 at the GUH.
Primary aim: acute admission avoidance within ED; assessing and transferring patients back out into the community.
Primary outcome measure: The proportion of older people who attend ED who are admitted and who are not admitted (reduce and increase respectively).



Green circles indicate points in time where there have been 6 or more data points below the median (indicating a shift)



Data Summary/Assumptions:
The below are assumptions about the data and not conclusions.
65y+: three shifts in the data have occurred in the past two year period – assumption that changes made within the system have caused a shift in the data and AFR has contributed to this.
75y+ : two shifts in the data, as above.
85y+ : no shifts in the data in the past two rolling years; no reduction in admissions from GUH ED amongst those aged 85+

Data Caveats
Whilst there has been a shift in some data sets it cannot be assumed that the AFR team on it's own has caused this.
AFR has contributed to this shift alongside the collective effort of teams within the system e.g. Community Admission Avoidance Therapy Team (CAATT), Home First, Acute Medical Unit, SAS Doctor, safety flow actions, etc.

The focus this year will be to demonstrate the impact. The AFR is one part of a number of pathway changes to reduce inappropriate admissions of the frail and elderly.

Goals Two, Three & Four Urgent and Acute Transformation:

- **Same Day Emergency Care** has an established improvement board which aims to identify and increase patient volume through each of the services to take pressure of the Emergency Department and Assessment Units. Both GUH and YYF have seen increased medical patient volume through their units in January – March 2024 (44 to 55 per week). Surgical SDEC maintains circa 100 patients per week and remains very well regarded by patients and clinical referrers.
- **System Navigation**, User feedback has clearly identified a desire to access our services through one single phone number. We are able to implement this change by providing access to three services through one single phone number with options (Frailty, Urgent primary Care and Flow Centre). This change was effective from February 2024 and Health Care Professionals are able to call 0300 303 3557 to access the three mentioned services. This will reduce complexity and improve awareness of alternative services.
- A new **Falls Pathway** has been introduced designed to reduce the number of non-injurious fallers conveyed to the Emergency Department by ambulance. Since implementation in December 2023, 47% of non-injurious falls patients are conveyed to an eLGH for initial clinical assessment. In addition, the RPB has approved financial support to enable an additional Level 2 community falls response within the Gwent Region from April 2024 (Paramedic and Physiotherapist / Occupational Therapist response)
- Completed The **Grange Level 1 service re-configuration** , increasing assessment and waiting space for both medical and surgical assessment units
- A 12-month pilot of **Electronic Registration and Triage software 'eTriage'** is still planned to go-live in Q1 2024 within the Emergency Department at GUH and Minor Injury Units at NHH and RGH. An initial start commenced in February 2024 but was paused as a defect was noted in communication between digital systems. Once embedded, an evaluation will be completed to assess the benefits of the system. Expected benefits include

improved patient dignity, earlier risk assessment of patients in the waiting rooms, improved staff experience and a more efficient triage process. .

- **WAST / ABUHB Collaborative Programme** continues with workshops held in March 2024 focused on reducing Ambulance conveyance to ED. Teams are working together to progress sustainable solutions to areas including community falls response, 'own transport' referrals into ED via 111 / 999 and the use of Advanced Paramedic Practitioners in portfolio roles.
- Tested concept of **Rapid Assessment and triage** within the Emergency Department which demonstrated a reduction in time to be seen by a clinician
- **Urgent Primary Care 24/7** now undertake a 24/7 pull from 111 Wales for patients appropriate for UPC centres. This over the past six months now equates to over 50% of daytime demand, ensuring appropriate signposting of patients to community services where appropriate and undertaking remote and face to face clinical assessment in order to support daytime GMS practices.
- Commenced capital works for **Emergency Department main wait expansion** to improve patient experience and outcomes , scheduled to complete in early 2025

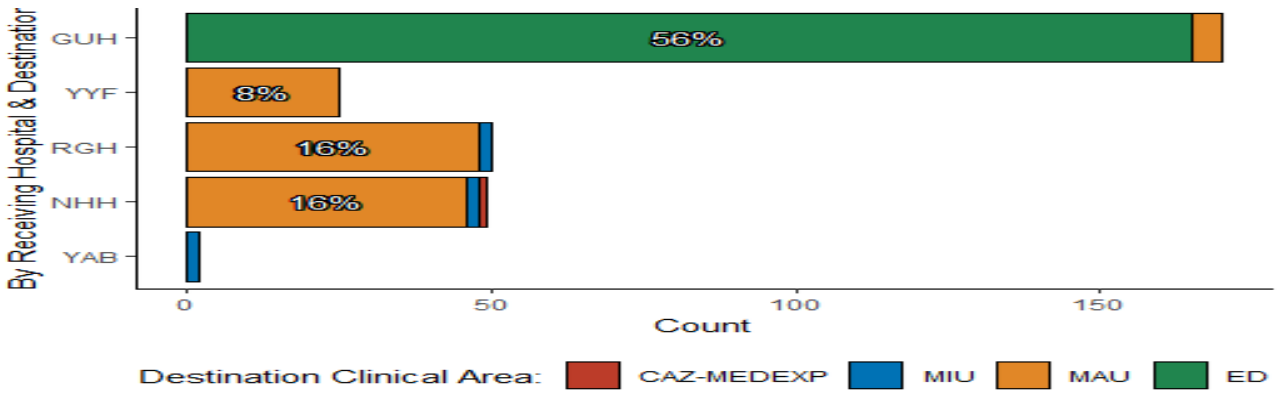
Initiative Evaluation: Falls Pathway to Reduce Conveyances to the Emergency Department

A new Falls Pathway was introduced this was designed to reduce the number of non-injurious fallers conveyed to the Emergency Department at the Grange University Hospital by ambulance.

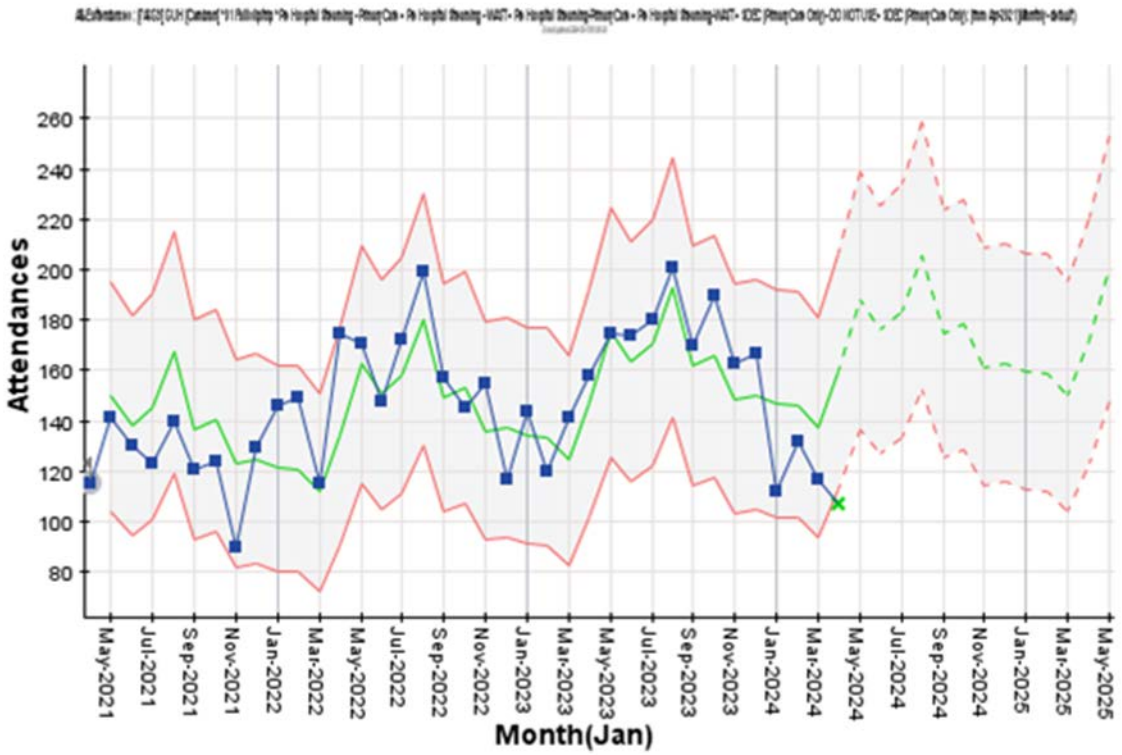
In the development of the pathways, consideration was given to:

- Injurious or non-injurious
- Type of injury (Head, Neck, Back, Hip)
- Red flags, anticoagulation, GCS, Frailty
- Could the patient be appropriate for assessment in an eLGH
- Designed to escalate more complex cases to senior clinician

Results of the Pathway implementation to date by hospital for the patients initial assessment:



- Since implementation on 18th December 2023 44% of non-injurious falls patients are conveyed to the eLGHs for initial clinical assessment instead of ED (As per bar chart above)
- The chart below demonstrates how the number of attendances to the Emergency Department (Via Flow Flow Centre) due to falls, trips or slips. In the months following implementation of the new pathway attendances are much lower. In October, November and December 2023 the number was 190, 163 and 167 per month respectively, whereas post implementation in January, February and March 2024 the attendances were 112, 132 and 117 with a significant change from December 2023 to January 2024



- There have been minimal levels of step-ups for patients initially assessed at the eLGHs.
- The pathway continues to be monitored to maintain its success and to ensure resources are aligned to the increased demand at eLGH sites

Goals Five & Six: Return and Stay Well at Home

- A total of 20 **Patient Safety Team** interventions have been delivered across all sites with a specific focus on the Royal Gwent Hospital and St Woolos Hospital since the end of September 2023, with the aim of rapidly improving the timely discharge of patients, delivering a step change in performance, safety and patient experience. There is good engagement and support from Local Authority colleagues. Lessons learned and evaluation report has been produced.
- **Discharge Lounge**, improvement in the function and performance of the discharge lounge model has been undertaken. Capital works have been undertaken at RGH to facilitate the move from D1W to D6W and includes alignment with the Discharge Hub and the Ready to Go Unit on the sixth floor. Capital works at NHH complete and new transport booking system is in

place. GUH there is scoping potential options for expansion, further work is on going regarding the realignment of pharmacy and WAST resource to facilitate discharges earlier in the day.

- **Ready to Go Unit** at RGH, established in April 2024 at D6E aligned to the relocation of two wards and repurpose of one ward from St Woolos Hospital to RGH, with the aim of optimising patients, physical, psychological and social wellbeing, supporting a seamless transition from hospital to home. Following implementation the costs and benefits will be evaluated.
- **Hospital to Home** £254,865 secured from RIF in August 2023 to facilitate earlier discharge for patients identified as clinically optimised, ready to transfer to an alternative care setting/home. Funding has been agreed via the Regional Partnership Board, piloting a new referral process in Monmouthshire including weekly review meetings at Chepstow hospital between the Clinical Lead for the Facilitated Early Discharge Team and Local Authority Social Workers. Future plans are considering how to embed the referral process and the team within other Local Authorities .
- **Discharge 2 Recover then Assess** (D2RA) digital solution this is being piloted across three wards at RGH and County Hospital. Roll out of the system across all sites/wards will begin week commencing 8th April including ongoing education and training. The system will support the capture of meaningful data including red to green days, medically optimised for discharge status and D2RA pathways.
- Delivery of **'Move it May' campaign**, promotion of physical and mental well-being in hospital by conducting meaningful activities supported by Activity Co-ordinators tailored towards the patient's goals and interests, prevention of hospital acquired deconditioning

Initiative Evaluation : Patient Safety Events

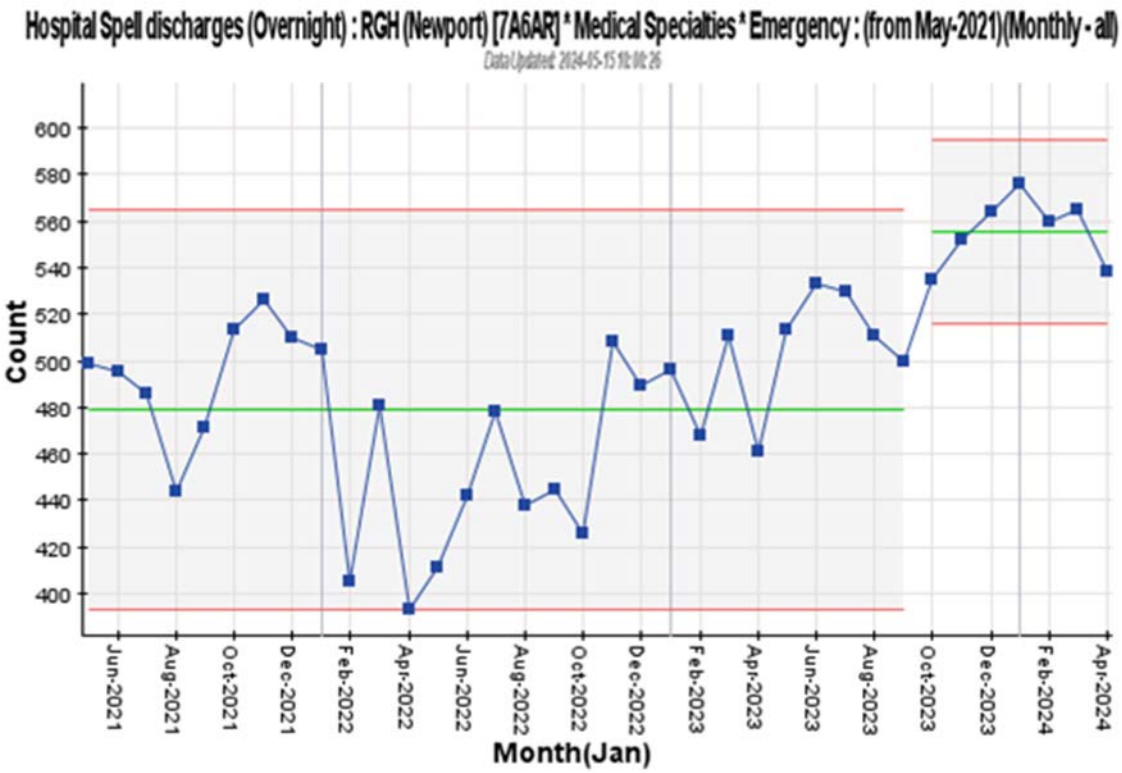
The Context for the Patient Safety Events was:

- Increasing number of patients who are medically optimised for discharge remain in hospital (Average of 300)
- Discharge delays - increased risk of patients deconditioning in hospital, further risk of infection/falls, causing patient harm
- Wider System impact, improving safety and quality of care
- Interdependencies with other work streams
- Alignment of bed base with the Clinical Futures model, following opening of GUH
- Benefits – increase number of discharges, reduced LOS, improved patient outcomes, improved flow, enhanced links with LAs, multidisciplinary working
- Aligned to UEC Six Goals : Goals 5 & 6, Return and Stay Well at Home

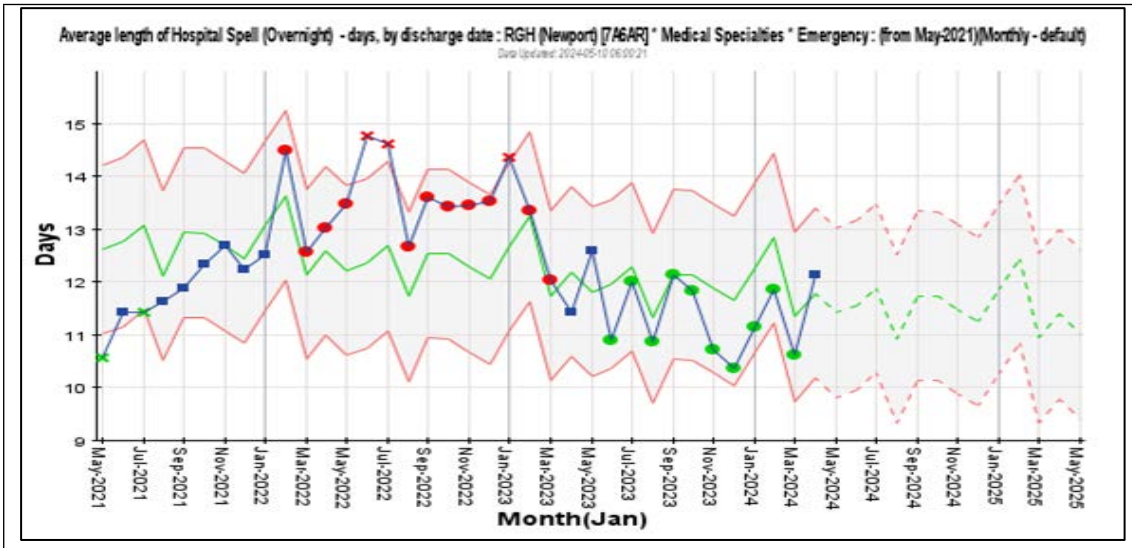
A total of 20 weekly PSEs events delivered across GUH/RGH/NHH/YYF and community hospitals between September 2023 and February 2024 with the aim of rapidly improving the timely discharge of patients.

Results to date

- Since October 2023, monthly Hospital Discharges (including transfers) from RGH have been 535 or higher , prior to this the average from May 2021 to September 2023 was 479 (Statistically significant improvement as per chart below)
- Numbers have continued between 535 and 576 since then but have slightly reduced since peaking in January
- January itself was an unusually busy month with particularly high MAU demand



- Hospital LOS for inpatients reduced sharply in March 2023 from 13-14 days to 11-12 days
- November, December 2023 and February 2024 had the shortest average LOS, but pre-PSE June and August 2023 LOS were comparably short due to seasonal trends



General Themes captured from the events included:

- Lack of awareness of services available in the community and how to access service across the five localities
- Focused Board Rounds/MDTs, ownership and progression of actions, what is stopping the patient going home, parallel discharge planning
- Step down improvement at GUH
- What matters conversations, asking, listening and understanding what matters to the individual in their lives
- Principles of Optimising Patient Flow Framework – D2RA, SAFER, Red to Green, deconditioning
- End of Life – ensure patients receive timely and co-ordinated care with involvement from appropriate services

Key Priorities for 24/25

Goal One: Redesigning Services for Older and/or Frail People (RSfOFP)

- Implement, as business as usual, extension **of CRT rapids provision** to 8am-8pm.
- Test and evaluate our ability to identify frail patients in the community **proactive frailty**) . Identifying patients is the first step to implementing preventative measures to reduce risk of admission, linking in with the HRAC Plans.
- Deliver phase 2 and 3 of **acute frailty response team** as part of the right sizing of community services, e.g. CRT provision and end of life care.
- Formally pilot a revised model of the **professional hub** within the flow centre and agree longer term service model including workforce requirements, capacity and operating hours in line with the right sizing of community services. This will include a clinician with frailty expertise being based within our flow centre supporting call handling colleagues appropriately directing patients into our services.

- Implement and evaluate revised **direct admissions pathway SOP**, to include the ability for direct admission to COTE.
- Develop proposal for increasing the number of **nurse led wards** within community hospitals.
- Commence implementation of programme of work, co-produced with **care home providers**, to reduce conveyances and increase time spent at home.
- Complete evaluation of **WAST led Luscii** pilot and agree next steps. The Luscii pilot is being piloted within a small number of care homes that provides remote monitoring technology. The remote technology is designed to communicate patient clinical information to Welsh Ambulance colleagues in order to safely prioritise the appropriate response.

Anticipated Programme Benefits for 24/25

- Increase in the number of frail patients supported at home
- Reduction in the number of patients attending Emergency Department and Medical Assessment Units
- Increase in the number of patients able to access Community Resource teams
- Reduction in the number of patients conveyed to the Emergency Department and Medical Assessment Units from care homes
- Increase in the number patients directly admitted to community hospitals
- Improved patient experience

Goals Two, Three & Four : Urgent and Acute Transformation

- **SDEC Strategy Setting and options appraisal** for the next phase of Ambulatory Care within ABUHB
- **Continuous improvement of SDEC Services** to increase medical patient selection and develop closer linkage for Elderly / Frail patients
- **Launch eTriage** pilot to improve visibility to waiting room risks and improve patient experience
- **Improve service interventions** for patients coming to Emergency Department via 111 / 999 via own transport
- Complete an evaluation for all of ABUHB **Pre-hospital admission avoidance services** to include PRU, CAAT, Falls response, AFR, Mental Health
- Proposal developments **for front door process re-design and pathway development** in readiness for ED Extension
- Complete **Fracture Liason Service** Evaluation
- Consideration of potential developments for eLGH **Integrated Assessment centre** (Integrated front door)
- Deliver a **UPCC model in 24/25 that ensures a 24/7** sustainable model through enhanced OOH support and 24/7 pull from 111 WAST and increased sustainability support for GMS.
- Complete Demand and capacity review focused on clinical resourcing
- Develop analysis outlining potential impact of a **Clinical Decision Unit or Short Stay Unit** at the Grange University Hospital

Anticipated Programme Benefits

- Increasing the number of patients accessing a Same Day Emergency Care pathway
- Maintaining an 80% Assess-out rate from Same Day Emergency Care pathways
- Simplification of Same Day Emergency care Services
- Increase the number of initial assessments for appropriate patients within the eLGHs
- Reduction in time to triage and time to be seen by a clinician
- Improved ambulance handover times
- Reduction in number of 12 hour and 24 hour stays in ED
- Increase in rate of re-directions to appropriate services
- Simplification of Pre-hospital admission avoidance services
- Improved patient experience

Goals Five & Six: Return and Stay Well at Home

- Consideration of options for a larger capacity **GUH Discharge Lounge,** ensuring it is fit for purpose, with the appropriate staffing model, aim to achieve better patient experience and increased patient flow
- **Hospital acquired deconditioning**, continue to embed the 'Get Up, Get Dressed' ethos across all wards, prevention of deconditioning champions across all Divisions
- **D2RA**, roll out of the new digital system across all sites, enhanced data capturing to support operational discharge planning, enabling ward level reporting re reason for delay, further work re integration with complex list, creation of a single repository of data
- **Future flow design**, progression of optimal 'workforce' and 'bed allocation' model across acute and community sites, realignment of workforce resource to maximise benefits, including nurse led discharge
- Creation of a **digital directory of services** signposting to community/third sector services, supporting timely discharge of patients, helping staff to access services across acute and community services
- Principles of **Optimising Patient Flow Framework**, continued to embed SAFER principles across all site, Red to Green days recorded and analyse, ongoing education and training re D2RA pathways,
- **POCD/Trusted Assessor**, on going weekly flow meetings across community and acute sites, 'fishbowl' meetings, progression of Trusted Assessor model aligned with RPB
- **End of Life Programme**, to ensure provision of high quality end of life care, taking a whole system approach, co-ordinate the use of Future Care Planning, delivery of bereavement model and co-ordination of strategic education programme

Anticipated Programme Benefits

- Increase in the number of patients discharged before 12pm
- Reduction in average length of stay
- Reduction in the number of pathway of care delays
- Increased co-ordination with partners
- Increased accuracy of Pathway of Care Delay Reporting
- Improved appropriateness and timeliness of step-down
- Increase in the number of discharges and transfers

- Reduced levels of boarding
- Improved patient experience
- Improved End of Life Pathway and Bereavement support

Argymhelliad / Recommendation

The Board is asked to note the update report for information and the priorities for 24/25 aligned to the Annual Plan and urgent and emergency care de-escalation framework.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Work streams are informed by risk assessment and mitigations
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 5.1 Timely Access 6.3 Listening and Learning from Feedback 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the wellbeing and engagement of our staff Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau:	GUH Grange University Hospital

Glossary of Terms:	UEC Urgent Emergency Care WG Welsh Government AHP Allied Healthcare Professional eLGH Enhanced Local General Hospital RSfOFP Redesigning Services for Older/Frail People NHH Nevill Hall Hospital RGH Royal Gwent Hospital STW St Woolos Hospital SBAR Situation Background Assessment Recommendation D2RA Discharge to Recover and Assess IMTP Integrated Medium Term Plan UPC Urgent Primary Care APP Advanced Practice Paramedic
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

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

Six Goals for Urgent & Emergency Care

22nd May 2024

Six Goals Programme Structure

Clinical Futures Programme Board

Regional Partnership Board

Six Goals Portfolio
Chair: Jennifer Winslade
PL: Simon Roberts
CL: Dr Andy Bagwell
Dr Paul Mizen (CPAG)

Redesigning services for Frail People	Urgent and Acute Transformation	Discharge Improvement
Goal 1	*Goals 2, 3 & 4*	*Goals 5 & 6*
Sponsor: Dr James Calvert *SRO : Kelly Downes* *PM: Shareen Ali* *Leadership Group*	*Sponsor: Peter Carr* *SRO : Paul Underwood* *PM: Simon Roberts* *Leadership Group*	*Sponsor: Jennifer Winslade* *SRO : Amanda Hale* *PM: Kate Fitzgerald* *Leadership Group*
Workstreams: ➢ *Early Intervention* ➢ *Ambulatory Care & Admission Avoidance* ➢ *Community Hospitals* ➢ *Care Homes*	***Workstreams:*** ➢ *Urgent primary Care* ➢ *Same Day Emergency Care* ➢ *Flow Centre Development* ➢ *Ambulance Handover* ➢ *ED Improvement* ➢ *Response units* ➢ *Fracture Liason Service*	***Workstreams:*** ➢ *Optimising patient flow framework (Patient Safety Days)* ➢ *Discharge Hubs* ➢ *Education & Training* ➢ *Early Supported Discharge* ➢ *Hospital to Home* ➢ *Trusted Assessor* ➢ *Deconditioning* ➢ *Ready to go Unit* ➢ *Discharge Lounge*

Interdependent Programmes
- *High Risk Adults*
- *End of Life care*
- *In-patient Reconfiguration*
- *Accelerated Cluster Development*

Programme Governance

- Clinical leadership throughout the Programme
- Reporting to the Executive Clinical Futures Programme Board
- Established Six Goals Board Meeting
- Whole system attendance including Local Authorities, WAST, NHS Executive
- Programme Leadership Steering group
- Workstream delivery groups in place led by the SROs
- Evidence based and PDCA approach

Key Achievements in 2023/2024

Goal 1

•Nurse led **Acute Frailty Response (AFR)** phase one commenced on 22nd January 2024; providing in-reach into the GUH

•Funding secured to enable the extension of **CRT rapids provision**.

•Phase one and two of **proactive frailty** approach complete;.

•**Professional hub pre-pilot** commenced and planning completed for phase one pilot.

•**Direct admissions pathway** SOP review and update complete

Goals 2 , 3 , 4

•A new **Falls Pathway** introduced designed to reduce the number of non-injurious fallers conveyed to the ED

•**Single Phone Number**, Introduced one single phone number for Health Care Professionals

•**SDEC: Increased Medical Patient volume** in SDEC GUH (to 40 weekly 100/week Surgery) and YYF (to 50 weekly),

•Tested concept of **Rapid Assessment and triage** within the Emergency Department

•Commenced capital works for **ED main wait expansion**

•The Grange **Level 1 re-configuration**

•**ABUHB / WAST Collaborative** generated opportunities to reduce attendances

Goals 5 , 6

•**Patient Safety Events** held across all sites with a specific focus on the Royal Gwent Hospital & St Woolos Hospital since

•Delivery of '**Move it May' campaign**, promotion of physical and mental well-being in hospital

•Development of **D2RA digital solution**, development to support operating discharge planning,

•**Ready to Go Unit D6E** at RGH to support a seamless transition to normal place of residence

•**Hospital 2 Home**, funding secured from RIF in August 2023 to facilitate early discharge,

•Review of the performance and function of the **Discharge Lounges** at RGH & NHH, capital works undertaken at RGH,

Key Priorities for 2024/2025

Goal 1

•Implement, as business as usual, **extension of CRT**

•Deliver phase 2 and 3 of **acute frailty response**

•Pilot **professional hub** within the flow centre and agree longer term service model

•Review, develop and appropriately reconfigure the provision of **acute assessment services**

•Implement and evaluate revised **direct admissions pathway**

•Develop proposal for increasing the number of **nurse led wards within community hospitals**.

•Commence implementation of programme of work to **reduce care home conveyance**

•Complete evaluation of **WAST led Luscii pilot** and agree next steps

Goals 2 , 3 , 4

•**SDEC Strategy Setting** and options appraisal

•**Continuous improvement of SDEC Services** to increase Medical patient

Improve service interventions for patients coming to ED via 111 / CSD

•Complete an evaluation for all of ABUHB **Pre-hospital admission avoidance services**

• Launch eTriage Pilot and prepare for ED main extension completion

•Complete **Fracture Liason Service** Evaluation

•Proposal developments for eLGH **Integrated Assessment centre** (Integrated front door)

•Deliver a **UPCC model in 24/25 that ensures a 24/7** sustainable model

Goals 5 , 6

•Consideration of a larger **GUH Discharge Lounge**

•**Hospital acquired deconditioning**, continue to embed the 'Get Up, Get Dressed' ethos

•**D2RA**, roll out of the new digital system across all sites for enhanced data capturing

•**Future flow design**, progression of optimal 'workforce' and 'bed allocation' model

•Creation of a **digital directory of services to improve discharge** signposting

•Embed **Optimising Patient Flow / SAFER Framework**,

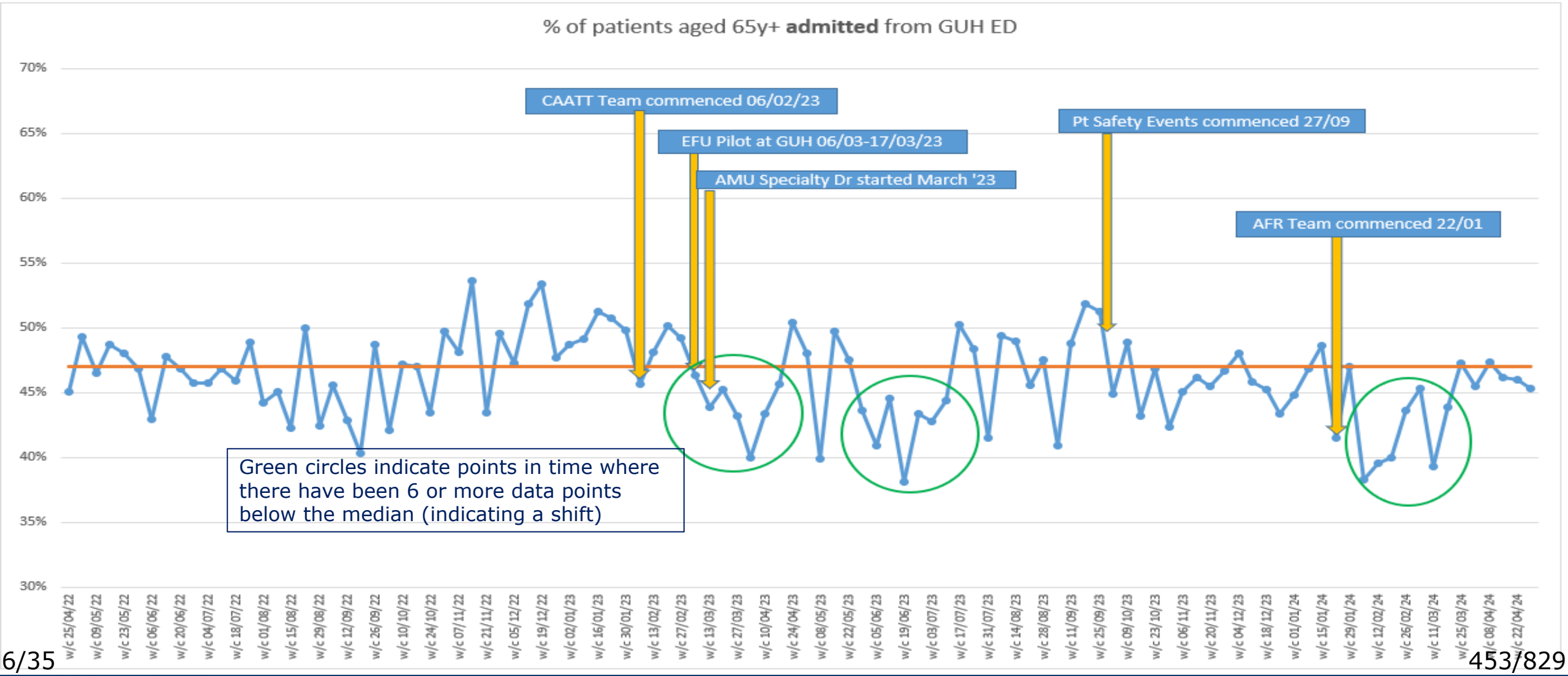
•**Progression of POCD/Trusted Assessor model**

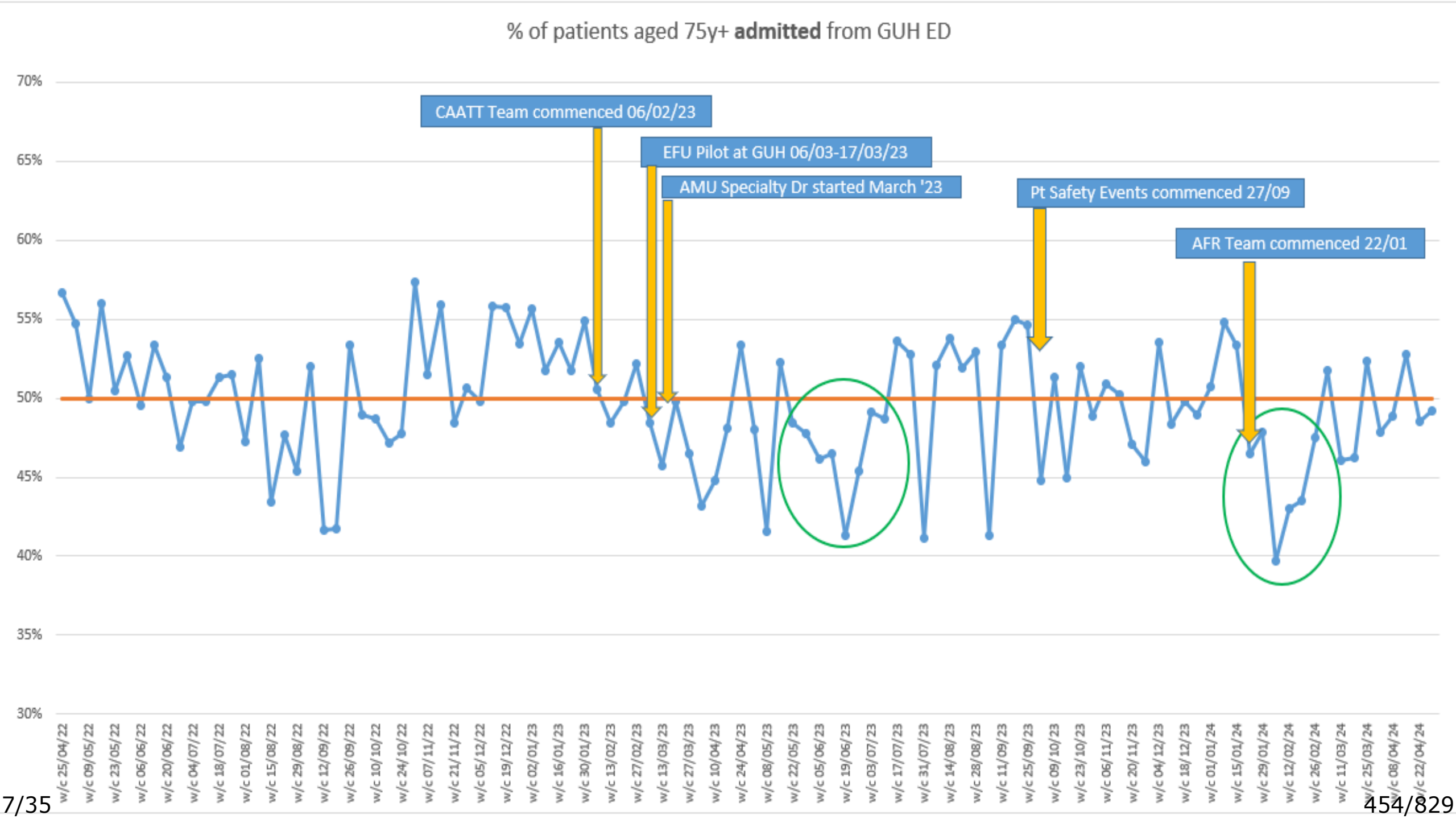
•**End of Life Programme Co ordindation**, to ensure provision of high quality end of life care,

Initiative Evaluation – Goal 1
Acute Frailty Response

Nurse Led Acute Frailty Response Team

- **Commenced** 22nd January 2024 at the GUH.
- **Primary aim**: acute admission avoidance within ED; assessing and transferring patients back out into the community.
- **Primary outcome measure**: The *proportion* of older people who attend ED who are admitted and who are not admitted (reduce and increase respectively).




% of patients aged 75y+ admitted from GUH ED
CAATT Team commenced 06/02/23
EFU Pilot at GUH 06/03-17/03/23
AMU Specialty Dr started March '23
Pt Safety Events commenced 27/09
AFR Team commenced 22/01
70%
65%
60%
55%
50%
45%
40%
35%
30%
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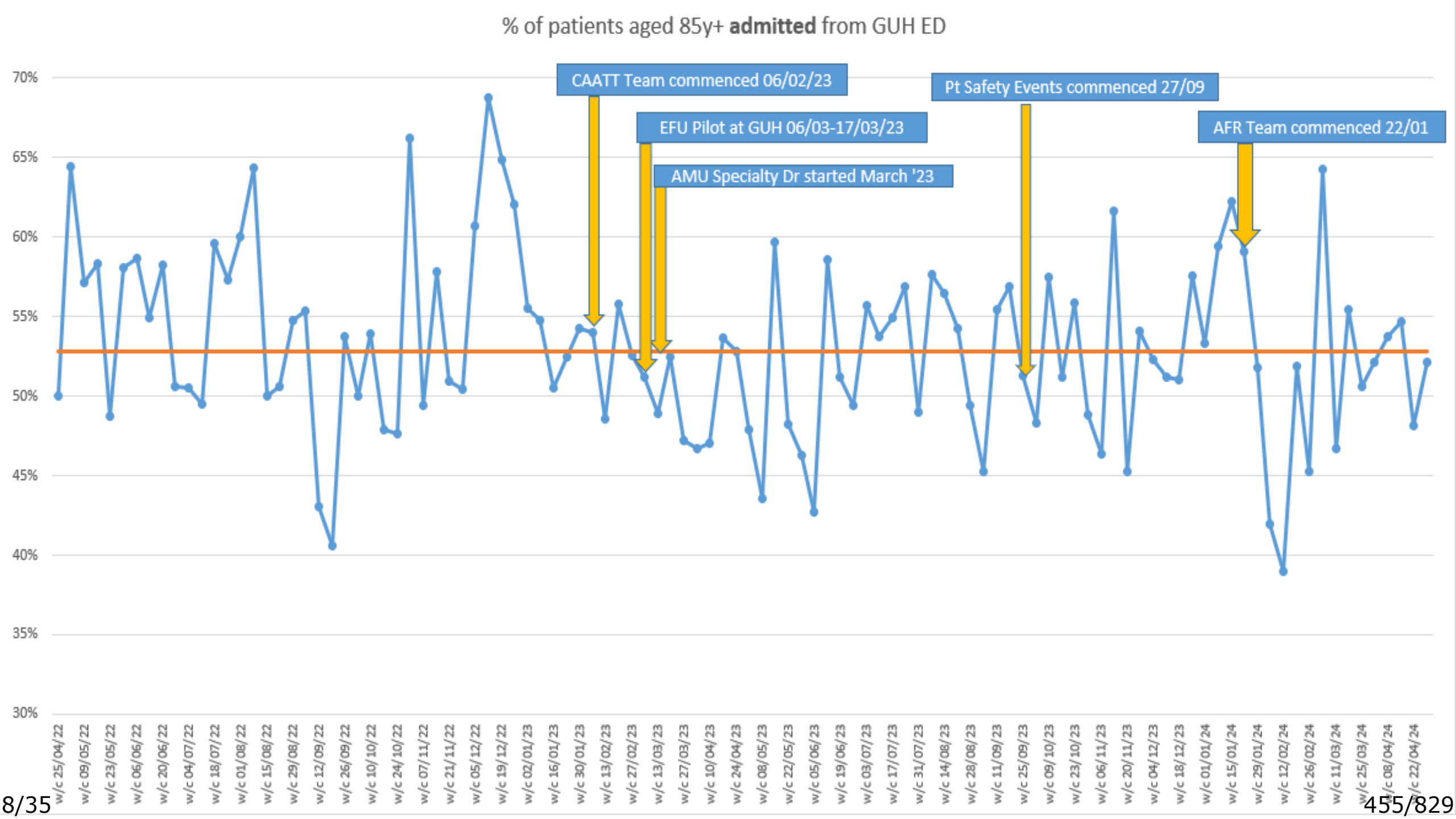
% of patients aged 85y+ admitted from GUH ED
CAATT Team commenced 06/02/23
EFU Pilot at GUH 06/03-17/03/23
AMU Specialty Dr started March '23
Pt Safety Events commenced 27/09
AFR Team commenced 22/01
70%
65%
60%
55%
50%
45%
40%
35%
30%
w/c 25/04/22
w/c 09/05/22
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w/c 22/04/24

Nurse Led Acute Frailty Response Team

Data Summary/Assumptions:

The below are assumptions about the data and **not** conclusions.

- 65y+: three shifts in the data have occurred in the past two year period – assumption that changes made within the system have caused a shift in the data and AFR has contributed to this.
- 75y+ : two shifts in the data, as above.
- 85y+ : no shifts in the data in the past two rolling years; no reduction in admissions from GUH ED amongst those aged 85+

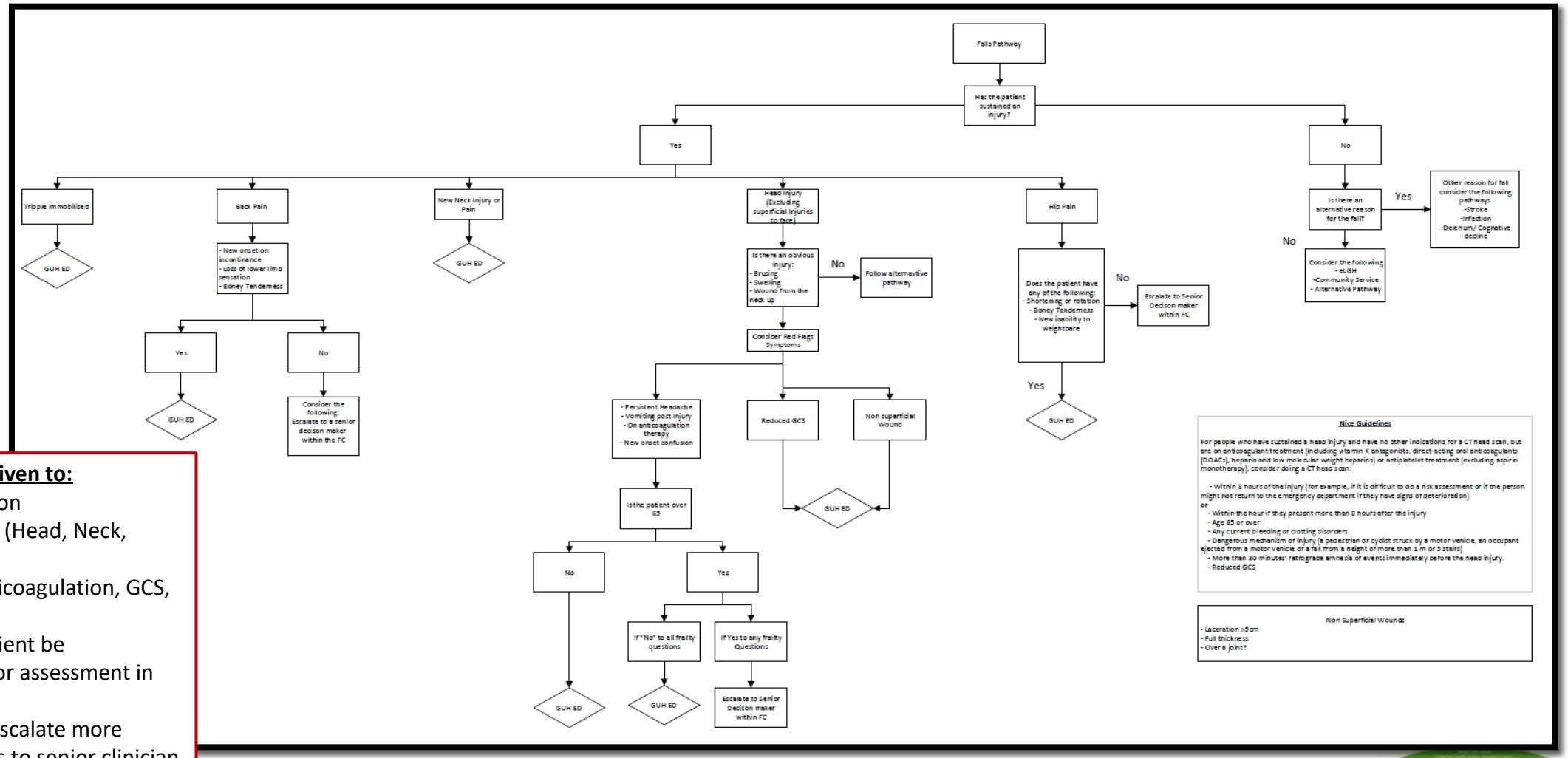
Data Caveats

- Whilst there has been a shift in some data sets **it cannot** be assumed that the AFR team on it's own has caused this.
- AFR has **contributed** to this shift alongside other teams/work/collective efforts within the system e.g. CAATT, Home First, AMU SAS Dr, safety flow actions, etc.

Further work required to continue and continue and sustain change to demonstrate impact and added value.

Initiative Evaluation – Goal 2, 3, 4
Falls Pathway

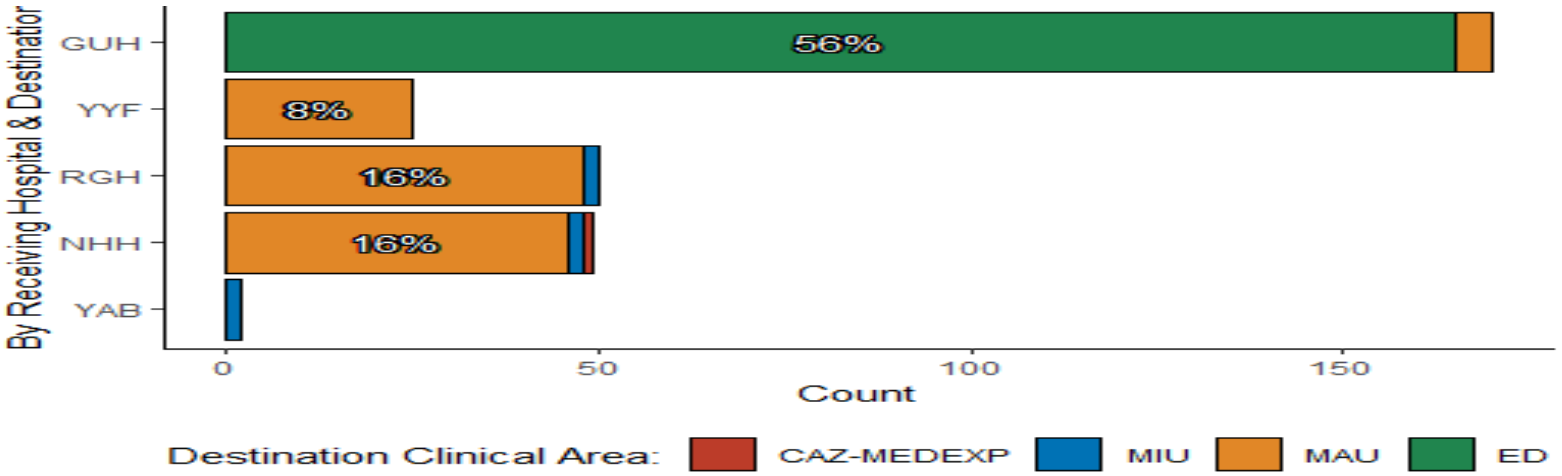
Falls Pathway Overview:



Consideration Given to:

- Injurious or non
- Type of injury (Head, Neck, Back, Hip)
- Red flags, anticoagulation, GCS, Frailty
- Could the patient be appropriate for assessment in an eLGH
- Designed to escalate more complex cases to senior clinician

New Falls Pathway Results



- The new Falls Pathway was introduced designed to reduce the number of non-injurious fallers conveyed to the Emergency Department by ambulance.
- Since implementation on 18th December 2023 44% of non-injurious falls patients are conveyed to the eLGHs for initial clinical assessment instead of ED
- There have been minimal levels of step-ups for patients initially assessed at the eLGHs
- The pathway continues to be monitored to maintain its success and to ensure resources are aligned to the increased demand at eLGH sites

Initiative Evaluation – Goal 5, 6
Patient Safety Events

Patient Safety Events - Context

- Increasing number of patients who are **medically optimised** for discharge remain in hospital (Average of 300)
- **Discharge delays** - increased risk of patients deconditioning in hospital, further risk of infection/falls, causing patient harm
- **Wider System** impact, improving safety and quality of care
- **Interdependencies** with other work streams
- Alignment of bed base with the **Clinical Futures** model, following opening of GUH
- **Benefits** – increase number of discharges, reduced LOS, improved patient outcomes, improved flow, enhanced links with LAs, multidisciplinary working
- Aligned to **UEC Six Goals : Goals 5 & 6**, Return and Stay Well at Home

Delivery Approach

Multi-disciplinary working in partnership with the Local Authority and third sector, led by Deputy Medical Director and Deputy Director of Nursing

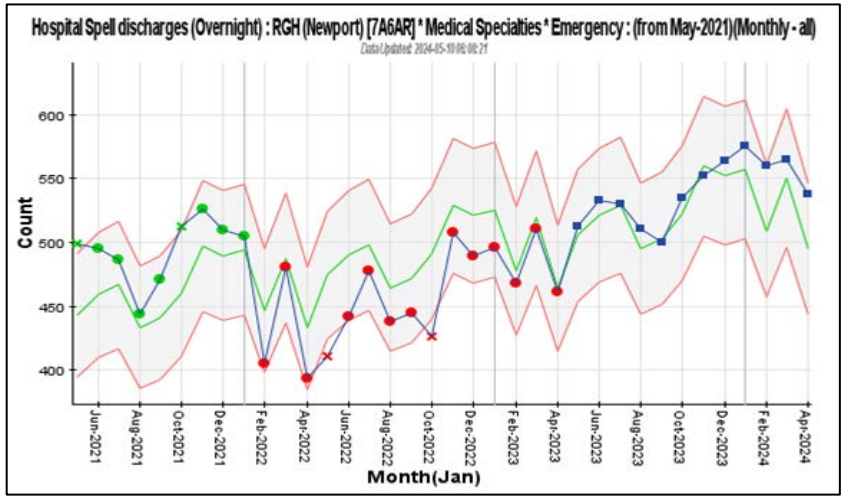
Aim to rapidly improve the timely discharge of patients essentially delivering a step change in performance, safety and patient experience

A total of 20 weekly PSEs events delivered across at GUH/RGH/NHH/YYF and community hospitals between September 2023 and February 2024

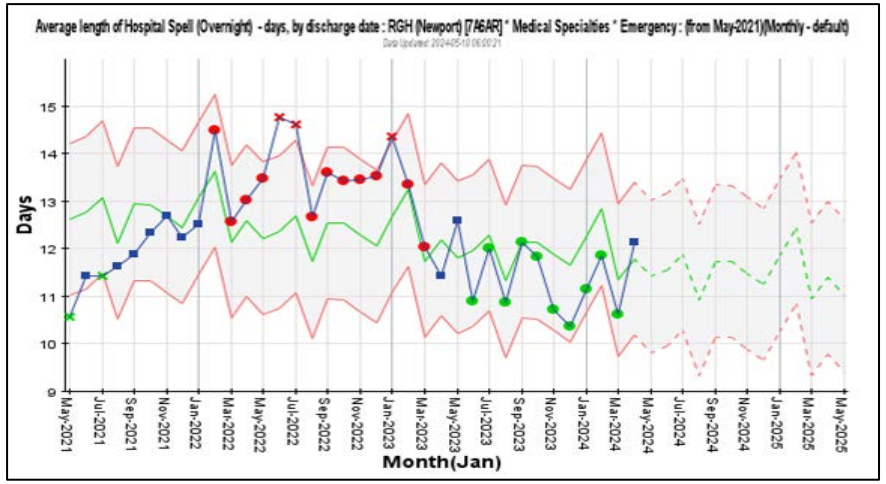
Measured activity, data collection
One day of intervention on site, follow up actions
Discharge Improvement Plan, track progress

Discharge Data - RGH

- Since October 2023, monthly Hospital Discharges (including transfers) from **RGH have been 535 or higher**
- Numbers have continued **between 535 and 576** since then but have slightly reduced since peaking in January
- January itself was an unusually busy month with particularly high MAU demand



- Hospital LOS for inpatients reduced sharply in March 2023 **from 13-14 days to 11-12 days**
- November, December 2023 and February 2024 had the **shortest average LOS**, but pre-PSE June and August 2023 were comparably short due to seasonal trends



Themes/Actions

Theme	Actions
• Lack of **awareness of services** available in the community and how to access service across the five localities	• Poster produced and distributed at RGH site • Produce posters for all sites • Development of CRT application to raise awareness of services • Teaching sessions as part of PST going forward
• **Focused Board Rounds/MDTs**, ownership and progression of actions, what is stopping the patient going home, parallel discharge planning	• Revised PST format, QI approach targeting wards • Develop ward bases 'tools' aligned to framework • Ward leadership programme • Education/training
• **Step down** improvement at GUH	• SBAR improvement, review purpose of documentation, roles and process • Raise awareness of opportunities to discharge or transfer to community hospitals • Education and training
• **What matters conversations**, asking, listening and understanding what matters to the individual in their lives	• Development of Patient Passport, • Develop prompts guide for staff • Patient outcomes approach, focusing on patients, services and needs
• Principles of **Optimising Patient Flow Framework** – D2RA, SAFER, Red to Green, deconditioning	• Embed safer principles across all sites • Red to Green days recorded on CWS2 and analysed • All patients have deconditioning plans
• **End of Life** – ensure patients receive timely and co-ordinated care with involvement from appropriate services	• End of life Divisional leads tbc • Roll out Advanced Care Planning • Develop end of life checklist

Appendix

- National Six Goals Priorities
- Plans on a page
- Project Highlights

National Six Goals Priority Areas

Implementation of an Urgent Care Service

- Integrated front door alongside MIUs
- Closer working with Flow centre and frailty as a 'hub'
- Significant proportion of contacts via MIUs
- Follow-up audit of 'primary care' attendances to GUH
- Additional resilience to GMS practices in-escalation
- Significant proportion of contacts via Think 111 First

Implementation of SDEC Services

- Strong Surgical Model, Medical Model stepped-up in 23/24
- Developing service with Acute Frailty Service
- YYF SDEC seeing proportionally high numbers of frail/older patients
- Strategic review of all SDEC services across HB
- Developing ED Next day returner offer
- Implemented Acute Oncology
- Established an SDEC advice line

Reduction of Handover waits and conveyance

- Collaborative programme between WAST / ABUHB
- Collectively reviewing Flow Centre compliance, Clinical Support Desk and fit to sit policies
- EM Action plan developed that includes:
- Continued focus on new falls pathway / CRT intervention
- Acute Release Area
- Daily operational rigour
- Feasibility of dedicated forecourt Senior Decision maker

Reduction of POCD >7 and >21 days Targeting Frailty

- D2RA Digital Development
- Patient Safety Events throughout winter
- Discharge Lounge improvement and expansion
- Step Down Improvement Plan
- Development of ready to go ward
- Hospital to home project with Monmouthshire
- Trusted assessor proposal to RPB

Goal 1 Re-designing services for older / Frail People

Urgent & Emergency Care Six Goals - Goal 1

Programme Title	UEC Goal 1	SPM	Shareen Ali	SRO	Kelly Downes	Executive Sponsor	Dr James Calvert

Programme Aims & Objective	Improving access to care and support for older and/or frail people in order for them to remain at, or as close to, home as possible and avoid unnecessary hospital admissions and lengths of stay by redesigning, optimising and building appropriate capacity within community services.

Supporting Workstreams	Key Deliverables	Intended Benefits (Annual Plan)
Early Intervention	Extend, optimise and standardise CRT rapids provision. Deliver phase 2 and 3 Acute Frailty Response as part of ongoing work to expand/right size community services e.g., CRT and end of life. Test the concept of proactive frailty; the systematic identification, screening, assessment and intervention to improve patient outcomes by e.g., delaying deterioration, maintaining independence and reducing need for unplanned care.	Increase number of frail people supported at, or close to, home. Reduce unnecessary ED & MAU attendances and admissions. Improve outcomes by reducing deconditioning and time spent away from home.
Ambulatory Care/Admission Avoidance	Flow Centre professional hub pilot to inform long term service model. Review and development of appropriate acute, same day assessment services (including rapid diagnosis and reporting) in line with Goal 3 objectives.	Reduce and prevent unnecessary ED & MAU attendances. Improve outcomes by reducing deconditioning and time spent away from home.
Community Hospitals	Optimise the use of community hospital beds, including direct admissions pathway. Development of nurse led wards.	Increase direct admissions from the community and reduce acute admissions. Improve outcomes by reducing deconditioning and time spent away from home through the delivery of proportionate care.
Care Homes	Plan and implement agreed objectives to increase time at home; co-produced with care home providers. Delivery of WAST led Luscii pilot.	Increase time spent at home and reduce unnecessary conveyances to hospital.

Milestones

Q1 2024 – Apr-Jun

- Evaluate phase one of Acute Frailty Response Team and implement phase two, as part of building capacity within community services.
- Agree and commence implementation to extend CRT rapids provision.
- Develop plan to test the concept of proactive frailty.
- Phase one pilot of professional hub within the Flow Centre.
- Implement and embed updated community hospitals direct admissions pathway (DAP).
- Commence Luscii pilot.
- Scope and agree plan for development of acute same day assessment services.

Q2 2024 – Jul-Sep

- Review AFR team and agree phase 3 plan.
- Ongoing implementation of extension to CRT rapids provision.
- Complete task and finish group responses to recommendations of CRT deep dive report.
- Commence testing of proactive frailty approach.
- Evaluation of professional hub phase one pilot and agree phase two approach.
- Evaluate and agree next steps for LUSCII pilot
- Ongoing evaluation and embedding of DAP
- Scope design of care home support
- Scope and develop proposal for increasing the number of nurse led wards within community hospitals.

Q3 2024 – Oct-Dec

- Ongoing evaluation of AFR team and implementation of phase 3
- Ongoing evaluation and embedding of DAP.
- Ongoing evaluation of proactive frailty approach to inform next steps.
- Ongoing implementation of extension to CRT rapids provision.

Q4 2025 – Jan-Mar

- Ongoing evaluation of AFR team and agree long term model.
- Ongoing evaluation of proactive frailty approach to inform long term model.

Nurse Led Acute Frailty Response Team

Data Caveats

- Whilst there has been a shift in the data **it cannot** be assumed that the AFR team has caused this.
- AFR has **contributed** to this shift alongside other teams/work/collective efforts within the system e.g. CAATT, Home First, AMU SAS Dr, safety flow actions, etc – some of which are demonstrated in slide 3.

Phase One

- Workshop 18th April to further understand the collected added value between GUH based front door teams and opportunities for strengthening combined efforts, including evaluation processes.
- Recruitment to permanent AFR posts (as part of CRT capacity building) complete.

Phase Two

- Scoping underway.
- Led by Frailty leadership team in PCCS (Clinical Director, Nurse Consultant, DM, etc) and programme team.
- Maintaining proportionate in-reach capacity into ED.
- Continue to strengthen MDT 'front door' team, including knowledge and capacity building of GUH teams.
- Embedding of pathways out of ED.
- Systematic implementation of screening and proactive planning for recognition & treatment of deterioration in the community.
- Further understand and develop the acute frailty offer across ABUHB including opportunities to maximise value amongst e.g. CRT, PRU, AFR, CAAT, WAST, IACs, etc.

Extension of CRT Operating Hours

Update/Next Steps

- CRT acceptance of referrals to 5pm ongoing, however data does not demonstrate overall increase in patients; increase 3-5pm, and decrease following morning.
- Funding secured to enable extension of CRT operating hours to 8am-8pm, awaiting description of medical model
- Medical model in the process of being agreed to initiate:
  - OCP document update.
  - OCP process commencement.

Proactive Frailty

Update/Next Steps

- Phase one (appraisal of evidence and best practice) complete.
- Phase two (guidance document for Gwent model) developed and agreed.
- Phase three (pilot commencement) – formal agreement to commence agreed by Senior Leadership Team.
- No additional funding.
- Cohort of focus will be data driven.
- Planning underway for phase three.

Professional Hub

- Pre-pilot to inform phase one since 15th January.
- SOP and metrics finalised for CRT Consultant Role.
- Weekly and monthly review meetings planned to review progress (PDSA approach).
- Governance: patients referred via WAST appropriate for next days service – further work required to provide alternatives to admission.

Direct Admissions Pathway

- SOP updated to include direct admissions to COTE.
- Directorate report they are not in a position to roll updated version due to changes within teams including medical cover and bed base reconfiguration.
- Requires escalation and support/direction from the division.

Goals 2, 3 & 4
Urgent and Acute Transformation

Clinical Futures – Programme on a Page

Programme Title	Six Goals UEC (Urgent And Acute Goals 2 , 3, 4)	**SPM**	Simon Roberts	**SRO**	Paul Underwood	**Executive Sponsor**	Peter Carr

Programme Aims & Objective

Multi-faceted Improvement programme with the aim of reducing the number of patients attending the Emergency Department and improving experiences for those who do need to be there

Supporting Workstreams

- Same Day Emergency Care
- Urgent Primary Care
- ED Main Wait Improvement (eTriage/extension)
- Flow Centre Development
- Safety Flow Ambulance Handover
- Physician Response Unit
- Referral Improvement
- High Intensity User Service Model
- Digital Strategy (Symphony)

Key Deliverables

- Same Day Emergency Care Provision to include Surgery, Acute Medicine, speciality and COTE / Frailty
- Ambulance handovers within 4 hours
- Implement single point of access for UEC
- Evaluate Digital triage technology
- Sustain Physician Response Unit
- Integrate Urgent Primary Care with OOH for a 24/7 service
- Implement digital improvement for ED referrals to specialities
- Set out the service model for high intensity service users
- Conclude and open ED extension and improved front door process

Intended Benefits (linked to IMTP)

- Increased Assess-out Rates
- Greater assessments within alternative assessment services
- Reduction in ED congestion / Improved patient experience
- Improved handover times and referral to specialities
- Reduced time to be seen by first clinician
- Greater appropriate distribution across the eLGH settings
- Improved patient experiences
- Improved first time yield right place, first time
- Reduction in triage time
- Reduced attendances in over 65 group

Key Risks

- Clinical and non Clinical workforce constraints
- Demand Factors
- Partner resourcing
- Six Goals Funding

Interdependencies with other Programmes

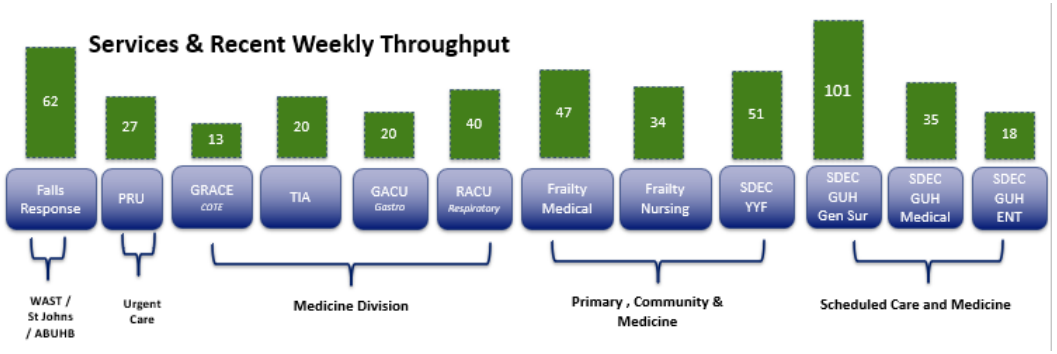
- eLGH Programme
- Place Based Care
- Planned Care

Milestones

Q1 24/25	Q2 24/25	Q3 24/25	Q4 2024
• Recruit to Fracture Liason Service • eTriage Go-Live • Continually Increase Acute Medicine Patient flow through SDEC • Evaluate and make Funding decision for YYF SDEC service • Additional Falls Level 1 community response • Resource assessment for potential dedicated forecourt decision maker • ED GIRFT Review	• Change the clinical model of Flow Centre • Strategy setting for HB wide SDEC / Ambulatory services • Implement next day returner process for ED to SDEC • Integrate SDEC services to better support older / frail people • Referral to speciality Digital enhancement • Additional Falls Level 2 community response • Implement sustainable 24/7 UPCC	• Scoping completion for full integration of frailty / Flow centre • Conclusion of Physician Response Unit funding and service model • assessment Ambulance handovers within 4 hours • Implement additional safety nets for CSD / 111 ED attenders • Review of integrated assessment centre opportunity • Conclude assessment of potential benefits from APP placements in Urgent Care (Swansea Model)	• Proposal developments for front door process re-design and pathway development in readiness for ED Extension • Fracture Liason Service Evaluation • E-triage evaluation and decision on post pilot investment • Acute element of Anticipatory care planning strategy proposals • Conclude IAC scoping and provide recommendations

SDEC / Ambulatory Care Improvement

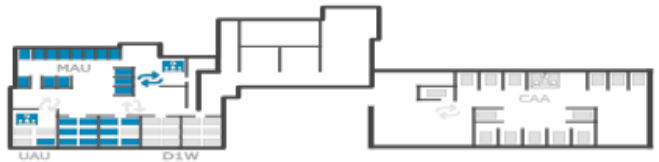
- **First Phase of 'discovery' completed**
  - Bringing teams together
  - Understanding structures & costs
  - Differences and similarities in criteria
  - Access method
  - Visibility to Data / KPI



- **Second phase 'Strategy Review'**
  - Workshop to be held in May with all key stakeholders to set the strategy for SDEC / Ambulatory Care
  - Possible Outcomes Include :

Preserve | Modify ⟷ | Transform

- Opportunities include:
  - Access and throughput Improvement
  - Further Pathway development: AOS / Palliative / T&O / ENT
  - ED Next day return model for Medical patients
  - Improving integration : GRACE / TIA / DVT / ENT
  - Opportunity for co-location (IAC Concept)



Effect of SDEC upon Assessment Units

GUH Gen Surgery

- 77% of SDEC Throughput
- SDEC patients have an AVG **4 Hours LOS**
- Same Day patients within SAU have an AVG **7 hours LOS**

- If SDEC did not exist, there would be an additional **21 admissions** to SAU each day
- Which would require an additional **10 beds / chairs** (with peaks up to 25)

GUH Medicine

- 23% of SDEC Throughput
- SDEC patients have an AVG **4 hours LOS**
- Same Day patients within MAU have an AVG **11 hours LOS**

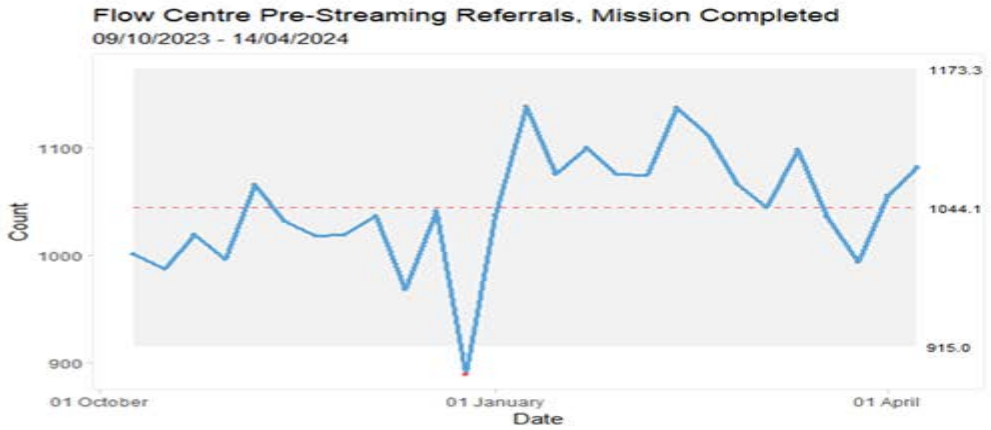
- If SDEC did not exist , there would be an additional **7 admissions** to MAU each day
- Which would require an additional **3 beds / chairs** (with peaks up to 10)

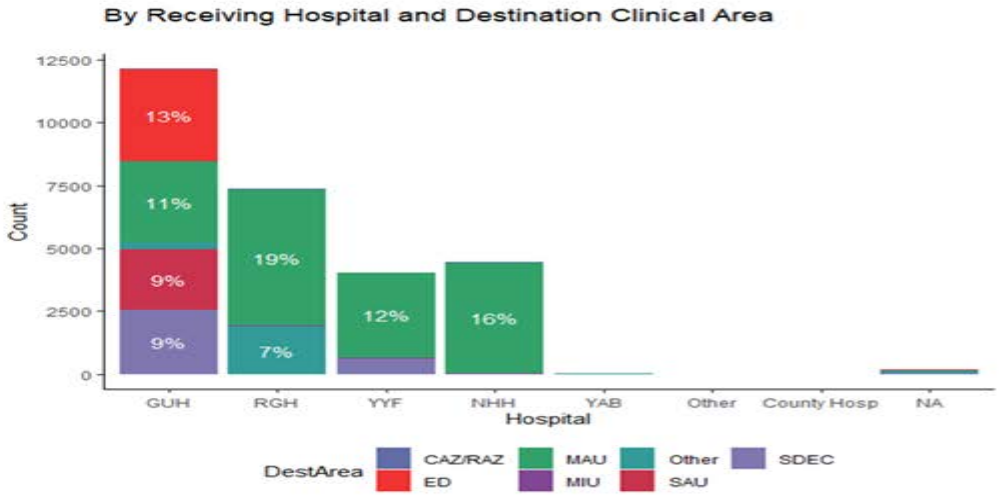
YYF Medicine

- SDEC patients have an AVG **3.5 hours LOS**
- Same Day patients within MAU have an AVG **8 hours LOS**

- If SDEC did not exist , there would be an additional **10 admissions** to MAU each day
- Which would require an additional **5 beds / chairs** (with peaks more than 10)

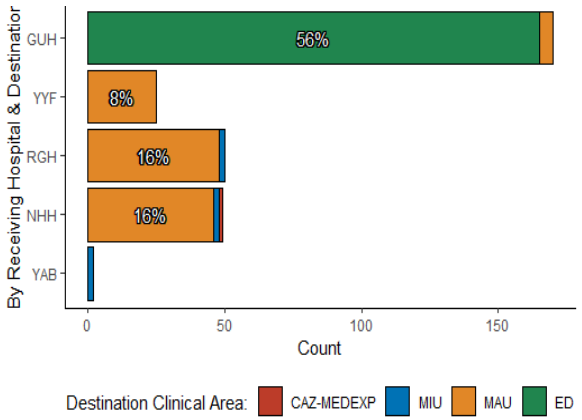
System Navigation – Via Flow Centre





- Flow Centre model is evolving after 3 years of maturation:
  - Dedicated management team 12/7 effective from Feb 2024
  - Medical Senior Decision Maker model withdrawn from April 2024 – an Advanced Decision Maker Model presented to Execs pending decision (With Medical Pathway Oversight)
  - New phone system (Avaya) Introduced in December
  - Launching new nugensis effective by May 2024
  - Single phone number for HCP Access introduced in Feb 2024
- Over winter we saw **greater utilization of eLGH assessment & Alternative services**. Some of this relates to higher primary care demand and also a new falls pathway introduced in December >

Falls Pathway



Pre-Hospital Response Services

- It is recognised that we offer multiple admission avoidance services within the pre-hospital space
- It has been requested that Six Goals complete a review of these services to include evaluation and recommendations to ensure optimum services are available to the public as well as ensuring there is value for money

Physician Response Unit (PRU)

Falls Response Service

Community Admission Avoidance Therapies

Acute Frailty Response

Mental Health Response

Traditional Paramedic Response

- The approach will be in three stages via a Task & Finish Group :
  - First Phase of 'discovery' to scope all of the available services, demand, staffing, costs and funding source
  - Second Phase to evaluate service similarities, differences and cost benefits
  - Third Phase to develop recommendations collectively

Goals 5 & 6 Return & Stay Well at Home

Urgent & Emergency Care Six Goals – Goal 5 & 6

Programme Title	UEC Goals 5 & 6	SPM	Kate Fitzgerald	SRO	Amanda Hale	Executive Sponsor	Jennifer Winslade

Programme Aims & Objective	Delivering optimal hospital care and discharge practice from the point of admission, delivering a home first approach to reduce risk of readmission

Supporting Workstreams	Key Deliverables	Intended Benefits (Annual Plan)
Patient Safety Events	Delivery of Patient Safety Events at RGH Delivery of Step Down events at GUH	Reduction in LOS 7 & 21 days Reduction in DTOCs
Discharge Improvement Models	Ready to Go Unit at RGH Revised Discharge Lounge model at GUH, RGH, NHH Hospital 2 Home roll out across all localities	Reduction in LOS 7 & 21 days Reduction in DTOCs
Optimising Patient Flow Framework	Embed SAFER principles across all sites Prevention of hospital acquired deconditioning, embed 'Get Up, Get Dressed, Get Moving' ethos	Prevention of deconditioning Reduction in LOS 7 & 21 days
Data and Digital	D2RA digital solution Data and information capture system, refined reporting across health and social care	Stream lined data capturing Meaningful reporting including reason for delay

Milestones

Q1 2024 – Apr-Jun

- Implementation of service improvements/discharges practices monitored via Discharge Improvement Board
- Delivery of D2RA short term digital solution
- Implementation of discharge lounge model at RGH & NHH
- Delivery of deconditioning campaign to raise awareness
- Establish Trusted Assessor Working Group in partnership with LAs
- Roll out Hospital 2 Home in Newport
- Options appraisal for GUH discharge lounge

Q2 2024 – Jul-Sep

- Implementation of service improvements/discharges practices monitored via Discharge Improvement Board
- Evaluation of Ready to Go Unit
- Explore digital solutions for data collection, bed management, complex list, D2RA data collection
- Alignment of WAST resources with discharge lounge model
- Implementation of new step down process, including review of SBAR including education and training

Q3 2024 – Oct-Dec

- Implementation of service improvements/discharges practices monitored via Discharge Improvement Board
- Delivery of patient safety events across all sites
- Review of new step down process
- Further progress digital data collection solution, undertake options appraisal
- Continued delivery of deconditioning campaign to raise awareness
- Development of Trusted Assessor action plan

Q4 2025 – Jan-Mar

- Implementation of service improvements/discharge practices monitored via Discharge Improvement Board
- Delivery of patient safety events across all sites
- Track benefits of discharge lounge model
- Sign off of new digital solution and reporting model
- Hospital 2 Home evaluation and next steps
- Continue to roll out Optimising Patient Flow Framework across all sites

Move it May – C4E RGH

Patient Story – Patient Safety Event at GUH

- Patient attended the **GUH Emergency Department** in December 2023 following a fall. Pain in right shoulder and upper arm
- **Patient lives alone, no package of care**, right numeral fracture. Stepped down to NHH the following day for rehabilitation, patient comfortable in a collar and cuff
- At the end of December 2023, the patient **stepped across to YAB**, clinically optimised and for discharge planning
- On 12th January 2024, patient deteriorated and **stepped up to GUH** due to vomiting. On 15th January 2024, patient identified for step down, while waiting for an emergency care package, two calls a day
- **Emergency Care at Home** advised there was no capacity, patient continued to wait for package at GUH
- On 17th January 2024, patient assessed by **Hospital 2 Home** during the GUH Step Down Patient Safety Event, her son was present and both expressed their wishes for her to go home as soon as possible.
- Patient was assessed as suitable for Hospital 2 Home, **patient discharged** with first call later that evening
- On 19th January 2024, Emergency Care at Home contacted Hospital 2 Home to advise they now had capacity and took over the **two call a day care package**

Hospital Acquired Deconditioning

- Focus on deconditioning for 2024/25, piloting collation of deconditioning metrics for NHS Executive, through Welsh Nursing Care Record
- Continue to embed the **'Get Up, Get Dressed, Keep Moving'** ethos across all wards i.e. using sitting out safely checklists and promoting independence ready for home
- Adapt **'Move it May'** campaign to maintain ethos and practices throughout the year, via personalised goal plans, advice from Therapists, staff engagement, information boards, manual handling masterclasses, physical activities
- **Engage** with the **MDT** and **Patient Experience Team**
- Establish **Deconditioning Prevention Champions** across all Divisions 'Come **Dine with Me'** pilot highlighted as best practice by NHS Executive, Rachel Taylor (Goal 5 National Lead) to visit C4E on 26th April, pilot to be evaluated, followed by **scale and spread** across all wards
- Develop **Activity Co-Ordinator** roles, across all sites

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	ABUHB Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Planned Care Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer Hannah Evans, Director of Strategy, Planning and
SWYDDOG ADRODD: **REPORTING OFFICER:**	Richard Morgan-Evans, Deputy Chief Operating Officer; Lois Jones, CF Service Improvement Manager; Carol Phelps, CF 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 report is to outline the position with respect to planned care including:

- Recap of national policy context,
- Recent Welsh Government request for further planned care improvements and new national planned care milestones and actions required,
- Recap of planned care commitments in 2024/25 Plan approved in March 24,
- Summary of progress across the Health Board Planned care Programme and the 5 workstreams

Cefndir / Background

This background section covers:

- Summary of extant policy position
- Recap of content of Health Board's Planned Care Programme
- Reminder of planned care commitment in 2024/25 Plan that was considered in March Board
- New request from Welsh Government regrading planned care

National Policy context

In April 2022 the Welsh Government launched the "Programme for Transforming and Modernising Planned Care and Reducing Waiting lists in Wales". It set out the 5 Goals for Planned Care and a national infrastructure of a Programme Board supported by a Strategic and Operational Group and seven clinical implementation networks.

The national five goals for planned care include:

This publication set out the delivery expectations and milestones for planned care:

- No one waiting longer than a year for their first outpatient appointment by the end of 2022,
- Eliminate the number of people waiting longer than two years in most specialties by March 2023,
- Eliminate the number of people waiting longer than a year in most specialities by Spring 2025,
- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024
- Cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026.

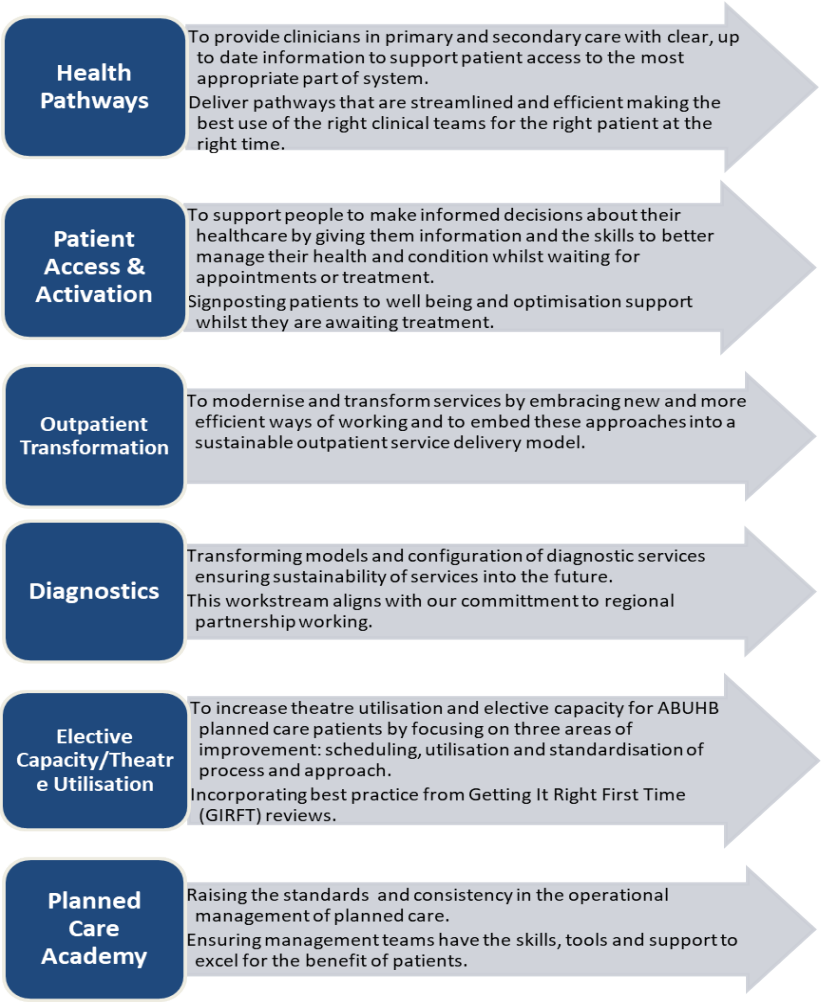
These delivery targets were modified during 2023/24 via a communication from the Deputy Chief Executive, NHS Wales on 6 June 2023 requiring:

- All patients waiting for first outpatient over 156 weeks to have a booked date by August 23,
- By the end of December 2023, 97% of all open pathways (total waits) should be less than 104 weeks,
- By end of March 2024, 99% of open pathways waiting should be waiting less than 104 weeks.

Health Board's Planned Care Programme

In the Health Board, in order to respond to the post pandemic legacy in respect of elective services, a Planned Care Programme was established. The purpose of the Programme is to transform delivery of elective care pathways, targeting best practice and high impact changes to reduce demand into services (using for example GIRFT), optimise use of elective capacity in both outpatients and theatres and to ensure the application of prudent principles for example Interventions Not Normally Undertaken (INNU's). Alongside this is a focus on supporting patients whilst waiting to access services and upskilling operational managers in the application of waiting list management tools and techniques.

The work is divided into 6 workstreams the aims of each are:



Health Board's Annual Plan: Three Year intent

In the Health Board's plan for 2024/25 that was considered in the March 2024 Board meeting, a number of performance commitments in respect of planned care were made. These were developed following detailed discussions with directorates on demand and capacity analysis, opportunities for further improvements via efficiencies or pathway changes and a consideration of financial choices. Appendix A repeats the detail that was provided in the plan. In summary, the plan committed to:

- Eliminate and maintain 0 patients waiting > 156 weeks from 31 patients at end of March 24 (this equates to managing a cohort of over 4,000 patients),
- Reduce number of specialties with patients waiting > 52 weeks for first outpatient from 9 to 5 with 31 out of 36 specialties delivering the target,
- Reduce number of specialties with patients waiting > 104 weeks total wait (all stages) from 6 to 3 with 33 out of 36 specialties delivering the target,
- Note that whilst number of specialties is reducing, total number of patients waiting > 52 week for first outpatient is forecast to grow (14,846 March 24 to 21,739 March 25) and numbers waiting > 104 weeks total wait from 4,086 March 24 to 8215 March 25.
- Reduce number of patients waiting > 8 weeks for a diagnostic from 4,209 to 1,160
- A commitment to reach 70% for Single Cancer Pathway by March 25

The trajectories have a number of improvements and efficiency assumptions already included:

- Maximum 5% DNA rate (which was extended to 10% to include CNA)
- Minimum 85% theatre utilisation across all specialties
- Treat in turn improvements by specialty and minimum required

As part of the "areas for further focus" there was a commitment to continue to test delivery and seek improvements in the challenged specialties, with a particular focus on ENT, Ophthalmology and Orthopaedics.

April 24 Welsh Government's Productive and Effective Planned Care Request

On 29 April 2024, Welsh Government wrote to all Health Board's setting out a requirement to produce a further plan to demonstrate that nationally identified opportunities and improvements were being realised and reflected in local plans. A number of high impact changes have been identified through national workstreams such as the "Getting it Right First Time" (GIRFT) reviews and the Outpatients Transformation Board and Welsh Government have set out an ambition to have elective care services running 52 weeks a year, 7 days a week and 15 hours a day. In terms of resources to deliver these ambitions Welsh Government note that £130m has already been allocated out on equal share, a Regional Planned care fund of £50m has been allocated and there is a £15m transformation fund for which bids are already with Welsh Government.

In terms of the £50m Regional Planned Care fund, the Health Board received £3.9m for 2024/25 which represents a £2m reduction from 23/24. There was been communication with Welsh Government colleagues about this allocation which is £5m less than an equivalent population share of the £50m that was returned to Welsh Government as part of the top slice to target long waiters.

The high impact opportunities which are to be reflected in the plan are framed around 5 key areas and specific as per below:

EFFECTIVE WAITING LIST MANAGEMENT SYSTEMS	
1.1	National Pathways
1.2	Management in line with RTT rules eg DNA
1.3	Treat in Turn rates
1.4	Effective Booking Processes
1.5	Demand/Referral Management
OUTPATIENT/PRE-OPERATIVE MODERNISATION	
2.1	"See on Symptoms" (SOS), "Patient Initiated Follow Up" (PIFU) and discharge protocols for highest volume specialties
2.2	Advice and Guidance – including national advice for 17 specialties and GIRFT further Faster
2.3	Pre-operative virtual clinics (50% ambition for virtual pre-op be year end)
THEATRE CAPACITY	
3.1	Fallow lists – a focus on utilisation of resourced lists and a reduction of > 25% of fallow lists
3.2	Scheduling and booking
"High Volume Low Complexity" (HVLC)/DAY CASE & GIRFT	
4.1	Implementation of HVLC lists to improve volumes
4.2	Orthopaedic and Cataract GIRFT standards as a priority
DIAGNOSTICS	
5.1	Regional/Community Diagnostic centre
5.2	Straight to Test (STT) pathways

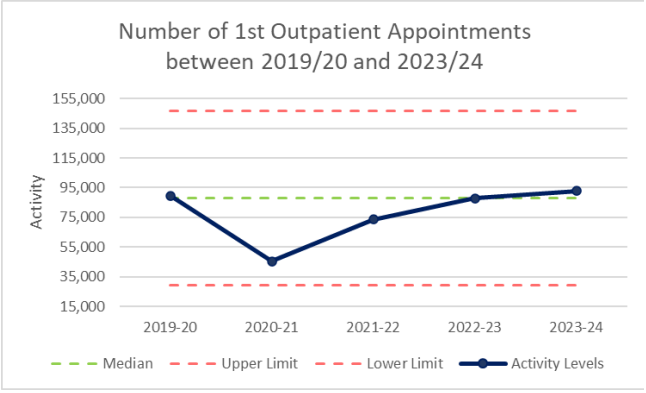
In addition to the above request, the Health Board received high level feedback on the 2024/25 Annual Plan confirming that further work was required to improve on delivery of the planned care targets (as well as the financial position) and a new set of milestones against national targets was issued with those relating to planned care highlighted in yellow:

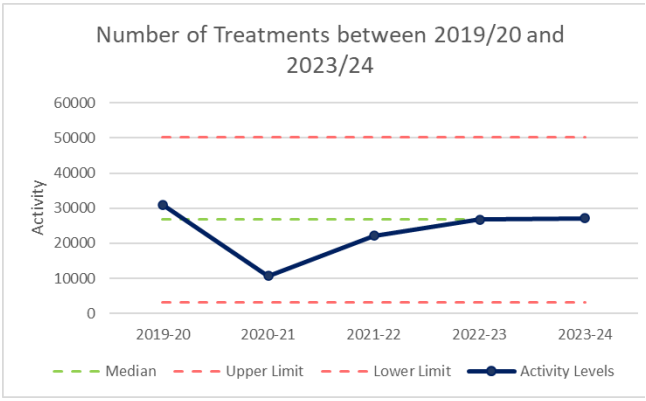
MEASURE	TARGET
Number of patients waiting more than 52 weeks for a new outpatient appointment[1]	40% reduction by end of September 2024 Zero by March 2025
Number of patients waiting more than 104 weeks for referral to treatment[1]	Zero end of December 2024
Number of patients waiting over 8 weeks for a specified diagnostic[1]	95% to be zero by December 2024
Percentage of patients starting their first definitive treatment for cancer within 62 days from point of suspicion (regardless of the referral route)	60% performance by December 2024 70% performance by March 2025
Number of ambulance patient handovers over 1 hour[1]	30% reduction by December 2024
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge[1]	20% reduction by September 2024 Further 20% reduction by March 2025
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	80% by December 2024
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	80% by December 2024

Asesiad / Assessment

Post pandemic, a number of planned care specialties remain in challenging positions with a mismatch in demand and capacity. These imbalances have been further exacerbated by a loss of activity in more recent months due to industrial action across a number of professional groups. The strained financial context has also limited the flexibility regarding the additional activity that is typically delivered through Waiting List Initiatives (WLIs), backfilling of fallow lists, outsourcing or other ad hoc mechanism eg Planned Additional Rates (PAR). There has been a long-standing history of the Health Board using these options to deliver on planned care targets. In spite of this, great efforts have been made to return to pre-covid levels of activity and increased activity delivered through core work.

The charts below show the overall activity levels for outpatients and treatments:





The tables below demonstrate the activity delivered through core capacity, WLI/backfill and outsourcing. Positively, from an outpatient perspective, more activity is being delivered through core capacity but there remains variation in respect of treatment activity, with overall numbers still not at pre covid levels in some specialties. In both outpatients and treatments, the level of backfill and WLI activity is down in line with resource driven decisions and affordability.

Planned Care Specialities - New Outpatients

	Financial Months 1 to 12										% Activity against 19/20	
	2019-20					2023-24						
Speciality	Core	Initiative/ Backfill	Outsourced	Total	% Additional Activity	Core	Initiative/ Backfill	Outsourced	Total	% Additional Activity	Core	Total
Dermatology	8,026	1,069		9,095	11.8%	16288			16,288	0.0%	102.9%	79.1%
Ear Nose & Throat	11,234			11,234	0.0%	6325	355		6,680	5.3%	-43.7%	-40.5%
General Surgery	13,923	2,981		16,904	17.6%	20214	1211		21,425	5.7%	45.2%	26.7%
Gynaecology	11,722	57		11,779	0.5%	13118	44		13,162	0.3%	11.9%	11.7%
Maxillo-Facial	4,027			4,027	0.0%	2907	106		3,013	3.5%	-27.8%	-25.2%
Ophthalmology	12,459	366	1,311	14,136	2.6%	11,858	6	300	12,164	0.0%	-4.8%	-14.0%
Trauma & Orthopaedic	8,774	5,721		14,495	39.5%	11,112	974		12,086	8.1%	26.6%	-16.6%
Urology	6,726	1,131		7,857	14.4%	7614	287		7,901	3.6%	13.2%	0.6%
Grand Total	**76,891**	**11,325**	**1,311**	**89,527**	**12.6%**	**89,436**	**2,983**	**300**	**92,719**	**3.2%**	**16.3%**	**3.6%**

Planned Care Specialities - Treatments

	Financial Months 1 to 12										% Activity against 19/20	
	2019-20					2023-24						
Speciality	Core	Initiative/ Backfill	Outsourced	Total	% Additional Activity	Core	Initiative/ Backfill	Outsourced	Total	% Additional Activity	Core	Total
Dermatology	1,619	4		1,623	0.2%	2,449	179		2,628	6.8%	51.3%	61.9%
Ear Nose & Throat	1,650	69		1,719	4.0%	1,358	59		1,417	4.2%	-17.7%	-17.6%
General Surgery	4,591	385		4,976	7.7%	3,606	790		4,396	18.0%	-21.5%	-11.7%
Gynaecology	1,929	937		2,866	32.7%	2,255	10		2,265	0.4%	16.9%	-21.0%
Maxillo-Facial	2,641	9		2,650	0.3%	2,436			2,436	0.0%	-7.8%	-8.1%
Ophthalmology	3,625	56		3,681	1.5%	3,013	122		3,135	3.9%	-16.9%	-14.8%
Trauma & Orthopaedic	5,282	2,360		7,642	30.9%	5,451	445		5,896	7.5%	3.2%	-22.8%
Urology	5,580	126		5,706	2.2%	4,684	192		4,876	3.9%	-16.1%	-14.5%
Grand Total	**26,917**	**3,946**	**0**	**30,863**	**12.8%**	**25,252**	**1,797**	**0**	**27,049**	**6.6%**	**-6.2%**	**-12.4%**

Appendix C outlines comparative information for months 1 – 11 with additional years added in and activity plans as per the Annual plan 2024/25.

The actual activity outlined above was impacted by the 3 incidents of Industrial action in 23/24 which resulted in a cancellation of 3,797 outpatient appointments and 389 treatments. The total loss of capacity was higher as some clinics or theatres session were just not booked into (rather than cancelled).

The above activity information is set against the backdrop of increasing demand and referrals from GP's and Optometrists into the planned care system. The tables below show the continuous growth in RTT referrals into the system by Division with the specialties with the highest growth are also noted:

Annual referrals by Division

Division	2019-20	2023-24	% Change
Clinical Support Services	2177	2360	8%
Family and Therapies	15161	19475	28%
Medicine	36840	41151	12%
Surgery	98086	119949	22%
Grand Total	152264	182935	20%

Annual referrals by specialty

RTT Specialty	2019-20	2023-24	% Change
Radiology	385	787	104%
Gynaecology	10363	14056	36%
Cardiology	7893	10639	35%

Clinical Pharmacology & Therapeutics	103	152	48%
Nephrology	871	1209	39%
Neurology	3759	4695	25%
Respiratory	5876	8506	45%
Clinical Haematology	7100	8077	14%
Dermatology	15799	19982	26%
General Surgery	19721	23847	21%
Maxillo-Facial	3546	4293	21%
Ophthalmology	13928	18988	36%
Orthodontics	589	967	64%
Trauma & Orthopaedic	14915	18025	21%
Urology	7340	9346	27%
ENT	12013	11108	-8%

As part of the deep dives, further work will be taken to understand these patterns. In the case of ENT, the reduction is being tested to assess if this is an impact of schemes to improve demand management such as redirection to advice and guidance and the GP gatekeeper role.

Response to Welsh Government "Productive and Effective Planned care Pathways

The Health Board has a number of commitments as part of the delivery of the 2024/25 plan but a further iteration of planning is required with teams to assess for further opportunities.

A composite response is being brought together that:
- Addresses the high impact opportunities identified in the 29 April letter from WG,
- Responds to the revised planned care milestones issued, and
- Addresses feedback on the annual plan with respect to planned care.

Work had already started to review the current demand and capacity plans and gaps, considering both backlog and underlying capacity shortfalls. Health Board teams attended an all-Wales workshop on 10th May to share opportunities an best practice in realisation of the identified opportunities.

A timeline to complete the work is as follows:

Draw out all existing actions, schemes from annual plan, programmes, directorate plans and GIRFT plans	17 May
Divisions and directorates to consider additional actions and opportunities to improve delivery	20 May
Executive team session to review and consider opportunities and any resource implications	23 May
Deep Dives with three key specialties ENT, Ophthalmology, Orthopaedics	20-23 May
Finalise plans – testing with the Chair and Board members	24 May – 30 May

Finalised new trajectories	28 May
Planned care Submission to Welsh Government	31 May

Health Board's Planned Care Programme

Progress against the 6 workstreams is set out in detail in Appendix B. It includes a high-level summary of each workstream. This includes their intended benefits, progress made to date, key objectives for the next period, key risks and current RAG rating. Overall, there has been progress made across all six workstreams with further work to be undertaken to support the realisation of the intended benefits. A key risk is the ongoing capacity challenges within the system which impacts on the ability of colleagues to engage with some of the workstreams. In spite of the challenging climate, engagement has generally been very positive and will be closely monitored as a key risk by the Planned Care Programme Board.

Updates against the programme (alongside other Clinical Futures/Transformation Programmes) are provided regularly into the Population Health, Planning and Partnerships Committee.

Argymhelliad / Recommendation

The Board is asked to:

- Note the recent request from Welsh Government for an additional Planned Care Improvement plan to be submitted by 31st May,
- Note the work in train to respond to the recent WG request, targets and actions in train for the three challenges elective specialties.
- Note the scope and progress of the Health Board's Planned Care Programme and its workstreams.

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):	1.1 Health Promotion, Protection and Improvement 3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 5.1 Timely Access 6.1 Planning Care to Promote Independence

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	3P's – Promote, Prevent and Prepare 6-4-2 – Theatres Scheduling process: • 6 weeks – early declaration of intention to use theatre lists 6 weeks in advance • 4 weeks – offering of list to other specialties where doubt of use exists • 2 weeks – closing down of lists (no further changes) ABUHB – Aneurin Bevan University Health Board CDH – Community Diagnostic Hub CE – Clinical Editor CF – Clinical Futures DHCW – Digital Health and Care Wales DNA – Did Not Attend GIRFT – Getting it Right First Time GP – General Practitioner GUH – Grange University Hospital HIT – High Intensity Theatres HVLC – High Volume Low Complexity KPI – Key Performance Indicator NCN – Neighbourhood Care Network NHH – Neville Hall Hospital ORMIS – Live clinical management peri-operative system PIFU – Patient Initiated Follow-up PIP – Pre-investment panel QI – Quality Improvement RAG – Red, Amber, Green

	RGH – Royal Gwent Hospital RN – Registered Nurse RTT – Referral to Treatment SME – Subject Matter Expert SOP – Standard Operating Procedure SOS – See on Symptoms WPAS – Welsh Patient Administration System YYF – Ysbyty Ystrad Fawr
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee Finance & Performance Committee

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

APPENDIX A – 2024/25 PLAN COMMITMENTS (March 24)

Planned Care- 52 Weeks Forward Look 24/25

Stage 1 - 52 Weeks					
Specialty	Baseline	Q1	Q2	Q3	Q4
Cardiology	0	0	0	0	0
Care Of The Elderly	0	0	0	0	0
Chemical Pathology	1	0	0	0	0
Clinical Haematology	0	0	0	0	0
Clinical Pharmacology & Therapeutics	0	0	0	0	0
Dermatology	14	0	0	0	0
Diabetes & Endocrinology	2	0	0	0	0
Diabetic Medicine	0	0	0	0	0
Ear Nose & Throat	4,716	5,306	5,885	5,834	5,841
Endocrinology	1	0	0	0	0
Gastroenterology	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	9	0	0	0	0
Gynaecology	1	0	0	0	0
Infectious Diseases	0	0	0	0	0
Maxillo-Facial	891	1,029	1,172	1,264	1,337
Nephrology	0	0	0	0	0
Neurology	0	0	0	0	0
Ophthalmology	5,436	6,545	7,182	7,623	8,421
Orthodontics	104	78	52	26	0
Paediatric	0	0	0	0	0
Paediatric Diabetes	0	0	0	0	0
Paediatric Epilepsy	0	0	0	0	0
Paediatric Inherited Metabolic	0	0	0	0	0
Paediatric Neurology	0	0	0	0	0
Paeds Gastro Spin	0	0	0	0	0
Pain Management Service	0	0	0	0	0
Radiology	0	0	0	0	0
Respiratory	0	0	0	0	0
Restorative Dentistry	0	0	0	0	0
Rheumatology	0	0	0	0	0
Stroke	0	0	0	0	0
Transient Ischaemic Attack	0	0	0	0	0
Trauma & Orthopaedics	2,158	3,041	3,921	4,423	4,623
Urology	1,031	1,124	1,215	1,337	1,517
Vascular Surgery	0	0	0	0	0
Total	**14,364**	**17,124**	**19,427**	**20,506**	**21,739**

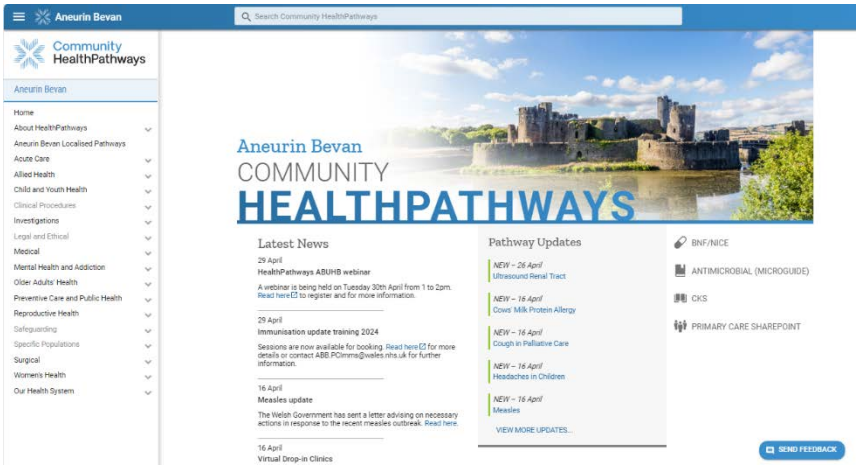
Total Waiting - 52 Weeks					
Specialty	Baseline	Q1	Q2	Q3	Q4
Cardiology	80	0	0	0	0
Care Of The Elderly	0	0	0	0	0
Chemical Pathology	2	0	0	0	0
Clinical Haematology	0	0	0	0	0
Clinical Pharmacology & Therapeutics	8	0	0	0	0
Dermatology	14	0	0	0	0
Diabetes & Endocrinology	0	0	0	0	0
Diabetic Medicine	0	0	0	0	0
Ear Nose & Throat	5,750	6,498	7,175	7,192	7,188
Endocrinology	3	0	0	0	0
Gastroenterology	45	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	969	1,401	1,728	2,042	2,214
Gynaecology	285	252	218	162	155
Infectious Diseases	0	0	0	0	0
Maxillo-Facial	1,037	1,322	1,586	1,793	1,909
Nephrology	0	0	0	0	0
Neurology	0	0	0	0	0
Ophthalmology	6,528	7,853	8,663	9,185	9,913
Orthodontics	104	78	52	26	0
Paediatric	1	0	0	0	0
Paediatric Diabetes	0	0	0	0	0
Paediatric Epilepsy	0	0	0	0	0
Paediatric Inherited Metabolic	0	0	0	0	0
Paediatric Neurology	0	0	0	0	0
Paeds Gastro Spin	0	0	0	0	0
Pain Management Service	0	0	0	0	0
Radiology	51	38	25	12	0
Respiratory	0	0	0	0	0
Restorative Dentistry	0	0	0	0	0
Rheumatology	0	0	0	0	0
Stroke	0	0	0	0	0
Transient Ischaemic Attack	0	0	0	0	0
Trauma & Orthopaedics	8,143	9,911	11,157	11,847	12,472
Urology	1,595	1,724	1,840	2,023	2,376
Vascular Surgery	0	0	0	0	0
Total	**24,615**	**29,077**	**32,445**	**34,283**	**36,228**

Planned Care- 104 Weeks Forward Look 24/25

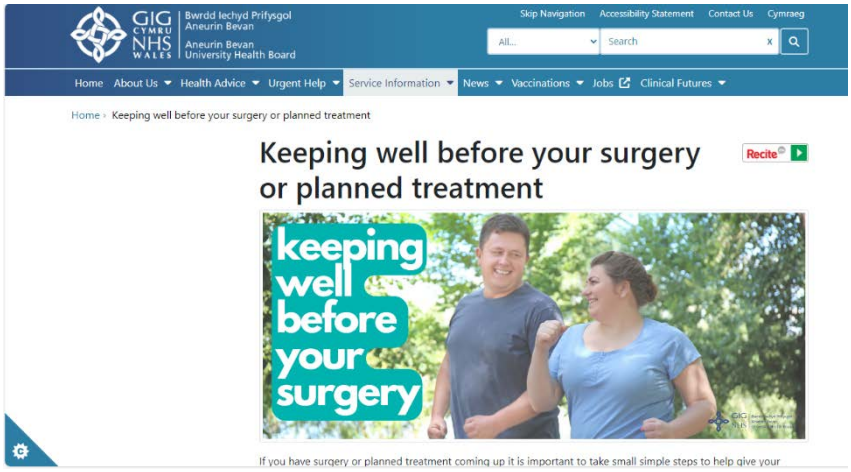
Stage 1 - 104 Weeks					
Specialty	Baseline	Q1	Q2	Q3	Q4
Cardiology	0	0	0	0	0
Care Of The Elderly	0	0	0	0	0
Chemical Pathology	0	0	0	0	0
Clinical Haematology	0	0	0	0	0
Clinical Pharmacology & Therapeutics	0	0	0	0	0
Dermatology	0	0	0	0	0
Diabetes & Endocrinology	0	0	0	0	0
Diabetic Medicine	0	0	0	0	0
Ear Nose & Throat	1,240	1,834	1,976	2,082	2,431
Endocrinology	0	0	0	0	0
Gastroenterology	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Gynaecology	0	0	0	0	0
Infectious Diseases	0	0	0	0	0
Maxillo-Facial	71	0	0	0	0
Nephrology	0	0	0	0	0
Neurology	0	0	0	0	0
Ophthalmology	657	638	1,036	1,384	1,968
Orthodontics	0	0	0	0	0
Paediatric	0	0	0	0	0
Paediatric Diabetes	0	0	0	0	0
Paediatric Epilepsy	0	0	0	0	0
Paediatric Inherited Metabolic	0	0	0	0	0
Paediatric Neurology	0	0	0	0	0
Paeds Gastro Spin	0	0	0	0	0
Pain Management Service	0	0	0	0	0
Radiology	0	0	0	0	0
Respiratory	0	0	0	0	0
Restorative Dentistry	0	0	0	0	0
Rheumatology	0	0	0	0	0
Stroke	0	0	0	0	0
Transient Ischaemic Attack	0	0	0	0	0
Trauma & Orthopaedics	356	423	523	636	829
Urology	30	0	0	0	0
Vascular Surgery	0	0	0	0	0
Total	**2,354**	**2,896**	**3,535**	**4,103**	**5,228**

Total Waiting - 104 Weeks					
Specialty	Baseline	Q1	Q2	Q3	Q4
Cardiology	0	0	0	0	0
Care Of The Elderly	0	0	0	0	0
Chemical Pathology	0	0	0	0	0
Clinical Haematology	0	0	0	0	0
Clinical Pharmacology & Therapeutics	0	0	0	0	0
Dermatology	0	0	0	0	0
Diabetes & Endocrinology	0	0	0	0	0
Diabetic Medicine	0	0	0	0	0
Ear Nose & Throat	1,587	2,294	2,474	2,645	3,047
Endocrinology	0	0	0	0	0
Gastroenterology	1	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	117	168	163	107	0
Gynaecology	0	0	0	0	0
Infectious Diseases	0	0	0	0	0
Maxillo-Facial	89	11	4	2	0
Nephrology	0	0	0	0	0
Neurology	0	0	0	0	0
Ophthalmology	869	848	1,277	1,597	2,218
Orthodontics	0	0	0	0	0
Paediatric	1	0	0	0	0
Paediatric Diabetes	0	0	0	0	0
Paediatric Epilepsy	0	0	0	0	0
Paediatric Inherited Metabolic	0	0	0	0	0
Paediatric Neurology	0	0	0	0	0
Paeds Gastro Spin	0	0	0	0	0
Pain Management Service	0	0	0	0	0
Radiology	0	0	0	0	0
Respiratory	0	0	0	0	0
Restorative Dentistry	0	0	0	0	0
Rheumatology	0	0	0	0	0
Stroke	0	0	0	0	0
Transient Ischaemic Attack	0	0	0	0	0
Trauma & Orthopaedics	1,481	1,727	2,145	2,461	2,951
Urology	144	22	4	1	0
Vascular Surgery	0	0	0	0	0
Total	**4,289**	**5,072**	**6,066**	**6,813**	**8,215**

APPENDIX B – PLANNED CARE PROGRAMME UPDATE

HEALTH PATHWAYS	
Intended Benefits	• Provide a comprehensive advice, guidance and standardised referral criteria model for primary care to assist practitioners in navigating a complex system. • Reduce the number of online locations that GP's go to for clinical advice. • Maximise the use of resources across the system. • Reduce unnecessary demand into secondary care. • Reduce unnecessary clinical investigations. • Reduce unwarranted variation.
RAG Rating	
Progress Made so Far	• Progress since Project initiation: • Site launched on 19th April 2024 with 50 pathways Home - Community HealthPathways Aneurin Bevan– over 4,000 page views and 600 users within the first two weeks.  •Phase 2: o Priority pathways identified o Key metrics agreed and evaluation plan in process: further developments in pathway coding at triage stage required
Objectives for the Next Period	• Key tasks and milestones as below: • Embed Clinical Governance Framework locally and associated process for detaching from national pathways. • Develop and implement longer-term communications and engagement plan to support embedding and behaviour change (to include liaison with Primary & Community Care Academy). • Continue to write up pathways, further pathways to go live on site – target of 100 by the end of Q3 2024-25. • Continue to embed and maximise inclusion of available advice systems (Consultant Connect, eAdvice) as part of HealthPathways and confirm opportunities for improved triaging processes.

	• Refine evaluation strategy and plan to illustrate benefit and impact for focus specialty areas.
Key Risks	• Number of pathways required to develop in 2024-25 and capacity of SMEs to engage to support this in view of operational pressures. • Failure to embed HealthPathways as part of behaviour change due to misconceptions of the purpose and aims of HealthPathways.

PATIENT ACCESS & ACTIVATION	
Intended Benefits	• Increased access and uptake of self-management support and advice via online resources. • Improved patient preparation for surgery. • Positive patient experience through increased knowledge of services. • Improved patient communication allowing them to be better informed on waiting times.
RAG Rating	
Progress Made so Far	• A public page has been created in collaboration with the Communications team and is currently live Keeping well before your surgery or planned treatment - Aneurin Bevan University Health Board (nhs.wales) ○ Total of 4,126-page views as at 16th April 2024  • Roll out plan for the 'Keeping Well' service completed – to include appointment of x3 Band 3 call handlers. • 3P's Implementation Plan submitted to Welsh Government. • Developed a new format for reporting waiting times information to both patients and primary care.
Objectives for the Next Period	• Publish 'Keeping Well' page on local ABUHB 'Pulse' page. • Continue communications and engagement activity with key stakeholders – to include distribution of 'Keeping Well' brochures. • Agree how ABUHB Patient Waiting Times are communicated to patients. Further discussions required with the Executive and Communications teams. • Audit of WPAS data recording to be completed and approved. • Recruit Band 5 RN.
Key Risks	• Capacity of the system to engage with the workplan. • Delays in the recruitment of Band 5 RN (JD approved).

OUTPATIENT TRANSFORMATION	
Intended Benefits	• Higher number of patients on SOS/PIFU pathways. • Reduced follow up waiting lists. • Reduced DNA rates. • Increased virtual activity to free up physical space in outpatients.
RAG Rating	
Progress Made so Far	• Hospital Cancellation Policy drafted.

	• Clinically Led Outpatient Model Meetings commenced with priority specialties – to be continued during 2024-25.
	• Key metrics update:
	  ○ Advice Only – 12,942 advice only attendances April – March 2023/2024 (April – March 2022/2023 numbers were 11,273, an increase of 1,669 for the same time period).
	  ○ DNA's – 2023-2024 rate 5.7% (target 5%). Focus on cohorts with high DNA rates; aim to understand patterns for DNA's and potential reasons, along with analysis of Secondary Care activity following DNA to understand impact. Patient contact commencing in May 2024 for further exploration of reasons.
	  ○ SOS and PIFU – 2023-2024 13.2% (2022-2023 11.9%). Gap analysis being undertaken against pathways in other health boards to identify potential opportunities of new areas.
	  ○ Virtual activity – 2023-24 23.2% (2022-23 24.5%).
	  ○ Total on follow-up waiting list – 133,449 as at 2nd May 2024 (total 124,527 reported at the end of April 2023).
	  ○ Follow-up appointments 100% past target – 28,918 as at 2nd May 2024 (total 22,544 reported at the end of April 2023).
	• Increased number of specialties/services utilising the Consultant Connect platform.
	• Initiation of process for design and development of a two-way eAdvice functionality.

Objectives for the Next Period	• Development of Outpatient Treatment Unit. • Continue the development of the Hospital Cancellation Policy to support a reduction in Hospital Initiated Cancellations. • Continue work to increase number of specialties/services utilising the Consultant Connect platform. • Continue work with the two-way eAdvice functionality design and development – aim for go live in Q2/3. • Updating of Directorate Outpatient plans aligned to the new three-year strategy targets. • Change in the patient contact validation process from letters being run by DHCW to internally via health board WPAS.
Key Risks	• Ongoing challenges in relation to the capacity the of system to engage in the workplan. • Risk of Divisions being unable to decrease 100% past target trajectory, noting competing demands.

DIAGNOSTICS	
Intended Benefits	• Coordinated approach to involvement in regional diagnostic developments. • Oversight of internal diagnostic updates.
RAG Rating	

Progress Made so Far	• Continued engagement in regional diagnostic developments as part of the Regional Diagnostic Programme:
	  • CDH
	  • Pathology
	  • Endoscopy
	• Attendance at joint South East Regional Executive session.

Objectives for the Next Period	• Endoscopy team to complete efficiencies plan. • Resolve identified funding issues for the Endoscopy Decon Unit.
Key Risks	• Ongoing challenges in relation to the capacity of the system to engage in the workplan. • Availability of funding for the Endoscopy Decon Unit solution. •

ELECTIVE CAPACITY / THEATRE UTILISATION	
Intended Benefits	• Increased theatre utilisation through improved compliance with KPI's/metrics. • Access to improved, standardised and reliable data for monitoring against key metrics.
RAG Rating	
Progress Made so Far	• 6-4-2 Theatres Scheduling Policy launched and SOP approved. • First 'HIT' list held on 25th April *(x2 theatres working simultaneously with x1 Surgeon)*. • ORMIS upgrade completed. • QI Safety Advisor in post and QI training commenced. • Asset verification exercise completed.
Objectives for the Next Period	• Embed the agreed performance metrics and 6-4-2 theatres scheduling policy, with the aim of improving health board theatres utilisation performance. • Deliver further 'HIT' lists, and take learning to inform HVLC activity in response to GIRFT improvement opportunities. • Commence work on business case development for ORMIS replacement.
Key Risks	• Capacity of the system to engage with the workplan. • Availability of capital and revenue funding. • Limitations of the ORMIS data.

PLANNED CARE ACADEMY	
Intended Benefits	• Provision of a consistent and optimised approach to planned care delivery. • Improved staff experience due to optimised training – higher levels of confidence within their roles. • Increased recruitment and retention due to the creation of clear planned care career paths and support for staff.
RAG Rating	
Progress Made so Far	• Training strategy and plan has been formulated focusing on key skills and competencies required in planned care management. • Revised training schedule collated and agreed. • WPAS team and digital colleagues reviewed current WPAS profiles and mapped out roles to tailor training accordingly. • 58 new user guides produced, breaking down into specific elements of WPAS and RTT guidance.
Objectives for the Next Period	• Refine new user guides, training materials and RTT training material in readiness for the launch of new training packages in July 2024. • Introduce a booking app for users to increase accessibility and enable a more streamlined booking process. • Deliver communications plan regarding new training schedule and access arrangements. • Deliver WPAS train the trainer activity to support the spread and scale of training provision.
Key Risks	• Capacity of staff within the organisation to engage with the work required to ensure that they can provide input into the training materials for specialty areas which, in turn, impacts the ability of the WPAS team to provide bespoke specialty training. • Capacity of the WPAS team to fulfil all requirements of the new training programme. • Release of staff for both initial and refresher training.

APPENDIX C

Surgery Care New Outpatients

Main specialties only included in table
Activity excludes Fracture and Ophthalmology Eye Casualty
Excludes March due to reduced activity 2020 due to COVID

	Financial Months 1 to 11																				
	2019-20					2022-23					2023-24					% Activity 2023/24 vs 2019/20		2024-25 Plan				
Specialty Name	Core	Initiative / Backfill*	Outsourced	Total	%Additional Activity	Core	Initiative / Backfill*	Outsourced	Total	%Additional Activity	Other	Initiative / Backfill*	Outsourced**	Total	%Additional Activity	Core	Total	Other	Initiative / Backfill*	Outsourced**	Total	% Additional Activity
Dermatology	7,640	1,068		8,708	12.3%	8,635	64		8,699	0.7%	14,889	0		14,889	0.0%	195%	171%	14,745			14,745	0.0%
Ear Nose & Throat	10,587			10,587	0.0%	6,586	149		6,735	2.2%	5,793	234		6,027	3.9%	55%	57%	5,725			5,725	0.0%
General Surgery***	13,033	2,721		15,754	17.3%	18,692	636		19,328	3.3%	20,123	1,127		21,250	5.3%	154%	135%	20,994			20,994	0.0%
Maxillo-Facial	3,771			3,771	0.0%	2,696	95		2,791	3.4%	2,697	53		2,750	1.9%	72%	73%	2,931			2,931	0.0%
Ophthalmology	7,757	366	1,104	9,227	15.9%	8,311	1,223	362	9,896	16.0%	7,449	6	659	8,114	8.2%	96%	88%	11,390		596	11,986	5.0%
Rheumatology	1,994	6		2,000	0.3%	2,786			2,786	0.0%	2,852	0		2,852	0.0%	143%	143%	2,846			2,846	0.0%
Orthopaedics	8,410	5,486		13,896	39.5%	8,258	5,005		13,263	37.7%	8,594	965		9,559	10.1%	102%	69%	10,778			10,778	0.0%
Urology	5,725	1,046		6,771	15.4%	5,224	406		5,630	7.2%	6,557	260		6,817	3.8%	115%	101%	7,411			7,411	0.0%
Grand Total	**58,917**	**10,693**	**1,104**	**70,714**	**16.7%**	**61,188**	**7,578**	**362**	**69,128**	**11.5%**	**68,954**	**2,645**	**659**	**72,258**	**4.6%**	**117%**	**102%**	**76,820**	**0**	**596**	**77,416**	**0.8%**

* Initiative/Backfill identified by text within the name of the outpatient clinic.
** This will include regional cataract and represents whole pathway inlcuding upto 650 treatments
*** General Surgery includes Vascular

Treatments

	Financial Months 1 to 11																				
	2019-20					2022-23					2023-24					% Activity 2023/24 vs 2019/20		2024-25 Plan				
Specialty Name	Core	Initiative / Backfill*	Outsourced	Total	%Additional Activity	Core	Initiative / Backfill*	Outsourced	Total	%Additional Activity	Other	Initiative / Backfill*	Outsourced**	Total	%Additional Activity	Core	Total	Other	Initiative / Backfill*	Outsourced**	Total	% Additional Activity
Dermatology	1,543	4		1,547	0.3%	1,968	228		2,196	10.4%	2,230	163				145%	0%	2,369			2,369	0.0%
Ear Nose & Throat	1,567	59		1,626	3.6%	1,078	135		1,213	11.1%	1,239	43				79%	0%	1,057			1,057	0.0%
General Surgery***	4,374	367		4,741	7.7%	2,824	960		3,784	25.4%	3,332	773				76%	0%	3,776			3,776	0.0%
Maxillo-Facial	2,528	9		2,537	0.4%	1,988	46		2,034	2.3%	2,255					89%	0%	1,915			1,915	0.0%
Ophthalmology	3,465	56		3,521	1.6%	2,635	105		2,740	3.8%	2,702	122				78%	0%	2,152		745	2,897	25.7%
Orthopaedics	5,058	2,234		7,292	30.6%	3,972	1,404		5,376	26.1%	5,092	418				101%	0%	5,327			5,327	0.0%
Urology	5,255	118		5,373	2.2%	4,503	360		4,863	7.4%	4,450	189				85%	0%	4,880			4,880	0.0%
Grand Total	**23,790**	**2,847**	**0**	**26,637**	**10.7%**	**18,968**	**3,238**	**0**	**22,206**	**14.6%**	**21,300**	**1,708**	**0**	**0**		**90%**	**0%**	**21,476**	**0**	**745**	**22,221**	**3.4%**

Agenda Item:4.7

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nursing, Midwifery and SCPHN Workforce Strategy 2023-2026
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Linda Jones - Head of Nursing Education, Development and Regulation

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board (ABUHB) launched its 2023-26 Nursing, Midwifery and SCPHN Workforce Strategy in May 2023. The Strategy sets out our ambition and vision to support continued growth, development and innovation in Nursing and Midwifery practice.

The purpose of this report is to provide Board with an update against the priority action plan articulated within the strategy.

Cefndir / Background

Five strategic ambitions underpin and guide the delivery of the strategy, each ambition is centered on providing excellent and compassionate care to everyone who touches our services.

The five strategic aims are:

- Staff development and career progression
- Excellence in leadership at all levels
- Quality improvement, innovation and learning in pursuit of excellence in patient safety, outcomes and experience.
- Research and Innovation

- Professional identity & influence

It was agreed that the strategic ambitions would be achieved through the delivery of a detailed overarching action plan with identified clear milestones and lines of accountability.

By way of assurance, overall progress on delivery of the strategy is monitored by the Executive Director of Nursing. Progress features as a regular agenda item at the Senior Nursing & Midwifery Leadership Group.

Asesiad / Assessment

The development and delivery of the strategy represents a collaborative approach with an ambition to produce meaningful priorities which can be recognised, understood and proud to implement as a profession.

Since its launch positive progress has been made to deliver against the priority action plans, which are:

- **Recruitment Effectiveness**
  - Clear link to IMTP
  - International recruitment
  - Succession and career planning
  - Innovation in the way we recruit
  - Innovation in the roles we recruit into

- **Recruitment Experience**
  - Innovative use of social media to create visibility
  - Process to ensure "every contact counts"
  - Key Performance Indicators

- **Brand and Marketing**
  - Marketing and branding support
  - Innovative use of social media
  - Focus on NHS incentives
  - Create an environment where people feel proud to work for ABUHB

- **Career Development/Educational Opportunities**
  - Embrace career progression
  - Endeavour to support development by way of education and training
  - Provide career opportunities at the highest level

- **Retention**
  - Understand why people stay and leave
  - Focus on turnover data
  - Identify what really matters to our staff
  - Focus on flexible working arrangements

Appendix one demonstrates the progress made against each priority action plan in the first year since the inception of the strategy.

Although it is pleasing to note the positive progress against 2023-24 priorities, a focus on 2024-25 is now required to ensure the full extent of the strategy is realised.

To this end, 2024-25 priorities are:

- A continued focus on the achievements of 2023-24 to ensure progress is tracked against expected outcomes.

- Career Development/ Educational Opportunities:
  - Focus on nurse led services, providing career opportunities and a platform for nurses in transforming and re-designing services.
  - Integrate the Professional Framework for Enhanced, Advanced and Consultant Practice to enable practitioners to utilise their skills to their full potential, optimising their contribution to meeting population health needs whilst contributing to the support and leadership within the Health Board.
  - Align education and resource to ensure standardisation, relevant and equitable access and opportunity.
  - Ensure the Health Board is closely aligned to the Registered Nurse Associate work being progressed with Welsh Government.
  - Secure a fit for purpose education facility for nursing and midwifery education.

- Retention:
  - Support the implementation of the career-spanning support for supervision recommendations. To include:
    - Ensuing a positive preceptorship experience for newly registered nurses.
    - Implementing and embedding restorative clinical supervision to support reflective practise and help build resilience within the nursing workforce.
  - Upscale the use of self-rostering, with an aim for this to be piloted in all Divisions.
  - Identify career aspirations of the current workforce with a focus on talent mapping.

- Recruitment Experience:
  - Focus on hard to recruit vacancies, such as, health visiting, mental health and learning disabilities. Placing attention on career advancement, career pathways, training and support, incorporate flexibility and work-life balance opportunities.
  - Introduce the all-Wales recruitment for International Educated Nurses to support onboarding and induction
  - Refresh and evaluate the nurse & HCSW induction programmes to support retention and improve turnover in the first 12 months
  - Review recruitment process for Flexible route student nurses to ensure wrap around of Health Board to support them into substantive posts.

- Recruitment Effectiveness:
  - Attract and engage staff through retire and returns and return to practice.

- Map commissioned student numbers for the duration of this strategy.

- Brand and Marketing:

  - Explore SLA with Coleg Y Cymoedd to secure the future HCSW workforce.
  - Marketing Career Pathways (to include enhanced, advanced & consultant practice) at Student Streamlining events, at the point of job advertisement

Argymhelliad / Recommendation

The Board is asked to:

- Take assurance that the Nursing, Midwifery and SCPHN Strategy is being progressed in collaboration with key stakeholders and the priority actions delivered in order to achieve the vision of the strategy.
- Note the 2024-25 priorities.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7.1 Workforce Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper

• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. 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

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

NURSING, MIDWIFERY, SCPHN WORKFORCE STRATEGY PRIORITY ACTION PLANS 2023-2026

Priority Action Plan – Recruitment Effectiveness

Action	What will this achieve?	Progress:
Develop an annual recruitment Plan	• Ensure a co-ordinated, sustainable flow of candidates linked to the Health Board's Workforce Plan • Ensure a planned approach to on-boarding and training needs	Annual planner in place that includes recruitment of: - 75 IENs per year - 20 nurse cadets (exceeded - 37 cadets for 23'24) - RCN connect students - Offers Coleg Gwent H&SC students' opportunity to join bank - Centralised HCSW recruitment to recruit to turnover
Continue to invest in internationally trained nurses	• Address long term vacancies and contribute to the ongoing supply of nurses into ABUHB	- 75 IENs being recruited each year until end of 2025, plan to recruit family / friends and local IEN's employed by AB. - Accommodation secured for next 2 years. - Support café - pastoral & educational
Recruit to the future nurse and midwifery academy	• Ensure a future pipeline of candidates to undertake under-graduate nursing and midwifery training • Attraction and Retention • Nursing career becomes a career of choice	- Internal HCSWs identified to progress to nurse training - Apprentice HCSW and HCSW adverts being advertised with the addition of a future nurse advert - Using social media platforms top advertise adverts/posters - Engaging early with H&SC students in schools and colleges and explaining the routes to nursing including the flexi route - RCN Healthcare Connect students – 4 in first cohort (one is exploring the flexi route) - 10 MH nurses supported to access K102 – OU flexible route
Develop succession and career planning approach for ABUHB	• Attract and retain nurses to work and stay within ABUHB • Offer developmental and career opportunities within all fields of nursing	• Future nurse adverts • Internal HCSWs identified to progress to nurse training • N&M Academy, LEAD6, N&M bespoke Academy for 8b's planned for Sept 24. JOE programme being rewritten – will incorporate leadership / succession of band 5 – 6. • Assistant Practitioner governance / developmental group - meeting being arranged with all Divisional representation

Priority Action Plan: Recruitment Experience

Actions	What will this achieve?	Progress:
Easy to find and refreshed Recruitment intranet and internet pages to include recruitment and selection training for managers	• Managers will know where to go for all things Recruitment	• In progress • Significant improvement in job advertising via social media platforms
Introduction of talent pools	• A space to hold appointable candidates that have already been interviewed to offer future posts for high turnover posts • Create a mechanism for the public to register their interest to work for the Health Board	• HCSWs are being recruited centrally into talent pools by location (to improve retention) • Plans to expand this to include a talent pool for those interested in a future nurse role (starting at apprentice or band 2 HCSWs level)
Engagement with local community	• Attract local population and develop Employer of Choice recognition	• Working with comms to link in with their communication strategy 2023 – 2026 to ensure job vacancies and career opportunities are published to our communities to develop a sense of employer of choice. • Work underway to visit schools and colleges to share the career opportunities available within N&M
Review and streamline recruitment processes to ensure they support equality and diversity for our local communities	• Supports our workforce to reflect the diversity of the community • More enjoyable experience for the candidate	• Undertaking events in various community locations such as schools, colleges and with job centres. In doing so we are offering unemployed residents an opportunity to gain employment.
Introduction of KPIs for Bank and continue to monitor General Recruitment KPIS	• Monitoring of time to hire and identify key areas for immediate intervention	• Bank KPIs in place • Monitoring time to hire and working on clearing old records in Trac (where people have started in post before checks complete)
Continued training and retention for Recruitment Teams	• Improvements for on-boarding leading to reduction in time to hire	• NWSSP training sessions and drop-in sessions in place. • Resource team to offer training to manager to reduce time to hire and best practice tips

Priority Action Plan: Brand and Marketing

Actions	What will this achieve?	Progress:
Uniform standardisation of brand	• Strong connection and promotion of ABUHB	• Posters developed with ABUHB colours and all in same format • Link with Comms to better incorporate recruitment into comms strategy ie HCSW week etc • Job of the week advertising being progressed
Increase attendance and visibility in the community	• Community awareness of ABUHB as an employer (for all jobs)and mutually beneficial links with partner HEI's • Improve relationships with key stakeholders	• Developed strong connections with Coleg Gwent, DWP and Careers Wales and have a strong presence at events being run across ABUHB patch. • Further work to be done with linking in with comms on this point for community awareness.
Review internal processes for staff engagement and feedback	• A greater sense of belonging and feeling valued	• NWSSP to re-design the manager and candidate surveys on the recruitment process
Review current advertising platforms and seek all opportunities	• Effective advertising and best value for money	• Social media platforms reach a large audience at no cost. • Advertising newly created RN vacancies to Bristol and Birmingham universities • Work on-going to review current platforms and other platforms available

Priority Action Plan: Career Development/Educational Opportunities

Actions	What will this achieve?	Progress:
Review service developments and potential opportunities for clinical nurse specialists, advanced practise and consultant nurse roles.	• Opportunities to develop, educate and retain existing workforce and attract staff form outside the Health Board.	• ACP role – JD standardisation. • Implementation of the multiprofessional framework – including network of ACP's, portfolio workshops, research workshop planned. • First multi-professional framework meeting to share and standardise practice across professions in line with framework. • Services now being developed around the role of Nurse Consultants/ANP's
Secure a fit for purpose education facility for nursing and midwifery education	• Provision for essential education, timely progression of IEN's to NMC registration, efficient use of resources	• Raised to Accommodation Committee – discussion to be picked up at Exec level in relation to equitable education resource for all Health Board staff.
Develop clear and ambitious pathways and opportunities.	• Will support individuals to reach their ambition, improve job satisfaction and ensure a skilled workforce.	• Future Nurse Academy – clear pathway from school to RN – ability to step in and step out.
Increase opportunity for professional support and development.	• A supportive culture.	• 12 PNA places secured to implement RCS framework • Current supervisors scoped as a priority for training • 2 courses supervision secured for MH/LD which will support 24 new supervisors • Constant flow of access to ILM coaching qualifications • Coaching conversations to be included as a master class at next Alumni – rolled out as "business as usual". • Prerceptorship programme under review to strengthen support for new registrants. • Support to undergraduate students strengthened through coffee and connect sessions, points of contact, education / support opportunities.

Priority Action Plan: Retention

Actions	What will this achieve?	Progress:
Implement exit questionnaires	• Feedback on what we need to do to be the employer of choice and improve retention of current staff.	• Questionnaires now on ESR and are autogenerated prior to individuals leaving the organisation. • Benchmarking across Wales taking place to design and implement 'stay conversation' to complement exit questionnaire process. • Retention group established with the purpose of identifying and designing support systems in retaining our staff. This includes interrogating data from multiple sources.
Encourage and support the use of self-rostering	• Increased staff satisfaction, reduce sickness absence.	• Retention self assessment plan being piloted within Community and Childrens Nursing. • Tracker developed for all Wales Retention Action Plan
Retire and Return Initiative	• Encourage experienced staff to return to work.	• Poster being developed to encourage retirees back to work on FTCs or bank
Optimise flexible working opportunities	• Work-life balance • Return to practice • Make the profession more attractive	• Poster being developed to encourage retirees back to work on FTCs or bank. • Retention engagement chat cafes across the organisation have taken place with engagement of over 500 staff. • Self rostering trial on ICU and NICU

Priorities 2024-25

Actions
A continued focus on the achievements of 2023-24 to ensure progress is tracked against expected outcomes
Career Development/ Educational Opportunities: • Focus on nurse led services, providing career opportunities and a platform for nurses in transforming and re-designing services. • Integrate the Professional Framework for Enhanced, Advanced and Consultant Practice to enable practitioners to utilise their skills to their full potential, optimising their contribution to meeting population health needs whilst contributing to the support and leadership within the Health Board. • Align education and resource to ensure standardisation, relevant and equitable access and opportunity. • Ensure the Health Board is closely aligned to the Registered Nurse Associate work being progressed with Welsh Government. • Secure a fit for purpose education facility for nursing and midwifery education.
Retention: • Support the implementation of the career-spanning support for supervision recommendations. To include: ○ Ensuing a positive preceptorship experience for newly registered nurses. ○ Implementing and embedding restorative clinical supervision to support reflective practise and help build resilience within the nursing workforce. • Upscale the use of self-rostering, with an aim for this to be piloted in all Divisions. • Identify career aspirations of current workforce with a focus on talent mapping.
Recruitment Experience: • Focus on hard to recruit vacancies, such as, health visiting, mental health and learning disabilities. Placing attention on career advancement, career pathways, training and support, incorporate flexibility and work-life balance opportunities. • Introduce the all-Wales recruitment for International Educated Nurses to support onboarding and induction • Refresh and evaluate the nurse & HCSW induction programmes to support retention and improve turnover in the first 12 months • Review recruitment process for Flexible route student nurses to ensure wraparound of Health Board to support them into substantive post.
Recruitment Effectiveness: • Attract and engage retire and returns and return to practice. • Map commissioned student numbers for the duration of this strategy.
Brand and Marketing: • Explore SLA with Coleg Y Cymoedd to secure the future HCSW workforce. • Marketing Career Pathways (to include enhanced, advanced & consultant practice) at Student Streamlining events, at the point of job advertisement

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	18 April 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Individual Patient Funding Requests (IPFR)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Ann-Marie Matthews Lead for Clinical Commissioning/IPFR

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Individual Patient Funding Request (IPFR) process enables requests for funding to be submitted to the Health Board for NHS healthcare that falls outside of the range of services and treatments that the Health Board has arranged to routinely provide.

This paper seeks to provide the Board with assurance in relation to the operation of the IPFR policy process within Aneurin Bevan University Health Board and how this links with wider national work streams.

Cefndir / Background

Individual Patient Funding Requests (IPFR's) are defined as requests to a Health Board to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board has arranged to routinely provide or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device, or piece of equipment.

Such requests will normally be for treatments that are either new, novel, developing or unproven and are not within the Health Board's routine schedule of service and treatments, such as a cancer drug not yet approved for use in that a particular condition; or for a treatment that is provided by the Health Board in certain clinical circumstances, but the patient is not eligible in accordance with the clinical policy criteria, such as varicose vein treatment for cosmetic reasons alone.

The IPFR policy also confirms that NHS Wales does not operate a blanket ban for any element of NHS healthcare, equally the granting of funding in one case does not mean that funding will be provided for the same treatment for other patients.

Each IPFR is considered on its individual merits and in accordance with the arrangements set out in the All-Wales IPFR Policy. Each Health Board has a dedicated IPFR Panel comprising of clinical and lay representatives in accordance with the IPFR policy's terms of reference. The policy sits within a legal framework and often gains political interest; therefore, adherence to a robust process is paramount when considering IPFRs. Each IPFR is considered on its own merits and in accordance with the arrangements set out in the policy. Panel members will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment, based on the evidence available, and whether the cost of the treatment is in balance with the expected clinical benefits.

Asesiad / Assessment

Aneurin Bevan University Health Board continues to be the Health Board with the highest number of IPFR requests for medicines. The Joint Commissioning Committee (JCC), formerly know as the Welsh Health Specialised Services Committee (WHSSC) receives the highest number of non-medicines IPFRs, however this number is made up of a high percentage of requests for PET scans that fall outside of the current commissioning policy criteria.

The Health Board consistently adheres to the policy criteria, as noted by the All-Wales IPFR Quality Assurance Committee, and is therefore seen an exemplar for the way in which our IPFR panel conduct its business, and for the way in which the IPFR policy is implemented.

Decision Making Process

IPFR requests are submitted by the patient's clinician. Generally, this is the patients secondary care consultant, however requests are also received from GP's and other health professionals.

Each request will contain the patient's current clinical status, along with their clinical history and details of the treatment required. In the application, the clinician must explain why the patient is likely to gain a significantly clinical benefit from a treatment when compared to other patients with the same/similar conditions, and why the value for money for the treatment is likely to be reasonable. The panel in reaching its decision will consider: -

- Evidence base – the purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective. This will include any guidelines from the National Institute for Health and Care Excellence (NICE), Health Technology Wales (HTW), One Wales Medicines Advisory Group (OWMAG), clinical journal publications etc.
- Cost effectiveness - this includes the likely overall costs to the NHS compared with the next best alternative treatment that is routinely funded, any potential offset costs, and any quality-adjusted life year (QUALY) data provided that is relevant to the case.
- Ethical considerations – there is always an ethical challenge of meeting the needs of individuals within the resources available and to ensure justice in

the allocation of those resources. Decisions must be based on the evidence both about the effectiveness of those interventions and their cost to ensure they are fair and not arbitrary.

Approvals provided by the IPFR panel are usually time limited. This ensures the efficacy of a treatment is demonstrated before a longer-term financial commitment is made. In the case of requests for a medicine, the panel will usually approve a treatment for the minimum timeframe in which the patient is expected to receive a response, usually 3-6 months. A clinical report outlining the patient's response to treatment is required before further funding is provided. In the case of non-medicines, approval of funding is in place for a period of 12 months. If the treatment is not received within this timeframe, re-authorisation is required with confirmation that the clinical status of the patient has not changed.

All-Wales Oversight

The IPFR process links in with a number of all-Wales processes thus helping to identify any cohorts or trends in new treatments, whilst monitoring consistency in approach to quality assurance. The processes in place are as follows: -

All-Wales IPFR Database

Each IPFR received is recorded on a central All-Wales database hosted by the All-Wales Therapeutics and Toxicology Centre (AWTTC). The database is regularly monitored and any cohorts (usually 3 or more requests for the same treatment, for the same indication) identified will trigger a review by the One Wales Medicines Advisory Group for requests for medicines, or Health Technology Wales for non-medicine requests. Data collected is also used to populate the IPFR annual report.

The Health Board also receives input from our local Quality Assurance Pharmacy Team. Evidence summaries are produced to support requests for medicines. These summaries are uploaded to the evidence library on the All-Wales IPFR database.

Quality Assurance Group

The IPFR Quality Assurance Group was established to monitor and support IPFR panels to ensure quality in decision-making and consistency across Wales. The group meet on a quarterly basis to review a randomly selected IPFR request from each IPFR panel across Wales. The quality assurance group consider each case for compliance against the IPFR policy criteria, ensuring that there is completeness of the application, timeliness for consideration, and efficiency in communication with the requesting clinician and patient. The group report to the Deputy Chief Medical Officer for Wales highlighting any concerns through the existing quality and clinical governance processes.

Aneurin Bevan consistently achieves high rates of concordance with the IPFR policy and the IPFR panel recently received extremely positive feedback following a panel observation by a member of the quality assurance group.

Annual IPFR Workshop

Each year an IPFR workshop is held. The workshop is usually well attended by individuals across Wales who are either directly involved in the IPFR process or are clinicians and/or other health professionals who may have either submitted an IPFR or want to learn more about the process.

The workshop is a full day event, with the morning focusing on key topics such as 'value for money' and the afternoon comprising of 'mock' IPFR panels. The mock

panels are made up of attendees who are given sample cases to discuss. This encouraged the sharing of experiences across health boards and discussion about the different factors that IPFR panels need to consider when making their decisions. This exercise develops good practice and helps ensure consistency in decision-making across all the IPFR panels in Wales.

IPFR Annual report

Each year an annual report is compiled to report the data available for IPFR requests across Wales. The report also seeks to highlight the work being done at a national level and within individual IPFR panels in relation to guidance for clinicians completing forms, promoting the collection of outcome data, internal audits, and training for new members.

One Wales Medicines Process

The One Wales Medicines process enables one decision for all of NHS Wales about access to a medicine that is not routinely available for a group of patients (a patient 'cohort') who have an unmet clinical need. This includes medicines that are used 'off-label' and also licensed medicines, where it is a chance to collect more data before health technology assessment.

Analysis of IPFR submission data from Health Boards across Wales has been used to inform part of the work programme of the One Wales Medicines Assessment Group (OWMAG). The OWMAG considers the evidence on the effectiveness of the medicine and makes a recommendation on the use of the medicine in NHS Wales.

Ongoing monitoring of the IPFR data has shown that soon after publication of a positive OWMAG decision, applications are no longer submitted for these indications. This positively demonstrates that the process effectively reduces the burden on IPFR panels and encourages equity of access to these medicines across Wales.

In 2022-23 eight medicines/medicine combinations were assessed through the One Wales process, all were supported for use and are now routinely available for patients in Wales.

Health Technology Wales (HTW)

Similar to that for OWMAG, IPFR submissions also inform part of the work programme for HTW. Their role is to assess non-medicine health and social care technologies, and issue independent authoritative guidance based on the best available evidence and expertise. Their work informs commissioning by NHS Wales and supports evidence-informed decision for both technology investments and disinvestments. In addition, they will produce rapid evidence-based appraisals for IPFR panels on request.

Interventions Not Normally Undertaken (INNU)

The NHS has historically identified marginally effective and ineffective interventions (tests, procedures, and medicines) that are deemed to have no or limited clinical value. These are routinely considered to be a low priority and should not normally be undertaken by Health Boards. This is because: -

- There is insufficient evidence of clinical/and or cost effectiveness; and/or
- The intervention is considered to be of a relatively low priority for NHS resources.

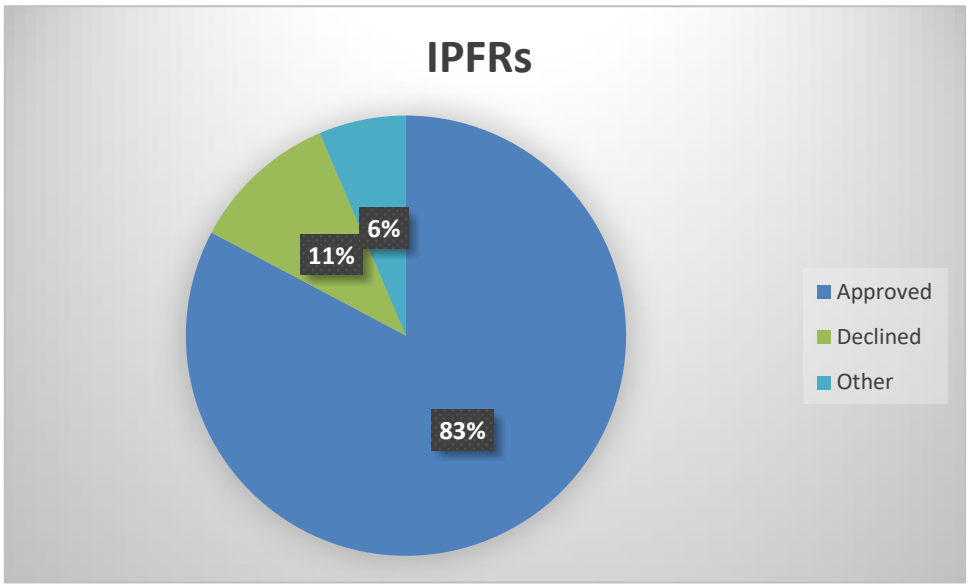
Each Health Board across Wales currently have their own INNU policy detailing a number of interventions that should not be undertaken unless they meet strict criteria for use. Should an intervention not list any criteria for use, or should a patient not meet the eligibility criteria, an exemption can be requested where it can be demonstrated that the intervention is likely to provide particular clinical benefit to the individual and provide value for money.

It has been recognised that inconsistencies exist, in part, due to locally held INNU policies. Whilst health boards have tried to work collaboratively, efforts have been supported with the development of an all- Wales approach to INNUs. This work is currently ongoing and will remain aligned to the IPFR process.

IPFR DATA

The number of new IPFR application received for the financial year 2023/24 was 203, an increase on the 148 received in 2022/23, which are now back in line with pre-COVID levels. This figure is reflective of the position across Wales which saw an increase for both medicine and non-medicine request by 5% and 6% respectively.

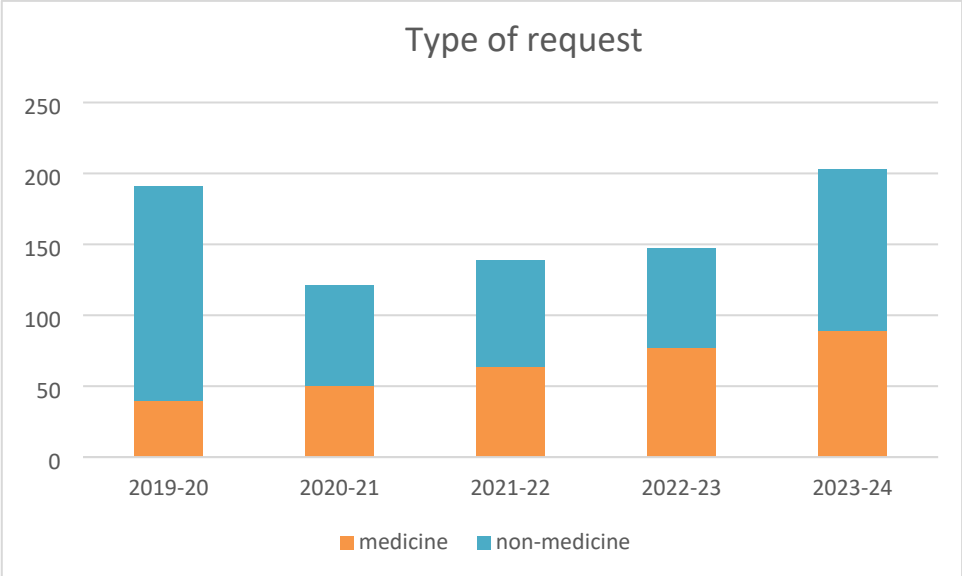
The percentage of applications approved and declined for the financial year 2023/24 can be found in the table below. Those marked as other would include cases deferred, waiting further information, or were later withdrawn due to a possible change in the patients' clinical circumstances.



In addition to new applications, additional requests for continued funding were also received following a patient's positive response to the initial treatment approval.

The number of IPFRs approved across Wales increased from previous years. Data collected by the All-Wales Therapeutics and Toxicology Centre for the IPFR annual report outlines that 79% of all IPFRs were approved in 2022–2023. The approval rate for medicine IPFRs increased from 80% in 2021–2022 to 85% in 2022-2023. A similar approval rate for non-medicines was seen over the last two years, with 73% approved in 2022-2023 compared with 70% approved in 2021–2022. The data for the 2023/24 report is currently being collated.

The number of applications received by Aneurin Bevan University Health Board since 2019 are as follows.



The data has been broken down into the number of medicine and non-medicine requests received. Non-medicine requests include interventions such as surgical procedures, specialist assessments and therapies.

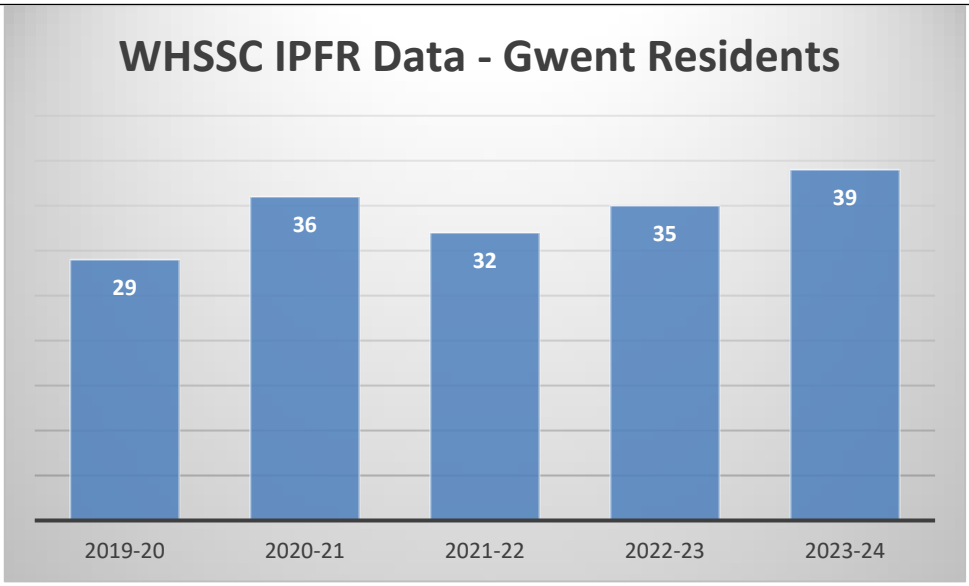
The decrease in non-medicine applications for 2020-22 is linked to the COVID-19 pandemic and reflects the move from routine hospital work to emergency care. The number of 'off label' medicines requests increased, with the aim of patients avoiding hospital attendance for routine drug administration, especially for immunosuppressed patients.

IPFR's for the use of a medicine would happen for three main reasons:

- Advice in relation to a licensed indication for that medicine is not available from the All-Wales Medicines Strategy Group (AWMSG) or the National Institute for Health and Care Excellence (NICE).
- AWMSG or NICE has given advice and has not recommended the medicine or is unable to recommend it.
- The medicine is being used 'off-label', that is: used outside the terms of the medicine's marketing authorisation (product licence).

The largest number of medicine requests relate to haematology and oncology conditions, followed by neurology and rheumatology.

In addition, the Welsh Health Specialised Services Committee (WHSSC), now known as the Joint Commissioning Committee (JCC), also consider IPFR requests for Gwent residents. The number of requests for 2019-24 are detailed in the table below.



These requests were for treatments that fell within WHSSC's commissioning remit, and would include requests for interventions such IVF, plastic surgery, paediatric treatment, and requests for PET scans for patients who did not fulfil the policy criteria.

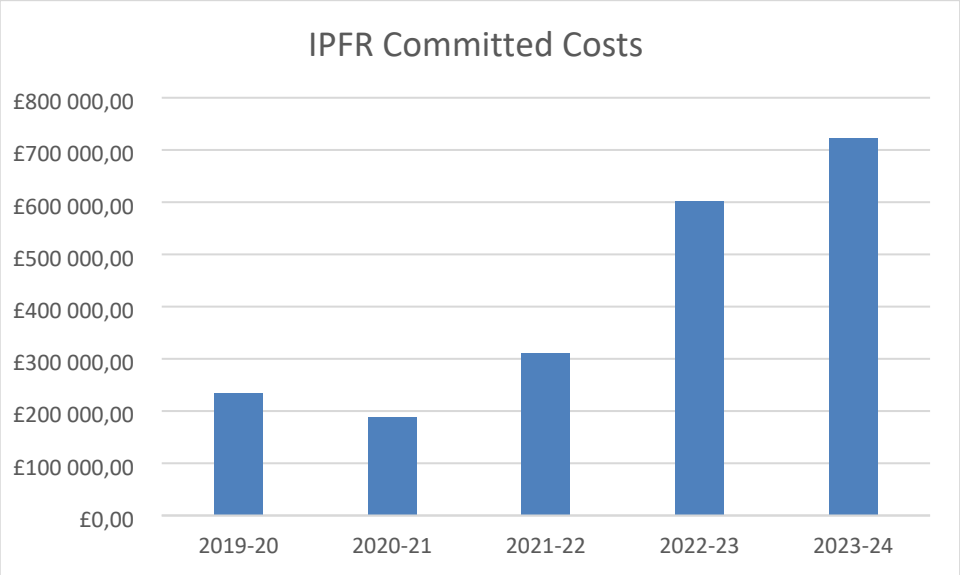
Finance

It has long been recognised by those involved in the IPFR process, including members of the finance team, of the unpredictable nature of IPFR.

It is not only difficult to predict the volume of IPFR's we will receive each year, but we can't foresee how patients will respond to treatments which are approved, nor for how long. We also can't predict when a patient is likely to receive a treatment.

For most medicine requests we would expect the patient to commence treatment within a few days/weeks of approval, however for non-medicine requests most patients will be added to a waiting list which could result in the treatment being approved in one financial year, but not received until the next.

The IPFR budget currently stands at £839,332. Current commitments against this budget for the period 2023/24 are £723,024.38, however due to the unpredictable nature of IPFR, this figure is likely to alter subject to a patient's response to treatment and/or any additional costs which may be received following approval of treatment in Trusts in NHS England.



The significant increase in cost from 2021-22 to 2022-23 relates to patients who received approval for high cost medication in addition to the changing picture following the COVID 19 pandemic.

Applications are considered, and decisions are made based on the evidence provided to conclude whether a patient is likely to gain significant clinical benefit from the intervention requested. As part of the decision-making process, the panel will exercise its broad discretion to decide whether the value for money of an intervention for a particular patient is likely to be reasonable.

Any decision resulting in a financial cost in excess of the panels authorisation limit will be reported to the Executive Medical Director and Chief Executive officer for authorisation.

Judicial Review

Following a Judicial Review of an IPFR decision made by the Welsh Health Specialised Services Committee (WHSSC) in December 2021, the Judge found that the WHSSC IPFR Panel had not acted legally. In this respect, the Judge deemed that the correct comparator group had not been used, the documentation of the decision was inadequate, and the relevant guidance had not been interpreted properly.

In response to the comments raised, WHSSC implemented a number of changes including, an increased number of panel meetings from monthly to every two weeks, a review of the WHSSC IPFR panel terms of reference to help quoracy of meetings and to ensure robustness and appropriate governance support and strengthened documentation, economic evaluation, and use of references.

As part of the response to the Judicial Review, Welsh Government instructed WHSSC to undertake a de minimis review of the IPFR policy. This has been done in collaboration with the IPFR Quality Assurance Group and the IPFR Policy Implementation Group, alongside the health board panels. With legal support, the changes to the policy have strengthened the wording around the approach to decision-making by the IPFR panels and the process for documentation and

included an update to the complaints process. The updated all-Wales IPFR policy is due to be implemented imminently.
Argymhelliad / Recommendation
The Board is asked to note the contents of this report as assurance that the Health Board is managing the operation of the IPFR in line with the Welsh IPFR Policy and Processes

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):	3. Effective Care 4. Dignified Care Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	N/A
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs 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

Agenda Item

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Communications and Engagement Annual Report 2023/24**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Karen Newman, Assistant Director of Communications and Engagement

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide assurance to the Board on the Health Board's Communications and Engagement activities during 2023/24.

Cefndir / Background

The report highlights the Health Board's Communications and Engagement activities over the past 12 months and details initiatives and campaigns that have been delivered to enhance both internal and external communications and engagement. The requirement to adapt and change the way we communicate and engage with our staff and the public has become more obvious over the last 12 months as we tested how staff and the public want to receive and share information. The Health Board has also developed an approach to storytelling that ensures our content is authentic, captures lived experience and is inspiring to others.

The past year has also seen a focus on staff communication and engagement and the approval of the Communications and Engagement Strategy in September 2023. It has also been a very challenging time with a number of very difficult reactive issues that threatened to damage the reputation of the Health Board, including periods of industrial action, medical and technological incidents, outbreaks and negative patient experiences. The Communications and

Engagement team has used its experience and skills to manage these issues and the proactive work to highlight the amazing work of our staff and services has helped to counteract negativity, raise staff morale and protect the reputation of the Health Board during very difficult times for the NHS across Wales and the UK.

Assessment

The Annual Report for 2023/24 describes the Communications and Engagement activity over the past 12 months and the work that has been done to support the Health Board to meet its aims and objectives. During the year the Health Board launched its new Communications and Engagement Strategy to ensure the Health Board continues to reach key audiences across Gwent, future proof our communications and innovate our approaches. All communication and engagement activity is planned around a number of key priority areas including the Health Board IMTP, Six Goals for Urgent and Emergency Care and a number of national policies which can be found in our Communications and Engagement Strategy. The aim set out in the Communications and Engagement Strategy is to deliver a 'best in class' communications and engagement approach to support staff, patients and the public and the report sets out how progress is being made against this aim.

Over the 12 months, the Health Board further developed its staff communications and engagement, with an ambitious Staff Communications Plan guiding the work to strengthen engagement with staff across the Health Board. The 'One AB' brand was launched for this important work, developing engaging content on the AB Pulse Intranet site, and introduced a programme of Executive Team drop-in sessions with staff. The introduction of the online 'Catch up with Nicola' sessions for all staff, where staff have the opportunity to engage with the CEO and ask questions have also proved to be very popular.

There has also been a continuation of refining and expanding the Health Board's social media presence, with a particular focus on growing the Health Boards visibility and engagement on the increasingly popular TikTok platform, with the aim of engaging with a younger audience. Over the last 12 months social media engagement has significantly exceeded expectations with:

- Post reach of 20million+
- 3 million+ minutes of Health Board videos viewed
- 1.2million+ reactions
- 30,000 inbox messages received from the public and responded to
- 3,383 posts published on the Health Boards social media platforms.

The team have dealt with a significant number of reactive queries from the public and media, whilst also producing a variety of proactive content for our audiences in Gwent to demonstrate the positive work our staff are doing to address the priorities set out in our IMTP, Clinical Futures programme, Six Goals for Urgent and Emergency Care, Building a Fairer Gwent and other important programmes.

We continued to focus on helping the public to access our services appropriately and the launch of the Gwent Health Guide this year has provided a bespoke tool to help them navigate our model of healthcare in Gwent. Social Media comments and questions have provided an opportunity to gather the views of our patients and communities, enabling us to feed back to service leads and managers and the

intelligence gathered from our engagement sessions directly informing our communications and services.

The Communications approach has helped to relieve service pressures through public messaging - particularly on how to access local NHS services appropriately. Despite all the pressures in 2023/24, many positive sentiments towards staff have been seen and shared internally to help raise morale. A number of successful events, awards ceremonies, and ministerial and media visits have also been a key component of the Communications and Engagement work programme

The Health Board has continued with its ambitious engagement programme over the last 12 months and has visited over 175 venues across Gwent, engaging directly with our communities and with partner organisations. A new initiative for 2023/24 was to engage with employers in order to reach working people who otherwise would not have the opportunity to engage with the Health Board. Starting in Newport on a trial basis, we have visited Eastman Chemical Company, the Celtic Manor Resort, Wales and West Utilities, Hasbro, Newport City Council, Office for National Statistics and Asda Duffryn to speak with staff members about Health Board Services. This initiative has proved successful and will continue throughout 24/25.

The work over the past year has set a foundation for the further development of the Health Board's powerful, engaging, and innovative Communications and Engagement approach.

Argymhelliad / Recommendation

The Board is asked to note the progress with the Communications and Engagement agenda over the past 12 months and to consider the future priorities set out at the end of the report.

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):	Not Applicable Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. All
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	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:	IMTP – Integrated Medium Term Plan NCN – Neighbourhood Care Network
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Every picture has a story to tell, and we are here to tell it

Communications and Engagement

Annual Report 2023/24

Foreword

I am proud to present this 2023/24 Annual Report, which showcases the incredible work of the Health Board's Communications and Engagement Team throughout a very challenging past 12 months for the Health Board. Building on lessons learned from previous years and taking into account analytics, we have continued to develop and progress our practices to offer first class communications and engagement to our staff and the public.

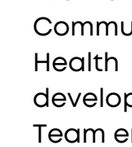
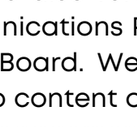
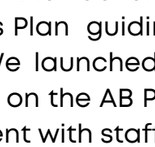
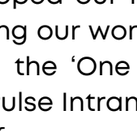
Our public communications and engagement activities enable us to effectively inform and listen to patients, people and communities across Gwent. The Health Board's Communications and Engagement Team has used its experience and skills to manage difficult issues and the proactive work we have done to highlight the amazing work of our staff and services has helped to counteract negativity, raise staff morale and protect the reputation of the Health Board during very difficult times for the NHS across Wales and the UK.

We have also further developed our internal communications, with an ambitious Staff Communications Plan guiding our work to strengthen engagement with staff across the Health Board. We launched the 'One AB' brand for this important work, continued to develop content on the AB Pulse Intranet site, and introduced a programme of Executive Team engagement with staff.

The team has also continued to refine and expand our social media presence to ensure we keep up with technological advancements and meet the demands of our communities, exemplified by our focus on developing the increasingly popular TikTok platform to reach younger audiences. We have dealt with a large amount of reactive queries from the public and media, whilst also producing a variety of proactive content for our audiences in Gwent to demonstrate the positive work our staff are doing to address the priorities set out in our IMTP, Clinical Futures programme, Six Goals for Urgent and Emergency Care, Building a Fairer Gwent and other important programmes. We continued to focus on helping the public to access our services appropriately and the launch of the Gwent Health Guide this year has provided a bespoke tool to help them navigate our model of healthcare in Gwent. Community Engagement and Social Media comments and questions have provided an opportunity to gather the views of our patients and communities, enabling us to feed back to service leads and managers.

I am immensely proud of all we have achieved and the challenges we have overcome over the past year. I would also like to thank the Executive Team and Board for their continued support and encouragement.

Nicola Prygodzicz
Chief Executive

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

Driving change through priority

This year the Health Board launched its new Communications and Engagement Strategy to ensure we continue to reach and interact with our patients and communities across Gwent, future proof our communications, and innovate our approaches.

All of our communication and engagement activity is planned around a number of key priority areas, including the Health Board's IMTP, Six Goals for Urgent and Emergency Care programme, and a number of national policies outlined in our Communications and Engagement Strategy.

A summary of our Year in Numbers

1.Social Media

153K+ Social Media Followers

- 110,000 +
- 27,000+
- 13,000+
- 1800+
- 1400+

Our Engagements in a nutshell

- Post reach 20 million +
- Minutes of video viewed 3 Million+
- Reactions 1.2 million +
- Link clicks 40,000
- Inbox messages 30,000+
- Posts published 3,383

BREAKING NEWS

2.Press & Media

Press Enquiries Received **397**

Proactive Press Releases Sent **42**

3.Internal Communications

- All Staff Bulletins 100+
- Ask the CEO Questions 340+

4.Community Engagement

- Conversations 3000+
- Venues Visited 175+
- Stakeholder Emails 190+
- WhatsApp Messages 115+

5.Website

- Total Views 1.2 Million +
- Unique Visitors 399,000+

Popular Web Pages

- Grange Hospital 44K Views
- Vaccinations 25K Views
- Sexual Health 24K Views

Our Internal Communications

Keeping our staff informed and engaged...

1.From AB Pulse to One AB

During the past year, the Health Board has developed and launched an internal communications brand that aims to bring staff together and helps them to feel informed and engaged with the organisation. They key objectives of the 'One AB' brand are based on the *Staff Communications and Engagement Plan,* which is centred around improving on existing channels and the quality of communications that reach staff, as well as providing better access to these, such as making SharePoint available on personal phones and devices. It also explores staff being a more integral part of the conversation to share stories, ideas, and help us recognise positive achievements and raise awareness of teams across all departments.

2.Executive Drop-in Sessions

Between January and April 2024, there have been 19 Exec Team Drop-ins across 12 Health Board sites. The Communications & Engagement team play an active role in advertising and offering on-the-day support for these sessions.

Each session is typically attended by between 2 and 8 staff, and most staff are made aware of the drop-ins via AB Pulse, email, word of mouth, or posters. Along with providing a tremendous opportunity for Executive staff to be visible and available to all staff, it also provides a transparent two-way communication process for staff to easily highlight any issues.

The majority of reasons behind staff wanting to speak to the Executive team are related to areas of concern. However, most feedback received from staff on the process itself has been positive and supportive. As one staff member said recently after speaking to an Executive: "I feel like a load has been lifted from my shoulders." Sessions at Mamhilad and Llanarth House have been added to the ongoing schedule.

3.One AB Champions

To support our staff communications and engagement, One AB champions have been recruited across the Health Board, with the main purpose of helping to achieve the above goals whilst also providing valuable communications experience and guidance to champions that seek this pathway in their development. Champions become part of an online informal group, receive bitesize / key updates, and future training to help support their involvement and personal development.

4.Future Developments

Other avenues are also being explored for further growth over the next period, such as Digital / Communications clinics, which staff could use to get more connected to communications channels such as SharePoint and Outlook with assistance. A closed staff-only Facebook group has been set up as a pilot involving One AB Champions, with a view to a wider role out in the future.

Having recently introduced a new way of working within the Communications & Engagement team, where each site has a designated Communications representative, this goes hand-in-hand with the new One AB brand and its approach. This new initiative will offer an opportunity for more connection to the grassroots of staff areas, and getting to know staff is key to truly representing, celebrating and communicating with our staff going forward.

5.Chief Executive's online catch-up...

As part of the One AB brand, the Chief Executive has been hosting a bi-monthly 'Catch-up with Nicola', which features as an all-staff briefing that gives ABUHB staff a chance to learn about important things that are going on, give their views, and ask questions. There have been 3 meetings throughout this period, with a positive turnout of typically 100+ staff per session. Each session is informal, provides a detailed update of particular important areas at that time, and allows any staff member to ask Nicola a question to be answered.

6.Ask the CEO

Over the past year, this Intranet staff forum feature generated **346** questions from staff members across the Health Board.

The **Top 3 themes** of the queries were:

1. **Parking** – particular issues include difficulties in parking across sites (especially GUH and RGH), concerns in relation to inconsiderate parking, staff parking inappropriately in disabled bays, and EV charging bays.
2. **Staff restaurants** – highlighted issues include pricing, the variety and quality of food, and the use of non-recyclable containers.
3. **Smoking** – many concerns were raised in relation to staff and visitors smoking on hospital grounds.

7.All-staff emails & the AB Pulse News Round-Up...

Over the year, we sent 101 email bulletins to every member of staff in the Health Board.

Every Friday, the ***AB Pulse News Round-up*** is sent to all staff via email to highlight these key stories. Feedback for the weekly bulletins has been very favourable, with staff telling us they look out for them and find them useful - particularly when they don't have time to check the news articles on AB Pulse each day.

OUR PLATFORMS

Across the Press

This year remained an incredibly busy time for press and media activity, with themes of press enquiries involving a broad range of topics; from ED waits, flow issues and ambulance handover times; to vaccinations, waiting lists, and GP Practice closures. This year was arguably the most challenging yet, due to the vast majority of the press enquiries received focusing on negative elements of the Health Board's services and actions. Through media monitoring, we are able to learn valuable lessons about how the public perceive the organisation and its services.

Press Enquiries Received

397

In the Headlines

The Health Board featured heavily in a wide range of local, national and international media outlets this year due to some high-profile events which made news-worthy stories. Our relationship with local and national media outlets continued to strengthen as we distributed proactive news stories in an effort to inform and educate our population.

We did this by sharing essential health and service messages via the media, including asking relatives to help loved ones leave hospital; promoting public engagements; and warning of busy periods during the junior doctor strikes.

Stories also included praise from previous patients and their families, or those raising awareness of the signs of illnesses and conditions, as well as releases celebrating staff achievements, and new services and initiatives.

Yahoo News UK

Health board could save thousands of pounds by giving patients paracetamol tablets

CHANGES to the way one Gwent hospital administers paracetamol could save £13,000 and nearly half a tonne of plastic waste each year.

South Wales Argus

Ysbyty Ystrad Fawr breast care unit welcomes first patients

The Breast Care Unit at Ysbyty Ystrad Fawr serves to collate expertise from across the health board area and provide a more "effective"...

South Wales Argus

Grateful Newport teen thanks NHS staff that saved her life

A 17-year-old from Newport has expressed gratitude to NHS health care staff who saved her life, after being diagnosed with a rare form of...

42 **Proactive Press Releases Sent**

Cwmbran Life

The 1am to 7am overnight minor injuries unit at Nevil Hall Hospital recommended for closure - Cwmbranlife

HEALTH chiefs are being recommended to approve the overnight closure of a hospital's minor injuries unit when they meet this week.

Our Website

Throughout the year, we have seen a large amount of traffic through the website, which the team have worked hard to update based on demand of information. As we move into the next year, we will be looking to improve the navigation of the Health Board website.

398,000+ Total Visitors

1.2M+ Views

Popular Pages

- Grange University Hospital — **44K Views**
- Vaccinations — **25K Views**
- Sexual Health — **24K Views**
- Royal Gwent Hospital — **23K Views**

About our page visitors

Devices used:

- Mobile - 66%
- Desktop - 30.9%
- Tablet - 3.1%

Browser:

- Safari - 162k
- Chrome - 131k
- Edge - 60k

Geography of visitors:

- Newport - 38k
- Cardiff - 32k
- Cwmbran - 19k
- Pontypool - 9k
- Caerphilly - 8k
- Abergavenny - 7k
- Merthyr - 6k
- Abergavenny - 5k

Languages of visitors:

- English- 394,965
- Welsh - 524
- Polish - 500
- Chinese - 356
- Spanish - 253
- German - 176
- French - 174
- Russian - 170
- Italian - 165

OUR PLATFORMS

Across Our Social Media

Through social media, the Health Board has a chance to connect with and involve hundreds of thousands of individuals daily. This past year has been exceptionally successful and active for social media in the Health Board. We began the year by reviewing all of our Social Media channels and planning the way in which each were to develop through the year.

Our goal was to elevate our social media presence and expand our audience – and the work has paid off! With more than 150k followers on our four main channels and a reach of 20 million throughout the year, our key messages have resonated widely.

TikTok LIVE

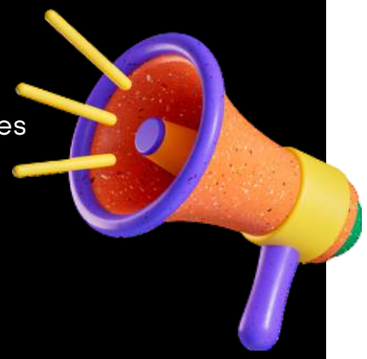
Over the past year, we have continued to make the development of our TikTok channel a key priority of our day-to-day social media agenda. In line with key Health Board objectives, our key objectives for TikTok are to engage with younger audiences about health and empower younger communities to live well through self-care and healthy living. In addition to this, we see our channel inspiring young people to a future role in health.

In the past year, we have grown our following to over 1.8k - with our top performing post reaching over 342k views - and we have engaged with our growing community by listening to their questions and feedback, and providing them with the content they want.

What our communities had to say on Social Media

With a combined total of over 30k messages and comments, our social media team had a busy year responding. Key topics of conversation from our followers included:

- Positive feedback to our patient stories
- Positive feedback for Staff
- Primary Care waiting times and access to appointments
- Outpatient appointment queries and missed calls from the Booking Team
- NHS Wales App / My Health Online closure
- Booking Centre text messages - are they a scam?
- Concerns about waiting times in ED and or ambulances
- Concerns about waits for operations



Our Top 3 Posts

Engagements: **19,230**
Reactions: **1,394**

This was a post announcing the opening of our brand-new, purpose-built Endoscopy Unit at the Royal Gwent Hospital.

Engagements: **17,755**
Reactions: **522**

A post celebrating Mother's Day with a series of photos and stories from those who became Mothers on Mother's Day at The Grange University Hospital.

Engagements: **16,401**
Reactions: **1,477**

This post celebrated our Cancer Clinical Nurse Specialists who support people through their diagnosis and treatment of cancer.

153K+ Social Media Followers

- 110,000 +
- 27,000+
- 13,000+
- 1800+
- 1400+

Our Engagements in a nutshell

- **Post reach 20 million +**
- **Minutes of video viewed 3 Million+**
- **Reactions 1.2 million +**
- **Link clicks 40,000**
- **Inbox messages 30,000+**
- **Posts published 3,383**

Our Communication Campaigns

Introducing the Gwent Health Guide

To further improve knowledge of local urgent care services in the area, the Health Board developed and launched the Gwent Health Guide – a free web tool to help patients choose the right urgent care service for them, first time.

To establish this new tool, the Health Board's NCN team, working with Primary Care professional collaborative leads, distributed a survey to Care Navigators in the area to find out which services they were navigating to most frequently and from where they were retrieving the information to do this. The insight gained from the survey results informed the content of the Gwent Health Guide. All content on the guide was then reviewed and approved by the clinical leads for all relevant services.

Launched in December 2023, promotional material for the Gwent Health Guide was then distributed to all areas of Primary Care in Gwent, as well as hospital sites, local businesses, and public areas.

Celebrating #NHS75

In 2023, we celebrated 75 amazing years of our NHS! To mark the occasion, we highlighted a number of long-standing services and staff across Gwent.

On the day, we travelled to all of our hospitals to cover the festivities happening across the different areas of Gwent. From tea parties, fancy dress, games, face paints, choirs, themed afternoons, singers - and even a baby born on the birthday of the NHS - we saw it all!

ITV News joined us at The Grange University Hospital to cover the action, where they interviewed 103 year old Owen Filer, who visited the GUH site each week when it was being built. He is a huge supporter of the NHS and is also very proud of his granddaughter, Sarah, who works at the hospital.

Primary care services were celebrated through a series of videos filmed at long-standing local primary care providers. These included two pharmacies, a GP Practice, and a local optician's, all of which have been serving their communities for over a Century.

"It doesn't matter what role you're in, any NHS job is really special and is something to be proud of."

Dyfodol Clinigol Clinical Futures

1.Endoscopy Unit Opens at RGH

"We're so proud to be able to offer our patients the service they deserve."- Endoscopy Team

The opening of the Endoscopy Suite at the Royal Gwent Hospital in November 2023 was another key milestone in the Clinical Futures strategy, with the reconfiguration of services across our hospitals offering a new, larger space for Endoscopy in the former maternity birthing unit. Now in a purpose-built facility and having doubled their patient capacity, the Endoscopy team were delighted to be in their new home.

2. Breast Care Unit Opens at YYF

Opening the brand new Breast Care Unit at Ysbyty Ystrad Fawr in February 2024 was a significant highlight for the Health Board, and provided an opportunity to showcase the hard work, dedication and thought that went into the design. This good news story was received positively by patients, staff, stakeholders, public and local media.

3. Construction Begins on Satellite Radiotherapy Unit, NHH

Construction of the Satellite Radiotherapy Unit at Nevill Hall Hospital began this year, with the build now well underway and very much visible at the Nevill Hall site. This progress has also offered good news opportunities for the Health Board and for Velindre NHS Trust.

Our Communication Campaigns

Primary Care Communications

Throughout the year, the Health Board has continued efforts to enhance awareness and understanding of our Primary Care services across Gwent. This included spotlighting the Neighbourhood Care Network Development Programme and launching campaigns centred around Primary Care initiatives.

The Neighbourhood Care Network (NCN) Development Programme

This year saw a notable acceleration of the Neighbourhood Care Network (NCN) Development Programme, leading to considerable communications and engagement efforts. Our work has helped services amid pressures, aimed to increase low staff morale, and enhanced care navigation by promoting a "right place, first time" approach.

The NCN Intranet site serves as a portal for sharing local initiatives and NCN resources.

The site has gained momentum. In the last 90 days (up to 31/03/24), the site received 7,506 visits. NCN news is also shared via a monthly Pulse newsletter, distributed across Primary Care and NCN/locality teams, as well as through a quarterly PDF newsletter disseminated to the Health Board's 2,000-strong stakeholder list.

Our New Community Sites

1.The Bevan Health & Wellbeing Centre

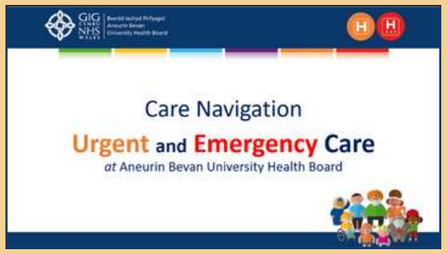
The Bevan Health & Wellbeing Centre in Tredegar opened its doors to patients in January 2024.
The Communications and Engagement team provided support to ensure the local community and patients were aware of developments and which services are available at the new centre.

2.19 Hills Health & Wellbeing Centre

The Health & Wellbeing Centre being built in Ringland has been named as '19 Hills' to reflect the biodiversity and ecology of the local area.
The Communications and Engagement Team has been engaging with all stakeholders and working with Newport City Homes to ensure the local community feel part of the project.

Key Highlights

Pharmacy Services Videos



Care Navigation

HealthPathways Project (sharepoint.com)

Recruitment Pilot (sharepoint.com)

ABUHB GP Screen Presentation

1.New Videos to Promote Pharmacy Services

News videos have been produced to increase awareness of the Contraceptive Service and Sore Throat Test and Treat Service in community pharmacies. The videos were posted on the Health Board website and promoted through our communications channels.

2.Care Navigation guide for staff

A new guide was created for Care Navigators to help when signposting to urgent and emergency care at Aneurin Bevan University Health Board.

This has helped staff to understand our unique model of healthcare in Gwent so they can better direct patients and communities.

3.HealthPathways Programme

The communication of the Health Pathways programme has been vital to ensure that our GPs and other healthcare professionals engage with the programme.

A promotional video was created to help communicate the purpose of HealthPathways and its benefits

4.Recruitment Campaign Pilot

A pilot recruitment campaign was launched in Monmouthshire. Its goal: enhance recruitment in primary care and community services and raise the Health Board's employer profile.

Working closely with NCN Leads and healthcare professionals across Monmouthshire, gaps in service were identified, and a recruitment campaign produced.

Following evaluation of the pilot project, the campaign will now be rolled out Health Board wide.

5.NEW ABUHB Screen Presentation

A presentation containing health messages, campaigns and service information has been created for use on public facing screens.
The presentation has been sent to all GP Practices across the Health Board area.

Our Communication Campaigns

Public Health Communications

Helping Gwent Live Well

LEARN MORE

As part of the priority of supporting the public to easily access information to support their physical and mental wellbeing, we developed the new 'Live Well' Hub, containing a number of key topics to empower and support our communities to live well.

These include:

- Eating Well
- Moving More
- Cost of Living
- Mental Health and Wellbeing
- Stopping Smoking
- Immunisations
- In your local area

The information has been developed in collaboration with a number of divisions, including Public Health and Family & Therapies. To springboard the launch of this page, we developed the '*Let's Feel Good For Life, not just for January*' campaign. This was in partnership with Dietetics and was a miniseries that focused on building healthy habits; setting goals; what to do when you hit bumps in the road; and how to get support from those around you. The miniseries was accompanied by a downloadable guide, meal planners and recipe cards developed to support those on a budget.

Health Protection

This year was the toughest year in vaccination uptake for both public and staff. The Communications & Engagement team coordinated the Health Board's Winter vaccination communications, ensuring alignment of messaging and maximising of campaigns across Gwent using partners.

We also took a direct marketing approach and utilised SMS messaging in certain campaigns, enabling us to put information into the hands of our communities. We worked hard to promote vaccine uptake using human stories from across Gwent with both video content and written quotes about why people get their vaccine.

We worked with Welsh Government and the BBC to use a Health Board trusted voice to talk about the importance of vaccine uptake. Dr Ami Jones very kindly supported this work by delivering a very sobering message of what Winter could look like if vaccine uptake remained low.

Helping Fans Get Fit..

Working with the EFT Trust and Dragons RFC, we developed a number of case study videos to promote the free 12 week Fit Fans programme in Gwent. Utilising a number of current and former participants in the programme, we were able to capture the benefits and successes gained by the programme. The campaign video saw 1,248 link clicks through to the website for sign up information.

Our future, our voice: babies, children and young people of Gwent

*WARNING: Contains dangerous animals

This year's Director of Public Health Report aimed to amplify the voices of babies, children and young people. Having done away with the traditional formalities of a Director of Public Health Report, this report was written with babies, children and young people at the heart of everything to help us to understand the legacy the pandemic has left and the impact on our children, along with what health means to them. As part of the research process, we hosted interactive engagement sessions at a number of local schools to listen to children and young people. Then, through words, art and expression, they shared their lived experiences with us, which formed the beating heart of this report.

There are a number of key areas within the report:

- A Glimpse into Gwent Child Health & Wellbeing
- Covid-19 through children & young people's eyes
- Pandemic Park: Covid-19 Zoo Safari
- How can we get it right for our babies, children and young people? - An email from our children

LEARN MORE

The report was launched to over 2000 stakeholders, as well as across social media channels. The feedback has been highly positive from both partners as well as parents across Gwent, who were able to get a glimpse into how their children felt through a very unknown time.

Our Community Engagement

With over 600,000 residents living across the Aneurin Bevan University Health Board area, we know we cannot engage with them alone. Together with our partners, we can achieve so much more.

Partnership Working

Engaging with young people and their families is a key priority for us. Throughout the year, the Health Board attended **Coleg Gwent** Health & Wellbeing Fairs, Freshers Fayres and Learner Services sessions across all campuses to share information and speak to young people and college staff about their health needs and experiences. The team also attended the **University of South Wales** Freshers Fair and spoke with students new to the area.

Information is shared with all **Gwent schools** on a regular basis, and the team attend Parents' evenings, coffee mornings and provide support and guidance at events throughout the year in order to speak with families. The Engagement team attended the **Gwent Youth Question Time** event organised by the **Office of Police and Crime Commissioner for Gwent,** where young people from across Gwent were able to ask questions and share feedback about services that mattered to them.

In conjunction with **Local Authorities** and other partners such as **WAST; GAVO (Gwent Association of Voluntary Organisations); TVA (Torfaen Voluntary Alliance)** and **Age Connects**, we have had many opportunities to engage with our communities at local events and sessions including warm hubs, food banks and community fridge groups, along with specific activities for older people and carers at Luncheon Clubs, Wellbeing Cafes and 50+ Forums. The team has also attended Carers Rights Day, Lets Connect Newport, International Older Persons Day and the 999 Emergency Services Day events.

The team has developed good links with local organisations including the **Regional Partnership Board**, **Bron Afon**, **Newport City Homes** and the **Caerphilly Parent Network** to deliver different sessions together for staff and customers.

Our Engagement in Numbers

- Conversations 3000+
- Stakeholder Emails 190+
- WhatsApp Message 115+
- Venues Visited 175+
- 33 in Blaenau Gwent
- 37 in Caerphilly
- 31 in Torfaen
- 47 in Newport
- 29 in Monmouthshire

Nye's Community Champions

Nye's Community Champions continue to support the Health Board to share its important messages and to be the eyes and ears on the ground in our communities. Champions share valuable insight from our communities at our 6-weekly meetings and help us to shape future delivery of services. Champions receive up-to-date factual information that they share with their networks and have the opportunity to listen to guest speakers at each meeting.

Our Talks to Groups

This year, the Health Board was asked to deliver 12 Talks to groups about its services as part of its annual community engagement program. Groups included:
Cwmbran Community Council; Maesycwmmer Ladies Craft group; Fourteen Locks Seniors; the NHS Retired Fellowship; Chepstow Stroke Experience Group plus 50+ Forums across Gwent.

Supporting our Diverse Communities

We attended the Kidcare4u Iftar Breaking Fast session in April and a Family Fun event at Pill Millennium Centre in August. The Health Board also organised health events across Mosques in Newport that the team were able to attend to speak with people about a range of health board services.

Our Community Engagement

Engaging with Employers across Gwent

A new initiative for 2023/24 was to engage with employers in order to reach working people who otherwise would not have the opportunity to engage with the Health Board. Starting in Newport on a trial basis, we have visited Eastman Chemical Company, the Celtic Manor Resort, Wales and West Utilities, Hasbro, Newport City Council, Office for National Statistics and Asda Duffryn to speak with staff members about Health Board Services. This initiative has worked well and we will continue to engage with large employers across Gwent starting with Blaenau Gwent in 2024/25.

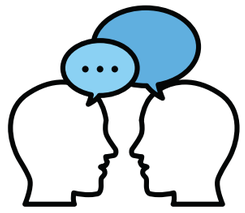
Listening, insight and information

Topics of Conversations included:

- **Primary Care Services:**
  - Difficulties in accessing GP appointments
  - Common Ailments Service not consistently offered
- **Access to emergency and urgent care services**
  - People told us it is very confusing knowing which hospital to go to and to know what a minor injury is
  - many people told us they were passed from hospital to hospital due to a lack of staff available to do procedures such as X-rays
  - we received reports of 111 call handlers signposting people to the wrong hospitals
- **Information being online** - many older people told us that they do not access the internet or have smart phones so would prefer printed information

Information we have shared:

- How to appropriately access NHS services including when to visit the Emergency Department or Minor Injuries Units
- Gwent Health Guide
- Common Ailments Service
- NHS 111 Wales & 111 Option 2 - Urgent Mental Health Support
- Chat Health Text Service
- NHS Wales App
- Boots Pharmacy Closures
- Emergency Eye Care Changes
- YYF Breast Care Unit
- Measles and MMR vaccine



Green Healthcare

Following on from the development of the 'Green Healthcare' space last year, a regular flow of activity and awareness pieces have taken place based upon the initial 'Green Healthcare Communications and Engagement Plan', with the key objectives of assisting the Decarbonisation group in publicising messaging internally and externally, utilising a transparent and accessible approach. The plan aims to raise awareness of decarbonisation, encourage staff to get involved with activities and feel inspired and empowered to conduct their own sustainable changes; and to support the announcement and roll out of major organisational changes that ensure net zero carbon.

Paramount to supporting the messaging of decarbonisation and sustainable healthcare is the need to humanise achievements by focusing on success stories, such as revolutionary paracetamol practices and developments of green spaces and wildflower meadows.

The first newsletter for the group was released in the Winter of 2023, which highlighted key Health Board projects and offered encouragement for staff to get involved and learn more. A list of champions has been developed and as part of this, a community will be put together for these staff online to support their involvement and development in helping make sustainable changes all across the Health Board. We have also developed further stories for the next period that highlight and celebrate colleagues in primary care, estates and facilities and more.

Our Priorities for 2024/25

As you can see from the volume and variety of the work outlined in this report, we have certainly had a challenging, but productive, year. As we look forward to the next 12 months, we plan to focus on the following Communications and Engagement priorities in line with the Health Board's IMTP, our own Communications and Engagement Strategy, our Social Media Strategy, and Staff Communications Plan:

- Continue to build on the work already started in the last year to improve the way we communicate and engage with our staff
- Develop further our social media platforms in particular Tiktok to engage with our younger residents and patients
- Support the work internally and externally with the 10 Year Strategy
- Enhance our community engagement work with large employers, community groups and our diverse communities, supporting the public to understand how to access our services
- All communication and engagement work will be focussed to support the delivery of our IMTP
- Using behaviour change principles and the data available to us to deliver a number of targeted prevention campaigns to support and improve the health and well being of our communities inline with global priorities for Public Health

Agenda Item: 4.10

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Board with an assessment of strategic risks associated with achieving the Board's strategic priorities and assurance that the strategic risks are effectively managed.

This report also provides an assessment of any newly identified risk(s) that require Board oversight and inclusion on the Strategic Risk Register.

Cefndir / Background

At its last meeting in March 2024, the Board approved changes to the Strategic Risk Register as described below and broken down in Table 1.

The Board was assured that the current controls and mitigating actions were acceptable to reduce the likelihood and impact of four sub-risks, two of which were no longer considered to be strategic risks and were de-escalated to divisional risk registers and monitored at the divisional level. In addition, two sub-risks were reframed to account for changes in the risk environment and subsequent scope of the risks, and a new risk was identified in response to internal and external activity.

Table 1 – Breakdown of approved changes – March Board

Overarching Strategic Risk Description	Status	Sub Risk Description	Lead Director
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population.	Risk description reframed	**g)** Due to the failure to deliver a sustainable financial position and longer-term financial plan.	Director of Finance
	Risk score and level reduced	**h)** Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.	Director of Public Health
	New Risk	**i)** Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	Director of Strategy, Planning and Partnerships
SRR 003 - There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.	Deescalated to MH&LD Divisional Risk Register	**b)** Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.	Chief Operating Officer
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	Risk description reframed	**a)** Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	Director of Strategy, Planning and Partnerships
SRR 009 - The Health Board will be unable to protect those most vulnerable to serious disease.	Deescalated to the Public Health Directorate Risk Register	**a)** Due to delays in providing COVID-19 vaccinations because of challenges with the recruitment of registered and unregistered immunisers, as changes to the vaccination delivery programme.	Director of Public Health
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	Risk score and level reduced	**a)** Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements.	Director of Therapies and Health Science

At the end of March 2024, the Strategic Risk Register contained **eight** high-level strategic risks and **20** sub-risks for which the Board delegates responsibility to various committees for receiving and scrutinising assurances against specific strategic risks in line with the Committee's agenda.

Asesiad / Assessment

In accordance with risk management best practices, all strategic risks have been reviewed to ensure that the control environment is adequate to manage the risk; if not, the implementation of additional controls has been documented, and action is

being taken to address the gaps. Similarly, assurances are reviewed to ensure that there is adequate assurance across all three lines of defence to determine whether the controls in place are effective in risk management; if not, gaps in assurance are identified and the control environment is reassessed.

All risks have been updated where necessary in line with the agreed-upon review period for the severity of the risk and subjected to focused scrutiny by the delegated Committee (Table 2).

The full Strategic Risk Register is included as **Appendix A** and the individual risk assessments for the **20** sub-risks are included as **Appendix B**.

Table 2

Overarching Strategic Risk Description	Number of Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (8 – 12)	Extreme (15 – 25)		
***SRR 001 -** There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**9 (A-I)**	3	1	People	People and Culture Committee
		2	1	Service Delivery	Partnerships, Public Health & Planning Committee
		-	1	Financial Sustainability	Finance and Performance Committee
		-	1	Compliance and Safety	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**2 (A -B)**	1	1	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**1**	1	-	Compliance and Safety	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	**1**	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**3 (A – C)**	2	1	Service Delivery	Finance and Performance Committee

SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	**2 (A – B)**	2	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	**1**	-	1	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	**1**	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
Total	**20**	**12**	**8**		

*Change proposed

As previously stated, the Strategic Risk Register currently includes **eight** high-level risks and **20** sub-risks. Since the last presentation of this report to the Board and subsequent review of all strategic risks, the strategic risk environment has remained relatively stable, with only **one** risks (SRR 001D) requesting approval for a change in its risk score and level, as shown below.

Reduction in Risk Score and Exposure

SRR 001D - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population, *due to the threat of Industrial Action during ongoing disputes and negotiations at a national level.*

The likelihood of the risk occurring has been reduced from 'Likely' (score of 4) to 'Possible' (score of 3) as a result of the British Medical Association's (BMA) agreement to suspend all industrial action in Wales in order to resume negotiations with the Welsh Government over the 2023/24 pay award. It is also worth noting that the dispute has been settled in England.

Although the risk environment has remained stable, the Board should be aware of **six** sub-risks that exceed the risk threshold for their domain. As a result, the Board must decide whether it is willing to tolerate all risks outside of appetite. The **six** risks are shown below (Table 3).

Table 3

Overarching Strategic Risk Description	Sub-Risk Description	Risk Profile	Current Risk Score & Level Likelihood x Impact =
SRR 001 There is a risk that the Health Board will be unable to deliver and maintain high-quality	**g)** Due to long-term financial sustainability plans not being achieved through underachievement of strategic and operational	**Theme** Financial Sustainability **Appetite**	**5 x 4 = 20** **Extreme**

quality safe and sustainable services which meet the changing needs of the population	delivery plans to reduce costs to funded levels and improve outcomes.	Minimal - Score 8 and below	
	i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**4 x 4 = 16 Extreme**
SRR 002 There is a risk that there will be significant failure of the Health Board's estate	**a)** Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**3 x 5 = 15 Extreme**
	b) Due to significant levels of backlog maintenance and Structural Impairment		**3 x 4 = 12 High**
SRR 004 There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**a)** Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**3 x 5 = 15 Extreme**
SRR 010 The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	**b)** Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements	**Theme** Safety & Compliance **Appetite** Minimal - Score 8 and below	**3 x 4 = 12 High**

The infographic below depicts the Health Board's current risk exposure to the 20 strategic sub-risks, demonstrating that the majority of the strategic risks are in the upper right quadrant of the risk matrix, indicating a high level of risk exposure, and as previously stated in the report, five of those risks fall outside the Board's agreed-upon appetite level.

Risk Scoring Matrix					
Likelihood/ Frequency	**Consequence/Impact**				
	1. Negligible	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
5. Almost Certain (91%)				**1 x (Extreme)**	
4. Likely (61-90%)				**3 x (Extreme)**	
3. Possible (41-60%)			**1 x (High)**	**9 x (High)**	**3 x (Extreme)**
2. Unlikely (11-40%)				**3 x (Moderate)**	
1. Rare (1-10%)					

The Corporate Governance Directorate continues to work with risk owners to assess and improve controls and assurances, as well as to increase transparency on the work being undertaken to implement mitigation in the short, medium, and long term. This will be demonstrated through a revised risk assessment template that will have a greater focus on the high-level actions in place to implement additional controls to bring the risk to within appetite or to a level at which the Board is willing to tolerate the risk. The revised template will be implemented as of June 2024 and will be included in the Board's next report in July.

It should be noted that the Board will only be asked to consider tolerating a risk outside of appetite where there is nothing further that the Health Board can do to mitigate the risk.

If the Board accepts its strategic risk position, the Strategic Risk Register will include **eight** high-level strategic risks and **20** sub-risks, **six** of which are managed outside of their predefined risk appetite level.

Corporate Risk Register

Initial meetings with Directors have been held to discuss any potential high-level operational risks in their areas of responsibility that require the Executive Team's support and management via the Corporate Risk Register. The draft corporate risk portfolio will be discussed at the Executive Time Out session in June, during which a focused assessment of these risks, as well as strategic risks, will be conducted to ensure they are reflective of the operating environment and are recorded and reported at the appropriate level. A full report, including the status of strategic and corporate risks, will be presented to the Board at its next meeting in July 2024 to determine the Board's position on the current risk exposure and treatment.

Argymhelliad / Recommendation

The Board is requested to:

- **REVIEW** the strategic risks identified, ensuring that these remain fully reflective of any direct threat to the Board's strategic priorities;
- **CONSIDER** whether it has sufficient assurance that strategic risks are being assessed, managed, and reviewed appropriately and effectively;
- **NOTE** the risks outside of the agreed-upon appetite for the risk domain; and,
- **NOTE** the continued work to ensure risks are being mitigated as far as possible.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements**

	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged effectively	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against Appetite	Risk Appetite and Threshold Explained			Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
	People & Culture Committee	People	Director of Workforce and Organisational Development		a)Due to an inability to recruit and retain staff across all disciplines and specialities.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reliance on agency and bank staff •Litigation & Financial Penalties	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	<u>Staff Attendance:</u> Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work., "Hot spot" areas identified and plans in place to support. <u>Recruitment:</u> Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor, Annual programme of Apprentice recruitment, Overseas Nursing (All Wales), Nursing Workforce Strategy, Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) , Partnerships with employability schemes such as Kickstart and Restart, Actively working with Local Authorities to promote joint recruitment activities and Registration – Temporary register extended for 2 years to enable staff to return to practice. <u>Retention:</u> Development of career pathways (e.g., non-clinical to clinical), Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR, Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts, Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return, Agency reduction and Plan in place to monitor and review all agency, bank pay incentives supply and demand. <u>E-Systems:</u> Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff, Development of alternative and new roles , Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP, Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. and Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. <u>Training</u>: The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies, HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy, Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 <u>Staff:</u> Vacancy Numbers and establishment control Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies and Development of ESR establishments commenced on a national basis w/c 03/09/23.	Medium	3	2	6	Low	01/05/2024	01/06/2024
					b) Due to a deterioration in, and a failure to improve, the well-being of our staff	•High absence levels, with some sustained long periods •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reputational damage to the health board as an employer •Work-related industrial injury claims •Moral injury	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars)., Increase wellbeing initiatives: Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites, Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders), Train Mediators so there is team and organisational resilience and network, Regular Schwartz rounds arranged across the Health Board, Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. Close links with the Arts in Health programme, Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. Chaplaincy service for staff , Re-launching Chill out in the Chapel, Recruitment of staff counsellors, Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being , Scope, design and deliver a programme of research 'Healthy Working Day', Enhanced our financial well-being offer. Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management, Drafting of a 10-year plan focusing on optimising the employee experience of work , The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. Occupational Health Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes, Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted, Support equality and diversity of workforce Review of staff diversity networks, Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. Other Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC, Reducing fatigue poster developed	Medium	3	3	9	Moderate	01/04/2024	01/07/2024

SRR 001				There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	c) Due to insufficient and ineffective leadership levels throughout the organisation.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Poor levels of accountability and delivery •Reputational damage to the health board as an employer •Adverse impacts on staff recruitment and retention	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Talent and Succession Planning lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. Development leadership capabilities Designing learning journeys and access to Gwella Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Medium	3	2	6	Low	01/04/2024	07/07/2024
					d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Litigation & Financial Penalties •Reputational damage to the health board and loss of public confidence	3	4	12	High	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Services Business continuity plans in place. All Wales training sessions provide by legal and risk to support industrial action. Ensure early identification of mandated Statutory, and core critical clinical services. Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. Reducing impact on patients - Support for early supported discharge prior to industrial action. Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). Establish WOD hub with emergency planning to stand up as required Ensure early identification of mandated Statutory, and core critical clinical services. Review of business continuity plans Map services and staff provision and impacts of industrial action. Assess variable pay usage in case of work to rule applies. Assess current vacancies. Working with partners in Gwent on a system wide basis. Implementation of business continuity plans. Communication plans. Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	Medium	2	4	8	Moderate	01/04/2024	01/07/2024
	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	•Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to train teams in multi-morbidity management •Failure to comply with the Wellbeing of Future Generations Act (Wales) •Reputational damage and loss of public confidence	2	4	8	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	Medium	2	3	6	Low	01/04/2024	01/07/2024

					f) Due to unsustainable service models	• Harm or injury to patients and/or staff • Adverse impacts on delivery of care to patients across acute and non-acute settings • Increased demand • Increased patient acuity levels • Worsening of health inequalities • Worsening of health outcomes • Failure to deliver health board priorities, required improvements and achieve sustainability • Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	Medium	2	3	6	Low	01/04/2024	01/07/2024
	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	• Breach of statutory duty to breakeven over 3 years • Instigation of NHS Wales Escalation & Intervention Arrangements • Non – delivery of health board priorities, required improvements and achieve longer-term sustainability • Prioritisation and possible disinvestment in service delivery • Reputational damage and loss of public confidence	5	4	20	Extreme	Above Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	Medium	2	4	8	Moderate	01/05/2024	01/06/2024
	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Public Health and Strategic Partnerships		h) Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Unable to substantially improve the health of the population ➢ Reputational damage and loss of public confidence ➢ Multi-year CIP calculated on non-recurrent funding ➢ Major grants subject to funding cuts 24/25 ➢ No determined staffing establishment ➢ Possible at-risk TUPE posts ➢ £1.5 million temporary staff funding (RIF + EYP) majority on permanent contracts ➢ Government grants focused on particular risk factors	4	4	16	Extreme	Within Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Business cases being written for PIP to increase core funding to deliver objectives. Through Pip process work towards a funded establishment reduce risks associated with permanent staff being funded through temporary funding which impacts on the ability to plan long term.	Negative	2	3	6	Moderate	01/04/2024	01/07/2024
		Compliance and Safety			I) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications	4	4	16	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Performance Management and Assurance Framework Executive Accountability letters – to be issued by the end of May 2024 Divisional Directors Accountability letters – to be issued by the end of May 2024 Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reporting through to the Finance and Performance Committee via Executives Specific areas of focus are discussed at the Value & Sustainability Board System-wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. Embed in the regional programmes of work i.e. ophthalmology, diagnostics, and orthopaedics.	Medium	2	4	8	Moderate	01/05/2024	01/06/2024

SRR 002	Partnerships, Public Health & Planning Committee	Compliance and Safety	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation & Financial Penalties	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	At this stage, the controls in place are appropriate and practicable to monitor the issues and prepare medium-term responses in line with the timelines within the expert report.	Medium	1	2	2	Very Low	01/05/2024	01/06/2024
					b) Due to significant levels of backlog maintenance and Structural Impairment	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.	Medium	3	2	6	Low	01/05/2024	01/07/2024
SRR 004	Partnerships, Public Health & Planning Committee		Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Harm or injury to patients and/or staff •Health Board breaches statutory duties under the Civil Contingencies Act 2004 •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Testing programme of business continuity plans. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. Joint planning with PH response in response to infection disease and public health incidence. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. Continue to promote awareness in a timely manner. Continue to promote awareness of the requirement for BC across the Health Board. A tabletop BC exercise is planned for the 10th of October 2023. Continuing participation in multi-agency exercises. Programme plan to be developed to address the weaknesses in business continuity planning. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Development of Pandemic Plan.	Medium	2	3	6	Low	01/05/2024	01/08/2024
SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	Medium	3	3	9	Moderate	01/04/2024	01/07/2024

SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a)Due to the full or partial failure of existing digital infrastructure and systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Implement the recommendations from Templar report: • Outline a step by step process of how the proposed risk treatments need to be implemented. This should include the activities to be performed, who is responsible and deadlines for completion. • Complete any outstanding policy and process development, ensuring there is engagement with non ICT teams including the SIRO and board • Ensure ICT disaster recovery policies are complete and refer to any system specific recovery processes. • Ensure non ICT teams are aware of disaster recovery policies and processes and engaged in developing system breach/failure response definition. • Complete a policy and process review after each incident to identify if anything could be improved in detection, resolution or prevention of a cyber security incident. Also, ensure the same is done whenever there are significant system changes. • Develop the policy and processes for identity and access management to ensure that privileged and critical system accounts are reviewed periodically e.g. 6 to 12 months, with other accounts reviewed through joiners/starters, movers and leavers processes. • Investigate circumstances where dedicated devices can be used for critical system access • Consider plans for certification of users and devices and how those certifications can be used. • Consider how to monitor privileged accounts e.g. with additional logs managing not just by exception but random and planned audits • Assess whether MFA can be implemented for privileged user accounts • Review any critical system logs that are created • Update systems or request updates to create additional logs where possible and include creation of logs on user devices in any investigation • Investigate a means of alerting for specific log conditions • Consider collective identification of appropriate tools and working with other OES within NHS Wales to identify appropriate tools.	Medium	2	4	8	Moderate	01/05/2024	01/06/2024
					B)Due to an adverse impact on service delivery in the implementation of new digital systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Assurance activities included in project framework including clinical safety, information governance, health records and cyber security • An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects • Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success	Medium	2	3	6	Low	07/04/2024	01/07/2024
					c)Due to a failure to develop digital solutions that are sustainable and fit for the future	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• New governance structures to be put in place by the end of 2023. • Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities • Annual planning processes to include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process • New Digital Request processes refresh with senior leadership scrutiny of requests, implementation of new prioritisation process and quarterly reporting to DDAT sub-committee • Automation of request process via 'Seren' the ICT Portal • Portfolio optimisation to ensure the resources of the service are aligned to key priorities	Medium	2	4	8	Moderate	07/04/2024	01/07/2024
					a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	•Unmet patient need resulting in harm •Ineffective use of combined resources •Delayed decision making •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach. .	Medium	2	2	4	Low	10/04/2024	10/07/2024

SRR 007	Partnerships, Public Health & Planning Committee	Transformation and Partnership Working	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	b) Due to the impact of fragile services across the regional and supra regional geography	Changes of regional flow in an unplanned way Additional demand on UHB workforce to support fragile services Unmet patient need resulting in harm Ineffective use of combined resources Delayed decision making Failure to deliver health board priorities, required improvements and achieve longer-term sustainability Reputational damage and loss of public confidence	3	3	9	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a recent review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with recognition that these need to be 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions. Discussion to be had at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	Reasonable	2	2	4	Low	16/04/2024	16/07/2024
SRR 008	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	2	4	8	Moderate	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	Medium	2	2	4	Low	01/04/2024	01/07/2024
SRR 010	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Executive Director of Therapies and Health Science	The Health Board will fail to protect the Health and Safety of staff, patients and visitors in line with its duties under the Health and Safety at Work Act 1974	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	• Unintended physical harm; • Punitive actions from the Health and Safety Executive (HSE); • Increased levels of staff sickness; • Loss of estate due to unsafe environments; • Financial implications; • Adverse publicity; and, • Reputational damage	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established.	Negative	2	3	6	Moderate	01/05/2024	01/07/2024

Strategic Risk Dashboard

Reference				Risk Score Matrix
				2 · 4 · 5 · 6 · 8 · 9 · 10 · 12 · 15 · 16 · 20 · 25
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff	
			c) Due to insufficient and ineffective leadership levels throughout the organisation.	
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	
			f) Due to unsustainable service models	
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	
	Director of Public Health & Strategic Partnerships		h) Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants	
			i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	
			b) Due to significant levels of backlog maintenance	
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	
			b) Due to an adverse impact on service delivery in the implementation of new digital systems	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future	
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	
			b) Due to the impact of fragile services across the regional and supra regional geography	
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	

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

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

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**a)** Due to an inability to recruit and retain staff across all disciplines and specialties.		**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reliance on agency and bank staff ➢ Litigation & Financial Penalties				**Risk Appetite Threshold - Score 16 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN the** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*	
Next Review Monthly based on the current risk score	01 June 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing and HCSW). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Workforce planning supported by Compendium of new roles to support innovative workforce models. • Recruitment KPI's. • IMTP (Integrated Medium-Term Plan) Educational Commissioning. • Workforce Establishment controls national working group has been instigated. • Value and Sustainability Board. **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. • Annual programme of Apprentice recruitment	**Retention** • Development of career pathways (e.g., non-clinical to clinical). • Talent management and succession planning framework in process of internal assurance. Presented to TUPF through a development session and going to Exec Committee on 06 June 2024. • Career conversations and succession planning resources designed, will be available on intranet from 07 June 2024. • Career conversation workshops designed, plans in place to advertise dates post 06 June 2024. • All Wales self-assessment retention tool being completed at organisational level for Nursing and Midwifery to provide a baseline. **E- Systems** • Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Workforce reports to the Nurse Strategic Workforce Group. • Monthly sickness monitoring reports. • Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. • Medical Staffing Co-ordinator review of medical rotas. • Cross site operational calls. • Occupational Health and Wellbeing dashboards report KPIs. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. • Measurements of Wellbeing through the ABUHB • (Aneurin Bevan University Health Board) Staff Survey.	**Gaps in Assurance** • Detailed intelligence on the issues surrounding retention. **Action to Address Gaps in Assurance** • Outcome of the Internal Audit Staff Culture Review Q3 2024/25	**Positive Assurance**

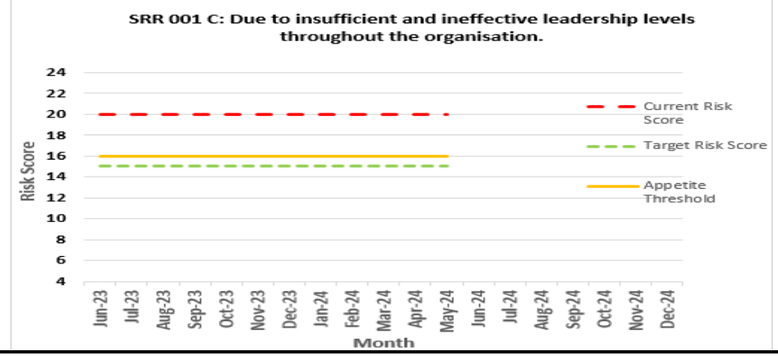
• Overseas Nursing (All Wales Recruitment programme) • Nursing Workforce Strategy agreed • Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) • Partnerships with employability schemes and FE/HE to widen access. • Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. • Registration – Temporary register extended for 2 years to enable staff to return to practice ending March 2024. **Retention:** • Retention lead appointed with programme action plan in place for the next two years. • Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. • Week of events planned to support retention agenda in June 2024. This will include a mixed method of online webinars, videos and retention materials. • Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. • Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return. **Variable pay reduction.** • Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. **E- Systems** • Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. eLocum Bank, eJob Planning, eAgency systems are all 'live' and rolled out within the Health Board. eRostering is planned to go live shortly following ESR interface testing. **Development of alternative and new roles** • A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent, and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care • The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management. **Training** • The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2024 and beyond which are required to support turnover and existing vacancies. • HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW	**Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. • Looking to increase assistant band 4 in Community/Mental Health • Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. • Increasing consultant therapy and nurse practitioners • Nurses with skills to support chronic disease management in Primary Care **Training** • HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy • Workforce planning within new competency framework commencing June 2024. • Development opportunity being scoped for Business support staff and Masterclasses being launched across the organisation for key business critical themes.	• Routine Reporting against nurse staffing levels. • Variable Pay Programme Board reporting to Value and Sustainability Board **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Long Term Sickness Absence Management (Q4) 2023 - 24 – Outcome Reasonable Assurance • Internal Audit Flexible Working 2023/24 (Q4) – Scheduled to be received in Q2 2024/25 • External quarterly vacancy reporting to WG • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience. • RN/HCSW Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (6 supported this year) • Cadet Nursing programme in place (20 candidates last year) • K102 bridging model now being offered to support HCSW pathways into registered nursing. • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) is in its second year. Similar program developed for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group which commenced 23 April 2024. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff. **Vacancy Numbers and establishment control** • Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period December 2024 there were circa 619 WTE vacancies. Reduction 109 WTE from March 2023. Next reporting update is due mid-May 2024. • Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan has been developed and approved by Executive Committee in April 2024. Project workstream established and work commenced. **Staff attendance** • Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • “Hot spot” areas identified and plans in place to support.				

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**b)** Due to a deterioration in, and a failure to improve, the well-being of staff.	**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ High absence levels, with some sustained long periods ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reputational damage to the health board as an employer ➢ Work-related industrial injury claims ➢ Moral injury			**Risk Appetite Threshold – Open Score 16 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*	
Next Review Due Quarterly based on the current risk score	01 August 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Monitoring Framework to support roll out of the People Plan. • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance. • Staff related policies. • National Staff Survey and Health Board Employee Experience Survey • External Employee Assistance Programme • Speaking up Safely action plan • Race/LGBT groups. • Wellbeing resources • Occupational Health Service • Staff diversity networks • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own.	• Increase wellbeing initiatives: • Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders). • Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. • Trained mediators so there is team and organisational resilience and network. • Scope, design and deliver a programme of research 'Healthy Working Day'. • Enhanced our financial well-being offer. • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and Facilities **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter	**Gaps in Assurance** • Understand if support is reaching all staff and if staff fell wellbeing is a priority for the organisation. **Action to Address Gaps in Assurance** • Meetings with Divisions ongoing to ensure all areas are aware of what's available. • Outcome of the Internal Audit Staff Culture Review Q3 2024/25	**Positive Assurance**

• Close links with the Arts in Health programme • Chaplaincy service for staff • Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales. • The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. This workstream began in October 2023 and will be developed over the next 12 months with a strong emphasis on evidence analysis and culture. The initial SUS Steering group was held on 14 March 2024, and an externally commissioned SUS hotline will be piloted in April 2024. • An external Employee Assistance Programme (Vivup) has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. **Occupational Health** • Additional occupational health resources secured to reduce waiting times. • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. **Support equality and diversity of workforce.** • A part time Disability Inclusion Officer has been seconded to the EDI Team (December 2023 – December 2024). • Band 5 EDI Officer appointed and commence in post at the end of March 2024. • Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. • Reverse Mentorship Programme launched February 2024. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC • Reducing fatigue poster developed.	**Occupational Health**. • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. **Support equality and diversity of workforce.** • Review of staff diversity networks. • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing.	• Internal Audit Long Term Sickness Absence Management (Q4) 2023 - 24 – Outcome Reasonable Assurance		

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**c)** Due to insufficient and ineffective leadership levels throughout the organisation	**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Failure to deliver health board priorities, required improvements and achieve sustainability; ➢ Poor levels of accountability and delivery; ➢ Reputational damage to the health board as an employer; ➢ Adverse impacts on staff recruitment and retention			**Risk Appetite Threshold - Score 16 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	3 *(Possible)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	2 *(Minor)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*	
Next Review Due Quarterly based on the current risk score	01 August 2024				

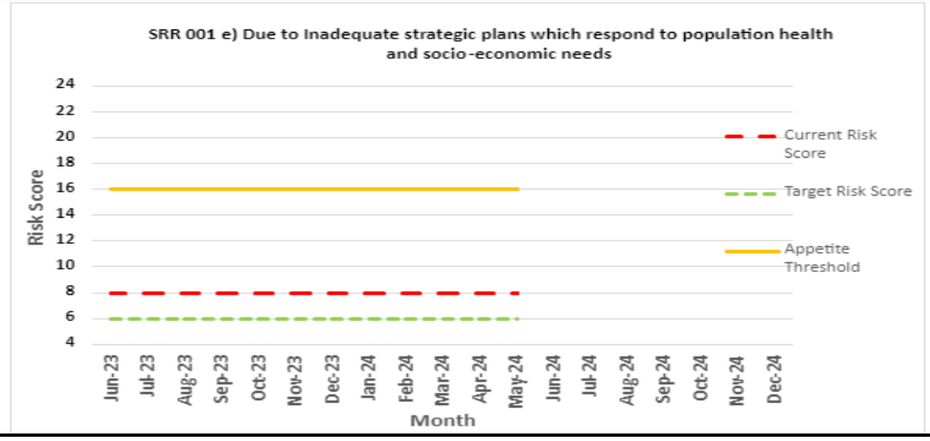
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Talent and Succession Planning • Monitoring Framework to support roll out of the People Plan- focus on Talent and Succession Planning • Monitoring frameworks with HEIW • Lead appointed in July 2023 on a secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify, and develop talent for critical roles across ABUHB. • HEIW schemes • 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. **Development leadership capabilities** • Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Leadership development offer now available for entry level leaders and managers, Clinical Directors, Directorate Manager development programme (DMx) to launch Q1 2024/25, Senior Nurses and multi-disciplinary teams. • Learning Masterclasses have been designed and developed for the organisation addressing key themes such as giving feedback, developing teams, and having courageous conversations. • Leading People Programme (starting cohort 8 May 2024) • 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	**Talent and Succession Planning** • Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. **Development leadership capabilities** • Currently exploring leadership funding options with USW in order to maximise Governmental Grants and utilisation of the apprentice levy. • Continued commitment to NHS graduate schemes.	Level 1 Operational *(Implemented by the department that performs daily operation activities)* • WOD Divisional reporting • Evaluation of internal leadership programmes and regular review of our internal offer Level 2 Organisational *(Executed by risk management and compliance functions.)* • Reporting to People and Culture Committee - progress against People Plan 22-25 **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Review • Talent and Succession Board	**Gaps in Assurance** • The effectiveness of the controls in delivering improvements in sufficient and effective leadership. **Action to Address Gaps in Assurance** • Outcome of the Internal Audit Staff Culture Review Q3 2024/25	**Positive Assurance**

RISK THEME	PEOPLE				
Strategic Risk - SRR 001	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**				
Strategic Threat	**d)** Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	**Publication Status**	Public	**Risk Appetite Level – Open** Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Litigation & Financial Penalties ➢ Reputational damage to the health board and loss of public confidence			**Risk Appetite Threshold – Open Score 16 and below.** Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	People & Culture Committee	**Likelihood**	*3 (Possible)* *x*	**2** *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	**4** *(Major)*	**4** *(Major)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review Due Quarterly based on the current risk score	01 August 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• All Wales Industrial Action Planning Group • Local Health Board planning arrangements • Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture • Effective derogation processes including Christmas Day cover definition. • Local Negotiating Committee (LNC) • Services Business continuity plans in place. • Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. • Command and control structure and leads established. • Derogation test completed. • Executive and Senior Manager leads established links with national planning cells. • All Wales training sessions provide by legal and risk to support industrial action. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Picketing guidance supported and agreed	• Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. • Issue of WHC AFC non pay elements of collective agreement 2022-24. Response to WG on immediate assurance by end May 2024 • Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). • Communication plans- public, stakeholders and partners • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. • Consideration of further additional national legal advice	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Local Staff re-deployments assessment • Divisional engagement and service planning arrangements in place • Local Negotiating Committee (LNC) • Trade Union Partnership meetings **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reporting to Executive team • Business Continuity groups • Command and control structure in place to be implemented as required. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • All Wales IA group and Welsh Government planning group. • Debriefing session planned to reflect and capture learning for any potential future action	**Gaps in Assurance** • Further industrial action **Action to Address Gaps in Assurance**	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	**e)** Due to inadequate strategic plans which respond to population health and socio-economic needs.	**Publication Status**	Public	**Risk Appetite Level - Open** Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to train teams in multi-morbidity management ➢ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➢ Reputational damage and loss of public confidence			**Risk Tolerance Level - Open Score 16 and below.** Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the set appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

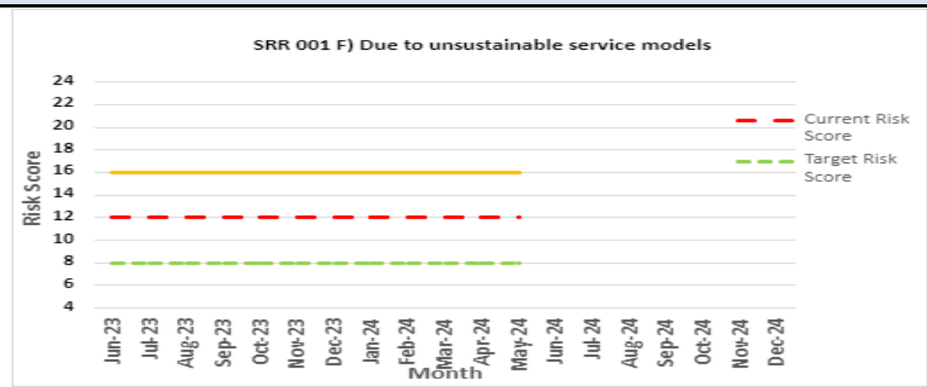
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)*	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 (*Major)*	3 *(Moderate)*
Last Reviewed	01 May 2024	**Risk rating**	**= 8** *(High)*	**= 6** *(Moderate)*
Next Review Due Quarterly based on the current risk score	01 August 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board IMTP and associated KPIs • Public Health Wales surveillance data • Qliksense – performance dashboard • Population Needs Assessment and Area Plan • Marmot Region Programme	• Area plan is being refreshed through the RPB • Marmot Region Implementation Plan • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Refresh organisational strategy with a central focus on population health and wellbeing. • Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Qliksense – performance information • SFN – performance information **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP Delivery and Outcomes Reporting to Board • Marmot Region Programme • RPB reporting to Board and Population Health, Planning and Partnerships Committee • Regional Planning reporting to Population Health, Planning and Partnerships Committee • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* Internal Audit Reviews 2023-24 1. IMTP Planning (Q1) Outcome – Reasonable Assurance	**Gaps in Assurance** • Effectiveness of the plans in delivering improvements **Action to Address Gaps in Assurance** • Outcome of the Internal Audit Partnership Arrangements Q1 2024/25	**Reasonable Assurance**

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	**f)** Due to unsustainable service models.	**Publication Status**	Public	**Risk Appetite Level - Open** Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➢ Harm or injury to patients and/or staff; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Increased demand; ➢ Increased patient acuity levels; ➢ Worsening of health inequalities; ➢ Worsening of health outcomes; ➢ Failure to deliver health board priorities, required improvements and achieve sustainability; ➢ Reputational damage and loss of public confidence.			**Risk Tolerance Level - Open Score 16 and below.** Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** the set appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

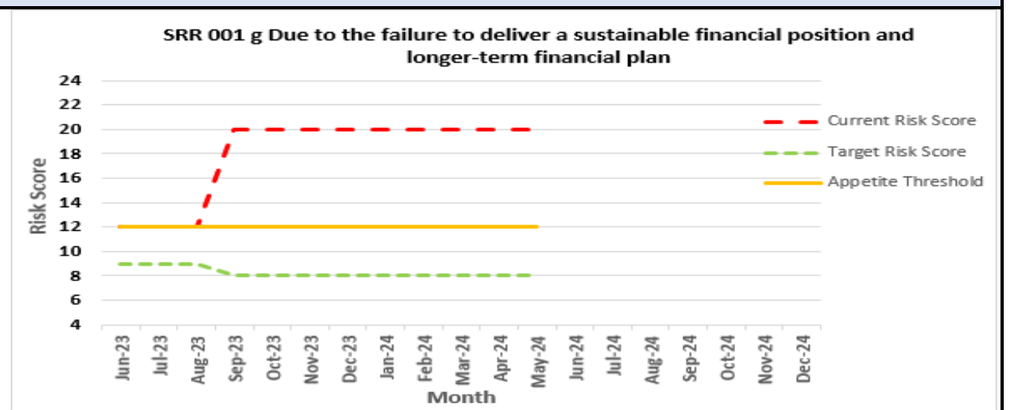
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*
Next Review Due Quarterly based on the current risk score	01 August 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• The Health Board IMPT and associated KPIs • Clinical Futures Transformation programmes. • Public Health Wales surveillance data – Covid, flu and other communicable diseases. • Qliksense – performance information. • Population needs assessment and area plan development by the RPB. • Southeast Wales Plan for fragile services.	• Area plan is being refreshed through the RPB. • Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. • Review of enhanced local general hospital service models to ensure sustainable quality services. • Development of SEW plan for fragile. • Review of organisational strategy – to launch Summer 2024.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Public Health Wales surveillance data – COVID, flu and other communicable diseases. • Qliksense – performance information. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • IMTP delivery and outcomes reporting to Board. • RPB reporting to Board and Population Health, Planning and Partnerships Committee. • Regional Planning reporting to Population Health, Planning and Partnerships Committee. • Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Reviews 2023-24 1. IMTP planning Q1 Outcome – Reasonable Assurance.	**Gaps in Assurance** • Effectiveness of individual arrangements in place to deliver service plans. **Action to Address Gaps in Assurance** • Internal Audit Q3 2024/25 IMTP – Service Delivery Plans	**Reasonable Assurance**

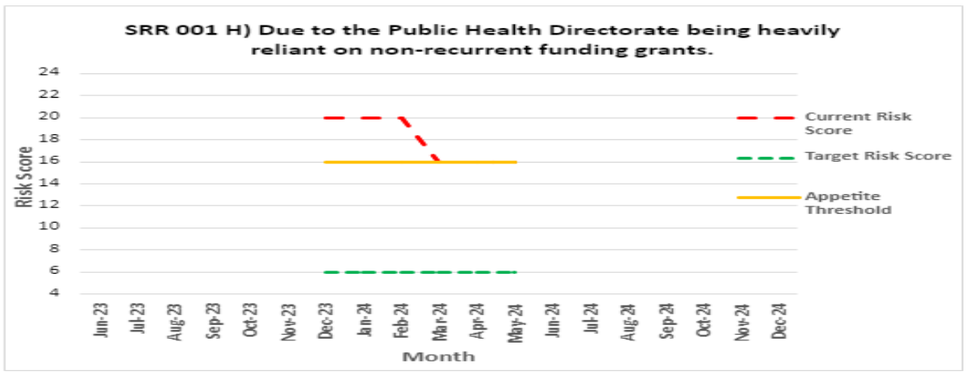
RISK THEME	FINANCIAL SUSTAINABILITY			
Strategic Risk- SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**g)** Due to the failure to deliver a sustainable financial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

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



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

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

RISK THEME	SERVICE DELIVERY				
Strategic Risk - SRR 001	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population.**				
Strategic Threat	**h)** Due to the Public Health Directorate being heavily reliant on non-recurrent funding grants.		**Publication Status**	Public	**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure**.**
Impact	➢ Avoidable harm ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings ➢ Increased patient acuity levels ➢ Worsening health inequalities ➢ Worsening health outcomes ➢ Unable to substantially improve the health of the population. ➢ Reputational damage and loss of public confidence	➢ Multi-year CIP calculated on non-recurrent funding. ➢ No determined staffing establishment ➢ Possible at-risk TUPE posts ➢ £1.5 million temporary staff funding (RIF + EYP) majority on permanent contracts ➢ Government grants focused on particular risk factors			**Risk Appetite Threshold – SCORE 16 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy
					SUMMARY The current risk level is **OUTSIDE** of the target level but **WITHIN** the set appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Lead Director	Director of Public Health & Strategic Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Population Health, and Planning Committee	**Likelihood**	**4** *(Likely)* *x*	**2** *(Unlikely)* *x*	
Initial Date of Assessment	01 December 2023	**Impact**	**4** (*Major)*	**3** *(Moderate)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*	
Next Review Due Monthly based on current risk score	01 June 2024				

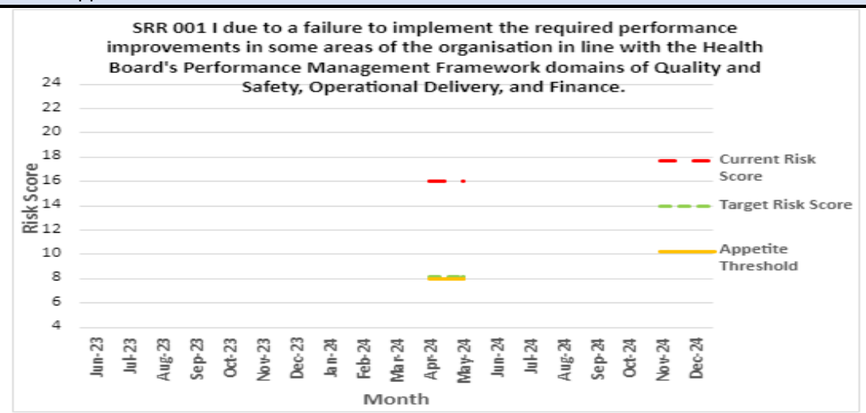
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Organisational Change Process (OCP) instigated which will enable change to the ways of working and moving to a fully funded permanent structure. • Meetings with finance to determine TUPE level and CIP calculation. • Local public health risk register. • Identified risk relating to structure and finance. • Business cases being written for PIP for preventative adverse deaths, Health Protection, and other public health areas. • SMT meetings to discuss progress on delivery of objectives linked to the available budget. • £11.2M recurrent funding has been agreed and received for Health Protection and vaccination. • Work has commenced transferring operational delivery of the vaccination service to Primary Care with oversight from Public Health to ensure effective delivery of programmes (funded by the new recurrent funding from WG to fund Health Protection and vaccination locally)	• Business cases being written for PIP to increase core funding to deliver objectives. • Through the PIP process work towards a funded establishment to reduce risks associated with permanent staff being funded through temporary funding which impacts the ability to plan long-term. • Establish a Health Protection offer within the core Public Health Team to do strategic planning and mitigation and assurance around vaccination delivery.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monthly finance meetings in place with the Director and Assistant Director • Monthly reporting on finance levels **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Escalation to the Strategic Risk Register for Board oversight • Highlighted and discussed at Corporate Review **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* • Report delivery of local progress against the national public health strategy through Public Health Peer Group	**Gaps in Assurance** • Unable to assess the full impact of gaps in delivering the Public Health offer against the prevention agenda **Action to Address Gaps in Assurance** • Through the OCP process we will be able to establish the appropriate areas to place Public Health business for efficient and effective health protection and vaccination delivery. • Developing a clear evidence base to understand population need for long-term public health planning.	**Negative Assurance**

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk - SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population			
Strategic Threat	**i)** Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	Public		
Impact	➢ Unintended patient harm ➢ Negative patient/public experience ➢ Loss of patient/public trust and confidence ➢ Reduced staff morale leading to potential absence from work	➢ Scrutiny from external organisations (AW/HIW/WG) ➢ Punitive Action ➢ Adverse publicity ➢ Financial implications		
Lead Director	Director of Strategy, Planning & Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance and Performance Committee	**Likelihood**	*4 (Likely)* **x**	2 *(Unlikely)* x
Initial Date of Assessment	19 April 2024	**Impact**	***4*** *(Major)*	4 *(Major)*
Last Reviewed	09 May 2024	**Risk rating**	***= 16 (Extreme)***	***= 8 (Moderate)***
Next Review (Monthly based on current score)	09 June 2024			

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

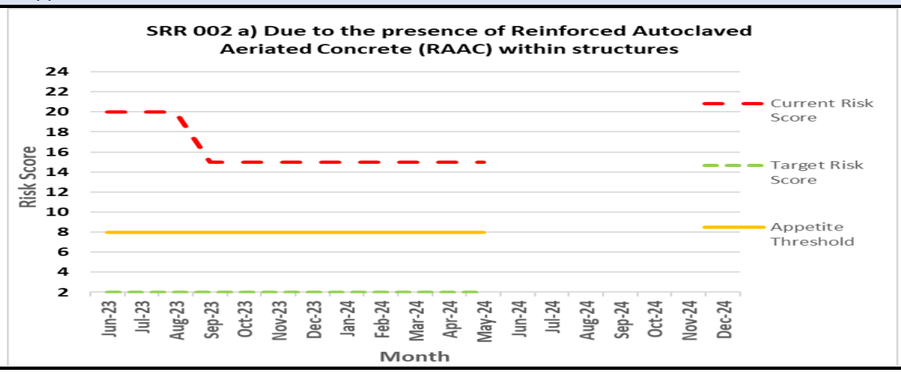
Risk Appetite Threshold – Score 8 and Below
Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Performance Management and Accountability Framework • Executive Accountability letters – to be issued by end of May 24 • Divisional Directors Accountability letters – to be issued by end of May 24 • Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions • Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. • Reporting through to Finance and Performance Committee via Executive Committee • Specific areas of focus are discussed at Value & Sustainability Board • System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc.	• 6-month review of Performance Management and Accountability Framework • Alignment of internal mechanisms to national escalation framework • Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. • Standardised Divisional Assurance Templates (pre-populated) • Commission external reviews to support improvements where required. • Implement the performance framework. • Appropriate Business Partnering Support and analytical support. • Review of JD to explicitly include in Assistant Director of Planning and Performance role. • Will realign capacity and/or redefine roles to provide explicit support	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • DMTs in place for all Divisions • Divisional oversight arrangements – monthly/fortnightly meetings • Divisional plans in place and focussed agendas • Cross Divisional meeting monthly – progress the wider system way of working. • System Leadership Team for awareness and updates **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established reporting to the Executive Committee • Established reporting to the Finance and Performance and Patient, Quality and Safety Committee • Established reporting to the Board. • Routine reporting through the IQPD process **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • HIW Inspections • Llais for feedback	**Gaps in Assurance** • How effective the Performance and Accountability Framework is delivering improvements. **Action to Address Gaps in Assurance** • Internal Audit 2024/25 Plan - Review of the Performance Management and Accountability Framework (Q3) • Internal Audit 2024/25 Plan - Review Divisional Governance Arrangements (Q2)	**Reasonable Assurance**

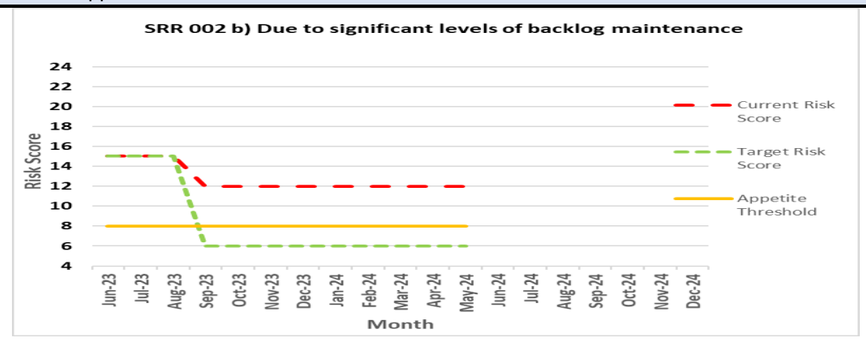
RISK THEME	COMPLIANCE AND SAFETY				
Strategic Risk - SRR 002	**There is a risk that there will be significant failure of the Health Boards Estates.**				
Strategic Threat	**a)** Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.	**Publication Status**	Public	**Risk Appetite Level - MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties			**Risk Appetite Threshold - SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of the target level and **OUTSIDE** the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold	
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare*) x	
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*	
Last Reviewed	01 May 2024	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*	
Next Review Due Monthly based on the current risk score	01 June 2024				



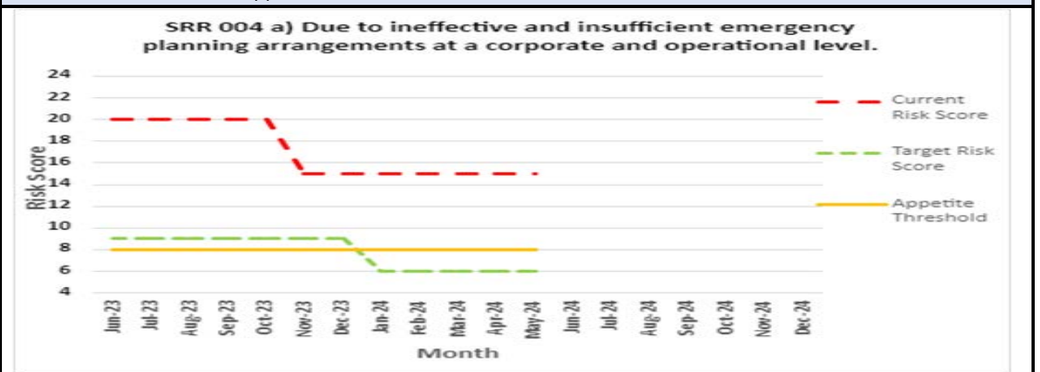
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Work to assess the risk has been undertaken with expert external surveyor advice and repeat surveys have recently been completed. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance. • Remediation work to areas of high-risk areas	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Fortnightly checks in place for the props in place • Ongoing engagement with expert surveyor and monitoring of RAAC with additional surveys continuing and reinspection of conditions (a regular 6 monthly inspection) scheduled for June 2024 • The estate's function has controlled access to roof areas and has developed and implemented toolbox talks for awareness for estate teams and contractors to work in those areas. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management. • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Risk assessments completed by the Health and Safety function in those departments with props to manage any consequences of the presence of props. Note: H&S assessments were around the location of props not of RAAC itself and they flagged no issues or alterations. • Formal update to full Board in May 2024 **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Estates Assurance - Estate Condition audit completed and been shared with Audit Committee and Finance and Performance Committee • Fortnightly dialogue with Welsh Government and Shared Services Estates. • Links with NHS England and other Health Boards in Wales for shared learning. • Ongoing engagement of external surveyors for regular monitoring of the situation in line with recommended timelines.	**Gaps in Assurance** • Ongoing management of the issues. **Action to Address Gaps in Assurance** • Repeat surveys have been completed and additional more specific and technical surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues. • Internal Audit Review Nevill Hall RAAC Q1 2024/25	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk - SRR 002	**There is a risk that there will be a significant failure of the Health Board Estates.**			
Strategic Threat	**b)** Due to significant levels of backlog maintenance and structural impairment.	**Publication Status**	Public	**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➢ Harm or injury to patients and/or staff. ➢ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➢ Non-compliance with health and safety legislation. ➢ Litigation and financial penalties.			**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **OUTSIDE** of the target level and **OUTSIDE** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	**Current Level**	**Target Level**
Of	Chief Operating Officer			
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** *(Minor)*
Last Reviewed	01 May 2024	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Next Review Due Quarterly based on the current risk score	01 August 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Health Board Estates Rationalisation Strategy • Health Board Estates Strategy • Health Board policies and procedures related to the maintenance of Health Board estate. • 6 Facet survey completed in 2019. • Divisional Risk Register • Multiple policies and SOPs published and communicated to staff. • A robust internal training programme in place covering all aspects of estate management including food hygiene. • Asbestos reinspection programme (over the next 3 years) • Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation	• Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. • A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. • Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. • Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. • Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. • Drive clinical service engagement in compliance meetings where engagement is low. • Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Estates and Facilities division improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) • Divisional reporting of Statutory and Mandatory training of staff • Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance. • The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Outcome of the Asbestos reinspection programme • Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023- 24** • Estates Assurance - Estate Condition audit completed and been shared with Audit Committee and Finance and Performance Committee • Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. • Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level	**Gaps in Assurance** • AE reports have shown a deterioration in ratings last year. • Membership of HB-wide compliance groups continues to be extended providing wider HB intelligence of the issues. **Action to Address Gaps in Assurance** • The Divisional Director (and DP) has implemented a clear approach to compliance monitoring and escalation of AE reports. • HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants. • Internal Audit Estates Assurance – Energy Management Review (Q4) 2024-25	**Reasonable Assurance**

RISK THEME	COMPLIANCE AND SAFETY				
Strategic risk SRR 004	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.**				
Strategic Threat	**a)** Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.	**Publication Status**	Public	**Risk Appetite Level – Minimal** Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls**.**	
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Harm or injury to patients and/or staff; ➢ Health Board breaches statutory duties under the Civil Contingencies Act 2004; ➢ Litigation & Financial Penalties; ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold – Minimal Score 8 and below.** Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is **OUTSIDE** of target level and **OUTSIDE** of the appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships				
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Risk Exposure**	**Current Level**	**Target Level**	
Initial Date of Assessment	01 June 2023	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Last Reviewed	01 May 2024	**Impact**	5 *(Catastrophic)*	3 *(Moderate)*	
Next Review Due Quarterly based on the current risk score	01 August 2024	**Risk rating**	**= 15** *(Moderate)*	**= 6** *(Moderate)*	

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Major Incident • Major Incident Plan – Refreshed and approved at March Board • Local/Divisional action cards are in place. • Training undertaken service-specific relating to local response. **Business Continuity (BC) /Critical Incident** • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents. • EPRR Group Established. • Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. • Awareness raising of the requirement for BC across the Health Board through various training programmes. **Infectious Diseases** • Joint plan with PH in response to infectious diseases and public health incidence response. **Overall**	• Major Incident Exercise 'Euclid' planned for 20th June 2024 – Faculty in place to plan scope and detail of exercise. • Testing programme of business continuity plans. • Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Develop further training programmes to support staff preparedness to response to an incident. • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. • Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. (as this is not fully implemented, it is still	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Departmental debrief following an incident to inform learning and enhance controls. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Debrief with key stakeholders following an incident to inform learning and enhance controls. • Report to the EPRR Group from debrief of incidents. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Review(s)** • Business Continuity Planning 2023-24 (Q2) outcome report published – Reasonable Assurance • Outcome and feedback from national exercises	**Gaps in Assurance** • Robustness of service business continuity plans within Divisions **Action to Address Gaps in Assurance** • Recommendations for strengthening resilience following testing of service business continuity plans	**Reasonable Assurance**

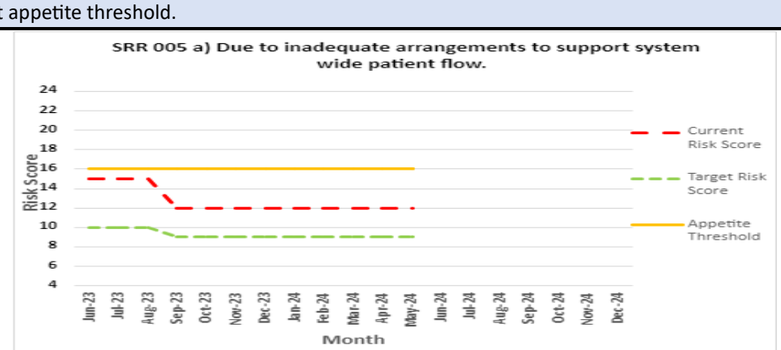
• Internal strategic on call training • Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	being worked through thus would make it additional control until in place)			

RISK THEME	SERVICE DELIVERY			
Strategic Risk - SRR 005	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	a) Due to inadequate arrangements to support system-wide patient flow	**Publication Status**	Public	
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3 *(Minor)*
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*
Next Review Due Quarterly based on the current risk score	01 July 2024			

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

Risk Appetite Threshold – Open SCORE 16 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

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



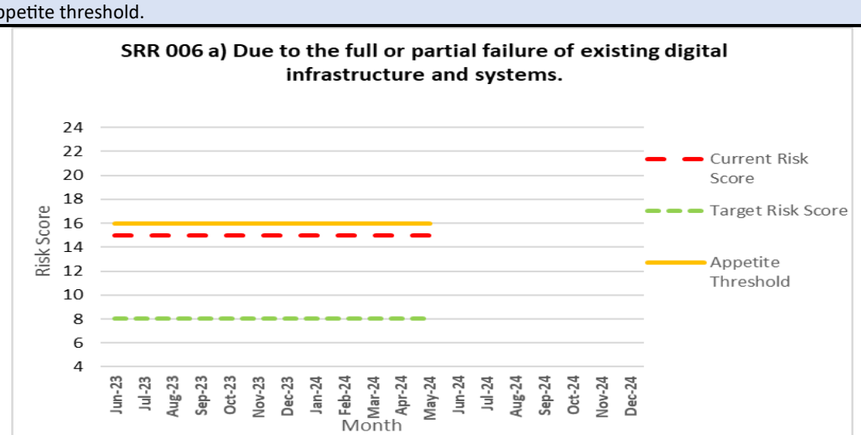
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Workshops in diary. • Improve regional acceptance of flow processes with neighbouring Health Boards.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews** 1. Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements. • Internal Audit 2024/25 Plan - Review of the Performance Management and Accountability Framework24/25 plan.	**Reasonable Assurance**

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

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

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

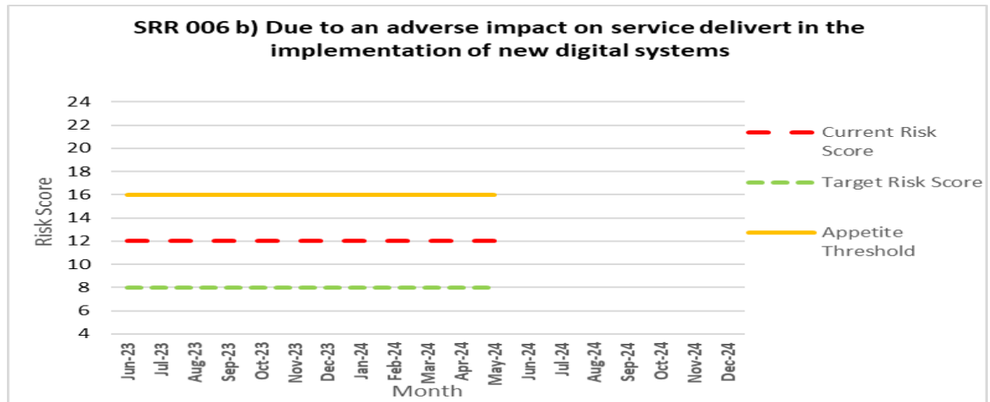
SUMMARY
The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.



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

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

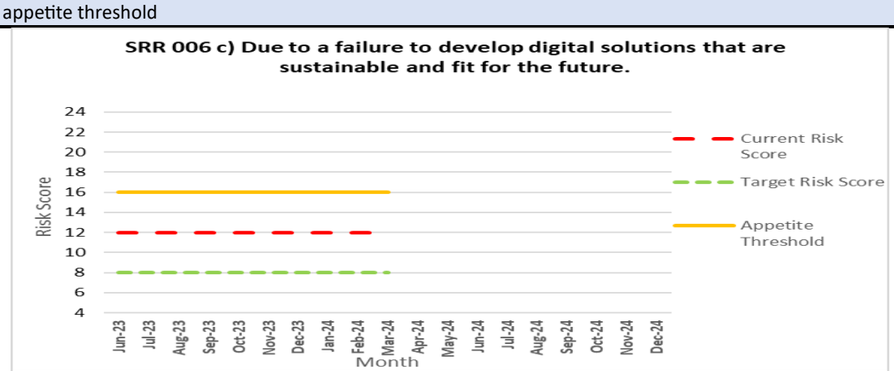
RISK THEME	SERVICE DELIVERY				
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				
Strategic Threat	**b)** Due to an adverse impact on service delivery in the implementation of the new digital systems.	**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 17 and below** Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* *x*	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*	
Last Reviewed	01 April 2024	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*	
Next Review Due Quarterly based on the current risk score	01 July 2024				



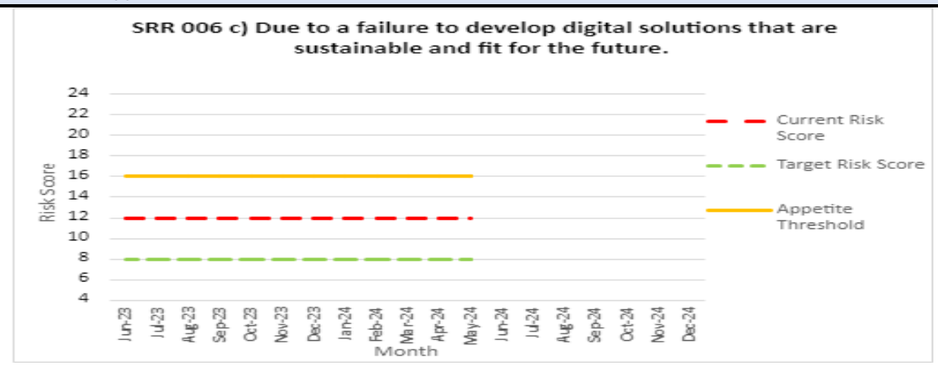
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. • Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. • Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. • Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. • Business change team in place to support services in improvement of clinical and administrative processes. • Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. • Projects support backfilling of clinical time where required.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Project Boards meet monthly and report into the quarterly Digital Portfolio Progress Group • Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. • Risk management approach and escalation processes in place in line with the Health Board's Risk Framework **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Oversight from NHS Wales Cyber Resilience Unit **Action to Address Gaps in Assurance** • Internal Audit Technical Continuity Review Q3 2024/25	**Reasonable assurance**

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

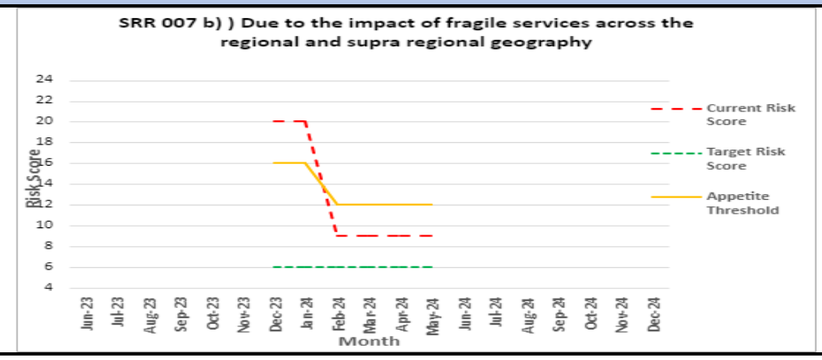
RISK THEME	SERVICE DELIVERY				
Strategic Risk - SRR 006	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**				
Strategic Threat	**c)** Due to failure to develop digital solutions that are sustainable and fit for the future.	**Publication Status**	Public	**Risk Appetite Level – OPEN** Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➢ Harm or injury to patients and/or staff; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Data breaches; ➢ Litigation & Financial Penalties; ➢ Reputational damage and loss of public confidence.			**Risk Appetite Threshold - Score 17 and below.** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold	
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*	
Last Reviewed	07 April 2024	**Risk rating**	**= 12** (High)	**= 8** *(Moderate)*	
Next Review Due Quarterly based on current risk score	01 July 2024				



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

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
Strategic Risk - SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**				
Strategic Threat	**a)** Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.		**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	➢ Unmet patient need resulting in harm; ➢ Ineffective use of combined resources; ➢ Delayed decision making; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability; ➢ Reputational damage and loss of public confidence.				**Risk Appetite Threshold** - SCORE 16 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**	**SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)* x	2 *(Unlikely)* x	
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*	
Last Reviewed	01 April 2024	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*	
Next Review Due Quarterly based on current risk score	01 July 2024				

Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: 1. **The Gwent Public Services Board (Gwent PSB)** brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. 2. **The Gwent Regional Partnership Board** As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	• Governance review of Regional Partnership Board undertaken in August 2023. • Renewed Strategy for strategic partnership Capital in place and revised governance processes. • New Long-Term Strategy for Health Board to focus on Partnership approach.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • PMO reporting to the Director of Strategy, Planning and Partnerships. • Regional Leadership Group Reporting **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Governance Review 2023/24 (Q2) – Underway – due to be reported to the Audit, Risk & Assurance Committee in July 2024.	**Gaps in Assurance** • Systematic reporting of outcomes • Systematic evaluation of schemes • Governance of financial control arrangements **Action to Address Gaps in Assurance** • Implementation plan to be developed following RPB governance review. • Health Board strategy development approach to focus on partnership approach. • Internal Audit Partnership Arrangements Review (Q1) 2024/25	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
Strategic Risk - SRR 007	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population**				
Strategic Threat	**b)** Due to the impact of fragile services across the regional and supra regional geography	**Publication Status**	Public	**Risk Appetite Level - OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	➢ Unmet patient need resulting in harm; ➢ Ineffective use of combined resources; ➢ Delayed decision making; ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability; ➢ Reputational damage and loss of public confidence.			**Risk Appetite Threshold - SCORE 12 AND BELOW** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. **SUMMARY** The current risk level is **OUTSIDE** of target level but **WITHIN** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Strategy Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x	
Initial Date of Assessment	04 January 2024	**Impact**	*3 (Moderate)*	2 *(Minor)*	
Last Reviewed	01 April 2024	**Risk rating**	***= 9*** ***(High)***	**= 4** ***(Moderate)***	
Next Review Due Quarterly based on the current risk score	01 July 2024				

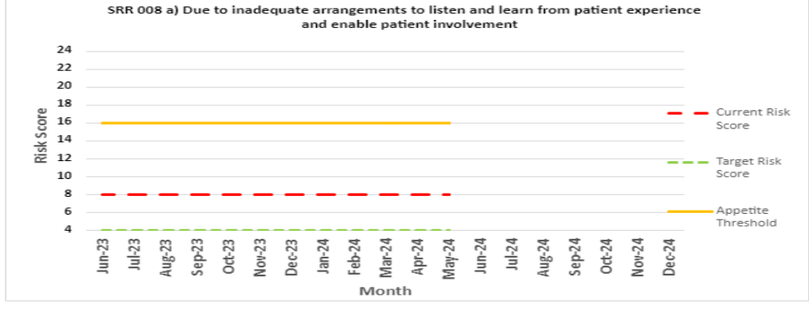
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. In addition to these formal arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	The southeast Wales health boards have agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. The revised priorities / forward work plan includes the following: - • An absolute commitment to delivering on the existing regional programmes of work but with these 're-baselined' for 2024/25 to ensure there is a continued regional consensus on objectives, outcomes, and planning assumptions. • The need to review the current regional working governance arrangements, to ensure these remain fit for purpose. • The need to further review the indicative list of fragile services for the Southeast region and begin considering the regions response to these. • The need to develop a regional clinical service plan that can articulate what a long-term sustainable secondary care system looks like for Southeast Wales that can then inform local decisions (collaborative work has been undertaken in March with a parallel WG review of fragile services across south Wales, to ensure alignment of assumptions and priorities) • A further workshop (to include Chairs, Executives and clinicians) has been arranged for June. Discussion ongoing at all Wales NHS CEOs and NHE Executive on governance and infrastructure to take forward cross regional planning to be reviewed considering IR and Neonatal work	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Service Divisions reporting to the Chief Operational Officer **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Assurance reporting to the Population Health, Partnerships, and Planning Committee. • Assurance reporting to the Board. • Regular touchpoint meetings of all key players to review progress and issues arising **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** • Alignment and effectiveness of partners to deliver integrated services **Action to Address Gaps in Assurance** • Internal Audit Partnership Arrangements Review (Q1) 2024/25	**Reasonable Assurance**

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk - SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.**			
Strategic Threat	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Publication Status**	Public	
Impact	➢ Adverse impact on patient experience; ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability; ➢ Reputational damage and loss of public confidence; ➢ Failure to deliver Duty of Quality.			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	01 April 2024	**Risk rating**	**= 8** *(High)*	**= 4** *(Moderate)*
Next Review Due Quarterly based on the current score	01 July 2024			

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

Risk Appetite Threshold – Open SCORE 17 AND BELOW
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

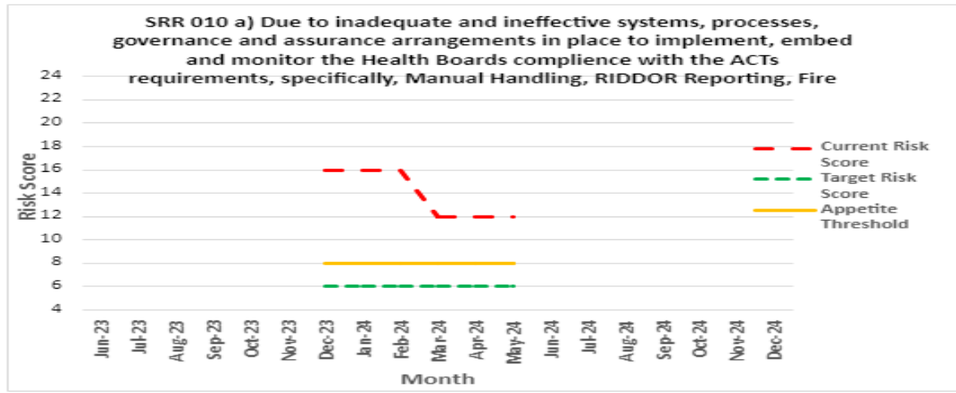
SUMMARY
The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. The target level is **WITHIN** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions. • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Ned to have discussions with facilities around rooms.	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes. • Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation • Immediate feedback and escalation to clinical teams following PALS queries and concerns. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • LLais Reports • HIW inspections • Advocacy reports	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • Scope of the bereavement offer needed. • Detailed assessment of patient experience across different themes. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor with pilot at ED. • Patient experience KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.	**Reasonable Assurance**

RISK THEME	COMPLIANCE & SAFETY			
Strategic Risk - SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**			
Strategic Threat	**a)** Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**Publication Status**	Public	**Risk Appetite Level - MINIMAL.** Any risk that has a MINIMAL risk appetite level should be managed to a **Score of 8 or below**.
				Risk Appetite Threshold - Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls**.**
Impact	➢ Unintended physical harm; ➢ Punitive actions from the Health and Safety Executive (HSE); ➢ Increased levels of staff sickness; ➢ Loss of estate due to unsafe environments; ➢ Financial implications; ➢ Adverse publicity; and, ➢ Reputational damage			**SUMMARY** The current risk level is **OUTSIDE** of target level and **OUTSIDE** appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

Lead Director	Director of Therapies & Health Science	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (*possible*) **x**	**2** (*Unlikely*) **x**
Initial Date of Assessment	01 December 2023	**Impact**	***4*** *(Major)*	**3** *(Moderate)*
Date Reviewed	01 May 2024	**Overall Risk Rating**	**= 12** *(High)*	**= 6** *(Moderate)*
Date of Next Review Quarterly based on the current score	01 August 2024			



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training / Development (delivered on 24 Apr 2024)	• Health and Safety Governance and reporting arrangements (Health and Safety Committee) • Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Health and Safety compliance data extracted from ESR and Datix and reported **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee • Established monitoring of H&S at the PQSO Committee **Level 3 Independent**	**Gaps in Assurance** • Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act. • Compliance on completion of risk assessments and mitigating actions **Action to Address Gaps in Assurance** • Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee	**Reasonable Assurance**

• Implementation of the Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern.	• Learning from events to be documented and communicated to the organisation.	*(Implemented by both auditors internal and external independent bodies.)* • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	• Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan • Internal Audit Health and Safety Review 2024/25 (Q4)	

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Regional Partnership Board Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Executive Director for Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Chris Dawson Morris, Deputy Director Strategy, Planning and Partnerships

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

Er Gwybodaeth/For Information

This report is to provide the Board with information in relation to the Regional Partnership Board activities and progress made during the last reporting period.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Social Services and Wellbeing Act 2014 sets out the requirement for Local Authorities and Local Health Boards to establish Regional Partnership Boards (RPB), to manage and develop services to secure strategic planning and partnership working. RPBs need to work with wider partners such as the third sector and providers to ensure care and support services are in place to meet the needs of their respective populations.

This report provides an update on, developments within the RPB, including progress in implementation of the recommendations of the Governance Review and updates to the Market Stability Report.

Cefndir / Background

This report is being provided to the Board for information, to ensure consistent messaging and updates are communicated between the Regional Partnership Board and the Health Board.

Since the last reporting period, several activities have taken place and continue to be taken forward. These include considerations of the relationship between RPB and other partnership structures such as Integrated Service Partnership Boards, consideration of the role of the sub groups of the RPB and finalisation of funded programmes for 2023/24.

Assessment

The Board is asked to note that since the last reporting period (March 2024) the following progress has been made in relation to key areas of work for the Regional Partnership Board (RPB) and via the Strategic Partnership meetings and the Regional Leadership Group.

Governance Review

Progress is being made against the actions set out in the Governance review. The full action plan progress report is attached as Annex 1. The role of the Leadership Group has been strengthened with progress already in terms of greater ownership, clarity and scrutiny of items going to the RPB. Actions relating to the simplification of processes and papers have been completed. An overarching Governance Framework is in development and being informed by a series of Workshops.

As reported last month the first of these workshops considered strengthening the strategic focus of the RPB and the following four areas were agreed:

1. **Focus on prevention.** This was not seen as solely as primary prevention but prevention across care pathways, focusing on activities which prevent decline in citizens health and well-being.
2. **Focusing on the longer term.** It was acknowledged the RPB is increasingly being drawn into immediate acute pressures, however it may add best value by focusing on longer term sustainability and preventative activity in order to break out of cycles of seasonal pressures. This was seen as particularly important given the demographic changes in the Gwent population.
3. **Focus on Early Years.** In the context of a longer-term preventative focus it was acknowledged focusing on early years is essential
4. **Relentless focus on citizen need.** Across all areas, ensuring a focus on understanding and meeting the needs of the population of Gwent working with citizens.

A second workshop took place in early March. This workshop focussed on the sub structures of the RPB, considering the role, purpose and function of each group under the RPB. The workshop considered how these groups could maintain focus on key strategic issues and resolution of population challenges rather than a perceived existing focus on allocation of grant funding. The second part of the workshop considered the relationship between RPB and the Primary Care Partnership Infrastructure with a particular focus on Integrated Service Partnership Boards. There is further work to do to bring clarity to these arrangements.

Building Community Capacity (Further Faster)

Welsh Government provided an allocation of funding via the Health board to support delivery of the ministerial led Building Community Capacity programme. Gwent Regional Partnership Board considered the decision making authority for the allocations and agreed the following arrangements:

- Anticipatory Care Planning and Community Capacity will be agreed through the Regional Partnership Board structure.
- Weekend Community Nursing and Palliative and End of Life Care allocated via Health Board governance.

The table below illustrates the funding streams, allocations, and decision-making authority.

Funding Area	Gwent 2023/24		Gwent 24/25		Delegated Decision Making
	£ (million)	%	£ (million)	%	
Weekend Community Nursing	0.14	8.70%	0.55	24.00%	ABUHB
Weekend/Bank Holiday Specialist Palliative & End of Life Care Nursing	0.04	2.30%	0.14	6.30%	ABUHB
Anticipatory Care Planning for 0.5% People Most at Risk of Urgent Care	0.45	28.30%	0.45	19.50%	RPB
Community capacity (this is in addition to the £5m awarded nationally previously for AHP community investment)	0.96	60.70%	1.15	50.20%	RPB
TOTAL	**1.58**	**100%**	**2.29**	**100%**	

23-24 Development & Mobilisation Period

To manage the development and consideration of plans against the objectives and funding allocations described above, the Regional Partnership Board considered appropriate delegated decision making.

The objectives relating to anticipatory care planning and community capacity were delegated to Regional Leadership Group (the executive group of the RPB). Proposals were developed via the county based Integrated Service Partnership Board (also referred to as Pan Cluster Planning Group), and were submitted for regional consideration. As set out previously, in order to maximise utilisation in 2023/24 given the late allocation of funding in the financial year, the allocation was predominantly used to support the essential switch over of home technologies from analogue to digital.

The weekend community nursing and weekend palliative care objectives were delegated to ABUHB, and a task and finish group established to consider regional plans and development activities.

2024-25 Development & Delivery Plan

The following provides a summary of the planned activity against the objectives of the Building Community Capacity Programme.

Enhanced Community Care: The predominant utilisation in 2024/25 relates to the expansion of Community Resource Teams with a focus on frailty response. These

plans seek to address the inequity in access to frailty services with a recurrent funding allocation of £1,240,084.

Anticipatory Care Planning: The Regional Leadership Group recognised the significant ability of the third sector to develop community capacity using the network of local organisations to directly meet need. It has therefore provided £359,916 to the third sector, to be allocated via the Community Voluntary Councils (GAVO and TVA) in partnership with Integrated Service Partnership Boards. Proposals will be developed on a local/county basis to respond to this priority area. In addition, anticipatory care planning will also be a thematic development across all of the programme areas to support a systematic approach to anticipatory and advanced care planning, supporting both preventative activity and also developments within community/palliative nursing services.

Community Nursing Specification: The Community Nursing Specification (CNS) has highlighted the need to expand district nursing services in order to increase provision for palliative care and to increase weekend provision to 60% of weekdays. Recruitment is underway to develop agile community capacity to support prevention activity aligned with areas of demand, providing flexibility between in-reach to acute sites and substantive community frailty resource. This will be realised from the allocation of £550,000.

Palliative Care Nursing: The Health Board has acknowledged a need to develop an End of Life Care Strategy for the region to be developed with partners including the hospices in the region, a strategic post employed by ABUHB will oversee pathway development and review the scope of all existing SLAs and system capacity for palliative care. Whilst pathways developments are undertaken to inform longer term plans, hospices will be commissioned to provide additional weekend specialist palliative care capacity. The above capacity will be realised from the allocation of £140,000.

Third Sector Provider Issue (Care Collective)

The Care Collective, previously known as Carer's Trust South East Wales, have been a long-standing delivery partner of the regional partnership. The organisation confirmed on Monday 11 March their decision to close the business at the end of the 2023/4 financial year.

The decision to close had implications for circa 88 staff members within the organisation with the potential impact for 900 unpaid carers. In addition, the regional hub building in Pontypool was owned and occupied by the organisation, but is subject to a legal charge, for which ABUHB is the beneficiary as the lead organisation/banker for ICF capital funding.

Both Community Voluntary Councils (CVCs) have confirmed that the Care Collective had not been recognised as an organisation potentially at risk. A review of information held by both the CVCs and the Partnership support teams has confirmed that no indication of organisational difficulty was notified by the Care Collective.

Risks associated with the organisation's closure were successfully mitigated following an at-pace engagement and development with the third sector network. A 6-month temporary arrangement has been established with an alternative third sector provider to support service continuity, whilst longer term plans are established.

In relation to the hub asset that is subject to a legal charge, receivers were appointed to take control of the hub building and confirmed their acceptance on the 27th of March 2024. This arrangement provides the ability to collaborate with Welsh Government and explore the transfer of the asset to an alternative provider in line with any longer-term arrangements established, whilst adhering with grant funding conditions.

Regional Resourcing of RPB

As well as making recommendations, The Governance Review, referenced earlier, in addition to making recommendation also made a general observation that the RPB should, as a matter of priority, consider reviewing the current funding arrangements for both the Regional Partnership Team and the Partnership Portfolio Management Office.

In response to this observation the task and finish group agreed to an action to undertake a review of the RPT and PMO functions and funding arrangements. These were presented to the Regional Partnership Board and a financial plan put in place that places both teams on a sustainable footing.

Following the completion of the wider recommendations of the governance review, a second phase review of the regional resource will be undertaken to establish joint objectives for the teams, and further review functions of both teams to ensure no duplication.

It was agreed there is a need for a future report to outline the longer term funding arrangements when the various grants come to an end in 2027.

Internal Audit

Within the 2023/24 Internal Audit Plan, the review of ABUHB Financial Controls for the Regional Partnership Board was included. The scope of the audit has covered the following areas:

- To determine if the Health Board's Model Standing Orders Reservation and Delegation of Power / Standing Financial Instruction (SFIs) / the Financial Control Procedures (FCPs) are adhered to;
- To ensure a sample of relevant requisition orders, invoice processing, receipting, Oracle posting and budget holder responsibility etc. are in accordance with the SFIs/FCP; and,
- To ensure appropriate monitoring and escalation processes are in place.

Audit activity in this respect has concluded, and findings are currently being written up for reporting to the Audit, Risk and Assurance Committee.

2023/24 Annual Reporting

Reporting activities for the Regional Partnership Board portfolio of transformation activity are currently underway. Reporting associated with the largest revenue source was successfully completed and submitted in draft by the 30 April 2024 deadline, pending ratification via Regional Partnership Board governance structures ahead of formal submission. Wider end of year reporting across ring-fenced and capital programmes remain underway, with a variety of timeframes for completion through May 2024. All reporting will be submitted in draft format pending ratification.

2024/25 Financial Allocation

It has now been formally confirmed that tapering of Regional Integrated Funding will not be applied for the remainder of the funded programme (to 2027). This would have been a process which required partners to taper down direct partnership funding from projects and replace this from existing budgets or close projects.

Whilst Tapering has been removed the RPB is still committed to undertaking evaluation of all programmes. Following RPB approval a two phased evaluation approach, has been implemented. An initial impact assessment of projects, based on agreed criteria, for assessing all ongoing Regional Integrated Fund revenue projects has been applied to the portfolio. There are several schemes that have been excluded from the impact assessment process due to the short-term nature and specific separate evaluation requirements. This relates to the System Resilience Plan activities (winter schemes), Community Voluntary Council Small Grants and the Neurodivergent Improvement Programme.

The following table provides a summary of the impact assessment categorisation by Strategic Partnership and programme. The purpose of the impact assessment is to identify where schemes may not be performing (Red/Amber) and therefore target deeper evaluation methodologies in these areas to inform future funding agreements.

Strategic Partnership	Programme	No. of Schemes	Green	Amber	Red
Carers	SP01 Support for Unpaid Carers	9	8	0	0
Children & Families	SP02 Children's Early Intervention & Resilience	21	21	0	0
	SP04 Children's Emotional Health & Development	7	7	0	0
Dementia	SP06 Dementia: Assessment & Diagnosis	5	1	2	1
	SP07 Dementia: Living with Dementia	11	2	8	0

Gwent Adults	SP05 Workforce Development	3	1	0	1
	SP08 Prevention & Wellbeing	17	5	6	0
	SP10 Place Based Graduated Care	21	11	7	1
	SP11 Improving System Flow	18	2	7	4
MH&LD	SP08 Prevention & Wellbeing	2	2	0	0
	SP12 Neurodivergent & Learning Disabilities Improvement Programme	11	9	0	0
ALL	SP09 Assistive Technology	7	2	4	0
Totals		133	71	34	7

Gwent Regional Partnership Board is in receipt of a number of revenue grant funding streams, issued by a number of Welsh Government departments to support a range of policy funding guidance. The summary below provides a position statement in relation to the known allocations for 2024/25.

Revenue Budgets Confirmed:

- Main Regional Integration Fund Revenue
- Ringfenced Integrated Autism Service
- Unpaid Carers Hospital Discharge
- Further Faster
- Dementia Action Plan
- Dementia Memory Assessment Services
- Carers Short Breaks
- Neurodivergence Improvement Programme

The RPB therefore has circa £30.4m revenue to allocate in 2024/25, the majority of which will be allocated to existing projects, with the caveat they are subject to evaluation. Within the Regional Integration Fund, £674k of available funding has been allocated to Children's preventative activity, the priorities for which will be developed by the Children & Families Strategic Partnership. A workshop took place on 29 April 2024 in this respect, with membership inclusive of Health, Social Care, Education and Third Sector partners.

Market Stability Report

Market stability reports (MSRs) are a legal requirement under section 144B of the Social Services and Well-being (Wales) Act 2014. The duty to prepare and publish an MSR sits with each local authority, but the Regulations require LAs to carry out this function on a regional footprint and in partnership with the Health Board so that one report is prepared for each of the seven RPB areas across Wales. MSRs must be published every five years, and the they must be reviewed annually and amended or updated as necessary.

Market stability is defined in the underpinning codes of practice as:
an assessment of the stability of the market for regulated services providing care and support (care homes for adults and children, domiciliary care, fostering services, adoption services, secure accommodation for children, adult placements, advocacy, and residential family centres). The current Gwent RPB Market Stability report is available on RPB website. Home - Gwentrpb

The MSR has been reviewed and updated with latest data; and priorities identified as set out below:

- Increased collaboration is vital as we move into a new phase of austerity.
- Relationships remain strong and productive across all market segments. However, it would be complacent to rule out provider withdrawals, failures and sufficiency impact on quality of services, straining of relationships etc.
- The elimination of profit from social care provides significant challenges and provider uncertainty for local authority Children Services
- Good progress on regional working in many areas building on earlier good practice to include:
    - Regular monthly performance and information exchange meetings with Care Inspectorate Wales and all commissioners
    - Template contract and performance management framework for domiciliary care and care home accommodation for older people.
    - Work to commence on contract addendum for the provision of equipment in care homes.
    - A joined-up approach to fees for 2024-25
- Providers are highlighting challenges with implementing real living wage during current financial cuts.
- Opportunities for pooled budgets is kept under regular review.

Overall, an improving picture for both stability and sufficiency are now threatened by financial cuts.

Argymhelliad / Recommendation

The Board is asked to note the update in respect of the Regional Partnership Board.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	**SRR009 – Transformation and Partnership Working**
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live healthily and age well Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Explained within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Planning, Partnerships and Population Health Committee.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Choose an item.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Executive Committee Activity: 18th March 2024 – 2nd May 2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Board with an overview of a range of issues discussed by the Executive Committee during the period 18th March 2024 – 2nd May 2024. Due to the nature of the Executive Committee's business, not all issues will be suitable for disclosure into the public domain.

Cefndir / Background

The Chief Executive Officer is responsible for the overall organisation, management and staffing of the Health Board and its arrangements related to quality and safety of care as well as matters of finance, together with any other aspect relevant to the conduct of the Health Board's business in pursuance of the strategic directions set by the Health Board's Board, and in accordance with its statutory responsibilities.

The Executive Committee is the executive decision-making committee of the organisation, which is chaired by the Chief Executive as Accountable Officer.

The Executive Committee is responsible for ensuring the effective and efficient co-ordination of all functions of the organisation, and thus supports the Chief Executive/Accountable Officer to discharge her responsibilities.

Asesiad / Assessment

The Executive Committee meets on a weekly basis and focusses on the breadth of the organisation's business. These formal meetings are supplemented by:

- Informal Executive Team Sessions, which are used to focus on strategic developments, information sharing and Executive Team engagement.
- A quarterly Clinical Futures Board, which enables the Executive Team to oversee implementation of the Board's strategic priorities, take decisions and resolve issues which may be impacting delivery.
- A monthly Executive Committee Performance Meeting, which enables the Executive Team to monitor the Health Board's integrated performance to enable a focus on quality, workforce, activity and financial performance.
- Regular Executive Team development sessions focussing on the effectiveness of the Executive Team and its way of working.

Much of the business of the Executive Committee informs onward reporting to the Board's assurance committees, providing assurance to the Board on the effective management of the organisation and achievement of the Board's strategic objectives. The Executive Committee's business also informs much of the Board's formal meeting agendas, given the Executive Team's responsibility for strategy development and its implementation.

The Workplan of the Executive Committee is based on five key areas to ensure appropriate focus, oversight of the organisation's business, and enable the Chief Executive Officer and Executive Team members to discharge their responsibilities effectively:

- Quality, Safety and Culture
- Delivery, Performance and Efficiencies
- Strategic Planning and Service Development
- Strategic Partnership Arrangements
- Transformational programmes (IMTP/Clinical Futures).

During the period 18th March 2024 –2nd May 2024 the following matters were some of the issues considered by the Executive Committee:

Quality, Safety & Culture

At each weekly meeting, the Executive Committee receives a Safety Briefing which includes a summary of recent Patient Safety Incidents, Complaints, Never Events, and Injurious Falls. The Executive Committee has also maintained a focus on the performance of the urgent and emergency care system, including ambulance handover delays and red release requests to ensure that the level of risk in the community is balanced across the entire system.

Other matters discussed include:

- Management of Higher Risk Surgical Patients in RGH POCU: The Executive Committee received an update on the use of the Surgical High Care (SHC) Unit (previously known as POCU), at RGH for higher risk surgical patients. This was

also presented to the Patient Quality and Safety Committee at its meeting on 30th April 2024.

- Health, Safety and Fire Improvement Plan: The Executive Committee received an update on the oversight and governance arrangements, and current progress of the Health and Safety Improvement Plan 2023/24. The Executive Committee approved the following:
    - The terms of reference and membership of the revised Health and Safety Committee.
    - Endorsed the development of a 3-year health and safety strategy and culture plan, and for the strategy and plan to be presented to the Executive Committee by the end of September 2024.

- Learning from Death Report: The Executive Committee received an overview of the Learning from Death Report and noted that the aim was to publish a bi-annual report on the Health Boards Learning from Death, with a Primary Care Death Report being available by the end of the year. The framework would allow the Health Board to ensure that services were safe and effective as well as enabling the scrutiny of outcomes of care. This was also presented to the Patient Quality and Safety Committee at its meeting on 30th April 2024.

- Volunteering Annual Report: The Executive Committee received the Volunteering Annual Report which identified the key achievements over the past 12 months and recognised the key contribution that volunteers play in enhancing services provided by paid staff, with the aim of improving the experience for patients, their families. This will be presented to the Patient Quality and Safety Committee at its next meeting.

- Race Pay Audit and Gender Pay Audits: The Executive Committee considered the audit reports prior to consideration by the Board at its meeting on 22nd May 2024.

Delivery, Performance & Efficiencies

The Executive Committee has monitored and discussed the Health Board's financial position continuously and implemented mitigating actions to improve the forecasted financial position. To ensure a consistent sufficient focus on delivery and to explore further opportunities across the Health Board, an Executive Value and Sustainability Board has been established, with progress reported through the Financial Performance Report presented to the Board.

Other matters discussed include:

- Welsh Health Circulars (WHCs): The Executive Committee received several WHCs, issued by Welsh Government, including Preceptorship & Clinical Supervision - Position Statement, Vaccination to Staff to protect against measles, Implementation of the Non-pay Elements of the 2022-24 Collective Agreement, Changes to Dietary Advice on feeding young children and National Clinical Guidance for Stroke.

- PROMPT Action Plan: The Executive Committee received an evaluation of compliance against the PROMPT Wales standards, during the period of 1

September 2022 and 31 August 2023. The Executive Committee noted improvements made and action plans to achieve compliance.

- Inquiry Programme Update: The Executive Committee received an update on the Health Boards response to date and preparedness for the UK COVID-19 inquiry as a core participant of Module 3.

- Complex and Long-Term Care Division: The Executive Committee supported a proposal to realign the Complex and Long-Term Care Directorate to a delegated function of the Primary and Community Care Division.

- MBRRACE-uk Perinatal Report 2021: Still Birth Update 2022 & 2023 (IUD Rates): The Executive Committee received an update on the perinatal mortality rates for 2022 and 2023, the ongoing work to reduce mortality rates, and improve outcomes for mothers and babies in the Health Board. The Executive Committee noted the report and discussed the actions taken as a result of the review, noting the improvements made and the positive reduction of mortality rates.

- Mat/Neo Programme: The Executive Committee received an update, noting the ongoing collaborative work regarding maternity and neonatal services and the response to the Maternity Neonatal Support Programme. The Executive Committee requested further discussions to strengthen the governance structure and a review of the ToR of Maternity Neonatal Group.

- British Association of Perinatal Medicine (BAPM) Standards: The Executive Committee received an update on NICUs current compliance with the British Association of Perinatal Medicine (BAPM) standards. The Executive Team noted the update outlining NICU's current compliance and its ambition and plans for improvement in areas such as Transitional Care, Medical Staffing and the establishment of Allied Health Professionals, including psychology and pharmacy.

- Interim All Wales 2024/25 FNC rate: The Executive Committee approved an interim FNC rate for NHS contributions with effect from the 1st of April 2024, pending finalisation of the National FNC rate for 2024/2025.

- System Flow Dashboard: The Executive Committee received a demonstration of a newly developed System Flow Dash Board which provides an overview of the management of data across the Health Board.

- Request for approval & release of external AHP funding to support the scale & spread of the Community Admission Avoidance Therapy Team **(**CAATT) 2024/2025 onwards: The Executive Committee re-considered a proposal to utilise external funding to support the scale and spread of the CAATT for 2024/25 onwards which includes the recruitment of a substantive Therapy team. The Executive Committee requested that the expansion of the service be aligned to the demand across the Medical Assessment Units at Ysbyty Ystrad Fawr Hospital and Royal Gwent Hospital.

- Welsh Intensive Care Information System: The Executive Committee received an update on the position of the Welsh Intensive Care Information System (WICIS) and was updated in relation to the clinical assurance review and further detailed user acceptance testing that had been carried out by the Health Board. The Executive Committee considered the options around progressing with this system in the context of the national contract.

Strategic Planning & Service Development

The Executive Committee received regular updates in relation to the Health Board strategic planning, service developments and sustainability, including business cases and programmes of work. The following key items were presented:

- Pharmacy Robot: The Executive Committee received an updated proposal for the pharmacy robot in the Royal Gwent Hospital and noted the additional costs. The additional costs were mainly due to dispensary alterations, a new fridge and IT costs that were essential for the dispensary to work effectively. It was noted that the new robot at RGH would be sufficient to support all robot services from NHH, minus the services currently provided at Nevill Hall Hospital (NHH) for Powys Teaching Health Board. The Executive Committee supported the additional costs required to replace the Robotic Dispensing System at the Royal Gwent Hospital and requested a Chairs Decision to agree the additional costs.

- HEIW Undergraduate Commissioning Numbers 2024-25: The Executive Committee received an update outlining the Health Education and Improvement Wales (HEIW) undergraduate educational commissioning numbers for the 2024-25 Integrated Medium-Term Plan (IMTP) submission. The Executive Committee approved the HEIW undergraduate educational commissioning numbers for the 2024-25 annual IMTP submission.

- Development of a Transitional Care Unit The Executive Committee received an update on the key issues for sustaining women and children's services in the Grange University Hospital (GUH) and noted the pressures on midwifery, gynaecology and neonatal service and discussed the proposed changes outlined in the report for the requirement for a Transitional Care unit at GUH.

Strategic Partnership Arrangements

The Executive Committee received updates on the Health Boards arrangements with strategic partners. The updates included:

- RPB Lead Organisation- Third Sector Partner Closure & Risks: The Executive Committee received the report requesting Executive Committee support for the continuity of hub provision for unpaid carers as a partner to the Regional Partnership. The Executive Committee noted the contents of the report, and the assurance provided that the governance arrangements put in place by the Partnership PMO had mitigated any financial liabilities being realised to the Health Board, associated with both revenue service provision and the capital asset as the banker/fund manager to the RPB.

Other Formal Business

As standing agenda items, the Executive Committee receives:

- Internal Audit reports issued;
- Routine reporting against Audit Recommendations Tracking; and
- Published Welsh Health Circulars and Ministerial Guidance.

In this reporting period, the Executive Committee has also considered development of papers ahead of Board and Committee consideration, including:

- Quality and Safety Performance Report
- Workforce Performance Dashboard
- Strategic Risk Report
- Financial Performance Report
- Activity & Performance Report
- Limited Internal Audit Reports; Risk Management Final Internal Audit Report April 2024 & Follow up of High Priority, YYF Breast Care Unit Final Audit, and the Internal Audit 2024/25 Workplan.
- Financial Control Procedures
- Race Pay Audit
- Gender Pay Audit
- Endoscopy Business Justification Case

System Leadership Group

The Executive Team established monthly System Leadership Group meetings in 2023, which have continued throughout 2024 with leaders from across the Health Board. The meetings have been used to discuss system wide priorities, including a focus on development of the Annual Plan 2024-25, Genomics Partnership Wales, and Innovation in Radiology, including GAE surgery and the artificial intelligence diagnostic imaging pilot.

Executive Team Development

The Executive Team continues to hold monthly sessions to focus on team development, informal discussion on the development of cultural and strategic aspects as well as enable dedicated attention to key risks and issues. In the last reporting period, the Executive Team has dedicated informal time to focus on team key risks, challenges and opportunities allowing space to explore matters in an informal and collective way.

Argymhelliad / Recommendation

The Board was asked to **NOTE** the update of the Executive Committee and the overview of some of its activities.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Linked to all IMTP priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	IMTP- Integrated Medium-Term Plan RAAC- Reinforced Autoclaved Aerated Concrete NICU- Neonatal Intensive Care Unit CMO- Chief Midwifery Officer MHLD- Mental health and Learning Disabilities SHC- Surgical High Care HEIW- Health Education and Improvement Wales OCP- Organisational Change Process FNC- Funded Nursing Care WHC- Welsh health Circulars RGH- Royal Gwent Hospital GUH- Grange University Hospital ToR- Terms of Reference EHCR- Electronic Health & Care Record

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

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

Agenda Item:4.13

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Committee and Advisory Group Update including Assurance and Committee Annual Reports**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Jones, Head of Board Business

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In line with the Health Board's Standing Orders, a number of Board Committees and Advisory Groups have been established. This report provides, for assurance,

- an overview of the business undertaken by these committees during the reporting period, and highlights key matters for Board consideration, where required, and,
- the Annual report of each Committee of its activities in 2023/24.

Cefndir / Background

The Health Board's Standing Orders, approved in line with Welsh Assembly Government guidance, require that a number of Board Committees and advisory groups be established. The following Committees and advisory groups have been established:

- Audit, Risk and Assurance Committee
- Charitable Funds Committee
- Patient Quality, Safety and Outcomes Committee
- Mental Health Act Monitoring Committee
- People and Culture Committee
- Remuneration and Terms of Service Committee

- Partnerships, Population Health and Planning Committee
- Finance and Performance Committee

Assurance Reporting

The following Committee assurance reports for the period are included at Appendix 1:

- Charitable Funds Committee- 7th March 2024
- Finance and Performance –14th March 2024
- Partnerships, Population Health and Planning Committee – 16th April 2024
- Audit, Risk and Assurance Committee – 16th April 2024
- Patient, Quality & Safety Outcomes Committee -30th April 2024

The annual reports of each Committee are included at Appendix 2 a-f. These reports comprehensively detail the activities of the committee throughout the 2023/24 year and provide further assurance.

Asesiad / Assessment

In receiving this report, the Board is contributing to the good governance practice of the organisation in ensuring that Committee business is reported to the Board and any key matters escalated, where appropriate.

Argymhelliad / Recommendation

The Board is asked to NOTE for assurance this report, and the updates provided from Health Board Committees.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Committee Chairs

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

Appendix 1

Name of Committee:	**Charitable Funds Committee**
Chair of Committee:	**Paul Deneen**
Reporting Period:	**18th March 2024**

Key Decisions and Matters Considered by the Committee:

Finance Report

The Committee received the Finance Report for the period ending 2023/24 noting that:

- The financial position of funds as of 31st January 2024 was £5852
- Expenditure of £1044K had been incurred in respect of increased expenditure on equipment specifically Ophthalmology and Urology and defibrillators in the community. There has also been increased expenditure for staffing costs relating to grant funded schemes in 2023-2024.
- CCLA investment unrealised gains of £244K
- Overall financial gain of the funds
- No accounts were overdrawn as of 31st January 2024 with no accounts being closed in the period.
- 5 funds have been merged since start of the financial year
- expenditure as a percentage of overall fund balance should increase as the year progresses and so far, to date there had been 730 donations.
- At Month 9, 411 funds had decreased in value compared to the previous quarter and 29 static funds had increased compared to the previous quarter.

The Committee was asked to approve two new grant funds as restricted funds, namely:

- Grant - The Health Foundation Grant – Head & Neck Cancer (Reducing the delay from referral to diagnosis for Head and Neck Cancer patients
- Grant – NHS CT – Stage 2 Community Partnership (Person Centred Meaningful Activities and Engagement)

The Committee was informed that a bid was to be submitted to the Greener Communities 2024 Programme for Decarbonisation Work.

The Committee **NOTED** the report and **APPROVED** for the two new grant funds to be established as restricted funds.

Financial Control Procedure Annual Review

The Committee received amendments to the Charitable Funds Financial Control Procedure for approval and was provided an overview of the proposed changes. The Committee was asked to approve three new sections into the procedure which were:

- 11.7 Team Building
- 11.7 Staff Wellbeing
- 11.7 Appendix 1 including information on accessing funds

The Committee **APPROVED** the amendments.

Briefing Pack for Divisional Managers for Accessing Charitable Funds – Funds Available/Applications

The Committee received the report which introduced a new guide on Accessing Charitable Funds for staff of the Health Board. The Committee was asked to approve the guide and agree for it to be published on the Staff Intranet.

The Committee was informed that once the Accessing Charitable Funds Guide was published the increased visibility and access would help increase the number of applications received.

The Committee **APPROVED** the Accessible Charitable Funds Guide and **AGREED** for it be added to the Financial Control Procedure and published.

Charitable Funds – Small Grants Scheme Funds Available and Applications for Consideration

The Committee was notified of the funds available for use in the general account, £22.5K, and was provided with an overview of two bids for consideration.

The Committee was informed that the two bids enclosed were in excess of 5K and both had Executive Director sponsorship. The Committee noted that at present no other source of funding could be found to fully fund the bids

The Committee was informed of the details of the two bids:

- CFC-266 - bid for Staff Recognition Awards and requested funding of £25K.
- CFC-265 - bid for staff resource for the Decarbonisation Programme at ABUHB and requested funding of 13.5K.

The Committee **AGREED** the Media Fund should fund bid CfC-266 in its entirety. The Committee **AGREED** CFC-265 would be funded in its entirety from the general pot but firstly other departments/funds would be contacted to see if they could assist with funding.

Development of Committee Annual Programme of Business 2024/25

The Committee was updated that the Corporate Governance Team was developing a programme of business for 2024/25.

The Committee **NOTED** the Annual Programme of Business.

Committee Annual Report 2023/24

The Committee received the Annual Report.

The Annual Report was welcomed with the request for future reports to note the post/lead rather than their name.

The Committee **NOTED** the report.

CCLA Investments Review

The Committee was appraised regarding the ratio of Charitable Funds managed by CCLA and funds that were invested in and noted the following proportions:

- 85% in an Ethical Investment Fund
- 15% in a Property Investment Fund

The Committee was asked to consider the following options: -

- The Committee could decide to do nothing and keep situation review
- The Committee could change the proportion of the investment in the property fund but this would result in the loss of an annual income stream

The Committee **NOTED** the report and decided to review the property fund allocation in 6 months' time.

Legislation Changes

The Committee received an oral update and **NOTED** there were no changes to legislation regarding the regulation of charitable funds at this point.

Small Grant Scheme – Well Being Pop-Up Event – Terms of Reference Update

The Committee received an update in respect of the Well Being Pop Up events that had previously been funded by the small grant scheme and was assured by the memorandum of understanding document put in place.

The Committee **NOTED** the Update.

Spending Plans Over £25K

The Committee received the report for information.

The Committee considered how assurance could be provided in respect of those funds where balances are in excess of £25K and how the funds were to be spent.

The Committee agreed that in the first instance those fundholders with no spending plans should be invited to the Committee to provide an overview of their spending plans.

The Committee **NOTED** the report and agreed to firstly invite high value fund holders to present their spending plans to the Committee.

Matters Requiring Board Level Consideration or Approval:
Board briefing on Charitable Funds
Key Risks and Issues/Matters of Concern:
None Noted

Planned Committee Business for the Next Reporting Period:
Forward work plan for 2024/25
Date of Next Meeting: 3rd July 2024

Name of Committee:	**Finance and Performance Committee**
Chair of Committee:	**Richard Clark**
Reporting Period:	**14th March 2024**
Key Decisions and Matters Considered by the Committee:	

Review of Committee Programme of Business – Committee Self-Assessment

The Committee received the outcome of the annual Committee self-assessment process that confirmed that the Committee was meeting the standards of performance.

The Committee **NOTED** the performance information contained within the report and **NOTED** that the improvement actions would be included within the Committee Forward Plan 2024/2025 and wider Board Business Improvement Plan.

Committee Strategic Risk Report

The Committee was informed that no new risks had been delegated by the Board to the Committee since the end of January 2024.

The Committee **NOTED** the report.

Estates Compliance Report, including Internal Audit Review of Estates and Facilities

The Committee received the Estates Condition Report which provided limited assurance and the Committee was assured that significant matters raised in the report that required management attention was with the Planning Department and Estates Team who were addressing these actions.

The Committee **NOTED** the report.

The Committee received the Internal Audit Review of Estates and Facilities. The Audit gave:

- Reasonable assurance to the Committee for bank process and rostering and,

- Unsatisfactory assurance was provided regarding stock management

The Committee was assured that an action plan would be developed to resolve the issues by the end of April 2024.

The Committee **NOTED** the report.

Performance Overview Report with Exception Reporting

The Committee received the Integrated Medium-Term Plan 2023/26 Quarter 3 Progress Report.

The Committee was updated on the progress that had been made on the Outcomes and Performance Framework.

The Committee was informed that:

- 22 of the 31 measures had either improved or were statistically similar with 9 deteriorated.
- Outcome measures for 'Every child has the best start in life' demonstrated good progress.
- There was mixed progress across the adult life course
- 5 out of the 7 outcome indicators for Older People had improved or was similar.
- Across the Dying well as part of life priority area good progress was evidenced

The Committee was also updated on the progress in relation to Ministerial Priorities and the Clinical Futures Programmes:

- Variable progress continued to be made
- High demand continued for services
- Cancer demand continues to increase
- The Health Board was ahead of trajectory in eliminating waits of over 156 weeks for treatment
- Growth in the total waiting lists
- Challenges remain in the timely provision of mental health assessment and interventions
- The performance of Urgent & Emergency Care system remains a priority

The Committee was also updated on the IMTP Planning scenario and the following progress was noted:

- The planning scenario had largely followed as predicted
- Outpatient and inpatient treatments was ahead of projections as of Quarter 3
- Progress had been made in reducing the number of the longest waiting patients for planned care treatments
- The Quarter 3 forecasts were in line with the actual activity for ED attendances

The Committee **NOTED** the position against IMTP 2023/24 commitments as at Quarter 3 and the mitigating and improvement actions in place.

Quarterly Update on Implementation of the Performance Management Framework

The Committee received an oral update on updates to the performance management framework.

The Committee was informed:

- Mental Health & Learning Disabilities and Urgent Care Divisions in accordance with the Escalation Framework had been placed into a state of escalation
- Welsh Government escalated the Health Board's level from enhanced monitoring to targeted intervention
- Corporate reviews had been held

The Committee **NOTED** the oral update.

Monthly Finance Report and Monitoring

The Committee received the Monthly Finance and Monitoring Report.

The Committee received the following assurance:

- The financial performance as at the end of January 2024 and forecast position against the statutory revenue and capital resource limits reported performance was £48.259m
- The savings position for 2023/24 is forecasted as £43.3m
- The Health Board's underlying financial position was a brought forward value of £89.6m
- The capital position as at the end of January was breakeven.

The Committee **NOTED** the report.

Draft Annual Plan 2024/25, including Draft Financial Plan

The Committee received the draft Financial Plan.

The Committee was advised the draft financial plan was predicated based on:

- Income assumption of £1,716m
- Aims to improve the revenue outturn; improve the underlying deficit identifies savings in excess of 2% that was the minimum set by Welsh Government; identifies medium and long-term opportunities to achieve a 3- year financial balance

The Committee reviewed the draft 2024/2025 forecast which had identified:

- £81.4m deficit at the start of 2024/25
- From analysis of national pressures £142.8m was identified
- New discretionary funding of £51.8m was included
- A worst-case position for 2024/25 position was £61.9m
- The best-case financial position for 2024/25 was £ 49.5m

The Committee **SUPPORTED** the draft financial plan to go forward to the Board for approval.

The Committee received the Draft Annual Plan 2024/25. The Committee was informed:

- The NHS Wales Planning Framework 2024-2027 Checklist
- Three Year Intent to achieve sustainable services by 2027
- How Success would be measured in each of the system change areas and priorities
- The Health Board was ahead of trajectory in eliminating waits of over 156 weeks for treatment. Improvements had also been made to wait times for treatments with a reduction in patient wait times although the Health Board remains off track to achieve Quarter 3 target.
- The growth in total waiting list remains an area of concern largely driven by the outpatient (stage 1) component. Mixed progress was noted across specialities with ENT, Orthopaedics and Ophthalmology currently behind trajectory.

The Committee **SUPPORTED** the draft annual plan to go forward to the Board for approval.

Operational Control Checklist

The Committee received a Governance and Control Escalation – Operational Control Checklist 2024 report.

The Committee was assured that:

- Divisional budget holders had been completing a Governance Operational Control Checklist for their respective areas since October 2023.
- The report showed progress at Divisional level since its inception and,
- The report demonstrated the agreed calculation method used to arrive at an overall Divisional Governance score
- An internal assessment checklist had been created by the Finance Team to improve financial control and governance with the aim to improve financial sustainability and this work was ongoing

The Committee **NOTED** the report.

An Approach to Reporting Benefits Realisation

The Committee received a report on the approach to Benefits Realisation from Business Case Investment report.

The Committee noted that:

- The Health Board's approach to benefits realisation process was completed through the Pre-Investment Panel (PIP)
- The PIP process scrutinises Business Cases against a set criterion to ensure they were fit for funding
- Benefits realisation was a key element of a business case and constitutes a key part of the PIP's review

The Committee was assured that benefits realisation was also monitored by:

- Digital, Data and Technology Directorate operates a benefits and business change process
- Value in Health Projects and Investments; reporting and evaluation was required nationally
- Regional Partnership Board evaluates Regional Investment Fund schemes
- Post Project evaluations were part of the HM Treasury Models
- Ad hoc requests from Welsh Government on reporting against ringfenced monies were also received

The Committee **NOTED** the report and next steps.

Matters Requiring Board Level Consideration or Approval:

Draft Annual Plan 2024/25, including Draft Financial Plan

Key Risks and Issues/Matters of Concern:

None Noted

Planned Committee Business for the Next Reporting Period:

Forward work plan for 2024/25

Date of Next Meeting: 17th June 2024

Name of Committee:	Partnerships, Population Health and Planning Committee
Chair of Committee:	Ann Lloyd
Reporting Period:	18th April 2024

Key Decisions and Matters Considered by the Committee:

Committee Strategic Risk Report

The Committee considered the Committee Risk Register, based on the Board's Strategic Risk Register, which included four high level strategic risks and corresponding nine sub-risks delegated to the Committee.

Public Service Board (PSB) Update and Action Plan

The Committee was informed that an action plan had been produced to ensure alignment of priorities with Marmot principles and would focus on key areas . The work of the Public Health team would support these improvements in conjunction with the Strategic Well-Being Action Group.

Two stakeholder workshops had taken place with a focus upon on the best start in life and that PSBs in Wales had been approached to join three national learning cohorts as part of the agenda to shape places for wellbeing in Wales.

Regional Partnership Board (RPB) Update

The Committee was updated on the work of the Regional Partnership Board and was assured that progress was being made against actions arising from the RPB's Governance Review.

The tapering of Regional Integrated Funding would not be applied for the remainder of the funded programme (to 2027). The Committee noted that the RPB was in receipt of a number of revenue grant funding streams to a value of £27m, with £26m allocated to existing projects and £1m available for allocation.

The Committee was updated on the Market Stability Report and noted that increased collaboration was ongoing, with relationships and productivity across all market segments identified as strong.

Regional Planning Update

The Committee was updated on the progress of a number of ongoing regional and South Wales service planning programmes, including Ophthalmology, Diagnostics, Spinal Surgery and Interventional Radiology

The Committee noted that the first phase of the cataracts programme continued to progress to schedule and a business case for longer term cataract development was being developed.

In respect of diagnostics planning, business case development was ongoing and focussed on solutions around a managed service approach for a diagnostics hub and endoscopy service.

The Committee received an update on spinal surgery planning and noted that a spinal surgery operational delivery network for South Wales was established, hosted by Swansea Bay University Health Board.

The Committee noted that in respect of interventional radiology planning focussed on options for delivering longer-term sustainability were under urgent consideration.

Vaccination Programme Update

The Committee was updated on the progress of the vaccination programme and noted that uptake for vaccinations was variable with Flu uptake for over 65s being the best in Wales at 75%, whilst for the younger age group an uptake of 42% was achieved. In respect of uptake for Covid, this focussed on eligibility groups and involved the vaccine being delivered through a blended approach, with a move away from vaccination centres. The Committee noted that an outbreak of MMR had been reported and work was ongoing to ensure that staff were vaccinated.

Integrated Medium-Term Plan 2024-27

Following the Board's discussion in March 2024, the Committee discussed next steps in the delivery of the IMTP and the focus of work to be undertaken in developing the detailed delivery plan for the Board to receive in July 2024.

Clinical Futures Programme Update

The Committee was updated on progress to date in the Clinical Futures Priority Programmes and was advised that:

- the Acute Frailty Response Service commenced in January 2024 with performance identified as positive;
- the etriage system that had recently been launched was paused due to technical issues and would be relaunched in the first quarter of 2024/25; Health Pathways Clinical Editors continue to develop pathways with subject matter experts. A launch date was scheduled for mid- April 2024 with 40-50

pathways ready to go live, with a number in draft or in development; with Phase 2 discussions continuing; the line management of Theatres had been transferred into the Clinical Support Services Division and an improvement plan had been developed for the current financial year; • the Satellite Radiotherapy Unit development was on track for opening in February 2025;a joint workshop had been held with Velindre University NHS Trust to explore opportunities to increase levels of Systematic Anti- Cancer Therapy (SACT); and • a workshop had taken place on the medical model and outputs of service models of Enhanced Local and General Hospital Configuration.
Matters Requiring Board Level Consideration or Approval:
None noted
Key Risks and Issues/Matters of Concern:
None noted
Planned Committee Business for the Next Reporting Period:
As per the Forward work plan for 2024/25
Date of Next Meeting: 1st July 2024

Name of Committee:	Audit, Risk and Assurance Committee
Chair of Committee:	Iwan Jones
Reporting Period:	16th April 2024

Key Decisions and Matters Considered by the Committee:

Apologies for Absence

The Committee was informed that due to apologies, the meeting was not quorate in line with the Committee Terms of Reference; however, a decision was made to proceed on the basis that two independent members were in attendance which met the requirements of the NHS Wales Audit Committee Handbook, it was agreed that all items for decision, where appropriate would be approved in principle with a summary of the reports would be presented for formal approval at the Committee's next meeting. This would be documented and reported in the Annual Governance Statement (AGS).

External Audit Progress Report 2023/24

The Committee received the External Audit Progress Report, which included five planned performance audits, outlined below. One had been completed, one in progress, three are in the planning stage.

- Follow-up of Primary Care Services - - Completed
- Unscheduled Care Arrangements – In progress
- Structured Assessment deep dive - Planning
- Follow-up Quality Governance Review - Planning
- Tackling NHS waiting lists - Planning

To Review the Primary Care Follow-up Report

The Committee reviewed the Primary Care Follow-up report following amendments made to the management responses by the Health Board.

Internal Audit Progress Report

The Committee received the Internal Audit Progress Report. The Committee was informed that from the 2023/24 Internal Audit Plan 13 audits had been reported in final, 6 had been produced in draft, 7 remain in progress and 1 remains at the planning stage.

Internal Audit Reports

The Committee received five reports from the Internal Audit Plan 2023-24 for assurance, three of which concluded reasonable assurance, one concluded substantial assurance and one not-rated.

Unified Breast Unit at Ysbyty Ystrad Fawr – Substantial Assurance

The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit which was completed in December 2022.

The Committee was informed that the project was forecast to generate a small surplus of £200,000.

Asset Management – Reasonable Assurance

This internal audit had been undertaken to provide an opinion over the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets.

The Committee that positive progress to introduce the RFID process at 67% with an anticipated completion date of March 2025.

Risk Management & Assurance – Reasonable Assurance

The audit sought to assess on the effectiveness of the risk management and assurance arrangements in place within the Health Board in order to ensure that strategic objectives are achieved.

Long-Term Sickness Absence Management – Reasonable Assurance

The audit sought to review the compliance with the NHS Wales Managing Absence at Work Policy. This was not an audit on the number of sickness absence episodes but whether the Health Board is acting promptly and managing the interests of all parties within the process of managing long term sickness absence.

The Committee was informed that the review took place over a sample of areas to determine compliance. Overall, a good level of compliance with the policy was found, particularly within the facilities department.

Follow-up of High Priority Recommendations – Not-Rated

The audit sought to assess whether high priority internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Audit, Risk and Assurance Committee via the Audit Recommendation Tracking Tool (the 'Tracker').

To Receive an Early Indication on the Head of Internal Audits Final Opinion Report

The Committee was informed that the number of limited assurance reports had improved, and Internal Audit was hopeful that this trend would continue, as it was seeing increased engagement and improvement as a result of previous audit recommendations, as well as greater visibility of risk management practices in place.

To Receive and Endorse the Internal Audit Annual Workplan for 2024/25

The Committee received an overview of the proposed Internal Audit Annual Workplan 2024/25.

Committee Risk and Assurance Report

The Committee received the report and noted that the strategic risks associated with achieving the Boards strategic priorities were effectively managed for assurance.

The Committee noted that two risks had been de-escalated, there had been a reduction in the risk score and exposure of a further two risks and one new strategic risk had been identified and that seven risks were being managed outside of the agreed appetite for the risk domain. The Committee was assured that the seven actions outside of the Health Board's risk appetite would be assessed and action plans established to bring them to within appetite/tolerance.

Audit, Risk and Assurance Committee Work Plan 2024/25.

The committee received the proposed 2024/25 committee workplan which had been produced in line with the Committees Terms of Reference (ToR) and delegated responsibilities.

The Committee was informed that it would retain responsibility for receiving and approving the Clinical Audit plan, as per the NHS Wales Audit Committee Handbook, however, the outcomes of clinical audit activity would be monitored by the Patient, Quality, Safety and Outcomes Committee.

Audit, Risk and Assurance Annual Report 2023/24.

The Committee received the Audit, Risk and Assurance Committee Annual Report 2023/24.

Internal and External Audit Recommendations Tracking

The Committee was provided with an overview of the report, which included 116 audit recommendations that had been identified as overdue during Quarter 4 (January 2024 – March 2024).

28 recommendations resulting from audits conducted between 2017 and 2021, with an additional 88 arising from audits conducted between 2022-2024 were outstanding; of the 116 recommendations, 61 had revised timescale requests, 5 had been completed, and 5 were overdue with no revised timescale for implementation.

Following Committee approval of the 61 revised timescale requests and 50 completed, the closing position of the Audit Tracker as of 31 December 2023 concluded with 105 live recommendations, 100 not yet due, and 5 overdue.

Single Tender Waivers

The Committee received and noted the ten Single Tender Actions, listed below awarded between 20 January 2024 and 22 March 2024, totalling £1,443,455.97 excluding VAT.

- Mobile Decontamination Unit Extension
- Security
- Bespoke Cot Bed/Safe Space for Child LP
- Bespoke Cot Bed/Safe Space for Child ES
- Nurses Accommodation
- Domestic Violence and abuse (DVA) training, support and referral programme NCN Primary/Community.
- Fibro scan Mini Machine – YYF Outpatients
- Gritting North Gwent
- Educational update for GP Practices CPD
- International Nurses Accommodation

Financial Governance, Reporting and Control Procedures

The Committee approved in principle the three financial control procedures listed below.

- Accounts Receivable
- Counter Fraud Communication Strategy
- Contract Management

The Committee noted that the NHS Public sector payment fell just short of the 95% target but was assured that efforts to achieve and maintain the target were being made. The non-NHS payment continued to exceed the 95% target.

Matters Requiring Board Level Consideration or Approval:

- No items

Key Risks and Issues/Matters of Concern:

- No Items.

Planned Committee Business for the Next Reporting Period:

- Formally approve the recommendations contained in the reports listed below from the Committee meeting on 16 April 2024.
- Counter Fraud Annual Report
- Counter Fraud Annual Work Plan 2024/25
- Clinical Audit Annual Report
- Clinical Audit Annual Work Plan 2024/25
- Review of the Health Boards Annual Report (Overview and Performance section) Part 1
- Draft/Final Accounts and Financial Statements (Part 3), including losses and special payments
- Review of Audit Enquires to those charged with Governance and Management
- Internal Audit Progress Report
- Internal Audit Reports

- External Audit Work Plan 2024/25
- Audit, Risk & Assurance Committee Programme of Business

Date of Next Meeting: Tuesday 21st May 2024 at 09:30

Name of Committee:	**Patient Quality, Safety and Outcomes Committee**
Chair of Committee:	**Pippa Britton**
Reporting Period:	**30th April 2024**

Key Decisions and Matters Considered by the Committee:

Quality Report (interim)

The Committee received the performance report for the period ending April 2024.

The report included an update on the following areas :-

- Bereavement Collaborative
- Volunteering Case Study
- Duty of Candor
- Complaints
- Health & Safety
- HIW
- Planned Care
- Never Events
- mortuary incidents

The key issues arising from this report were:

- A big conversation event was held on 20th March 2024, with 170 attendees. During the event 50 expressions of interest to join the bereavement collaborative were received.
- A Volunteer to Career story was shared and the Committee noted that there had been a reduction in people volunteering since Covid. The Committee noted that the aspiration was to recruit more volunteers into Mental Health and Emergency Department services.
- Improvement in patient experience feedback was noted, and a text option had been made available to patients.
- Since April 2023 24,895 Duty of Candour incidents had been reported with 42 incidents during this quarter.
- HIW inspections had taken place at Ty Lafant and Talygran Unit.
- ENT gate keeper was being used to screen outpatient referrals to facilitate a quicker return on advice and to better guide the patient to the correct pathway. 50 health care pathways were live. Phase 2 strategy was in place with a call centre providing advice to patients who require an outpatient's appointment, with oversight provided by the nursing team.

Listening and Learning Framework

The Committee received the Listening and Learning Framework. The framework would complement and build on Divisional and Directorate assurance arrangements by supporting the Health Board to learn lessons from a range of internal and external sources, with the framework acting as a learning repository for future use.

Development of Committee Annual Programme of Business 2024/25

The Committee received the Committee Annual Programme of Business for 2024/25. The programme was developed with regard to recommendations from the Committee Self-Assessment 2023/24 to enable the Committee to: -

- Fulfil its Terms of Reference; and,
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference.

The Committee was assured that there would be a balance of primary and community care and acute reporting throughout the year with a focus on primary care being included in the quality performance report.

Committee Annual Report 2023/24

The Committee received the Committee Annual report for 2023/24, which outlined the work of the Committee during 2023/24.

Committee Risk Report

The Committee received an overview of the risk reporting for assurance, that included a summary of the current strategic risks that had been delegated to the Patient Quality, Safety, and Outcomes Committee for monitoring.

The following 3 risks were reported at a risk level of High and Extreme:-

- **SRR 005** - There is a risk that the Health Board would be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system. (High)
- **SRR 008** - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public. (High)
- **SRR 010** - There is a risk that the Health Board would fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. (Extreme)

Overview of Audit Recommendations Tracking

The Committee received an overview of the internal and external recommendations resulting from planned audit reviews that fall under the remit of the PQSO Committee.

The Committee noted that there were presently 26 outstanding with 3 overdue actions in relation to this Committee.

The Committee was assured that the 3 overdue actions would be closed, with two actions included within the health and safety improvement plan, with the remaining action relating to o the Health Board failing to build positive relationships with patients, staff and the public to be completed by the next Committee meeting.

Learning from Death Report to include an update on the Learning from Death Framework

The Committee received the Learning from Death Framework that had been developed to include a number of mortality indicators. The Committee noted that the aim was to publish a bi-annual report on the Health Board's learning from deaths of patients with the hospitals and would would allow the Health Board to report on a Ward-to-Board level.

The Committee was advised the framework would allow the Health Board to ensure services are safe and effective and would facilitate scrutiny of outcomes of care. It was highlighted that to date the Health Board was coding 80% of learning from deaths.

Update on the Management of Higher Risk Surgical Patients in the Royal Gwent Hospital (RGH) POCU

The Committee received an update on the management of higher risk surgical patients in the Royal Gwent Hospital. The Committee was reminded that approval had been given by the Executive Committee to use the Surgical High Care Unit at RGH for patients with a pre-op mortality.

The Committee was assured the patients at risk on long waiting lists had been removed and provided with elective surgery and confirmed that to date the governance process was working effectively, with no patients being harmed.

3-year Welsh Government Assurance Report on Compliance with the NSLWA 2021-2024

The Committee received for assurance an overview of the 3-year performance of nurse staffing levels in respect of Compliance with the Nurse Staffing Levels Wales Act that provides the framework for the provision of sufficient nurses to allow time to care for patients sensitively wherever they were receiving nursing services.

The Committee was made aware of the measures taken to calculate and maintain nurse staffing levels throughout the 3-year reporting period and was assured of the Health Boards compliance with the Act.

Clinical Audit Annual Plan and Clinical Audit Annual Activity Report

The Committee received the report for information.

Healthcare Inspectorate Wales Annual Report

The Committee received the report for information.

WHSSC QPSC Chairs report presented to the JCC meeting on 23 April 2024

The Committee received the report for information.

Matters Requiring Board Level Consideration or Approval:

None Noted

Key Risks and Issues/Matters of Concern:

None Noted

Planned Committee Business for the Next Reporting Period:

- Review of Committee Programme of Business 2024/25
- Committee Risk Report
- NHS Wales Joint Commissioning Quality Committee Report
- Performance Report on the Pillars of Quality to include Mental Health and Learning Disabilities assurance
- Commissioning Assurance Framework, Development, and Implementation
- Falls and Bone Health Management Annual Report
- Clinical Audit Outcomes Report
- Internal and External Audit Reports relevant to the remit of the Committee
- Child and Adolescent Mental Health Crisis Hub and Safe Accommodation
- Covid 19 – key learning from programme
- Annual volunteering report

Date of Next Meeting: Tuesday 4th June 2024

AUDIT, RISK AND ASSURANCE COMMITTEE

ANNUAL REPORT FOR 2023-24

March 2024

Approved by: Audit Risk & Assurance Committee Date Approved: 16 April 2024

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FOREWORD

I am pleased to present the Audit, Risk and Assurance Committee's (the Committee's) Annual Report for the year ended 31 March 2024.

In this report we provide an overview of the work of the Committee and describe the steps taken to strengthen audit, risk management and assurance arrangements in the last 12 months.

The Committee has welcomed the main conclusion of the Auditor General for Wales' in the Structured Assessment for 2023 which concluded that Aneurin Bevan University Health Board: 'has broadly sound arrangements in place for governance, strategic planning and resource allocation and is making good progress in developing and refining its systems of assurance.' The report highlighted further opportunities for improvement in key areas, which will be monitored by the Committee.

The Committee has also acknowledged its role in overseeing the important work that is still being carried out in several areas to improve governance and assurance arrangements. This remains a key focus of the Committee's work in the year ahead.

Finally, I would like to express my personal thanks to all who contributed to the audit, risk, and assurance agenda over the last 12 months.

Special thanks must be extended to Shelley Bosson, whose term as an Independent Member of the Health Board came to an end in March 2024, and Paul Deneen, who served on the Committee until August 2023. Both provided invaluable perspective, challenge, and support to enable the Committee to carry out its duties.

Diolch yn Fawr / Thank you

Iwan Jones
Chair, Audit, Risk and Assurance Committee

INTRODUCTION

The Standing Orders[1] of Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB' or the 'Health Board') state that: "*The Board may and, where directed by the Welsh Government must, appoint Committees either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*". [Section 3]

The Term of Reference of the Audit & Assurance Committee (referred to throughout this report as 'the Committee') that applied in 2023/24 were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year, 2023/24.

The Committee formally adopted its Terms of Reference, following the Board's approval, on 23 March 2022.

The purpose of the Committee is to undertake scrutiny and review of matters related to audit, financial accounting, assurance, and risk management. In doing so, the Committee will support the Board and the Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

The remainder of this report describes how the Committee complied with and satisfied the requirements set out within its Terms of Reference during the period 1 April 2023 to 31 March 2024.

2023-2024 WORK PROGRAMME

ABUHB Standing Orders require the Director of Corporate Governance to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups.

When the Committee's Work Programme (see **Appendix 2**) was agreed care was taken to ensure that this was aligned to its Terms of Reference and the requirement for the Committee to 'proactively seek information to gain assurance for itself and/or on behalf of the Board'.

[1] abuhb-model-standing-orders-reservation-and-delegation-of-powers-september-2023

The Work Programme is, however, a framework rather than a prescriptive agenda. This gives the Committee flexibility to identify changing priorities or any need for further assurance or information.

FREQUENCY OF COMMITTEE MEETINGS AND MEMBERSHIP

The Terms of Reference state that the committee should meet at least bi-monthly. During 2023-24, the Committee met six times virtually via Microsoft Teams

- 18 April 2023
- 23 May 2023 (draft annual accounts)
- 18 July 2023 (final annual accounts)
- 12 September 2023
- 28 November 2023
- 8 February 2024

The Terms of Reference state that the Committee should have four members; the Committee consisted of the following Independent Members across 2023/24:

- Iwan Jones - Chair
- Richard Clark – Vice Chair
- Shelley Bosson *(up until March 2024)*
- Paul Deneen *(up until August 2023)*

As several Board Members' tenures on the Board have come to an end, membership across the committee structure is being reviewed to ensure the right skill mix across the committees to ensure they discharge their responsibilities effectively and to satisfy the Committee's Terms of Reference regarding membership.

Detail of the members and executive directors who attended these meetings is provided at **Appendix 3**.

Committee meetings were regularly attended by representatives from:

- Audit Wales; the Health Board's external auditor;
- Audit & Assurance Services NHS Wales Shared Services Partnership (Internal Audit) and;
- Local Counter Fraud Services

In 2023-24, the Committee received private briefings (without officers' present) from auditors and the local counter-fraud lead as below:

- Internal Audit (*November 2023*)
- External Audit (*April 2023 & February 2024*)
- Counter Fraud (September 2023)

COMMITTEE REPORTING ARRANGEMENTS

The minutes of Committee meetings are routinely submitted to the Board by way of an Assurance Report, these are included in an overarching Committee Assurance Report.

All Board papers can be accessed via the following link:
Audit Risk and Assurance Committee

COMPLIANCE WITH THE COMMITTEE'S WORK PROGRAMME

Among the key issues considered by the Committee during 2023-24, as outlined in the Committee's Work Programme, the following were also considered:

- Health Board Update Report on the Clinical Audit Plan
- Health Board Update Report on Clinical Audit Activity
- Audit Wales Orthopaedic Services in Wales: Tackling the Waiting List Backlog – National and Local Report
- Audit Wales Primary Care Follow-Up Report
- Audit Wales Stakeholder Perception Research Report

ASSURANCE AND IMPROVEMENT

The Committee reviewed and approved the audit strategies and plans for the auditors as listed below and received audit reports produced in support of them during 2023-24: -

- External Auditors, Audit Wales
- Internal Auditors, NWSSP Audit & Assurance Services

In approving the strategies and plans, the Committee ensured that they were robust and linked to the health board's risk profile.

Where reports received a less than reasonable assurance audit rating or where there were specific areas of concern, the appropriate Executive Directors were requested to attend Committee meetings. This process provided opportunities to discuss the reports more fully, and for the Committee to satisfy itself that the findings and recommendations raised in the reports were being addressed in a timely manner and implemented to address control weaknesses or compliance issues.

Certain reports were referred to other Committees of the Board for ongoing monitoring, for example reports relating to clinical governance issues were referred for further consideration by the Patient Quality Safety and Outcomes Committee.

EXTERNAL AUDIT – AUDIT WALES (AW)

The Auditor General for Wales is the statutory external auditor for the NHS in Wales. Audit Wales (AW) undertakes the external auditor role for the Health Board on behalf of the Auditor General.

The Audit Wales 2023 Structured Assessment work reviewed the Health Board's corporate governance and financial management arrangements, particularly the progress made in addressing the previous year's recommendations. Findings from the 2023 review were reported to the Committee in November 2023, prior to submission to the Board in January 2024.

Overall, the Audit Wales report stated: "**Overall, we found that while the Health Board governance arrangements are reasonably effective there is scope to provide clarity on both the impacts of actions set out in plans and actions taken to improve performance.'**

The report went on to say that:

- **Board transparency, effectiveness, and cohesion** – the Health Board's Board and Committee arrangements are reasonably effective; however, there are opportunities to improve the quality and timeliness of information to ensure effective oversight over the Health Board's key challenges.

- **Corporate systems of assurance** – the Health Board is making good progress in developing and refining its systems of assurance. However, it will need to effectively embed new arrangements across the organisation to manage the finance, performance, and quality risks it faces.

- **Corporate approach to planning** – the Health Board is developing a new long-term strategy that provides an opportunity to plan more sustainable services. There are reasonably effective arrangements for developing corporate plans; however, progress reports do not provide enough detail to demonstrate delivery is on track.

- **Corporate approach to managing financial resources -** The Health Board is facing significant financial challenges. Whilst there are reasonably effective financial planning and financial management arrangements, the Health Board needs to establish control over savings delivery to prevent the financial position from deteriorating.

Audit Wales was pleased to hear from Committee Members that they fully recognised the conclusions drawn and the key issues that required further improvement in the year ahead.

Copies of reports produced by Audit Wales can be accessed via the following link: Audit Wales Publications.

Each meeting of the Committee received a progress report from Audit Wales and during 2023-24 the Committee received two External Audit reports, relating to the Health Board's External Audit Plan.

- Audit Wales Orthopaedic Services in Wales: Tackling the Waiting List Backlog Local Report
- Audit Wales Primary Care Follow-Up Report

The following reports are expected to be received in Quarters 1 and 2 of the 2024-25 financial year: -

- Structured Assessment – Deep dive review of investment in digital (Q1)
- Follow up review of Quality Governance (Q1)
- Biodiversity and the Resilience of Ecosystems Duty (Q2)

INTERNAL AUDIT - NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

During the first quarter of 2023-24, the Committee received Internal Audit reports from the schedule for 2022-23 as well as reports from

the 2023-24 schedule, including management responses from the relevant Executive Director.

At the time of writing this report, **26** audit reviews have been reported to the Committee. These are detailed in the assurance rating sections.

The Committee will receive the following **five** final reports from the 2023-24 Internal Audit Plan at its April meeting. These are detailed in the assurance rating sections.

- Asset Management
- Risk Management & Assurance
- Follow-up of High Priority Recommendations
- Long Term Sickness Absence Management
- Unified Breast Unit at Ysbyty Ystrad Fawr

The three reviews listed below from the 2023 -2024 plan have been deferred.

- The Health & Social Care (Quality & Engagement) (Wales) Act
- Job Planning
- Allegations against Staff Policy

The following **16** reports form the 2023-24 audit scheduled will be presented at Committee meetings during Quarters 1 and 2 of the 2024-25.

- Savings Programmes
- Financial Controls
- Decarbonisation
- Medical Equipment and Devices
- Waiting List Management
- Directorate Review - Theatres
- Providing Care to Asylum Seekers
- Early Supported Discharge - Stroke
- Intra-site Patient Transfers
- Regional Partnership Board
- Maternity Action Plan
- Flexible Working (Advisory)
- LINC Programme
- Bevan Health and Wellbeing Centre
- Newport HWBC
- NHH Satellite Radiotherapy

The assurance sections that follow provide a summary of the scope of the Internal Audit Reviews that have been completed and received by the Committee during the financial year, April 2023 to March 2024.

Substantial Assurance

In the following review areas, it was reported that the Board could take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. The few matters that required attention were compliance or advisory in nature with low impact on residual risk exposure.

Cyber Security (2022 - 2023)
Executive Lead – Chief Executive Officer
The review sought to provide assurance that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

Unified Breast Unit at Ysbyty Ystrad Fawr (2023-2024)
Executive Lead – Chief Operating Officer
The audit sought to review the management arrangements in place to progress the Ysbyty Ystrad Fawr Unified Breast Unit – in the period after the prior audit, which was completed in December 2022

Reasonable Assurance

In the following review areas, it was reported that the Board could take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively.

Some matters required management attention in either control design or operational compliance and these had low to moderate impact on residual risk exposure until resolved.

Robotic Process Automation (2022-2023)
Executive Lead – Chief Executive Officer
The review sought to ensure that the organisation has an appropriate process in place to securely develop the Robotic Process Automation (RPA) function.

IT Strategy (2022-2023)
Executive Lead – Chief Executive Officer
The review sought to ensure that the organisation has developed an appropriate target operating model to enable to delivery of the Digital Strategy.

Financial Sustainability (2022-2023)
Executive Lead – Director of Finance and Procurement
The review sought to review the key financial management controls within Aneurin Bevan University Health Board including the development and monitoring of savings programmes required for financial sustainability.

Risk Management (2022 - 2023)
Executive Lead – Director of Corporate Governance
The review sought to provide an opinion of effectiveness of the risk management arrangements in place within a sample of divisions. To complete this, we considered key sections of the Risk Management Strategy and Framework.

Monitoring Action Plans (2022-2023)
Executive Lead – Director of Corporate Governance
The review sought to review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates (specifically Health Inspectorate Wales (HIW) and Health and Safety Executive (HSE).

Development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital (2022-2023)
Executive Lead – Director of Strategy, Planning and Partnerships.
The audit sought to review the delivery and management arrangements in place to progress the development of a Regional Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, and the performance to date against its key delivery objectives i.e. time, cost, and quality.

Royal Gwent Hospital – Redevelopment & Expansion of Endoscopy Services (2022-2023)
Executive Lead – Director of Strategy, Planning and Partnerships
The audit sought to review the delivery and management arrangements in place to progress the Royal Gwent Hospital Endoscopy Redevelopment & Expansion of Endoscopy Services project, and the performance to date against its key delivery objectives i.e., time, cost, and quality.

Infection Prevention and Control (2022-2023)
Executive Lead – Director of Nursing
The review sought to assess adherence to organisational policies and the Health and Care Standards in Wales.

Integrated Wellbeing Networks (2022-2023)
Executive Lead – Director of Public Health
The review sought to provide an opinion on the Health Board's plan to further develop Integrated Wellbeing Networks across the region.

Dementia Services (2022-2023)
Executive Lead – Director of Nursing
The review sought to ensure that Aneurin Bevan University Health Board has an appropriate process for Dementia Services.

Contract Management (2022-2023)
Executive Lead – Chief Operating Officer
The audit sought to provide a review of the effectiveness of themanagement of operational contracts entered into by Aneurin Bevan University Health Board.

Mental Health Transformation (2022-2023)
Executive Lead – Chief Operating Officer
The audit sought to provide a review of the controls in place for the projects that support the transformation of mental health services within Aneurin Bevan University Health Board.

Bank Office and Temporary Workers (2022-2023)
Executive Lead – Director of Workforce and Organisational Development
The review sought to provide an opinion over the Bank Office and Temporary Workers process. As well as undertook a follow-up audit work on the process for contract and off-contract agency nursing.

IMPT (2023-2024)
Executive Lead – Director of Strategy, Planning and Partnerships.
The review sought to provide an opinion over the controls to ensure the delivery of the IMTP / strategic objectives.

Safeguarding (2023-2024)
Executive Lead – Director of Nursing
The audit sought to review the arrangements in place to ensure that the Health Board discharges its statutory responsibilities.

Clinical Coding (2023-2024)
Executive Lead – Director of Digital
The review sought to provide an opinion over the timely recording of Finished Consultant Episodes (FCE), in accordance with clinical coding standards.

Business Continuity Planning (2023-2024)
Executive Lead – Director of Strategy, Planning and Partnerships.
The review sought to review the arrangements that the Health Board has in place to maintain business continuity in the event of a critical incident, including how learnings from the Covid-19 pandemic have been considered.

Integrated Performance Dashboard – Data Quality (2023-2024)
Executive Lead – Director of Digital
The review sought to assess the accuracy of data utilised within the Integrated Performance Report (IPR) dashboard. In particular, focused on the accuracy of a sample of data used within the reporting of key metrics within the IPR dashboard i.e. that the source data utilised was consistent with the figures within the dashboard.

Stakeholder Engagement on IT Projects (2023-2024)
Executive Lead – Director of Digital
The audit sought to review the framework in place for stakeholder engagement on key IT projects.

Asset Management (2023-2024)
Executive Lead - Director of Finance and Procurement / Director of Digital
This review provided an opinion on the effectiveness of the Health Board's processes to create and maintain accurate and up-to-date records of its equipment assets. The review focused on the roll-out of Radio Frequency (RFID) tagging.

Risk Management & Assurance (2023-24)
Executive Lead – Director of Corporate Governance
This review sought to assess the effectiveness of the risk management and assurance arrangements in place within the Health Board, to ensure that strategic objectives are achieved. This review focused on the management of risks within the Digital Services Directorate

Long-Term Sickness Absence Management (2023-24)
Executive Lead – Director of Workforce and Organisational Development
The review sought to determine compliance with the NHS Wales Managing Absence at Work Policy and whether the Health Board is acting promptly and managing the interests of all parties within the process of managing long-term sickness absence.

Limited Assurance

In the following review areas, it was reported that the Board could take **only limited assurance** that arrangements to secure governance, risk management, and internal control, within those areas under review, were suitably designed and applied effectively.

More significant matters required management attention with a moderate impact on residual risk exposure until resolved.

Bevan Health and Wellbeing Centre (2022-2023)
Executive Lead – Interim Director of Primary Care, Community and Mental Health
The audit sought to review the management arrangements in place to progress the Bevan Health & Wellbeing Centre.

Discharge Planning (2022-2023)
Executive Lead – Interim Director of Primary Care, Community and Mental Health
The review sought to provide an opinion on the discharge planning process of Aneurin Bevan University Health Board. It has focussed on the management and delivery of planned discharges and has included sample testing of patients admitted during April and May 2022.

Facilities (2023-2024)
Executive Lead – Chief Operating Officer
The review sought to provide assurance over whether appropriate stock processes are in place and whether applicable controls within the process for allocating/approving bank shifts are effective.

Estates Condition (2023-2024)
Executive Lead – Director of Strategy, Planning and Partnerships.
The audit sought to evaluate the arrangements put in place by the UHB to identify and manage key risks associated with the existing estate and the implementation of resulting strategies to manage/mitigate the risk.

No Assurance

There were no audited areas that reported **no assurance.**

Assurance Rating Not Applicable

The following reviews were undertaken as part of the audit plan and reported or closed by correspondence without the standard assurance rating indicator, owing to the nature of the audit approach.

Clinical Futures - Care Closer to Home (2022-2023)
Executive Lead – Director of Strategy, Planning and Partnerships.
The review sought to provide Aneurin Bevan University Health Board with a consolidated summary of audit work reported as part of the 2022/23 Internal Audit Plan that covers the area of Clinical Futures – Care Closer to Home, and whether the Health Board is on track to implement its overall objective of Care Closer to Home.

Putting Things Right (2023-2024)
Executive Lead – Director of Nursing
To review sought to determine if there are alternative processes or approaches that can be adopted by the Health Board to improve the overall management of Putting Things Right.

Follow-up of High Priority Recommendations (2023-2024)
Executive Lead – Director of Corporate Governance
The review sought to assess whether high-level internal audit recommendations have been implemented and the completeness and accuracy of the updates provided to the Committee via the Audit Recommendation Tracking Tool (the 'Tracker')

MONITORING AND IMPLEMENTATION OF AUDIT RECOMMENDATIONS

At each meeting, the Committee received an update on the status of internal and external audit recommendations. At the February 2024 meeting, assurance reports for pre-2022 audit recommendations were submitted to provide a greater level of assurance regarding the work being undertaken to implement and close any legacy recommendations.

The development of simplified processes and strengthened relationships with service leads and executive directors has resulted in improvements in the implementation of recommendations.

In April 2024, the Committee will receive an internal audit review of the monitoring and tracking of high-level recommendations, whilst this is an advisory report, there were a couple of findings with one medium-rated recommendation. The findings of the report will be used as a baseline to inform the areas of focus for 2024/25.

RISK MANAGEMENT

RISK MANAGEMENT FRAMEWORK

In May 2023, the Board reviewed its strategic risks to ensure they were consistent with its strategic objectives and ministerial priorities. This provided an opportunity to review the Health Board's risk management processes and update the Risk Management Framework, to enable the Health Board's risk management maturity to develop and progress.
The Committee received the revised Risk Management Framework, Policy, and Risk Appetite Statement for review and endorsement at its November

meeting before submitting it to the Board for formal approval in January 2024.

The Risk Management Framework, Policy, and Appetite Statement provide assurance that the Health Board has robust risk management processes in place, with a clear structure of risk escalation via hierarchical risk registers and assurance meetings to ensure delivery of operational and strategic objectives.

Since the refreshed approach and the establishment of the Strategic Risk Register, it has been determined that a greater emphasis on assurance mapping across the Three Lines of Defence Model to demonstrate assurance sources is necessary. Furthermore, reporting of the Corporate Risk Register will commence in 2024 to provide a holistic view of strategic and corporate risks (high-level operational risks).

To strengthen the internal control system, a system-wide assurance mapping exercise linked to the Quality Assurance and Performance Management Frameworks will be carried out to provide the Committee with the assurances it requires regarding its delegated responsibilities.

In late 2024, the Committee will receive an updated report on risk management that includes an assessment of the Health Board's risk management maturity.

Internal Audit completed its annual review of Risk management in March 2024. The purpose of the review was to assess the effectiveness of the risk management and assurance arrangements in place across divisions in order to ensure that strategic objectives are met. The review concluded with a reasonable assurance outcome and only one medium-rated recommendation, which is concerned with risk recording on the electronic risk management system, Datix, which is underway.

The development of a 'Once for Wales' risk management module is still in progress, with an implementation date postponed until the national group is satisfied that the system is fit for purpose and includes all the functions required for a robust and effective risk management system.

In the forthcoming financial year, 2024/25, the Corporate Governance Directorate will begin a period of communication and engagement with staff to launch the Risk Management Framework. To coincide with the launch, the Head of Corporate Risk and Assurance will increase visibility across the Health Board, raising awareness and providing staff with the knowledge and skills needed to incorporate risk management into their daily processes. This will be undertaken in a structured way, meeting with departments/directorates and divisions to begin embedding the Health

Board's agreed-upon approach to risk management and the escalation process to mature the Health Board's risk management practices.

FREQUENCY OF RISK REVIEWS AND REPORTING

At each meeting of the Committee, an overview of the Strategic Risk Register is provided with detailed risk assessments of the risks. The Board then receives the overview of the Strategic Risk Register, and any areas of concern are highlighted, as appropriate.

COMMUNITY OF PRACTICE – RISK MANAGEMENT

The Risk Management Community of Practice (CoP) has been temporarily suspended while its Terms of Reference are reviewed, and its purpose determined.

The risk management group will be refreshed in 2024 to enhance its value, promote risk maturity, and share best practices for risk management and organisational learning.

SELF ASSESSMENT & EVALUATION

The Committee undertook its first mid-year self-assessment in September 2023 with the findings reported to the Committee in November 2023.

Overall, the Committee agreed it was discharging its responsibilities effectively, that reports were appropriate and provided the necessary detail for assurance, though this assurance can be reinforced through appropriate questioning**.**

There were four specific actions the Committee felt would add value to the Committee's Programme of Business, these have been considered and included in the draft 2024/25 Committee Programme of Business for consideration by the Committee.

The similarities in findings across the Committee structure from the mid-year self-assessments are being considered as part of the wider Board Business Improvement Plan that will be implemented throughout 2024/25.

The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, the interconnectedness of the committees

and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

KEY AREAS OF FOCUS IN 2024-25

In the year ahead the Committee will continue to focus on those matters that will strengthen audit, risk, and assurance arrangements. The Committee Work Programme has been designed to ensure that in relation to all aspects of audit:

- internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- adequacy of disclosure statements (Governance Statement) which are supported by the Head of Internal Audit Opinion and other opinions;
- internal and external audit recommendations continue to be monitored, reviewed, and evaluated to ensure compliance and where compliance is not evidenced, clear, agreed rationale is provided;
- the policies and procedures related to fraud and corruption, and;
- that the system for risk management is robust in identifying and mitigating risks.

Thus, enabling the Committee to provide the Board with assurance that the risks impacting on the delivery of the Health Board's objectives are being appropriately managed.

The annual Committee Programme of Business will be reported to each meeting for discussion.

Hardcopies of the Work Programme can be obtained from the Director of Corporate Governance, Headquarters, St Cadoc's Hospital, Lodge Road, Caerleon, NP18 3XQ.

CONCLUSION

This report provides a summary of the work undertaken by the Committee over the past 12 months and demonstrates how the Committee has complied with the Terms of Reference.

APPENDICES

- Appendix 1 – Audit, Risk & Assurance Committee Terms of Reference 2023/24
- Appendix 2 - Audit, Risk & Assurance Committee 2023/24 Work Plan
- Appendix 3 - Independent Members and Lead Executives Attendance at the Audit, Risk & Assurance Committee Meetings 2023/24

Appendix 1

Terms of Reference & Operating Arrangements

Document Title:	Audit, Risk & Assurance Committee Terms of Reference – 2023/24
Date of Document:	March 2022
Current version:	Approved
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

Version: Approved

Date: March 2022

1. INTRODUCTION

1.1 Section 2 of Aneurin Bevan University Health Board's Standing Orders (referred to in this document as 'ABUHB or the 'Health Board') Standing Orders provides that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the THB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 The Board has established a committee to be known as the **Audit, Risk and Assurance Committee** (referred to throughout this document as 'the Committee'). The Committee has been established in order to enable the scrutiny and review of matters related to audit, financial accounting, assurance and risk management, to a level of depth and detail not possible in Board meetings.

1.3 The detailed Terms of Reference and operating arrangements approved by the Board for this Committee are detailed below.

2. PURPOSE

2.1 The purpose of the Committee is to support the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report by:

- independently monitoring, reviewing and reporting to the Board on the processes of governance, risk management and internal control in accordance with the standards of good governance determined for the NHS in Wales;
- advising the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further;
- Maintaining an appropriate financial focus demonstrated through robust financial reporting and maintenance of sound systems of internal control; and

- Working with the other committees of the Board to provide assurance that governance and risk management arrangements are adequate and part of an embedded Board Assurance Framework that is 'fit for purpose'.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Audit, Risk and Assurance Committee will advise the Board and Accountable Officer on:

- the design, operation and effectiveness of strategic processes for risk management, internal control and corporate governance across the whole of the organisation's activities;
- the Annual Accountability Report, which includes the Annual Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- the planned activity and results of internal and external audit;
- adequacy of management response to issues identified by audit activity, including external audit's management letter;
- assurances relating to the management of risk and corporate governance requirements for the organisation;
- systems for financial reporting to the Board (including those of budgetary control);
- proposals for tendering for the purchase of audit and non-audit services from contractors who provide audit services; and
- anti-fraud policies, whistle-blowing processes, and arrangements for special investigations.

The Audit, Risk and Assurance Committee will also periodically review its own effectiveness and report the results of that review to the Board.

3.2 The Committee's workplan will include:

- a report summarising any significant changes to the organisation's strategic risks and a copy of the strategic/corporate Risk Register;

- a progress report from the Head of Internal Audit summarising:

  - ✓ work performed (and a comparison with work planned);
  - ✓ key issues emerging from the work of internal audit;
  - ✓ management response to audit recommendations;
  - ✓ changes to the agreed internal audit plan; and
  - ✓ any resourcing issues affecting the delivery of the objectives of internal audit;

- a progress report (written/verbal) from the External Audit representative summarising work done and emerging findings (this may include, where relevant to the organisation, aspects of the wider work carried out by the Audit Wales, for example, Value for Money reports and good practice findings);

- management assurance reports;

- reports (where appropriate) on action taken within the Board's Scheme of Delegation as regards:
  - use of single tender waivers;
  - extensions of contracts:
  - writing off of losses; or
  - the making of special payments;

- A report summarising progress in the implementation of audit recommendations, together with a copy of the Audit Recommendations Tracker;

and when appropriate the Committee will be provided with:

- proposals for the terms of reference of internal audit / the internal audit charter;

- the internal audit strategy;

- the Head of Internal Audit's Annual Opinion and Report;

- quality assurance reports on the internal audit function;

- the draft accounts of the organisation;
- the draft Annual Accountability Report which includes the Annual Governance Statement;
- a report on any changes to accounting policies;
- external Audit's management letter;
- a report on any proposals to tender for audit functions;
- a report on co-operation between internal and external audit;
- the organisation's Risk Management strategy;
- periodic reporting on Post Payment Verification Audits, and arrangements for managing declarations of interest and gifts and hospitality; and
- annual review of the Board's Standing Orders and Standing Financial Instructions, monitoring compliance and reporting any proposed changes to the Board for consideration and approval.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 The Committee's programme of work will also be designed to provide assurance that:

- there is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;
- there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Experience, Quality & Safety Committee;

- there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's committees;

- the work carried out by key sources of external assurance, in particular, but not limited to the health board's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply; and

- the results of audit and assurance work specific to the health boards, and the implications of the findings of wider audit and assurance activity relevant to the HB's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisations governance arrangements.

Authority

3.5 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the health board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.6 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

Access

3.7 The Head of Internal Audit and the Engagement Partner/Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit, Risk & Assurance Committee.

3.8 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.9 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.10 The Committee may, subject to the approval of the LHB Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

4.1 Membership will comprise a minimum of four (4) members, comprising:

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Independent Member of the Board x 2
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge, and expertise.

Attendees

4.2 In attendance: The following members of the Executive Team will be regular attendees:

- The Accountable Officer
- Director of Finance, Procurement and VBHC
- Director of Corporate Governance

Other attendees will be:

- Head of Internal Audit
- Local Counter Fraud Specialist
- Representative of the Auditor General/External Audit

4.3 By invitation: The Committee Chair may extend invitations to attend committee meetings to the following:

- other Executive Directors; and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The secretariat for the Committee will be provided by the Office of the Director of Corporate Governance.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least three members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members notify the Committee Chair or Committee Secretariat that they are unable to attend a meeting, and there is a danger that the Committee will not be quorate, the Chair can invite another independent member to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings. However, meetings shall be held as a minimum on a **Bi-Monthly basis** (six times per year) and in line with the health board's annual plan of Board Business. However, additional meetings will be called, in agreement with the Chair of the Committee, if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.4 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);

- issue an annual programme of meetings (including timings and venues) and its annual programme of business;

- publish agendas and papers on the Health Board's website in advance of meetings;

- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and

- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g. interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.5 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the audit and assurance. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee, through its Chair and members, shall work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- appropriate escalation of concerns.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the health board's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the health board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g. Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g. where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

The Board and Board Committee Handbook provides detailed guidance on the conduct of the Committees business.

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix 2

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AUDIT, RISK & ASSURANCE COMMITTEE
PROGRAMME OF BUSINESS 2023/24

The purpose of the Audit, Risk and Assurance Committee is to support the Board and Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

This Annual Programme of Business has been developed with due regard to guidance set out in NHS Wales' Audit Committee Handbook (June 2012), to enable the Audit, Risk and Assurance Committee to: -

- fulfil its Terms of Reference as agreed by the Board (March 2023);
- seek assurance and provide scrutiny on behalf of the Board, in relation to the delivery of the key elements of the health boards internal and external audit, counter fraud and PPV arrangements (second and third lines of defence);
- seek assurance that governance, risk and assurance arrangements are in place and working well;
- seek assurance in relation to the preparation and audit of the Annual Accounts; and
- ensure compliance with key statutory, national, and best practice audit and assurance requirements and reporting arrangement.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Preliminary Matters								
Attendance and Apologies	Standing Item	Chair	√	√	√	√	√	√
Declarations of Interest		All Members	√	√	√	√	√	√
Minutes of the Previous Meeting		Chair	√	√	√	√	√	√
Action Log and Matters Arising		Chair	√	√	√	√	√	√
Committee Requirements as set out in Standing Orders								
Development of Committee Annual Programme of Business 2023/24	Annually	Chair & Director of CG	√					√
Review of Committee Programme of Business	Standing Item	Chair	√			√	√	
Annual Review of Committee Terms of Reference 2023/24	Annually **(April)**	Chair & Director of CG	√					
Annual Review of Committee Effectiveness 2022/23	Annually **(September)**	Chair & Director of CG					√	
Committee Annual Report 2022/23	Annually **(April)**	Chair & Director of CG	√					
Corporate Governance, Risk & Assurance								
Receive assurance on implementation of the Governance	Quarterly	Director of CG					√	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Priorities set out within the IMTP 2022-25								
Review and report upon the adequacy of arrangements for declaring, registering and handling interests	Annually	Director of CG			√			√
Receive full report of all offers of gifts and hospitality as declared	Annually	Director of CG			√			√
Compliance with Ministerial Directions	Bi-Annually	Director of CG			√		√	
Compliance with Welsh Health Circulars (WHCs)	Bi-Annually	Director of CG			√		√	
Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation	Annually	Director of CG						√
Audit Recommendations Tracking Report	Standing Item	Director of CG	√	√	√	√	√	√
Annual Review of Risk Management Strategy	Annually	Director of CG						√
Report on the Implementation of the Risk Management Strategy Realisation Plan	Bi-Annually	Director of CG	√				√	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Annual Review of the Board Assurance Framework Process	Annually	Director of CG	√					√
Committee Risk & Assurance Report	Standing Item	Director of CG	√	√	√	√	√	√
Financial Governance and Control								
Report of the use of Single Tender Action	Standing Item	Director of FPV	√			√	√	√
Report of Losses and Special Payments *(May report will be included in the Accounts)*	Bi-Annually	Director of FPV		√			√	
Reviewed and Updated Financial Control Procedures	As Required	Director of FPV	√			√	√	√
Annual Report and Accounts								
To consider the approach and timelines for the Annual Report and Accounts	Annually	Director of FPV & Director of CG	√					
Review the Health Board's Annual Report (Overview & Performance Section) (Part 1)	Annually	Director of CG		√	√			
Review Draft/Final Accountability Report, including Annual Governance Statement (Part 2)	Annually	Director of CG		√	√			
Review Draft/Final Annual Accounts and Financial Statements (Part 3)	Annually	Director of FPV		√	√			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Audit Enquiries to those charged with Governance and Management	Annually	Director of FPV		√				
Audit Wales, Audit of Accounts (ISA 260) including Letter of Representation	Annually	External Audit			√			
Final Annual Accounts Memorandum	Annually	External Audit					√	
Receive the Annual Head of Internal Audit Opinion (including Specialised)	Annually	Internal Audit			√			
Agree a recommendation to the Board in respect of the audited annual report and accounts	Annually	Chair			√			
Anti-Fraud								
Review of the Counter Fraud, Bribery and Corruption Policy	3-Yearly (Feb 2026)	Director of FPV	-	-	-	-	-	-
Receive the Counter Fraud Annual Report	Annually	Head of CF	√					√
Agree the Counter Fraud Annual Workplan	Annually	Head of CF	√					
Receive a Quarterly Report on Counter Fraud Activity	Quarterly	Head of CF			√		√	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Agree the Counter Fraud Functional Standard Return Declaration	Annually	Head of CF			√			
Receive the Post Payment Verification Annual Report	Annually	PPV Manager (Amanda Legge)				√		
Agree the Post Payment Verification Annual Workplan	Annually	PPV Manager		√				
Receive a Mid-Year update in respect of Post-Payment Verification Activity	Annually	PPV Manager					√	
Clinical Audit								
Ratify the Clinical Audit Plan 2023 – 2024 to be overseen by the PQSO Committee	Annually	Medical Director			√			
Receive an Annual Report 2023 – 2024 on Clinical Audit Activity	Annually	Medical Director						√
Internal Audit (Including Specialised Audit) – NWSSP Audit & Assurance Services								
Agree the Internal Audit Annual Workplan	Annually	Head of Internal Audit		√				
Receive Internal Audit Progress Reports	Standing Item	Head of Internal Audit	√	√	√	√	√	√

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
Receive Internal Audit Review Reports, reviewing the adequacy of executive & management responses to any issues identified, ensuring that they are acted upon	As Scheduled within Annual Work plan	Head of Internal Audit Plan						
Review and approve Internal Audit terms of reference (charter) and the effectiveness of internal audit	Annually	Head of Internal Audit with Chair			√			
External Audit – Audit Wales								
Receive the External Audit Annual Audit Report	Annually	Audit Wales						√
Agree the External Audit Annual Plan	Annually	Audit Wales		√				
Receive the 2023 Structured Assessment	Annually	Audit Wales					√	
Receive External Audit Progress Report 2023-24	Standing Item	Audit Wales	√	√	√	√	√	√
Review of External Audit Reports including results & the adequacy of executive & management responses	As Scheduled within Annual Work plan	Audit Wales						

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24					
			18 April 2023	May 23 *Draft Accounts*	July 18 *Final Accounts*	12 Sept	28 Nov	08 Feb 2024
to any issues identified, ensuring that they are acted upon								
Consider any Audit Wales National Value for Money Examinations & Performance Reports	Ad-hoc	Audit Wales						
Audit, Risk and Assurance Committee Members to meet Independently with:								
External Audit Team	Bi-Annually	Chair	√					√
Internal Audit Team	Bi-Annually	Chair					√	
Local Counter Fraud Team	Bi-Annually	Chair				√		

KEY	
D of CG	Director of Corporate Governance
D of FPV	Director of Finance, Procurement and Value
Head of CF	Head of Counter Fraud
PPV	Post Payment Verification

KEY	
√	Received at the scheduled meeting
X	Not received / Deferred to future meeting
Received √	Received deferred Item
	Draft & Final Accounts

Appendix 3

Attendance at 2023-24 Audit, Risk and Assurance Committee Meetings: Independent Members and Lead Executives

Meeting Dates	18 April 2023	23 May 2023	18 July 2023	12 September 2023	28 November 2023	08 February 2024
MEMBERS						
Iwan Jones (Chair)	√	√	√	√	√	√
Richard Clark (Vice Chair)	√	√	Apologies	√	√	√
Shelley Bosson	√	√	√	√	√	√
Paul Deneen	√	√	√	No longer a member of the Committee		
OFFICERS						
Chief Executive	√	Apologies	Apologies	Apologies	√	Apologies
Director of Finance & Procurement	Apologies *(Representative attended)*	√	√	√	√	√
Director of Corporate Governance	√	√	√	√	√	√

Charitable Funds Committee

Annual Report for 2023-24

DATE March 2024

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Chair’s Foreword

I took on the role of Chair of the Charitable Funds Committee (CFC) in the summer of 2023, and I am very pleased to present this Annual Report for the year ended 31st March 2024.

In this report we provide an overview of the work of the committee over the last 12 months. CFC ensures that the Board’s policies and procedures for charitable funds investments are followed in relation to legislative framework. The CFC also has responsibility of administering all charitable funds and providing information via an Annual Report to the ABUHB of its work. The funds are also audited annually by Audit Wales.

I take this opportunity to thank all members of the committee for their input and advice over the past 12 months. I also place on record my particular thanks to all the staff at ABUHB and others who have been involved with the CFC work for their support and professionalism, which is much appreciated.

Diolch yn Fawr / Thank you

Paul Deneen
Chair
Charitable Funds Committee

1. Introduction

1.1 Section 1 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Term of Reference of Charitable Funds (referred to throughout this document as 'CFC' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The purpose of the **Charitable Funds Committee** is to Ensure the stewardship and effective management of funds which have been donated, bequeathed, and given to the Aneurin Bevan Health Charity for charitable purposes by making and monitoring arrangements for the control and management of the Health Board's Charitable Funds.

1.4 This report describes how the CFC discharged its role and responsibilities during the period 1 April 2023 to 31 March 2024.

2 2023-24 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for CFC in 2023-24 is attached to this report (see **Appendix 2**).

A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive agenda. This gives CFC flexibility to identify changing priorities or any need for further assurance or information.

2.2

In January 2024, the Committee received the Charitable Funds Annual Accounts report for 2022/23 which provided Members with greater assurance of the work of the charity, this included the position of the financial actives or year ended 31st March 2023.

- **Donations, Legacies and Grants**, had decreased by £54K from the previous year to £614k.
- **Income from the Chartable activities, had** increased by £118k, mainly due to the funds received for the filming at St Cadocs Hospital.
- **Investment income** had increased by £13k from the previous year to £200k due to an increase of investments.
- **Expenditure** had increased by £118k due to the spends relate to staff education & welfare and new equipment.
- Loss on Investment Assets, there had been a loss of £370k due to the stock market increases on underlying investments.

The Annual Account report for the period can be accessed via this link on item 2.1 Link

2.3 Throughout the year the Committee received the Finance report on the current financial position for each quarter, providing Members with assurance of income, total spend, donations, grant income and total losses.

The charities position at the end of the finical year was reported as: -

- Income increased to £630k, although this was £254K less than last year due to a decrease in donations, legacies, and other incomes.
- Total expenditure was £113k, this was an increase compared to last year due to expenditure in relation to equipment and staff funding costs in the first 8 months of the year.
- CCLA investment was £80k.
- Overall deficit of £103k.
- £443k in the current account.
- No overdrawn accounts or new fund requests.
- 5 merged funds during the year.
- 609 donations with a total of £168k.

This provided the Committee with assurance that the charity was in a positive financial position going into the next financial year.

2.4 The Committee approved several small grants throughout the year, with each grant having a positive impact on the Health Boards duties.

Throughout the year the Committee received updates on the projects that had previously been agreed that included:

- **Incontinence fund bid**, 8k had previously been agreed to support the setup of the incontinence project, to date this project was still in progress and that a further update of the outcome of this project, would be presented at the March's Meeting.
- **Value Based Conference,** £4.5k had previously been agreed to support the education programme and the running of the conference. The outcome of the conference was positive and other projects had been identified during the conference that included:
    - MRI development
    - Increasing the uptake of breastfeeding.
    - Urgent suspected cancer referrals, patient health optimisation using digital forms.

The Committee was assured as to the benefits of the conference and noted that plans were in place for repeating the conference albeit on a more affordable basis.

During the year the Committee has agreed to support investment into the following projects :-

- **Health Board Decarbonisation programme** funding request of £1k agreed to support this project that will provide materials to support the Decarbonisation Programme.
- **Value Based Conference,** funding request of £4.5K to support the Person Centred Value Based Health Care (PCVBHC) Education Programme.
- **Clinical Supervision,** funding request of £3.5K to support the development a Clinical Supervision Programme based in the Quality and Safety Department, Mental Health and LD based at St Cadoc's Hospital.
- **Advanced Communication Skills Training, Cancer Services,** funding request of £3k towards the cost of the course provided by Reach Communication Skills.
- **Well Being Pop Up Event Across ABUHB,** funding request of £5K to continue with the development of the Well Being pop ups across the organisation for a further 6 to 8 months.
- **Mental Health & Learning Disabilities Well Being Space,** funding request of £3k to set up of a QR code to gather feedback from having the Well Being pop up in place.

- **Televisions for Bedwas Ward, Ysbyty Ystrad Fawr**, a funding request of £23k to allow new televisions on the Bedwas Ward at Ysbyty Ystrad Fawr Hospital.

2.5 The Committee also received assurance arising from the routine Annual Audit Wales Report regarding the 2023/23 financial statements which confirm that of ABUHB Charitable Funds and other related charities for the year ending 31st March 2023 were true and fair unqualified application was provided by Audit Wales. and noted: -

- A few minor changes to the Audit report with these now being corrected and no recommendations from Audit Wales.
- Audit Wales would be issuing an unqualified audit opinion.

2.6 The Committee approved the Levels of Reserves for 2023/24 at £396k. This would be utilised to cover any downwards movement in the stock market, and mitigate any risks and therefore provided Members with further assurance.

2.7 During the year, the Committee received regular updates on spending plans over £25K. The Committee noted that the Charity held a total value of £5.763M consisting of 419 individual funds as of 31st March 2023. Of these funds there were 56 that had balances over £25K.

2.8 Assurance was provided from CCLA Investments, including the current position for the charity's investments valuation at September 2023 was £803,368 with a forecast income for 2024 of £43,939.

There was a request from the Committee as part of strengthening their investments to have oversight of the current model being used and what other options the Charity had available to them. It was agreed that this would be presented to the March 2024 Committee meeting.

3 CF Committee Meetings and Membership

3.1 During 2023-24, the CFC met Four times via Microsoft Teams- June 2023, November 2023, January 2024, and March 2024. Detail of the members and executive directors who attended these meetings is provided at **Appendix 3**.

3.4 The Committee comprised the following Independent Members:

- Paul Deneen (Chair)
- Louise Wright Vice Chair

- Iwan Jones

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. Following the pandemic, the Committee has continued during the current year to meet virtually and this has therefore meant that the Health Board has not complied with its Standing Orders in this regard and this will be a key consideration as part of the Improving Board Business action plan.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's website in advance of meetings.

4 CFC Reporting Arrangements

4.1 Following each meeting, the CFC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link

5. Self-assessment and Evaluation

5.1 The Board has undertaken an overall assessment of its effectiveness during 2023/24 using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews.

The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements and has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working.

The outcome of the current years self-assessment that was reported to the Committee on 22nd January 2024 confirms that, the results of the individual self-assessment, combined with the analysis of the three completed self-assessments determined that the Committee is effective and meeting the standards.

Rating	Definition	Evidence
2	**Meeting standards**	The Charitable Funds Committee is performing to the required standard in this area. There may be room for improvement, but the Charitable Funds Committee can be seen to be discharging its responsibilities effectively.

Further, all of the respondents confirmed that the Committee was either meeting or excelling the standard for the effectiveness of this Committee.

Then main areas for improvement identified as part of the self-assessment are shown below:

Specific Actions to deliver improvements in the Committee's effectiveness			
Section	**Area of Focus requiring attention**	**How & by When**	**Action Holder**
1. Committee Processes: Composition, Establishment, and Ways of Working	• A programme of training for independent members to be developed • Agendas to include an item on reflection upon the meeting • Improved transition arrangements when the chairing of the committee changes	All actions to inform the development of an overarching Board Business Improvement Plan – March 2024 for Board approval	Director of Corporate Governance with Head of Board Business

These findings will be used to inform a comprehensive annual assessment of the Board's effectiveness. An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured Assessment, for delivery in 2024/25. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to

the Board, as well as the culture between the Health Board and its auditors, regulators and partners.

6. Key Areas of focus in 2024-25

6.1 There are no planned changes to the key areas of focus within the workplan for 2024/25 but from the findings of the Annual Committee Self-Assessment the approach will be better supported through:-

- A programme of training for independent members to be developed.
- The regular charitable funds reporting the Committee receives from the Finance team ensure Members are aware of the position of the Charitable Funds charity.

7. Conclusion

7.1 This report provides a summary of the work undertaken by the CFC during 2023-24, and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2022.

Appendix One

Charitable Funds Committee

Terms of Reference – 2022/23

Version: Approved

Date: March 2022

Document Title:	Charitable Funds Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Version:	Draft
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

1. Introduction

The Aneurin Bevan University Health Board's standing orders provide that "*The Board may and, where directed by the Welsh Government, must appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and*

assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In line with standing orders and the Health Board's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Charitable Funds Committee**.

Aneurin Bevan University Local Health Board (ULHB) Charitable Fund and Other Related Charities, also known as Aneurin Bevan Health Charity, is registered with the Charity Commission following a Deed of Amendment dated 7th January 2011 with Aneurin Bevan University Local Health Board as the Corporate Trustee, registration number 1098728.

The Aneurin Bevan ULHB was appointed as corporate trustee of the charitable funds by virtue of the Supplemental Deed of Declaration and that its Board serves as its agent in the administration of the charitable funds held by the ULHB.

The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out in this document. The Health Board, acting as trustee must approve any changes to these terms of reference.

2. Purpose of the Committee

The purpose of the **Charitable Funds Committee** ("the Committee") is to:

Ensure the stewardship and effective management of funds which have been donated, bequeathed and given to the Aneurin Bevan Health Charity for charitable purposes by making and monitoring arrangements for the control and management of the Health Board's Charitable Funds.

3. Delegated Powers and Authority

3.1. Authority

The Committee is authorised with the responsibility for

- Overseeing the day-to-day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the trustee and the requirements of the ULHB's Standing Financial Instructions;
- Scrutinising requests for use of the charitable funds to ensure that any such use is in accordance with the aims and purpose of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and ULHB guidance regarding the ethical use of funds and acceptance of donations;

- The appointment of an investment manager (where appropriate) to advise it on investment matters and may delegate day-to-day management of some or all of the investments to that investment manager. In exercising this power the Committee must ensure that:
- The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;
- There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;
- The performance of the person or persons exercising the delegated power is regularly reviewed;
- Where an investment manager is appointed, that the person is regulated under the Financial Services Act 1986;
- Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Director of Finance and Performance;
- Ensuring that the banking arrangements for the charitable funds should be kept entirely distinct from the Health Board's NHS funds;
- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts;
- Ensuring that the amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments;
- Ensuring the operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the LHB Board for applying accrued income to individual funds in line with charity law and Charity Commissioner guidance;
- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

The Committee may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee);

and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice to support investment

opportunities and to secure the attendance of outside representatives with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

The Committee may act on any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.2. Sub-Committees

The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

4. Function and Work Programme

4.1. Delegated Powers and Duties of Director of Finance & Performance

The Director of Finance (as Financial Trustee) has prime responsibility for the Health Board's Charitable Funds as defined in the Health Boards Standing Financial Instructions. The specific powers, duties and responsibilities are:

- The administration of all existing charitable funds;
- To identify any new charity that may be created (of which the Health Board is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity;
- To provide guidelines with respect to donations, legacies and bequests, fundraising and trading income;
- The responsibility for the management of investment of funds held on trust;
- To ensure appropriate banking services are available;
- To prepare reports to the LHB Board including the Annual Account.

4.2. Effective Assurance

The Committee's programme of work will be designed to provide assurance that:

- Within the budget, priorities and spending criteria determined by the Health Board as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the charitable funds in accordance with their respective governing documents.
- To ensure that the Health Board policies and procedures for charitable funds investments are followed.
- To make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000;
- The Charities Act 1993;
- The Charities Act 2006;
- Terms of the fund's governing documents.

- To receive at least twice a year reports for ratification from the Director of Finance and investment decisions and action taken through delegated powers upon the advice of the Health Board's investment adviser.
- To oversee and monitor the functions performed by the Director of Finance as defined in Standing Financial Instructions.
- To monitor the progress of Charitable Appeal Funds where these are in place and considered to be material.
- To monitor and review the Health Board's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

4.3. Access

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5. Membership

5.1. Members

The Committee shall comprise:

Chair:	Independent member of the Board
Vice Chair:	Independent member of the Board
Other Members:	Chair of the Stakeholder Reference Group Two (2) Executive Directors: *Chief Executive* *Director of Finance and Performance (as Financial Trustee)*

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

5.2. Attendees

Other officers of the Health Board will attend:

- Other Executive Directors will attend as required by the Committee

Others by invitation

The Committee Chair may invite any other Health Board officials and / or any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter. These may include:

- Director of Corporate Governance
- Assistant Director of Finance – Financial Systems & Services
- Head of Financial Services & Accounting
- Charitable Funds Manager
- Health Board's Investment Advisor

5.3. Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office.

During their period of appointment a member may resign or be removed by the Board.

6. Support

6.1. Secretariat

Secretariat arrangements will be determined and arranged by the Director of Corporate Governance.

6.2. Advice and Member Support

The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role;

  and

- Ensure the provision of a programme of organisational development for committee members as part of the Health Board's overall OD programme developed by the Director of Workforce and Organisational Development.

7. Committee Meetings

7.1. Quorum

At least three of the selected members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair

or Vice Chair, one other should be an Independent Member and one must be the Chief Executive or the Director of Finance

7.2. Frequency of Meetings

Meetings will be held **Quarterly** and otherwise as the Chair of the Committee deems necessary – consistent with the Health Boards plan of Board business.

7.3. Withdrawal of individuals in attendance

The Chairman may ask any or all of those who normally attend but who are not members of the Committee to withdraw to facilitate open and frank discussion of particular matters (an In Committee meeting).

7.4. Record of the Committee Meeting

A record of the meeting will be presented as notes and action points.

7.5. Public Meetings

The Committee will not routinely meet in public**.**

8. Relationship and Accountabilities with the Board and its Committees

The Committee is directly accountable to the Board, as Corporate Trustee, for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through its Chair and members, shall work closely with the Board and where appropriate its committees and groups, through the:

- Joint planning and co-ordination of Board and Committee business and
- Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. Reporting and Assurance Arrangements

The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board (as Trustees) on the Committee's activities.
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Health Board Chair and Chief Executive (as Accountable Officer) of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Director of Corporate Governance, on behalf of the Board, shall oversee a process of annual self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

10. Applicability of Standing Orders to Committee Business

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. Review

These Terms of Reference shall be reviewed annually by the Committee with reference to the Board.

Appendix Two

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			28th June	9th Nov	4th Jan (Accounts)	7th Mar
Preliminary Matters						
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓
Committee Requirements as set out in Standing Orders						
Development of Committee Annual Programme of Business 2023/24	Annually	Chair & Director of CG				✓
Review of Committee Programme of Business	Standing Item	Chair	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2023/24	Annually	Chair & Director of CG				✓
Annual Review of Committee Effectiveness 2023/24	Annually	Chair & Director of CG				✓
Committee Annual Report 2023/24	Annually	Chair & Director of CG				✓
Financial Reporting						
Financial Update including Investments Valuation	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓
Report on Significant Donations, legacies and grant income.	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓
Update on new and closed funds	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			28th June	9th Nov	4th Jan (Accounts)	7th Mar
Overdrawn Accounts	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓
KPIs Review	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓
Legislation Changes	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓
Expenditure Approval						
Funds available to the Committee	Standing Item	Assistant Finance Director	✓	✓	✓	✓
Consideration of Bids/Small Grants	Standing Item	Assistant Finance Director	✓	✓	✓	✓
Fund Holders						
Attendance at Meetings*	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓
Spending Plans over £25k	Annually	Head of Financial Services & Accounting				✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			28th June	9th Nov	4th Jan (Accounts)	7th Mar
Spending Plans Review	6 monthly	Head of Financial Services & Accounting		✓		✓
Governance and Assurance						
Level of Reserves	Annually	Assistant Finance Director	✓			
Review Investment Performance – CCLA to attend	Annually	Assistant Finance Director			✓	
Review of Financial Control Procedure	Annually	Assistant Finance Director				✓
Appointment of Investment Managers	One-off	Assistant Finance Director	✓			
General Reports						
Approval of Admin Charge/Unrealised Gain Apportionment 23/24	Annually	Head of Financial Services & Accounting		✓		
Update on Property	Standing Item	Head of Financial Services & Accounting	✓	✓	✓	✓
Annual Accounts and Report						
Draft Annual Report and Accounts	Annually		✓			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			28th June	9th Nov	4th Jan (Accounts)	7th Mar
Final Accounts and Annual Report Approval	Annually				✓	
Evaluation Reports						
None expected as at May 23						
Items requested by Committee members/internal stakeholders						

Appendix Three

Charitable Funds Committee: Attendance at meetings in 2023-24

Attended | **Did Not Attend** | **Not a Member/Required Attendee**

Meeting Dates	28th June	9th November	22nd January
Independent Members			
Paul Deneen	x	x	x
Louise Wright	x	x	x
Iwan Jones	x	x	x
Executive Directors			
Robert Holcombe	x	x	x
Nicola Prygodzicz	x	x	x

Rani Dash	x	x	x

Finance & Performance Committee

Annual Report for 2023-24

February 2024

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Chair's Foreword

I am pleased to present the Finance and Performance Committee's (the Committee's) Annual Report for the year ended 31 March 2024.

In this report we provide an overview of the work of the Committee in the ongoing development of an improving performance culture and acknowledge the significant financial challenges faced by the Health Board in 2023/24, which will continue into 2024/25.

I would like to express my personal appreciation to all who contributed to the finance and performance agenda and the development of the Finance and Performance Committee.

Diolch yn Fawr / Thank you.

Richard Clark
Chair
Finance and Performance Committee

1. Introduction

1.1 Section 1 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Term of Reference of the Finance and Performance Committee (referred to throughout this document as 'F&PC' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The purpose of the **Finance & Performance Committee** is to advise and assure the Board and the Accountable Officer of improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework. The Committee will also seek assurance that arrangements for financial management, and financial performance are sufficient, effective, and robust.

1.4 This report describes how the F&PC discharged its role and responsibilities during the period 1 April 2023 to 31 March 2024.

2. 2023-24 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups.
The Work Programme adopted for F&PC in 2023-24 is attached to this report (see **Appendix 2**).

2.2 A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive agenda. This gives F&PC flexibility to identify changing priorities or any need for further assurance or information.

The F&PC focuses on both assurance in respect of organisational performance management and financial management and performance. The monitoring of this is set out as follows:

Assurance in respect of financial management and performance:

- **Financial Recovery 2023-24**

The Committee routinely monitors the financial position of the Health Board through the provision of quarterly financial performance reports and specific focussed reports on efficiency and savings opportunities and delivery. The ABUHB IMTP submitted by the Board to Welsh Government (March 2023) included a financial plan for 2023/24 which presented a deficit of £112m and an ambitious savings requirement of £51m.

Financial risks and opportunities are presented quarterly to each committee meeting. During the year the Board, Executives, budget holders and staff have engaged in a rigorous and thorough review of the opportunities to improve the financial forecast for 2023/24.

Following the mid-year review a forecast deficit of £145m was reported, this was reflective of previously reported risks coming to fruition. The organisation undertook a significant exercise to consider further mitigations to improve the financial position including the establishment of a Quality Impact Assessment forum to assess patient implications, the focus of improvement has been to deliver better outcomes for patients while reducing costs in line with the core principles of Value-Based healthcare.

The Board received additional in year funding from Welsh Government of £88m which allowed a revised forecast to be reported of £57m. The funding is subject to improving the financial forecast towards a deficit control total of £13m.

The Board considered achievement of a £13m deficit was unlikely without significant service impact and patient harm risk, however, the Health Board continues to review and re-examine all savings options and further opportunities.

The CEO wrote an accountability letter to the Director General for NHS Wales on 16th October 2023 outlining the likely forecast position of £57m and confirming a continued focus to mitigate this further and develop a long-term plan for financial sustainability.

The Committee noted that the Executive Team had established the Value and Sustainability Board in September 2023, replacing the Efficiency Board, as part of the Health Board's enhanced financial recovery arrangements. The key focus of this Board is to identify opportunities to mitigate the financial deficit and challenge and support delivery. Thematic groups have been established to facilitate cross division working and align with Welsh Government thematic work.

Thematic areas include:

Workforce, Non-Pay, Prevention, CHC, Medicines Management, Digital & Service Redesign.

Focussed reports have been provided to the Committee periodically across the range of themes.

Benchmarking is a key tool to identify opportunities and the committee receives comparative reports on a regular basis, including a whole system review captured through the ABUHB efficiency opportunities compendium. Analysis of the national benchmarking publications highlighted significant efficiency opportunities in several key service areas, with a calculated worth/benefit totalling £17m. Considerable opportunities for efficiency improvements were identified to address deterioration in performance, in terms of reduction in bed days, improving outpatient services, reduction in both GP referrals and cancelled operations and theatre productivity.

The Committee has received the report for Value Based Healthcare in ABUHB, presenting the key service areas and patient groups benefitting from the use of patient related outcome measures.

Throughout the year, quarterly updates on Efficiency Opportunities were received, providing details of efficiency opportunities identified through:

- Medicines management efficiency opportunities were progresses through the Medicines Management Programme Board.
- Estates rationalisation efficiency opportunities were identified through the Capital and estates governance structure.
- The Welsh Government Utilisation Group,
- through national costing return exercises and,
- other proposals for identification of possible savings.

The Committee noted that data form Getting it Right First Time (GIRFT) reports were used to support actions to improve cost comparisons and service benchmarking. GIRFT reviews on specific specialities were presented throughout the year, identifying key performance improvements. Updates to the Committee included the Health Boards response to the data informing best practice in GIRFT Programme National Speciality Report on Ear, Nose and Throat Surgery 2019, the Health Board commissioned GIRFT assessment of its Stroke services in 2022.

The efficient use of capital has also been considered by the Committee, including opportunities to leverage leased estates opportunities and support revenue cost savings.
Improved governance training and user tools have been developed and shared with the committee including on-line budget holder training pack and Governance Operational Control self-assessment checklists. This has demonstrated an improving trend.

The revised forecast for 2023/24 is presenting an achievement of a £49m deficit.

Assurance in respect of organisational performance and management:

Quarterly updates on organisational performance were received through the Performance Overview reports, with exception reporting in identified areas. The Committee was informed of the improvements made throughout 2023/24, including the maintenance of childhood immunisation rates, an increase in Primary Care contracts, improvements in some areas of urgent care performance, and the reduction in the number of patients waiting over 52 weeks for treatment. The challenges around organisational performance were noted. These included the sustained operational pressures throughout 2023/24, challenges within the delivery of mental health interventions, sustainability of Primary Care access and increased pressure in urgent and emergency care.

During the year, the following exception reports were presented for assurance: -

- An update on overall performance against Ministerial Priorities for Planned Care was presented to the Committee in June 2023. This update highlighted that the Health Board did not achieve the Ministerial priorities by the June 2023 target. However, an update was provided to the Committee in September 2023, assuring members that a plan had been submitted to achieve all targets by the end of September 2024.
- The Stroke Improvement Plan, including progress against recommendations from the Getting It Right First Time (GIRFT) review in 2022 was presented, providing an overview of the ABUHB Stroke Improvement Plan. Progress and focus on GIRFT recommendations were presented, noting the actions that have been taken to implement specific recommendations have shown improvements in many key performance indicators that are indicative of good Stroke care across the pathway.

- An update on the Radiology Informatics Systems Procurement (RISP) Programme was provided, outlining the benefits of changing

systems and the financial implications of the overlap of systems resulting in a dual cost for the Health Board.

- An update on IT systems outlined the shortfall for funded and part funded digital schemes, and the associated risk with delays in national digital programmes. The Committee was advised that a Digital, Data and Technology Group would be set up and would provide quarterly assurance reports on progress, risks, and issues.

- A report on the Quality of Coding was presented, outlining the coding targets aligned to the Integrated medium-term plan (IMTP) and the recommendations of the *Quality of Coding* report. The Committee noted that to achieve the national clinical coding compliance targets, the service had maximised opportunities to code electronically, however, challenges were noted due to the significant backlog of case notes awaiting scanning. The Committee received a proposed structure for delivery for the improvement of coding services was presented, to enable the clinical coding services deliver a more modern and flexible service for the Health Board.

- A report on the Outpatient Transformation Programme was presented, describing a number of transformational schemes implemented, their impact, along with the programme plan for 2023/24. The programme of work was linked to the Health Boards Planned Care Recovery Programme. The Committee was assured that See on Symptom (SOS) and Patient Initiated Follow Ups (PIFU) approaches were introduced to assist with reducing the number of people on the follow-up waiting lists and working towards more sustainable ways of managing patients care. The Committee noted that Health Board had reduced the number of Did Not Attends (DNAs) from 6.9% in 2022/23 to 5.8% for 2023/24, improving towards achieving the WG target of 5% (as at June 2023). A Clinically Led Speciality Outpatient Guide (GIRFT) and subsequent action plan was shared with Divisions and noted that progress against the agreed recommendations continues to be monitored through the Outpatient Steering Group.

- Following an Internal Audit report on Robotic Process Automation (RPA) undertaken in 2022, the Committee received a detailed report on costing and benefits realisation detail on cost and benefit of the Robotics Process Automation (RPA) before the expansion of RPA provision could be considered. The Committee also noted that this matter had been submitted to the Executive Committee for additional resource in March 2023.

- An update on the Health Board's Discharge Programme and Delays, including an update on the progress and impact of the Integrated Discharge Hub, as part of the Six Goals Programme structure was presented. This highlighted the delays outlined, programme governance, work undertaken to improve discharge by the Patient Safety Team and an update of goals 5 and 6 Discharge Improvement, optimising patient flow framework. The Committee also noted the wider system impact and the plans to mitigate risks.

3. F&P Committee Meetings and Membership

3.1 During 2023-24, the F&PC met four times via Microsoft Teams- June 2023, September 2023, December 2023, and March 2024. Details of the Members and lead Executive Directors who attended these meetings is provided at **Appendix 3**.

3.2 The Committee comprised the following Independent Members:

- Richard Clark (Chair)
- Iwan Jones (Vice Chair)
- Dafydd Vaughan
- Shelley Bosson

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. Following the pandemic, the Committee has continued during the current year to meet virtually, and this has therefore meant that the Health Board has not complied with its Standing Orders in this regard, and this will be a key consideration as part of the Improving Board Business action plan.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's website in advance of meetings.

4. F&PC Reporting Arrangements

4.1 Following each meeting, the F&PC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link

5. Self-assessment and Evaluation

5.1 The Board has undertaken an overall assessment of its effectiveness during 2023/24 using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews.

The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements and has a strong focus on integrated governance and leadership across quality, finance, and operations as well as an emphasis on Organisational culture, improvement and system working.

The outcome of the current years self-assessment that was reported to the Committee on 14th March 2024 confirms that, the results of the individual self-assessment, combined with the analysis of the three completed self-assessments determined that the Committee is effective and meeting the standards.

Rating	Definition	Evidence
2	**Meeting standards**	The Finance and Performance Committee is performing to the required standard in this area. There may be room for improvement, but the Finance and Performance Committee can be seen to be discharging its responsibilities effectively.

In addition, all of the respondents confirmed that the Committee was either meeting or exceeding the standard for the effectiveness of this Committee.

Then main areas for improvement identified as part of the self-assessment are shown below:

Specific Actions to deliver improvements in the Committee's effectiveness			
Section	**Area of Focus requiring attention**	**How & by When**	**Action Holder**

Section 1 Committee Processes: Composition, Establishment, and Ways of Working	• Report template to be reviewed and training on report writing to be delivered. • Inclusion of reflection section at the end of each Committee agenda. • Consideration of required Executive attendees. • Consider increasing number of Independent Members on the Committee • Consider frequency of meetings and or briefings specific for this committee to enable greater scrutiny.	All actions to inform the development of an overarching Board Business Improvement Plan – March 2024 for Board approval.	Director of Corporate Governance with Head of Board Business
Section 2 Financial Management and Financial Performance	• Explore ways that future updates include wider scrutiny opportunities of Capital budgets.	To be strengthened within Committee Workplan 2024/25 – April 2024	Head of Board Business with the Director of Strategy, Planning and Partnerships

These findings will be used to inform a comprehensive annual assessment of the Board's effectiveness. An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured Assessment, for delivery in 2024/25. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

6. Key Areas of focus in 2024-25

6.1 To maintain focus on financial planning and performance for 2024/25, organisational performance, with attention to risk-based exception reporting. The forward workplan has been updated to include a:

- Achieving Ministerial priorities
- standing item on Strategic Risk and Assurance,
- Capital budgets and the inclusion of benefits realisation.

7. Conclusion

7.1 This report provides a summary of the work undertaken by the F&PC during 2023-24 and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2022.

Finance and Performance Committee

Terms of Reference – 2022/23

Version: Approved

Date: March 2022

Document Title:	Finance and Performance Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Current version:	Approved
Previous version:	N/A
Approved by:	Board
Review date:	March 2023

1. INTRODUCTION

1.2 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.3 In-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board has established a committee to be known as the **Finance and Performance Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are set out below.

1.3 The scope of the Committee extends to the full range of ABUHB responsibilities. This encompasses the delivery and performance management of all directly provided and commissioned services.

2. PURPOSE

2.1 The purpose of the Finance & Performance Committee will be to provide advice and assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan, in accordance with the standards of good governance determined for the NHS in Wales. In doing so, the Committee will seek assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework. The Committee will seek assurance that arrangements for financial management and financial performance are sufficient, effective and robust.

2.2 **ADVICE**

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework.

2.3 **ASSURANCE**

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances:

a. on timely and appropriate access to health care services to achieve the best health outcomes within agreed targets, for directly provided and commissioned services.
b. that services are improving efficiency and productivity, and financial plans are being delivered;
c. risks are suitably identified, mitigated and residual risks controlled, and corrective actions are taken as required to sustain or improve performance.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to specific powers delegated to it by the Board, the Committee will play a key role in monitoring the achievement of the Board's strategic aims, objectives and priorities and will:

A. Seek assurance that arrangements for **financial management** and **financial performance** are sufficient, effective and robust, including:

- the allocation of revenue budgets, based on allocation of funding and other forecast income;
- the monitoring of financial performance against revenue budgets and statutory financial duties;
- the monitoring of performance against capital budgets;
- the monitoring of progress against savings plans, cost improvement programmes and implementation of the efficiency framework;
- the monitoring of budget expenditure variance and the corrective actions being taken to improve performance;
- the monitoring of activity and financial information for external contracts to ensure performance within specified contract terms, conditions and quality thresholds;
- the monitoring of arrangements to ensure efficiency, productivity and value for money, including delivery of the Health Board's Efficiency Framework; and
- the monitoring of delivery against the agreed Discretionary Capital Programme

B. Seek assurance that arrangements for the **performance management** and **accountability** of **directly provided** and **commissioned services** are sufficient, effective and robust, including:
    - the implementation of the Board's Performance Management Framework, enabling appropriate action to be taken when performance against set targets deteriorates, and support and promote continuous improvement in service delivery;
    - the monitoring of performance information against the Board's Priorities and Objectives and associated outcomes;
    - the monitoring of performance information against National Outcome Frameworks, including the NHS Wales Outcomes Framework, the Public Health Outcomes Framework and the Social Services Outcomes Framework, developed in-line with the Wellbeing of Future Generations Act and the Social Services Wellbeing Act;
    - the monitoring of performance information across directly provided services including scheduled care, urgent and emergency care, medicine, family and therapies, primary, community care and mental health services;
    - the monitoring of performance information across commissioned services including Primary Care Contractors, complex care, specialist mental health and CAMHS services, WHSCC, EASC and NHS Wales Shared Services Partnership;
    - the monitoring of poor performance through effective and comprehensive exception reporting, including trajectories for improved performance; and
    - the review of performance through comparison to best practice and peers and identifying areas for improvement.

C. Seek assurance that arrangements for **information management** are sufficient, effective and robust, including:
    - the monitoring of information related objectives and priorities as set out in the Board's IMTP and Annual Priorities;
    - the monitoring of the implementation and application of information related legislation, policies and standards, including GDPR and Freedom of Information;
    - the review of arrangements to protect the integrity of data and information to ensure valid, accurate, complete and timely data and information is available for use within the organisation;
    - the reporting of data breaches, incidents and complaints, ensuring lessons are learned;
    - the recommendations arising from national and local audits and self-assessments, including assessment against the Caldicott Standards; and
    - the monitoring of arrangements to support the continued development of business intelligence and capacity.

D. Seek assurance that arrangements for the **performance management** of **digital and information management and technology (IM&T) systems** are sufficient, effective and robust, including:
   - the monitoring of digital related objectives and priorities as set out in the Board's IMTP and Annual Priorities; and
   - the monitoring of the annual business plan for IM&T.

E. Seek assurance that arrangements for the **performance management** of **capital**, **estates and support services related standards and systems** are sufficient, effective and robust, including:
   - the monitoring of capital and estates related objectives and priorities as set out in the Board's IMTP and Annual Priorities;
   - the monitoring of compliance with Health Technical Memorandums;
   - the monitoring of progress in delivery Board-approved capital business cases and programmes of work.

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:
- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

3.9 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage.
This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4. MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Independent member of the Board
Vice Chair	Independent member of the Board
Members	2 x Independent member of the Board
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Finance, Procurement and VBHC
- Director of Planning, Performance, Digital & IT

4.3 By invitation:
The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **Quarterly**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

in doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;

- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix Two

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24						
			21 June 2023	7 Sept 2023	21 Dec 2023	14 Mar 2024			
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓			
Declarations of Interest		All Members	✓	✓	✓	✓			
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓			
Action Log and Matters Arising		Chair	✓	✓	✓	✓			
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2023/24	Annually (date tbc)	Chair & Director of CG							
Review of Committee Programme of Business	Standing Item	Chair			✓	✓			
Committee Strategic Risk Report	Standing Item	Director of CG			✓	✓			
Annual Review of Committee Terms of Reference 2023/24	Annually	Chair & Director of CG							
Annual Review of Committee Effectiveness 2023/24	Annually	Chair & Director of CG							
Committee Annual Report 2023/24	Annually	Chair & Director of CG	✓						
Assurance in Respect of Organisational Performance Management									
Performance Overview Report with Exception Reporting	Standing Item	Director of Strategy, Planning and Partnerships	✓	✓	✓	✓			
Outpatient Transformation Update	Annually	Chief Operating Officer	✓						

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24						
			21 June 2023	7 Sept 2023	21 Dec 2023	14 Mar 2024			
Performance against Ministerial Priorities for Planned Care	Annually	Director of Strategy, Planning and Partnerships		✓					
Digital and information management and technology (IM&T) systems	Annually	Director of Digital			✓				
Capital and estates related objectives and priorities as set out in the Board's IMTP	Annually	Director of Strategy, Planning and Partnerships				✓			
Compliance with Health Technical Memorandums	Annually	Director of Strategy, Planning and Partnerships				✓			
Capital Business Cases and programmes of work	Annually	Director of Strategy, Planning and Partnerships				✓			
Commissioned Services	Annually	Director of Strategy, Planning and Partnerships				✓			
Performance Management and Accountability Framework Update	Standing Item	Director of Strategy, Planning and Partnerships			✓	✓			
Assurance in Respect of Financial Management and Performance									
Monthly Finance Report and Monitoring Returns	Standing Item	Director of Finance, Procurement and Value	✓	✓	✓	✓			
Efficiency Opportunities	Standing Item	Director of Finance, Procurement and Value	✓	✓	✓	✓			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24						
			21 June 2023	7 Sept 2023	21 Dec 2023	14 Mar 2024			
Value Based Healthcare Report 2022/23	Annually	Director of Finance, Procurement and Value	✓						
Financial Outlook for 2024/25, including Revenue Budget Allocation letter 2024/25	Annually	Director of Finance, Procurement and Value							
Review of Savings and Action Plans	Annually	Director of Finance, Procurement and Value		✓					
Benefits Realisation with exception reporting	Annually	D of S,P&P/ D of F&P				✓			
Items requested by Committee members/internal stakeholders									
ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT To receive a report on the quality of Coding	Ad-hoc	Director of Digital		✓					
ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT audiology Informatics System Procurement (RISP) Programme Update	Ad-hoc	Director of Digital		✓					
ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT Robotic Process Automation- cost and benefit realisation (ARAC action)	Ad-hoc	Director of Digital		✓					
ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT Stroke Reconfiguration Update (Action 1101/3.2)	Ad-hoc	Director of Therapies and Health Sciences			✓				

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24						
			21 June 2023	7 Sept 2023	21 Dec 2023	14 Mar 2024			
ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT Performance Overview Report with Exception Reporting to include an update on the progress and impact of the Integrated Discharge Hub (Action 2106/02.2)	Ad-hoc	D of S,P&P/Director of Nursing			✓				
ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT An update on the Discharge Programme and delays, including reporting against the new national data sets. (Action 2106/02.3.1)	Ad-hoc	Director of Nursing			✓				
ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE To Receive an Update of IT Systems- Action taken from November 2023 Board	Ad-hoc	Director of Finance & Procurement/ Director of Digital			✓				
Clinical Audit Activity Assurance on management of contracts that were scheduled to end (Item PQSOC 1312/3.4)	Ad-Hoc	Director of CG				✓			

Appendix Three

Finance and Performance Committee: Attendance at meetings in 2023-24

Attended	Did Not Attend	Not a Member/Required Attendee

Meeting Dates	21st June 2023	7th September 2023	21st December 2023	14th March 2024 (tbc)
Independent Members				
Richard Clark	✓	✓	✓	
Iwan Jones	×	✓	✓	
Dafydd Vaughan	✓	✓	✓	
Shelley Bosson	✓	✓	×	
Executive Directors				
Director of Finance & Procurement	✓	✓	✓	
Director of Strategy, Planning and Partnerships	✓	✓	✓	
Director of Corporate Governance	✓	✓	✓	

Mental Health Act Monitoring Committee

Annual Report for 2023-24

DATE February 2024

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Chair’s Foreword

I am pleased to present the Mental Health Act Monitoring Committee’s (the Committee’s) Annual Report for the year ended 31 March 2024.

In this report we provide an overview of the work of the Committee in ensuring compliance with the legislative requirements of the Mental Health Act.

Diolch yn Fawr / Thank you

Pippa Britton
Chair
Mental Health Act Monitoring Committee

1. Introduction

1.1 Section 1 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Term of Reference of the Mental Health Act Monitoring Committee (referred to throughout this document as 'MHAMC' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The purpose of the **Mental Health Act Monitoring Committee** is to advise and assure the Board and the Accountable Officer by critically monitoring and reviewing the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983 (the MH Act).

1.4 This report describes how the MHAMC discharged its role and responsibilities during the period 1 April 2023 to 31 March 2024.

2. 2023-24 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for MHAMC in 2023-24 is attached to this report (see **Appendix 2**).

A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive agenda. This gives MHAMC flexibility to identify changing priorities or any need for further assurance or information.

2.2 The focus of the MHAMC is to monitor and review the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983. The Committee therefore receives the Mental

Health Act and Compliance quarterly report, that provides an overview of performance across key areas and in doing so provides assurance to the Committee on the level of compliance with the legislative requirements of the Mental Health Act.

2.3 Arising from this report during the year, the Committee heard that the number of detentions held under Section 4 of the Mental Health Act, that permits an emergency application for detention in hospital for 72 hours demonstrated that numbers had increased for those who are detained but are within the normal range for Wales.

2.4 As part of strengthening reporting arrangements and to provide greater assurance, Members requested that moving forwards that within this report a performance trend is provided and that this would include the annual figures for each section to better aid comparison and the identification of trends.

2.5 The Committee also received assurance that the number of Asylum Seekers presenting with Mental Health concerns following their arrival in the UK was not an area of concern as numbers are low. Members were also assured that when a young person is detained there was a planned approach of the patient to the Community.

2.6 During the year the Committee also reviewed and agreed the revised Mental Health Act Managers Policy, that provides for two associate members of the Power of Discharge Committee to attend the Committee, although confirmation was sought as to who would be the responsible owner for this policy moving forwards.

2.7 **Power of Discharge Sub Committee(PDSC):**

The Health Board, as Hospital Managers, may arrange for their functions under the Mental Health Act to be performed on a day-to-day basis by an Officer or Lay Member on their behalf. These individuals appointed by the Health Board are known as Associate Hospital Managers and form the membership of the Power of Discharge Sub-Committee.

During the year the Committee discussed what the Sub-Committee had done to move forward with the requirements of the Power of Discharge Sub Committee. The Committee was assured to note that the actions included:

- The minutes of the meetings are now routinely shared with the Committee as part of the regular update.
- Regular meetings had been arranged to align with the MHAMC.

- Reports from the PDSC are routinely share with the Committee for assurance and developmental purposes.
- Effective structure and process are in place.
- Recruitment of 8 new members are in train to support the Sub-Committee.

This provides the Committee with assurance that the processes and procedures that operate in respect of the Power of Discharge Committee are fit for purpose.

3. MHAM Committee Meetings and Membership

3.1 During 2023-24, the MHAMC met four times via Microsoft Teams- June 2023, September 2023, December 2023, and February 2024. Details of the Members and Executive Directors who attended these meetings is provided at **Appendix 3**.

3.2 The Committee comprised the following Independent Members:

- Pippa Brittons (Chair)
- Vice Chair (Vacant post)
- Paul Deneen

Arrangements are underway to fill the vacant position on this committee to ensure that it appropriately constituted.

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. Following the pandemic, the Committee has continued during the current year to meet virtually and this has therefore meant that the Health Board has not complied with its Standing Orders in this regard and this will be a key consideration as part of the Improving Board Business action plan.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's website in advance of meetings.

4. MHAMC Reporting Arrangements

4.1 Following each meeting, the MHAMC submits an Assurance Report to

the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link

5. Self-assessment and Evaluation

5.1 The Board has undertaken an overall assessment of its effectiveness during 2023/24 using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews.

The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements and has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working.

The outcome of the current years self-assessment that was reported to the Committee on 21st February 2024 confirms that, the results of the individual self-assessment, combined with the analysis of the three completed self-assessments determined that the Committee is effective and meeting the standards.

Rating	Definition	Evidence
2	**Meeting standards**	The Mental Health Act Monitoring Committee is performing to the required standard in this area. There may be room for improvement, but the Mental Health Act Monitoring Committee can be seen to be discharging its responsibilities effectively.

Further, all of the respondents confirmed that the Committee was either meeting or excelling the standard for the effectiveness of this Committee.

Then main areas for improvement identified as part of the self assessment are shown below:

Specific Actions to deliver improvements in the Committee's effectiveness			
Section	**Area of Focus requiring attention**	**How & by When**	**Action Holder**

Section 1 Committee Processes: Composition, Establishment, and Ways of Working	• Inclusion of a standard agenda item to facilitate Committee Members reflection of the meeting held. • Members to have oversight of the Terms of Reference on an annual basis. • Induction training for Committee Members.	All actions to inform the development of an overarching Board Business Improvement Plan – March 2024 for Board approval	Director of Corporate Governance with Head of Board Business
Section 2 Governance and Assurance	• RCRP/Concordat information report to be shared with Committee Members for information to support when reviewing multi agency protocols/policies.	to be factored into the Committee's workplan 2024/25	Director of Corporate Governance with Head of Board Business

These findings will be used to inform a comprehensive annual assessment of the Board's effectiveness. An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured Assessment, for delivery in 2024/25. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

6. Key Areas of focus in 2024-25

To maintain focus on ensuring compliance with the legislative requirements of the Mental Health Act, and will also be informed by the findings of the Annual Committee Self-Assessment that will include for the RCRP/Concordat information reports to be routinely shared with the Committee when reviewing multi agency protocols/policies. Members have also requested that a standing agenda item on reflection is included on future agendas to enable a continuum of learning, reflection and improvement.

7. Conclusion

7.1 This report provides a summary of the work undertaken by the MHAMC during 2023-24, and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2022.

Appendix One

Mental Health Act Monitoring Committee

Terms of Reference 2022/23

Document Title:	Mental Health Act Monitoring Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Current version:	Approved
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

1. Introduction

The Aneurin Bevan University Health Board's standing orders provide that "*The Board may and, where directed by the Welsh Government, must appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

In line with standing orders and the Health Board's Scheme of Delegation, the Board shall nominate annually a committee to be known as the **Mental Health Act Monitoring Committee**.

The Committee is formed of Independent Members of the Health Board and has no executive powers, other than those specifically delegated to it by the Board as outlined in these Terms of Reference.

The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out in this document.

2. Purpose of the Committee

The purpose of the **Mental Health Act Monitoring Committee** ("the Committee") is to:

Advise and ***assure*** the Board and the Accountable Officer by critically monitoring and reviewing the way in which the Health Board discharges its functions and responsibilities under the Mental Health Act 1983 (the MH Act).

It will support the Health Board in discharging its accountabilities and responsibilities for the achievement of the Health Board's objectives and organisational requirements in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer (Chief Executive) on where and how its system of governance and assurance may be strengthened and further developed.

3. Delegated Powers and Authority

3.1. Authority

The Committee is authorised by the Board to investigate or to have investigated any activity (clinical and non-clinical) within its Terms of Reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit (ensuring patient, service user, client and staff confidentiality, as appropriate). It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee);

and

- any other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outside representatives with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

The Committee may act on any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.2. Sub-Committees

The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

In this respect a ***Power of Discharge Sub-Committee*** will be created.

The Health Board, as Hospital Managers, may arrange for their functions under the Mental Health Act to be performed on a day-to-day basis by an Officer or Lay Member on their behalf. These individuals appointed by the Health Board will be known as Associate Hospital Managers and will form the membership of the Power of Discharge Sub-Committee.

The Sub-Committee will report routinely to the Committee for assurance and developmental purposes.

4. Function and Work Programme

4.1. Governance and Assurance

The Committee's programme of work will consider:

- how the delegated functions under the Mental Health Act are being exercised (for example using a programme of Annual Audit) and in line with the 'Code of Practice' requirements
- the operation of the 1983 Act within the Aneurin Bevan University Health Board area
- the multi-agency training requirements of those exercising the functions (including discussing the training report for assurance)
- issues arising from the operation of the hospital managers' power of discharge
- a suitable mechanism for reviewing multi agency protocols/policies relating to the 1983 Act
- trends and patterns of use of the Mental Health Act 1983
- cross-agency audit themes and sponsor appropriate cross-agency audits
- lessons learnt from difficulties in practice and the development of areas of good practice

To assist it the Committee will utilise the work of scrutiny and other assurance services including NHS Wales Internal Audit and Audit Wales, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.2. Risk Management

The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

4.3. Access

The Head of Internal Audit and the Auditor General and his representatives shall have unrestricted and confidential access to the Chair of the Committee at any time, and vice versa.

The Chair of the Mental Health Act Monitoring Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5. Membership

The Mental Health Act 1983 gives responsibility to health and social care organisations and practitioners, in collaboration with a range of other agencies including police and ambulance services, as well as third sector

bodies such as advocacy providers. Therefore, consideration will be given to reflecting this wider partnership in the membership of the Committee, as different agencies and practitioners have differing responsibilities and duties under the Act.

5.1. Members

The Committee shall comprise of three (3) members:

Chair:	Vice Chair of the Health Board
Vice Chair:	Independent member of the Board
Other Members:	One other independent member of the Board

The committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

5.2. Attendees

Health Board:

- Director of Primary Care, Community and Mental Health will be the lead Executive but will not be a formal member of the Committee.
- Other Executive Directors will attend as required by the Committee

Others by invitation

The Committee Chair may invite any other Health Board official and / or any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

5.3. Member Appointments

The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office.

During their period of appointment a member may resign or be removed by the Board.

6. Support

6.1. Secretariat

Secretariat arrangements will be determined and arranged by the Director of Corporate Governance.

6.2. Advice and Member Support

The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role;

  and

- Ensure the provision of a programme of organisational development for committee members as part of the Health Board's overall OD programme developed by the Director of Workforce and Organisational Development.

7. Committee Meetings

7.1. Quorum

At least two of the selected members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

The Director of Primary Care, Community and Mental Health (or deputy) will count towards quorum, although is not considered a member of the Committee.

7.2. Frequency of Meetings

Meetings will be held quarterly per annum and otherwise as the Chair of the Committee deems necessary – consistent with the Health Boards plan of Board business.

7.3. In Committee and withdrawal of individuals in attendance

The Chairman may ask any or all of those who normally attend but who are not members of the Committee to withdraw to receive information which may include matters of a sensitive and/or confidential nature.

7.4. Record of the Committee Meeting

A record of the meeting will be presented as notes and action points.

7.5. Public Meetings

The Committee will be open to the public.

8. Relationship and Accountabilities with the Board and its Committees

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business and
- Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. Reporting and Assurance Arrangements

The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of committee minutes and written reports throughout the year;
- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;
- Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Accountability Report and the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the committee's self-assessment and evaluation.

The Board may require the Committee Chair to report upon the Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Board Secretary, on behalf of the Board, shall oversee a process of annual self-assessment and evaluation of the Committee's performance and operation including that of any sub committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

10. Applicability of Standing Orders to Committee Business

The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. Review

These terms of reference shall be reviewed annually by the Committee with reference to the Board.

Appendix Two

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			19th June	5th Sept	6th Dec	21st Feb
Preliminary Matters						
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓
Committee Requirements as set out in Standing Orders						
Development of Committee Annual Programme of Business 2023/24	Annually	Chair & Director of CG				✓
Review of Committee Programme of Business	Standing Item	Chair	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2023/24	Annually	Chair & Director of CG				✓
Annual Review of Committee Effectiveness 2023/24	Annually	Chair & Director of CG				✓
Committee Annual Report 2023/24	Annually	Chair & Director of CG				✓
Mental Health Act Compliance						
Mental Health Act Compliance Report	Standing Item	Head of Quality & Improvement	✓	✓	✓	✓
Power of Discharge Committee Update	Standing Item	Head of Quality & Improvement	✓	✓	✓	✓
Items requested by Committee members/internal stakeholders						
Annual Benchmarking Report **MHMAC/05/09/3.1** BC Requested for June/July 2024	Annually	Director of CG				

Appendix Three

Mental Health Act Monitoring Committee: Attendance at meetings in 2023-24

Attended	Did Not Attend	Not a Member/Required Attendee

Meeting Dates	19th June	5th September	6th December
Independent Members			
Pippa Britton	x	x	x
Paul Deneen	x	x	x
Executive Directors			
Chris O'Connor	x	x	x
Leanne Watkins	x	x	x
Rani Dash	x	x	x

Patient Quality, Safety and Outcomes Committee

Annual Report for 2023-24

April 2024

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Chair's Foreword

I am pleased to present the Patient Quality, Safety and Outcome Committee's (the Committee's) Annual Report for the year ended 31 March 2024.

In this report we provide an overview of the work of the Committee, which extends to the full range of Health Board responsibilities; and encompasses all areas of patient experience, quality and safety relating to patients, carers and service users.

In particular, I welcome the approval of the Quality Strategy by the Board in March 2024, which will ensure that quality is embedded in our culture and that we are delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do.

Finally, I would like to express my personal appreciation to all who contributed to the patient quality, safety and outcomes agenda over the last 12-months.

Diolch yn Fawr / Thank you

Pippa Britton
Chair
Patient Quality, Safety and Committee

1. Introduction

1.1 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Term of Reference of the Patient Quality, Safety and Outcomes Committee (referred to throughout this document as 'PQSOC' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The Committee formally adopted its Terms of Reference, following the Board's approval, on 05 April 2022.

The purpose of the PQSOC is to provide: evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

1.4 This report describes how the PQSOC discharged its role and responsibilities during the period 1 April 2023 to 31 March 2024.

2 2023-24 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for PQSOC in 2023-24 is attached to this report (see **Appendix 2**).

2.2 A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive

agenda. This gives PQSOC flexibility to identify changing priorities or any need for further assurance or information.

3 PQSO Committee Meetings and Membership

3.1 During 2023-24, PQSOC met Six times via Microsoft Teams- in April 2023, June 2023, July 2023, October 2023, December 2023 and February 2024. Detail of the Independent Members and Executive Directors who attended these meetings is provided at **Appendix 3**.

3.2 The Committee comprised the following Independent Members:

- Pippa Britton Chair
- Louise Wright Vice Chair
- Paul Deneen
- Helen Sweetland

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. Following the pandemic, the Committee has continued during the current year to meet virtually and this has therefore meant that the Health Board has not complied with its Standing Orders in this regard and this will be a key consideration for the Improving Board Business action plan.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's website in advance of meetings.

3.4 The Committee's agenda and papers were made public, save where it was necessary to meet 'in private', which it did on four occasions in 2023-24. Private meetings are held where it would not be appropriate to discuss a matter in public, due to issues of patient or staff confidentiality, commercial confidentiality, or discussion of serious incidents or escalated concerns which would not be in the public interest.

4 PQSOC Reporting Arrangements

4.1 Following each meeting, the PQSOC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link.

5. PQSOC Work Programme: 2023-24

5.1 During the year the Committee received updates in respect of the following items:

5.2 The Committee received a regular Committee Risk Report that details the summary of the key risks allocated to the Committee and the position of each risk. At the end of the year the Committee had 3 risks identified as a level of Extreme (20) which were:-

- There was a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse. – Risk level 20
- There was a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974. – Risk level 20
- There was a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system. – Risk level Extreme 20

5.3 During the year as part of managing risks, the Committee received an updated in relation to the management of medical devices and equipment within the Health Board. The Committee was advised of the challenges in achieving compliance with the 2017/18 Internal Audit recommendation. The Committee was assured that work had progressed to confirm the location of devices at ward level, noted improvements with staff competency whilst using devices and that the action was scheduled to be completed by May 2024. The Committee was advised that a Working Group within the QPS team would be established to ensure that compliance with recommendations was maintained and that a progress report would be brought back to the Committee in 2024.

5.4 At the February 2024 meeting, the Committee was provided with an overview of the internal and external audit recommendations resulting from the planned audit reviews that fall under the remit of the Committee. The audit reports were:

- Health & Safety
- Medical Equipment and Devices
- Medicines Management
- Monitoring Action Plan
- Discharge Planning

- Dementia Service
- Structure Assessment
- Putting Things Right: Advisory Review

The Committee was assured that appropriate action plans were in place to cover all recommendations with progress updates being provided to the Audit, Risk, Assurance Committee.

5.5

The Committee also received an update on the progress made in the development of the business case to replace the Pharmacy Robot at the RGH. The Committee was advised that the lifespan of the robot had been exceeded and was increasingly failing and noted that contingency plans had been developed should this occur. The Committee noted that the risk had been included in the corporate risk register and that a decision to procure and fund from next year's capital budget, a replacement pharmacy Robot had been made.

5.6 During the year, the Committee received a quarterly report on the Performance of Patient Quality and Safety Outcomes. During the year the following information was reported:

Duty of Candour Triggers

At the last meeting of the year, the Committee was advised that since 1 April 2023 to February 2024 there had been 20,807 incidents affecting patients reported on the Datix Cymru system, noting since the implementation of duty of candour reporting there had been an increase in incidents. The Committee noted that this was due to incidents being reported even if a patient did not come to harm.

In February 2024, it was agreed that the performance report would include a breakdown of reporting themes to improve the understanding.

Infection Prevention and Control

During the year the Committee noted that the main areas of infection concern was C.Difficile, and was advised that a deep dive had taken place on all patients testing positive since April 2023.

At the April 2023, the Committee received an update on Covid cases and noted that 32 positive incidents had been reported in respect of patients in hospitals. The Committee also noted that Covid-19 testing guidance had changed and that Covid would now be managed as a seasonal illness.

Covid-19 Investigations

At the April 2023 meeting, the Committee noted that Wave 1 of Covid Investigations was 100% complete and was advised that Wave 2 and 3 was underway. The Committee was assured that the Health Boards reporting on this matter had been identified as one of the best.

Fall incidents

Throughout the year the Committee received regular updates in respect of falls. At the April 2023 meeting, the Committee was advised that there had been a significant increase in falls throughout December 2022, when hospitals were under extreme winter demand and pressure. However, the Committee was assured to note at the December 2023 meeting that performance had improved and noted that there was now a consistent approach in place with regards to falls management as a result of the implementation of the falls policy that had been released in 2021.

Health, safety and security

At February 2024 meeting, the Committee was advised that throughout the year there had been 94 incidents reported to the Health and Safety Executive (HSE), in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The Committee was also informed that the HSE had notified the Health Board of a breach in relation to health and safety law, as a result of the failure to report a fall at Nevill Hall Hospital in 2019 within the specified timeframe.

The Committee noted that 7 risk areas had been identified as a focus for improvement in 2024, and was assured that these would be progressed through the implementation of an action plan.

Complaints, concerns and compliments

At the February 2024 meeting, the Committee was assured that progress had been made in responding to complaints with a 30-day period, although there was an acknowledgment that further work was required to achieve better compliance. The Committee was advised that a new Head of Complaints had been appointed earlier in the month and this role would be instrumental in securing improvements with compliance.

HIW Inspection

At the last meeting of the year, the Committee was advised that a HIW inspection had been undertaken in January 2024, at the Talygarn Unit, County Hospital. Following the inspection the Committee was advised that an improvement notice had been issued in respect of the inspection which had been responded to.

5.7 The Committee was provided with an overview of the Maternity Services three-year improvement plan and agreed to receive regular progress updates. The Committee was assured that when implemented this would:

- ensure the consistent provision of high quality individualised maternity care,
- a approach to individualised, and,
- a reduction in health inequalities.

5.8 **Annual Reports**

Throughout 2023/24, the Committee received the following Annual reports: -

Blood Management

The Annual Blood Management report provided the Committee with an overview of the progress made in addressing the priorities in respect of this area. The report acknowledged the assistance of the Hospital Transfusion Committee, and noted that one issue that remained was in respect of the level of compliance with traceability reporting and noted that a training plan was in place to address this matter.

Pharmacy and Medicines Management

The Committee received the Annual Pharmacy and Medicine Management report which confirmed progress in the four priority areas of safe prescribing; antimicrobial stewardship; cost efficiency; and access to medicine.

The report also outlined the following risks:-

1. Storage of IV Fluids at the Royal Gwent Hospital.
2. Concern regarding the functionality of the RGH pharmacy robot, responsible for the distribution of medicines to all wards, including The Grange University Hospital.

The Committee was assured that the business case to renew the pharmacy robot had been developed.

Research and Development

The Research and Development strategy was presented to the Committee, noting that the Research and Development was a University Health Board function, and the Health Board would produce an annual report to showcase the work being undertaken on the implementation of the strategy throughout the year and an update on its future strategic development. The Committee noted that the aim was to develop an infrastructure where research and development could flourish and where the Health Board could maximise the benefits of its investment in the new Clinical Research Centre at the Royal Gwent Hospital.

Infection Prevention and Control

At the July 2023 meeting, the Committee received the Annual Infection Prevention and Control report. The report confirmed that statistically the Health Board was in the lower average rate for all infections in Wales. The report identified that it had been a challenging year for the team and that a restructure had taken place and the teams function now included infection prevention in the wider community.

The following was highlighted:-

- The team were finalists for the Houdini Programme for the NHS Awards in Wales.
- Covid and flu data showed lower hospital onset in comparison to other Health Boards.
- The team has supported the following serious incidents, that included, a sporadic case of CJD, M-pox agenda, patient pathways and assessment of patients, increase in wound infections in trauma and orthopaedics, and Group A Strep infection.

Safeguarding

The Committee receive the statutory Annual Safeguarding report that highlighted:-

- A learning Group had been established to monitor the progress of the recommendations of the priorities for 2022/23.
- There were challenges around the national requirements for training compliance in respect of Level 3 Children and Adults. The Committee noted that this was as a result of the size of the cohort

requiring this training and was assured as to how the matter would be addressed.

- Increase in the numbers of children being harmed, that had resulted in attendance at strategy meetings.
- Increase in adult safeguarding concerns with a Datix submitted for each incident reported

The Committee was also informed that support was being provided to one local authority, as a result of their capacity issues and noted that a progress update would be provided at the April 2024 meeting.

Annual Clinical Audit Activity Report 2022/23

During the year the Committee received the Annual Clinical Audit Activity Report 2022/23, which included details of the Health Board's participation in the National Clinical Audit and Outcomes Review Plan for the present financial year. The Committee requested that future audit reports include a clear timeline of action, that when triangulated with data will enable greater assurance.

The Committee noted the following:-

- The Clinical Audit team was to develop a clinical audit programme for 2023/2024.
- the Health Board policy on Clinical Audit was to be updated.
- AMaT audit management system would be implemented across the Health Board.

5.9 The Committee received an overview of the of the Health Boards priority outcomes that aligned to the 6 Pillars for the Quality Strategy framework that included how the outcomes would be delivered, measures and continuously improved:-

- Priority 1 – Deliver PATIENT CENTRED care which involves patients, relatives, families, careers and system partners in the planning of care and opportunities to improve patient safety.
- Priority 2 - Provide SAFE care. We aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.
- Priority 3 – provide TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time.
- Priority 4 – Provide EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome.

- Priority 5 – provide care that is EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste.
- Priority 6 – Provide EQUITABLE care, ensuring equal opportunities for individuals to attain their full potential for a healthy like which does not vary in quality and is non-discriminatory.

5.10

In October 2023, the Committee received the National Incident Reporting Policy that detailed the arrangements of revised incident reporting. The Committee was assured that the Health Boards Patient Safety Incident Reporting & Management Policy had been reviewed to align with the expectations set out in the new national policy that was published in May 2023.

In particular the Committee noted the following:-

- Quality and patient safety resources would fall under the Nursing Directorate.
- Clear engagement practices in respect of the management of incident investigations with families were in place.
- A learning framework would be produced to ensure that learning from incidents informs quality patient safety planning processes.
- A family liaison officer/point of contacts would be identified to support families/patients throughout investigations.
- Staff support was provided throughout the investigation process.

5.11

In December 2023, the Committee received a report that detailed the outcomes of the review into Never Events that had been completed by Theatres. The review identified the following themes to be addressed that included wrong site injections and retained swabs. The Committee was assured that the Orthopaedic and Radiology Governance leads would continue to work with the Anaesthetist team to standardised the process across all Theatres.

6. Patient Centred Care

6.1 On behalf of the Committee at Board level the presentation of Patient-Staff Stories continued. Topics presented included:

- Alcohol Care Team
- Children's Rights and Participation Forum
- Tyleri Ward Community Resource Team.

7. Self-assessment and Evaluation

7.1 The outcome of the current years self-assessment that was reported to the Committee on 13th December 2023 confirmed that the results of the individual self-assessment, combined with the analysis of the three completed self-assessments determined that the Committee was effective and meeting the standards.

Rating	Definition	Evidence
2	**Meeting standards**	The Committee is performing to the required standard in this area. There may be room for improvement, but the Committee can be seen to be discharging its responsibilities effectively.

The table below details the specific areas where suggestions for improving the Committee's effectiveness were made.

Specific Actions to deliver improvements in the Committee's effectiveness			
Section	**Area of Focus requiring attention**	**How & by When**	**Action Holder**
1 Committee Processes: Composition, Establishment, and Ways of Working	• Report template to be reviewed and training on report writing to be delivered • A programme of training for independent members to be developed • Agendas to include an item on reflection upon meeting	All actions to inform the development of an overarching Board Business Improvement Plan – January 2024 for Board approval	Director of Corporate Governance with Head of Board Business
2 - Clinical Quality Governance 3 - Patient Experience and Involvement	• Explore ways of ensuring greater assurance and opportunities for committee members to be better appraised of patient experience matters	To be strengthened within Committee Workplan 2024/25 – April 2024	Head of Board Business with Director of Nursing

4 - High Quality, Safe and Effective Healthcare	• Strengthened focus on reporting of Joint Committee activity to this Committee	To be considered within the development of the Commissioning for Quality Framework	Director of Corporate Governance with Director of Nursing
5 - Research and Development and Improvement and Innovation	• Secure a greater understanding of those improvement projects through better reporting to the Committee and to capture this on the fwp for the Committee	To be strengthened within Committee Workplan 2024/25 – April 2024	Head of Board Business with Medical Director and Director of Nursing
6 - Compliance with Health and Safety Regulations and Fire Safety Standards	• Health and Safety Assurance reporting to be strengthened to include a focus on risk and assurance gaps.	In future reporting arrangements, in-line with the Committee's workplan.	Director of Therapies and Health Science with support of Head of Risk and Assurance

These findings will be used to inform a comprehensive annual assessment of the Board's effectiveness. An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured Assessment, for delivery in 2024/25. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators and partners.

8. Key Areas of focus in 2024/25

8.1 As a result of the work of the Committee in 2023/24 the following areas of focus were identified:

- Explore ways of ensuring greater assurance and opportunities for committee members to be better appraised of patient experience matters.
- Strengthened focus on reporting of Joint Committee activity to this Committee.
- Secure a greater understanding of those improvement projects through better reporting to the Committee and to capture this on the forward work plan for the Committee.
- Health and Safety Assurance reporting to be strengthened to include a focus on risk and assurance gaps.
- Agendas to include an item on reflection upon meeting to aid ongoing self evaluation.

9. Conclusion

9.1 This report provides a summary of the diverse and often complex work undertaken by the PQSOC during 2023-24, and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2022.

Appendix One

Patient, Quality, Safety and Outcomes Committee

Terms of Reference – 2022/23

Version: Approved

Date: March 2022

Document Title:	Patient Quality, Safety and Outcomes Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Version:	Draft
Previous version:	May 2021
Approved by:	Board
Review date:	March 2023

1. INTRODUCTION

1.2 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.3 The Health Board has established a committee to be known as the **Patient Quality, Safety & Outcomes Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

2.1 The scope of the Committee extends to the full range of ABUHB responsibilities. This encompasses all areas of patient experience,

quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose:

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a. The robustness of the Board's Clinical Quality Governance Arrangements;
b. the experience of patients, citizens and carers ensuring continuous learning;
c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and
d. the effectiveness of arrangements in place to support Improvement and Innovation.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's **Clinical Quality Governance Arrangements** remain appropriate and aligned to the National Quality Framework and is embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:
    - the delivery of the Patient Experience Plan; and
    - the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
    - the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
    - the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on ABUHB's behalf;
    - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
    - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
    - the arrangements in place to ensure that there are robust infection prevention and control measures in place in all settings;
    - the development of the Board's Annual Quality Priorities; and,
    - performance against key quality outcomes focussed indicators and metrics.

D. Seek assurance on the arrangements in place to support **Research and Development** and **Improvement and Innovation**, including:
    - an overview of the research and development activity within the organisation;
    - alignment with the national objectives published by Health and Care Research Wales (HCRW);
    - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with Health and Safety Regulations and Fire Safety Standards** are sufficient, effective and robust, including:
    - the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls,

patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage.
This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise of five (5) members:

Chair:	Independent member of the Board
Vice Chair:	Independent member of the Board
Other Members:	Three other independent members of the Board *[one of which should be the Vice Chair of the Health Board and the Chair of the Audit, Risk and Assurance Committee]*

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing
- Director of Therapies and Health Science
- Medical Director
- Director of Primary, Community Services and Mental Health

4.3 By invitation:
The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;

- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly (six times yearly)**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public

session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is

considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.2 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee – after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix Two

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG			✓	
Review of Committee Programme of Business	Standing Item	Chair			✓	✓
Annual Review of Committee Terms of Reference 2023/24	Annually	Chair & Director of CG				
Annual Review of Committee Effectiveness 2023/24	Annually	Chair & Director of CG				
Committee Annual Report 2023/24	Annually	Chair & Director of CG				
Pharmacy and Medicines Management Annual Report	Annually	Medical Director				
Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Annually	Medical Director				
Focus on Pillars of Quality - Infection Prevention and Control and Safeguarding - Incident report and Health Safety and Security - Patient and staff feedback and Complaints and Concerns				✓	✓	✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Mtg 30th April or 4th June - Jan to March data, Mtg 2nd July - no performance report, Mtg 1st October -April to June data, Mtg 10th December July to Sept data. Mtg 4th Feb October to December data						
Mental health and learning disabilities assurance			✓	✓	✓	✓
Learning from Death Report	Bi-Annually	Medical Director				
Cleaning Standards Annual Report	Annually	Director of Operations				
Nutrition and Hydration Standards and Strategy'	Annually	Director of Therapies & HS				
Falls Prevention and Management Report	Bi-Annually	Director of Therapies & HS				
Health and Safety Compliance Report	Annually	Director of Therapies & HS				
Safeguarding Annual Report	Annually	Director of Nursing				✓
Safeguarding Group Highlight Report (In Quality report)	Quarterly	Director of Nursing			✓	
Operation Jasmine Action Plan	Bi-Annually	Director of Nursing		✓		
Children's Rights & Participation Forum	Bi-Annually	Director of Nursing				✓
Infection Prevention and Control Annual Report (In Quality report)	Annually	Director of Nursing			✓	
Infection Prevention and Control Report	Quarterly	Director of Nursing			✓	
Blood Management Annual Report	Annually	Medical Director				

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Organ Donation Annual Report	Annually	Medical Director				
Quality Assurance Framework Annual Review and Evaluation of Progress	Annually	Clinical Executives				
Commissioning Assurance Framework, Development and Implementation	Bi-Annually	Clinical Executives				
Clinical Effectiveness and Standards Committee Report (In quality report)	Bi-Annually	Medical Director				✓
Annual Clinical Audit Plan (prior to ratification) by the Audit, Risk & Assurance Committee	Annually	Medical Director			✓	
Clinical Audit Activity Report (Local and National) Feb 23 to include Annual Clinical Audit Draft Internal Audit Report	Quarterly	Medical Director			✓	
Quality Improvement Annual Report	Annually	Director of Planning				
Research and Development Annual Report	Annually	Medical Director				
Medical Devices Annual Report	Annually	Director of Therapies & HS				
Point of Care Testing Annual Report	Annually	Director of Therapies & HS				
Quality and Safety Outcomes Report (In Quality report)	Standing Item	Clinical Executives	✓	✓	✓	✓
Committee Risk Report, including BAF	Standing Item	Director of Corporate Gov	✓	✓	✓	✓
WHSSC QPS Committee Report	Standing Item	Director of Nursing	✓	✓	✓	✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Patient Story (In Quality report)	Standing Item	Clinical Executives	✓	✓	✓	✓
Putting Things Right Policy (in quality report)	Every 3-yrs (2022)	Director of Nursing				✓
Putting Things Right Reporting (complaints, compliments, and redress) (In quality report)	Standing Item[1]	Director of Nursing				✓
Quality & Engagement (Wales) Act, Preparedness and Implementation (In quality report)	Annually	Director of Nursing				✓
Patient Experience Report	Quarterly	Director of Nursing		✓		
Dementia Care Annual Report	Annually	Director of Nursing		✓		
Clinical Negligence Claims and Coroners Inquests Report (In quality report)	Bi-Annually	Director of Nursing				✓
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓
Covid-19 Concerns and Claims	Bi-Annually	Director of Nursing		✓		
Learning Disabilities	Annually	Director of PCCMH			✓	
Urgent and Emergency Care Demand and Impact on Outcomes	Quarterly	Director of Operations			✓	
Maternity Services: Organisational Improvement and Action Plan	Bi-Annually	Director of Nursing		✓		✓
Child and Adolescent Mental Health Crisis Hub and Safe Accommodation	Annually	Director of Nursing				

[1] Via Quality and Safety Outcomes Report
[2] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Self-Harm & Suicide - Children & Young People	Annually	Director of Nursing				
Primary Care Quality	Bi-Annually	Director of PCCMH				
Internal Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives				
External Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives				
Action Plan for "*Review of Quality Governance Arrangements*" Audit, Wales Review (2021/22)	Bi-Annually	Clinical Executives		✓		
Internal Audit Review - Quality Governance arrangements for the commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities (limited assurance) – Action Plan Update	Bi-Annually	Director of Primary, Community Care & Mental Health				✓
Internal Audit Review – Medical Devices – Action Plan Update	Bi-Annually	Director of Therapies & HS				✓
Overview of Audit Recommendation Tracking (relevant to the Committee)	Quarterly	Director of Corporate Gov			✓	
Inspections of Healthcare Inspectorate Wales	Ad-hoc	Director of Nursing				
Inspections of the Community Health Council	Ad-hoc	Director of Nursing				
Tracking of Improvement Actions Arising from Inspections and Reviews	Quarterly	Director of Nursing		✓		✓
Healthcare Inspectorate Wales Operational Plan (In Quality report)	Annually	Director of Nursing			✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	11th October	13th December	7th Feb
Healthcare Inspectorate Wales Annual Report	Annually	Director of Nursing				
WRP Report and Management Response/Action Plan: National Review of Consent to examination and treatment standards in NHS Wales		Medical Director				
HIW Report/ Stroke Assurance (Requested at October A/S meeting)		Director of Therapies & HS			✓	
Configuration of Midwifery-led Units evaluation	Ad - Hoc	Director of Nursing				✓
Committee Self-Assessment Results		Director of Corporate Governance			✓	

Appendix Three

Patient Quality, Safety and Outcomes Committee: Attendance at meetings in 2023-24

Attended	Did Not Attend	Not a Member/Required Attendee

Meeting Dates	April	June	July	October	December	February
Independent Members						
Pippa Britton						
Louise Wright						
Paul Deneen						
Helen Sweetland						
Executive Directors						
Medical Director						
Director of Therapies & Health Science						
Director of Therapies & Health Science						
Chief Executive						
Director of Corporate Governance						

Partnerships, Population Health, and Planning Committee

Annual Report for 2023-24

April 2024

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Chair's Foreword

I am pleased to present the Partnerships, Population Health, and Planning Committee's (the Committee's) Annual Report for the year ended 31 March 2024.

In this report we provide an overview of the work of the Committee, which covers all matters relating to areas of Partnership Working, Population Health and Planning across the full breadth of the Health Board's responsibilities.

During this year of this Committee, we have considered the development of the clinical futures programme and the changes it required. We have commissioned the development of a new long-term plan and estates strategy and plan. We have been pleased to see the determination of our planning teams in implementing discussions and actions in respect of regional services and regional working for the population, a key priority for the Minister for Health and Social Services Wales.

We also recognise the commitment to the work undertaken towards creating collaborative partnership working in Gwent, with the work in relation to the Marmot region beginning to take effect and changes being made to improve working, governance and accountability within the Regional Partnership Board (RPB). Initial progress has been made during the year in the provision of additional jointly provides services and care between partners in Gwent as a result.

Finally, I would like to express my personal appreciation to all who contributed to the Committee over the past 12 months.

Ann Lloyd
Chair
Partnerships, Population Health and Planning Committee

1. Introduction

1.1 Section 1 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Term of Reference of the Partnerships, Population Health and Planning Committee (referred to throughout this document as 'PPHPC' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The purpose of the **Partnerships, Population Health and Planning Committee** is to advise the Board on all matters relating to areas of Partnership Working, Population Health and Planning across the full breadth of the Health Board's responsibilities. The Committee will provide accurate, evidence based and timely advice to the Board in respect of the development of the Health Board's priorities and plans to improve population health and wellbeing; strategic frameworks and plans for the delivery of high quality and safe services; business cases and service planning proposals, including the alignment of supporting and enabling strategies, including workforce, capital, estates and digital. The Committee also provides advice to the Board in relation to any implications for service planning arising from strategies and plans developed through the Joint Committees of the Board or other strategic partnerships, collaborations or working arrangements approved by the Board.

1.4 This report describes how the PPHPC discharged its role and responsibilities during the period 1 April 2023 to 31 March 2024.

2. 2023-24 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups.

The Work Programme adopted for PPHPC in 2023-24 is attached as **Appendix 2**.

The PPHPC focuses on both assurance in respect of strategic partnerships, strategic planning and developments and the development of plans in respect of the key Clinical Futures priorities. The monitoring of this is set out as follows:

Assurance in respect of Strategic Partnerships:

Public Service Board (PSB)

The Committee received quarterly updates on the work of the Public Service Board (PSB). The Committee was informed of the work of the PSB throughout 2023/24, including the following key areas:

- The progress of the 'Building a Fairer Gwent, Gwent Marmot Programme'. The five year 'Building a Fairer Gwent delivery and action plan' (2024-2029) would encompass Marmot recommendations and objectives, with an internal public health approach for the Health Board and partnerships through a social, environmental, and economic lens. A delivery group, aligned to the PSB, would be overseeing the delivery of associated actions.

- Health Board engagement and collaboration with Local Authority Partners, working on long-term plans and recommendations to tackle health inequalities for the population.

- The alignment of the UCL Institute of Health Equity (IHE) Gwent Marmot Region report and the Gwent Public Service Board (PSB) Wellbeing Plan.

- The Gwent Marmot region communication and engagement strategy. The Committee was informed that throughout the year the PSB had held engagement events with a focus on closing the gap between statutory and community services, with four main themes of 'Best start in life', 'the impact of crime and community safety', 'Economic factors' and 'Environmental factors'.

-

Regional Partnership Board (RPB)

Quarterly updates were received in respect of the business of the Regional Partnership Board (RPB). The Committee was informed of the work on the Area Plan and the development of the Partnership Capital Strategy and Plans, that included the following key areas:

- A collaborative evaluation of RPB and Regional Integration Funding (RIF) spending would take place in 2023/24, alongside a review of the partnership governance arrangements. An overview of this would be presented to the Committee on completion.

- The Health Board is tasked with piloting a dashboard measuring the impact of RPB funding on the population of Gwent.

- The Welsh Government had commissioned a national funding evaluation, with phase due to be complete at the end of 2023 and phase two in 2024. Professor Marcus Longley was undertaking a national evaluation of the effectiveness of the RPB. The Committee awaits the outcome of this work.

- An overview of the Welsh Government requirement for submission of a ten-year Regional Capital and Strategy Plan was provided. The Health Board would review and monitor all internal and partnership plans regularly to ensure alignment with its strategic direction.

- The Health Board has fully engaged in the development of a Partnership Capital Strategy and Plan; this had been evaluated through the internal capital governance structure.

- An overview of the RPB Governance Review has been in progress and an implementation action plan is being drafted.

- An update is being provided on the proposals for Estate Rationalisation in the context of correspondence from Welsh Government and the planned review of the prioritisation the Estate Strategy Objectives.

- Further work is required to strengthen accountability on regional and local partnership working. An RPB workshop, discussing the work carried out within Integrated Service Partnership Boards (ISPBs) and Neighbourhood Care Networks (NCNs) was rescheduled for March 2024.

- The RPB's community-based teams were undertaking a review of Frailty Services and ongoing projects, to determine benefits for the population.

- The current financial governance of partnerships were reported as good. Further improvement work on benefits realisation is required. To promote compliance with good governance, agreements, and plans of all partners within the RPB; clear

delegation, mutual agreement of expectations, and ownership from all partnership bodies is be required.

Assurance in respect of Strategic Planning and Development:

Quarterly updates on strategic planning and development were received through the Regional Planning update reports, with exception reporting in identified areas. Health Board planning teams across South Wales continued to meet throughout 2023/24 to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience and best practice, and consider future opportunities for closer working to mutual benefit.

The Committee was informed of regional planning work undertaken throughout 2023/24, in regional Ophthalmology, Orthopaedics, Diagnostics services, Cancer services, Vascular services, Stroke services, Thoracic services and Hepato-Biliary and Pancreatic Surgery, and the Welsh Sexual Assault Service. The following updates were presented to the Committees:

Regional Ophthalmology:

The Committee was advised that the regional Ophthalmology Programme made good progress throughout 2023/24. In particular the Committee noted:

- The awaited decision on the interim capital business case for Cataract Recovery by Welsh Government, noting the risk based upon potential delays. Delays had occurred in implementation of the Ophthalmology Electronic Patient Record, led by DHCW. For further assurance a detailed update on plans progress of the Ophthalmology Electronic Patient Record (Open Eyes Project) was sought.

- At the November 2023 meeting, the Committee noted that the Ophthalmology business case had been amended due to funding being decreased from £10m, to £7m. At the January 2024 meeting, an interim Ophthalmology business case had been agreed. The first regional ophthalmology patients, led by the Health Board, were planned to be treated in the Nevil Hall Hospital hub on the 5th of February 2024, and outsourcing to the Ophthalmology hub in Cardiff continued. The Committee was assured by the positive impact of additional activity, noting that within one week of this additional activity, funded by Welsh Government, there had been a 4-week reduction from the cataract waiting times. The Committee received a further update on the progress of an electronic record for Ophthalmology patients, an options appraisal had been received

from DHCW; however, the Health Board was completing an internal review of options for an electronic record for Ophthalmology patients.

Orthopaedics:

- An update on the regional Orthopaedic Programme was presented to the Committee, informing of the purchase by Cwm Taf Morgannwg, via Welsh Government funding, of the Health Park in Llantrisant ('Concorde' development) and plans for this to host elective Orthopaedic services in South Wales.

Diagnostics:

- The Committee was updated on Diagnostic services and informed that a business case was in development for the opportunity to use current Health Board space for additional diagnostics. The Health Board is pursuing an in-house development for diagnostics, as this is considered to provide the best option in terms of affordability, deliverability, and sustainability.

Cancer Services:

- In May 2023, the Committee was informed of version 2 of the Cancer Services business case, containing feedback from all Health Boards and outlining plans for a complementary cancer centre at the Nevil Hall hospital site, alongside the approved Satellite Radiotherapy centre. At the July 2023 meeting, a further update was provided, informing of partnership meetings that had taken place between the Health Board and Velindre NHS Trust, discussing the development of a cancer unit and the restating of the roles, responsibilities, and joint commitment to the Satellite Radiotherapy Unit.

Welsh Sexual Assault Service:

- The Committee received an update on Welsh Sexual Assault Service (WSAS – formerly SARC). Health boards, police forces, Police and Crime Commissioners and third sector partners continued to work closely to implement and deliver the new service model for sexual assault services in South Wales, Dyfed Powys, and Gwent. This involved an enhanced hub for acute services at Cardiff Royal Infirmary (CRI), supported by spoke facilities in Risca and Merthyr. The Committee was informed that Health Board clinical, finance and planning representatives remained fully engaged with the programme.

Thoracic Services:

- The Committee noted that at the start of 2023, Thoracic Services had not been formally monitored through the regional collaborative structure. The outline business case awaits appraisal by Welsh Government and further conversations were required with the South and East Wales Directors of Planning.

Hepato-Biliary and Pancreatic Surgery:

- The Committee requested that the Hepato-Biliary and Pancreatic Surgery service be reviewed for quality and accessibility. At the meeting in July 2023, future options for a combined single site for Hepato-Biliary and Pancreatic Surgery based either in Cardiff or Swansea were discussed. In November 2023, project teams had escalated the risk of the pace of the service improvement through their project board. In January 2024, an options appraisal failed to be completed against original timeframes, and a clinical review took place in February 2024. The Committee suggested that the Health Board review opportunities for alternative services to secure the best service for the population.

Interventional Radiology (IR) Service:

- The Committee was informed of the risk of the failure of the Interventional Radiology (IR) service in Swansea. The Committee noted that two of the Health Boards Interventional Radiologists were supporting this service. Plans were being reviewed, including the implications for vascular services and options for sustainability. The Committee was assured that the fragility of services was monitored through the corporate risk register.

Vaccination Programme:

- An update on the Vaccination programme was presented to the Committee in November 2023. The Committee was informed of the critical risk of not achieving the Winter Flu and COVID vaccination targets for both staff and the population. The Health Board was working in partnership with local authorities, to provide a targeted vaccination offer, increasing communications to staff members of availability of vaccinations, and utilising vaccination bank staff. The Committee was assured and endorsed plans to mitigate the critical risk of meeting the vaccination targets for winter flu and COVID vaccinations.

Neighbourhood Care Networks (NCNs):

- An update on the development of the Neighbourhood Care Networks (NCNs) was presented to the Committee in June 2023. The intent of the new NCN planning structure was to improve the alignment of Regional Partnership Board (RPB), Integrated Services Partnership Board (ISPB) and NCNs. The plan to deliver the Area Plan, alongside Place Based Care, whilst progressing with the Primary Care Model for Wales was noted.

Joint Commissioning:

- The Committee was informed that work was ongoing to establish the new Joint Commissioning Committee and its governance framework.

Assurance in Respect of the Strategic Approach

During the year the Committee received updates in respect of the following:-

Capital Programmes and Strategic Capital Projects:

- An update on Major Capital Programmes and strategic capital projects was presented to the Committee in May 2023. The Committee was assured that all capital schemes submitted to Welsh Government would include significant decarbonisation measures, in line with the decarbonisation programme. A review of the governance of capital programmes, the strengthening assurance on reporting mechanisms, would be undertaken by the Director of Strategy, Planning and Partnerships with updates presented to the Committee.

- An update on Strategic Capital Projects and Estate Rationalisation was presented to the Committee in November 2023. The Committee noted the potential risk of the *Hollow Beam Survey* taking place in Nevil Hall Hospital (NHH), associated with RAAC. Plans for services at NHH were being worked through by the Health Board to present to Welsh Government in 2024. Further discussions on RAAC have taken place at the Board. Key milestones were discussed, including the planned opening of the Ysbyty Ystrad Fawr (YYF) Breast Unit in February 2024, the Royal Gwent Hospital (RGH) Endoscopy Suite, and Phase 1 of the Bevan Health and Wellbeing Centre (Tredegar).

- An overview of the revised and improved arrangements for the management and governance of Strategic Capital and Discretionary Capital within the Health Board was presented to the Committee in July 2024. The Committee was assured that there would be connectivity between the workstreams of the Health Board's Strategic Capital and Estates Group and the RPB's Regional Capital Group. The Health Board applied the same governance arrangements to capital projects worked in partnership.

Long Term Strategy and IMTP:

- An update was provided on the approach to developing the Long-Term Strategy for the organisation, outlining links with strengthening partnership working through the PSB, Marmot and the RPB. The Committee endorsed the approach. The Committee noted that the strategy incorporated meaningful engagement with staff and communities. The Committee was assured that the reconfiguration of Health Board services would take place in parallel with the development of the Long-Term Strategy and the IMTP.

- At the November 2023 meeting, the Committee received an update on the development of the Integrated-Medium Term Plan, for 2024-2027. The Committee was assured that the IMTP had been linked to the Clinical Advisory Board targets previously discussed by Board. At the January 2024 meeting, the Committee received the Health Boards emerging plan for 24/25, including cluster plans.

South East Wales Vascular Network (SEWVN):

- The Committee received an overview of the first annual report since the establishment of South East Wales Vascular Network (SEWVN) in July 2022. The Committee was advised that good progress had been made, with no major safety issues reported during the transitional stage at a time of significant urgent care system pressure.

Public Health Protection:

- An update on Public Health Protection was presented to the Committee for assurance. The Heath Board had utilised Welsh Government funding to create a Gwent Health Protection Service for 2023/24, led by the Director of Public Health. Next steps included plans to strengthen links between the health protection and resilience and emergency planning. Work would be undertaken around sustainability of provision, including a permanent Health

Protection team. The Committee endorsed the requirement for a permanent Health Protection team.

Decarbonisation:

- An update on the Decarbonisation programme was presented to the Committee for assurance, including the Decarbonisation action plan for 2023/24, and progress against the national programme to deliver the goal of Net Zero emissions by 2050.

Major Incident Plan:

- An update on the Health Boards Major Incident Plan was provided to the Committee. The Committee endorsed the plan for Board approval in March 2024.

Assurance in respect of the development of plans of the key Clinical Futures Priorities:

The Committee received quarterly updates on the delivery of the Health Boards Clinical Futures Programme, aligned to the Integrated Medium-Term Plan. At the start of the year, the Committee was informed that a review of the Clinical Futures programme had been undertaken, streamlining the original priorities into 7 key areas, and reframing the Six Goals for Urgent and Emergency Care Strategy. The following key areas were discussed:

Stroke Services:

- The challenges to maintaining rehabilitation Stroke services across three Health Board sites. The Committee was assured that a report outlining the challenges would be presented to the Board. The eLGH programme was driving forward priorities linked to the financial plan, including bed base, Stroke and Minor Injuries Units.

Homeward Bound Wards:

- Homeward Bound Wards had not delivered as expected, with best practice informing new plans in the Health Board's Winter Plan. An assessment of the impact on patient care and services would be included in the Winter Plan evaluation report.

General Internal Medicine:

- The Medical Director was leading a workstream to evaluate the pathways for patients presenting at the front door as General

Internal Medicine (GIM) patients. Early data indicated that GIM patients currently had the longest waits.

Minor Injury Units:

- Minor Injury Units: based upon workforce sustainability issues and low demand, a proposal to align the out of hours services at Nevil Hall Hospital with those at Ysbyty Ystrad Fawr had been endorsed by the Executive Team.

Mental Health Services:

- The Committee was informed of plans to align the Mental Health Transformation Programme and improvement plans for issues noted in internal monitoring within the service.

Acute Frailty Response Team:

- A nurse led Acute Frailty Response Team went live in January 2024, placing additional community teams in the Royal Gwent Hospital emergency department. This was having a significant positive impact in directing patients to the best care to suit their needs. At the January 2024 meeting, the Committee noted the commencement of an Acute Frailty Response (AFR) model and a pilot of a frailty consultant located in the Flow Centre to redirect care.

Falls Pathway:

- A new falls pathway had been introduced in December 2023 to reduce the number of non-injurious fallers conveyed to the Emergency Department by ambulance. Since implementation, 47% of non-injurious falls patients had been conveyed to the eLGHs instead of GUH for initial clinical assessment.

Welsh Ambulance Service Team (WAST):

- Further work being undertaken on the Health Board and WAST collaborative programme, ensuring pathways were followed, in particular the use of the flow centre.

Place Based Care:

- At the January 2024 meeting, the Committee was informed that Place Based Care had been deprioritized due to current operational issues.

Primary Care Sustainability Board:

- A report from the Primary Care Sustainability Board was presented to the Committee. The Committee noted the progress of the Primary Care Sustainability Board since August 2022, and the additional capacity and capability that may be required to accelerate delivery of the action plan. The Committee endorsed the re-establishment of the Primary and Community Care Academy and the Draft Primary Care Sustainability Action Plan.

Planned Care Recovery:

- An update on the Planned Care Recovery Programme was presented for information. The update included intended benefits, progress made to date, key objectives for the next period and key risks for each of the 6 workstreams within the Programme. The 6 workstreams for planned care were;
    1. Health Pathways
    2. Patient Access and Activation
    3. Outpatient Transformation
    4. Diagnostics
    5. Elective Capacity/Theatre Utilisation
    6. Planned Care Academy

3. PPHPC Committee Meetings and Membership

3.1 During 2023-24, the PPHPC met four times via Microsoft Teams- May 2023, July 2023, November 2023, and January 2024. Details of the Members and lead Executive Directors who attended these meetings is provided at **Appendix 3**.

3.2 The Committee comprised the following Independent Members:

- Ann Lloyd (Chair)
- Vacant (Vice Chair)
- Richard Clark
- Dafydd Vaughan
- Phil Robson (ex-officio member, Special Advisor to the Board)

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. Following the pandemic, the Committee has continued during the current year to meet virtually, and this has therefore meant that the Health Board has not complied with

its Standing Orders in this regard, and this will be a key consideration as part of the Improving Board Business action plan.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's website in advance of meetings.

4. PPHPC Reporting Arrangements

4.1 Following each meeting, the PPHPC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link

5. Self-assessment and Evaluation

5.1 The Board has undertaken an overall assessment of its effectiveness during 2023/24 using the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews.

The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements and has a strong focus on integrated governance and leadership across quality, finance, and operations as well as an emphasis on Organisational culture, improvement and system working.

The outcome of the current years self-assessment that was reported to the Committee on 31st January 2024 confirms that, the results of the individual self-assessment, combined with the analysis of the three completed self-assessments determined that the Committee is effective and meeting the standards.

Rating	Definition	Evidence
2	**Meeting standards**	The Partnerships, Population Health and Planning Committee is performing to the required standard in this area. There may be room for improvement, but the Partnerships, Population Health and Planning Committee can be seen to be discharging its responsibilities effectively.

In addition, all of the respondents confirmed that the Committee was

either meeting or exceeding the standard for the effectiveness of this Committee.

Then main areas for improvement identified as part of the self-assessment are shown below:

Specific Actions to deliver improvements in the Committee's effectiveness			
Section	**Area of Focus requiring attention**	**How & by When**	**Action Holder**
Section 1 Committee Processes: Composition, Establishment, and Ways of Working	• A programme of induction for committee members to be developed. • Report template to be reviewed and training on report writing to be delivered.	All actions to inform the development of an overarching Board Business Improvement Plan – March 2024 for Board approval.	Director of Corporate Governance with Head of Board Business
Section 4 Strategic Planning	• Explore ways that future updates include clear alignment between priorities, resources and enabling plans.	To be strengthened within Committee Workplan 2024/25 – April 2024	Head of Board Business with the Director of Strategy, Planning and Partnerships

These findings will be used to inform a comprehensive annual assessment of the Board's effectiveness. An overarching Board Business Improvement Plan will be developed, informed by the assessment of the Board and its Committees and other feedback such as Structured

Assessment, for delivery in 2024/25. The effectiveness of the Board's Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board's Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

6. Key Areas of focus in 2024-25

6.1 To maintain focus on strategic partnerships, planning and developments for 2024/25, the forward workplan has been updated to include a:

- Long term Strategy development, 'Strategy 2035'
- Standing item on Strategic Risk and Assurance.

7. Conclusion

7.1 This report provides a summary of the work undertaken by the PPHPC during 2023-24 and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2022.

Appendix 1

Partnerships, Population Health, and Planning Committee

Terms of Reference – 2022/23

Version: Approved

Date: March 2022

Document Title:	Partnerships, Population Health and Planning Committee Terms of Reference – 2022/23
Date of Document:	March 2022
Current version:	Approved
Previous version:	N/A
Approved by:	Board
Review date:	March 2023

1. INTRODUCTION

1.2 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.3 In-line with Standing Orders and the Board's Scheme of Delegation and Reservation of Powers, the Health Board has established a committee to be known as the **Partnerships, Population Health and Planning Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are set out below.

1.4 The scope of the Committee extends to all areas of Partnership Working, Population Health and Planning across the full breadth of the Health Board's responsibilities.

1.5 This Committee will not be responsible for the development of strategy, which is a collective Board responsibility and therefore reserved for full Board discussions.

2. PURPOSE

2.1 **ADVICE**

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters consistent with the Board's overall strategic direction:

a. strategy, strategic frameworks and plans for the delivery of high quality and safe services, consistent with the board's overall strategic direction.
b. business cases and service planning proposals;
c. the alignment of supporting and enabling strategies, including workforce, capital, estates and digital;
d. the implications for service planning arising from strategies and plans developed through the Joint Committees of the Board or other strategic partnerships, collaborations or working arrangements approved by the Board; and
e. the Health Board's priorities and plans to improve population health and wellbeing.

2.2 **ASSURANCE**

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances in:

a. the robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership;
b. plans and arrangements for the following matters are adequate, effective and robust and achieving intended outcomes:
   (i) Joint committee and partnership planning;
   (ii) Engagement and communication; and
   (iii) Civil Contingencies and Business Continuity;
c. that partnership governance and partnership working is effective and successful; and
d. that those arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to specific powers delegated to it by the Board, the Committee will:

a) Partnership Working

i. consider the development of strategies and plans developed in partnership with key strategic partners
ii. monitor work undertaken with partner organisations and stakeholders to influence the provision of services to meet current and future population need
iii. seek assurance that partnership governance and partnership working is effective and successful.

b) Population Health

i. consider population health and wellbeing assessments and other key information that underpins the strategic planning process to ensure the robustness and best fit of developing plans;
ii. consider plans for whole-system pathway development and re-design;
iii. seek assurance on plans, systems and processes to deliver health improvement and increase health equity;
iv. seek assurance on the work of the Health Board to reduce avoidable health inequalities.

a) Strategic Planning

a. Seek assurance that the health board's Planning arrangements are robust and fit for purpose, including the approach to developing the Integrated Medium-Term Plan and Annual Priorities;

b. Seek assurance that the Health board Has sufficient enabling plans to support the achievement of strategic objectives;
c. Seek assurance that the Health Board's arrangements for engagement and consultation in respect of service change matters are robust and effective;
d. Seek assurance that national and regional planning guidance is used to inform the development of strategic plans;
e. Seek assurance on the process for the development of the Board's Capital Discretionary Programme and Capital Business Cases;
f. Seek assurance that the Health Board's Commissioning Plans robust and fit for purpose;
g. Seek assurance on the effectiveness of the Health Board's Civil Contingency Plans and Major Incident Planning;
h. Seek assurance that plans respond to the Wellbeing of Future Generations Act (Wales) 2015; and
i. Seek assurance that the Health Board's plans give due regard to the Socio-economic Duty for Wales.

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, subcommittee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

3.9 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage.
This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4. MEMBERSHIP

Members

4.1 Membership will comprise:

Chair	Independent member of the Board
Vice Chair	Independent member of the Board
Members	Independent member of the Board x2
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Planning, Performance, Digital & IT
- Director of Public Health & Strategic Partnerships
- Director of Finance, Procurement and VBHC

4.3 By invitation:
The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5. COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **three times yearly**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between

scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix 2

PARTNERSHIPS, POPULATION HEALTH AND PLANNING COMMITTEE

PROGRAMME OF BUSINESS 2023/24

The purpose of the Partnerships, Population Health and Planning Committee is to seek assurance on the robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership; that plans and arrangements are adequate, effective, robust and achieving outcomes in relation to Joint Committee and partnership planning, engagement and communication and Civil contingencies and business continuity; that partnership governance and partnership working is effective and successful; and that the arrangements in place to improve population health and wellbeing are robust and effective and delivering intended outcomes.

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

- the Committee's Terms of Reference as agreed by the Board in March 2023;
- the Board's Assurance Framework (based on its Annual Objectives for 2022/23 and 2023/24);
- delivery of the IMTP 2023-25;
- key risks identified through the Corporate (Strategic) Risk Register and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee); and
- key statutory, national, and best practice requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			17 May 2023	12 July 2023	1 Nov 2023	31 Jan 2024
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓
Development of Committee Annual Programme of Business 2023/24	Annually	Chair & Director of CG	✓			
Review of Committee Programme of Business	Standing Item	Chair	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2023/24	Annually	Chair & Director of CG				✓
Annual Review of Committee Effectiveness 2023/24	Annually	Chair & Director of CG				✓
Committee Annual Report 2022/23	Annually	Chair & Director of CG	✓			
Committee Annual Report 2023/24	Annually	Chair & Director of CG				D

Overview of work of the Gwent PSB, including an update in respect of Developing a Marmot Region	Standing Item	Director of Public Health	✓	✓	✓	✓
Overview of discussions at the Regional Partnership Board (RPB)	Standing Item	Chair	✓	✓	✓	✓
Update on the development and delivery of a Strategy for Mental Health Services in Gwent	Annually	Dir. PC,C&MHS		✓		
Gwent Marmot Region Communication and Engagement Strategy	Annually	Director of Public Health			✓	
Approach to developing the Integrated Medium-Term Plan	Annually	Director of Strategy, Planning and Partnerships			✓	
Draft Integrated Medium-Term Plan 23-26/Annual Plan 24/25 (First Draft Jan 2024)	Annually	Director of Strategy, Planning and Partnerships	✓		✓	✓
Regional Planning Update	Standing Item	Director of Strategy, Planning and Partnerships	✓	✓	✓	✓
A report on the evaluation of the Vascular Services Network	Annually	Director of Strategy, Planning and Partnerships				✓
Update on the Overarching Clinical Futures Programme	Standing Item	Director of Strategy, Planning and Partnerships	✓	✓	✓	✓
Placed Based Care, Key IMTP priority (added as per action 1611/06) • ISPB/Accelerated Clusters Update	tbc	Director of Strategy, Planning and Partnerships				✓
1. Public Health Protection and Population Health Improvement	Annually	Director of Public Health				✓
2. Accelerated Cluster Development	Annually	Dir. PC,C&MHS				
3. Redesigning Services for Older People	Annually	Medical Director				
4. Mental Health Transformation	Annually	Dir. PC,C&MHS				✓
5. Planned Care Recovery: *Outpatient Transformation & Pathway Optimisation*	Annually	Director of Operations			✓	
6. Urgent and Emergency Care Improvement, to include an update on SDEC	Annually	Director of Operations	✓			
7. Enhanced Local General Hospital Network	Annually	Director of Operations		✓		

8. Transforming Cancer Services	Annually	Medical Director			✓	
9. Net Zero – Decarbonisation	Annually	Director of Finance, Procurement & VBHC	✓		✓	
Enablers: Update on the development and delivery of an Agile Working Strategy	Annually	Director of Workforce & OD		✓		
Enablers: Capital Programme	Annually	Director of Operations		✓	✓	✓
Enablers: Digital Strategy	Annually	Chief Executive				
Information on Regional Partnership Boards (RPB) funding plans and allocation- in relation to the Primary Care Evaluation Report- Action transferred from the People & Culture Committee- (2002/05) 2022		Director of Strategy, Planning and Partnerships		✓		
To receive a report from the Primary Care Sustainability Board		Chief Operating Officer	✓			
To receive an update on the development of the Neighbourhood Care Networks		Chief Operating Officer		✓		
Review of the Estates Strategy		Director of Strategy, Planning and Partnerships		✓		
PHW- Working Together for a Healthier Wales- Our Long-Term Strategy 2023-2025		Director of Public Health		✓		
To receive an update on the Vaccination Programme		Director of Public Health			✓	
To discuss and endorse the approach to developing the Long-Term Strategy (Strategic Planning and Developments)		Director of Strategy, Planning and Partnerships			✓	
To receive an update on the National Commissioning Implementation Programme		Director of Strategy, Planning and Partnerships			✓	
To receive and discuss an update on Regional Planning: A paper outlining the detailed proposal for Hepato-Biliary and Pancreatic Surgery to be presented to members (Action 1207/02.5)		Director of Strategy, Planning and Partnerships				✓

KEY	
D of CG	Director of Corporate Governance
Dir. PC,C&MHS	Director of Primary, Community and Mental Health Services

Appendix 3

Partnerships, Population Health, and Planning Committee: Attendance at meetings in 2023-24

Attended	Did Not Attend	Not a Member/Required Attendee

Meeting Dates	17th May 2023	12th July 2023	1st November 2023	31st January 2024
Independent Members				
Ann Lloyd (Chair)	✓	✓	✓	✓
Richard Clark	✓	✓	×	✓
Dafydd Vaughan	✓	✓	✓	✓
Louise Wright *			✓	
Phil Robson (non-members, special advisor)	✓	✓	×	✓
Executive Directors				
Director of Public Health	✓	✓	✓	✓
Director of Strategy, Planning and Partnerships	✓	✓	✓	✓
Director of Corporate Governance	✓	✓	✓	✓

*Louise Wright, Independent Member, stood in for Richard Clark, Independent Member, at the November 2023 meeting, for quoracy purposes. Louise Wright is not a regular member/required attendee.

Agenda Item:
4.14 a

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 May 2024
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	NHS Wales Joint Commissioning Committee (JCC) Update Report – May 2024
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Joint Commissioning Committee (JCC) as a Joint Committee of the Board.

Cefndir / Background

The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (the Directions) came into force on 7th February 2024 which provide that the Local Health Boards in Wales will work jointly to exercise functions relating to the planning and securing of services specified within the Directions or as identified by the Local Health Boards. Specifically, these are: (a) specialised services for: (i) cancer and blood disorders, (ii) cardiac conditions, (iii) mental health and vulnerable groups, (iv) neurosciences, and (v) women and children; (b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis; (c) emergency medical services; (d) non-emergency patient transport services; (e) emergency medical retrieval and transfer services; (f) NHS 111 services; (g) sexual assault referral centres; and (h) other services as directed by the Welsh Ministers.

For the purpose of jointly exercising those functions set out within the Directions, the Local Health Boards established a joint committee, the NHS Wales Joint Commissioning Committee (JCC), which became operational on 1st April 2024.

Asesiad / Assessment

The JCC met on 9th and 23rd April 2024. The papers for these meetings are available at Meeting Dates and Papers - NHS Wales Joint Commissioning Committee .

A summary of the business discussed at these meetings included:

9th April 2024 Meeting:

- Joint Commissioning Committee Standing Orders (inc Scheme of Delegation) & Standing Financial Instructions (SFI's) (inc financial authorisation matrix)
- Interim Operating Model Framework
- Transitional plan for Quarter 1
- Legacy statements from EASC,WHSCC, National Collaborative Commissioning Unit NCCU, Sexual Assault Referral Centre (SARC) and 111 Service
- WHSSC -Joint subcommittee reports

23rd April 2024 Meeting

- Update on the 6-month appointment of an interim Chief Commissioner.
- The JCC received feedback from all Health Boards on the Emergency Medical Retrieval and Transfer Service (EMRTS) Service Review. The Committee was advised that the majority of Health Boards (5 of the 7) supported the four recommendations with Betsi Cadwaladr University Health Board and Powys Teaching Health Board not supporting the recommendations. The JCC agreed the four review recommendations and requested that additional detailed work be undertaken, aligned to key milestones for delivery and noted that there was a need to provide the public with confidence on the process and impact across Wales. The JCC agreed a further two recommendations:
    - Recommendation 5 Lessons Learned - Implementation of a lessons learned exercise of the review and engagement process to help inform the future work of the JCC; and
    - Recommendation 6 –to receive regular progress reports on achievement of the implementation plan milestones, and benefits realisation.

The full assurance reports for these meetings are included at Appendix 1 and 2. A glossary of terms is also appended to this report.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this report by way of an update on NHS Wales Joint Commissioning Committee (JCC) activity.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

JOINT COMMISSIONING COMMITTEE (JCC)
EXTRAORDINRY MEETING BRIEFING – 9 APRIL 2024

The Joint Commissioning Committee (JCC) held an inaugural extraordinary public meeting on 9 April 2024. The next public meeting will take place on 23 April 2024. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the JCC.

The Chair welcomed members and the newly appointed Lay Members to the newly established JCC.

The papers for the meeting can be accessed using the link below:
Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

1. Joint Commissioning Committee Standing Orders (inc Scheme of Delegation) & Standing Financial Instructions (inc Financial authorisation matrix)

Members received a report requesting that the JCC approve the JCC Standing Orders (including the scheme of delegation) & the Standing Financial Instructions (SFI's) (including the financial authorisation matrix.

Members noted that guidance on the handling of interests had been developed, that the memorandum of agreement between the 7 Health Boards (HBs) will be established; and that the hosting agreement between the host body CTMHB and the 6 HBs will be established to outline the accountability arrangements and resulting responsibilities of the Host Body, the JCC and its team.

Members (1) **Noted** the establishment of the NHS Wales Joint Commissioning Committee (JCC) from 1 April 2024, as directed by Welsh Ministers, (2) **Noted** that the JCC has superseded the Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) with effect from 1 April 2024, (3) **Noted** the development of the JCC's governance framework, as a key component of the Health Board's governance framework, (4) **Approved** 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 March 2024, (5) **Approved** the Standing Financial Instructions for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 19 March 2024, (6) **Approved** the financial authorisation matrix; and (7) **Noted** the JCCs accountability map for information.

2. Interim Operating Model Framework for the NHS Wales Joint Commissioning Committee (JCC)

Members received a report requesting that the JCC note the transitional plan for Quarter 1 to enable the JCC to transact business when it went live on 1 April 2024. The plan incorporates the transitional plan developed by Welsh Government and the actions required to ensure stability and business continuity of the functions to be delivered.

Members **noted** the report.

JOINT COMMISSIONING COMMITTEE (JCC)
MEETING BRIEFING – 23 APRIL 2024

The Joint Commissioning Committee (JCC) held its latest public meeting on 23 April 2024. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the JCC.

The papers for the meeting can be accessed using the link below:
Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

1. Minutes of Previous Meetings
The minutes of the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC) meetings held on the 19 March 2024 were **approved** as a true and accurate record of the meetings. The minutes of the Joint Commissioning Committee (JCC) meeting held on 9 April 2024 were **approved** as a true and accurate record of the meeting.

2. Chairs Report
Members received the Chair's Report and **noted**:

- **The update from the new Chair of the JCC -** the inaugural JCC meeting on 9 April 2024 received and approved the governance framework for the new JCC after it had been approved by the 7 x Health Boards (HBs) in March 2024, and the overwhelming first impression was of an organisation in good heart and in good shape, notwithstanding the significant challenges and complexities of combining the different organisations into one new national NHS sub committee,
- **JCC Induction Programme –** an update on introductory meetings with key personnel and partners and the local induction session attended and the forthcoming NHS Wales Induction programme for new Independent Members (IMs),
- **Chair's Action WHSSC – Approval of the WHSSC Legacy Statement** – the Chairs action taken by the Chair of WHSSC on 25 March 2024 to approve the WHSSC Legacy Statement as part of the work to support the establishment of the new NHS Wales Joint Commissioning Committee (JCC) from 1 April 2024 in accordance with the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024 was ratified; and
- **Key Meetings attended.**

Members (1) **noted** the report; and (2) **ratified** the WHSSC Chairs action taken on 25 march 2024 to approve the WHSSC legacy statement.

3. Interim Chief Commissioners Report

Members received the interim Chief Commissioners Report and **noted** the following updates:

- **New Interim Chief Commissioner** - an update on the interim 6 month appointment of Chief Commissioner, meetings held with key partners, staff and stakeholders to build relationships and the warm welcome received from everyone; and
- **NHS Wales Joint Commissioning Committee Implementation -** The programme of work to establish the new NHS Wales JCC came to fruition on 1 April 2024. The final Welsh Government Oversight Board meeting is being held on 30 April 2024 to complete the programme. JCC members received the transitional plan for Quarter 1 2024-2025 at its meeting on 9 April 2024 which incorporated the transitional plan developed by Welsh Government and the actions required to ensure the stability and business continuity of the functions to be delivered.

Members **noted** the report.

4. Emergency Medical Retrieval and Transfer Service (EMRTS Service Review

Members received a report presenting the Joint Commissioning Committee (JCC) with recommendations of the Emergency Medical Retrieval and Transfer Service (EMRTS) Service Review which has been ongoing since November 2022 and overseen by the Emergency Ambulance Services Committee (EASC) up until 31 March 2024 which had responsibility for commissioning these services prior to the establishment of the Joint Commissioning Committee (JCC) on 1 April 2024.

The Committee gave thanks to stakeholders for their patience during the time taken to ensure the work could be carried out robustly, and were especially grateful for the way in which the Charity and EMRTS had supported and contributed to the Review in what had been challenging circumstances for them given the uncertainty affecting their people and business planning.

The Committee expressed gratitude to Llais, the national citizens voice body for Wales, who advised on the engagement as well as NHS Wales colleagues to have helped deliver the all Wales engagement with citizens.

Members noted that since taking up appointment the Chair and the interim Chief Commissioner felt it was important to listen to a variety of concerns and had been proactive in meeting with key stakeholders and had been struck by the passion and high regard that is held for the Wales

Air Ambulance Charity and the clinical teams of EMRTS, which had been acknowledged throughout the Review.

Members noted that the report presenting the recommendations of the EMRTS Service Review had been considered individually by each of the 7 x Health Board (HBs) in Wales between 20 March and 11 April, and they gave consideration to the following recommendations:

Recommendation 1 – **EMRTS Service Model.** The Committee approves the recommended service model for EMRTS including the consolidation of the Emergency Medical Retrieval and Transfer Services currently operating at Welshpool and Caernarfon bases into a single site in North Wales (Option A) as it best meets the objectives of the EMRTS Service Review,

Recommendation 2 – **Implementation.** To enable delivery of the agreed service model, the Committee requests that the Charity secures an appropriately located operational base in line with the agreed service model (as per the final recommendations of the Review),

Recommendation 3 – Implementation. The Committee approves that a joint plan is developed by EMRTS and the Charity, that maintains service provision across Wales during the transition to a new base and develop a comprehensive implementation plan for the agreed service model. This plan will be reflected in the Committee's future commissioning arrangements with EMRTS and the Charity,

Recommendation 4 – Additional service provision. The Committee approves the development of a commissioning proposal for bespoke road based enhanced and / or critical care services in rural and remote areas to enhance the core service model. It is recommended that the Ambulance and 111 Commissioning Team establish a Task and Finish Group to further refine and develop the approach and to deliver a detailed implementation plan by the end of September 2024. The Group will work in partnership with HBs and Llais and other key stakeholders and report to the JCC in October 2024. Following conclusion of this work, and agreement of the way forward, the implementation plan will be updated,

Recommendation 5 – **Lessons Learned.** The Committee supports a Lessons Learned exercise of the review and engagement process to help inform the future work of the JCC; and

Recommendation 6 – Implementation. The Committee agrees to receive regular progress reports on achievement of the implementation plan milestones, and benefits realisation.

Members discussed the recommendations and through a majority of 5 of the 7 HBs supporting, along with the 3 Lay members and Chair the recommendations were approved. Members noted that Betsi Cadwaladr UHB and Powys tHB did not support the recommendations.

Members requested that additional detailed work be undertaken, aligned to key milestones for delivery and that there was a need to provide the public with confidence on the process and impact across Wales.

Members (1) **Noted** the risks outlined above, (2) **Noted** the risk to patients and under-utilisation levels across Wales, (3) **Noted** the national feedback provided by the Picker Institute, (4) **Noted** the localised feedback from communities surrounding Caernarfon and Welshpool bases, (5) **Noted** the representations raised by Llais and the other representations, (6) **Noted** the risks to the Charity, (7) **Noted** that communications and engagement strategies are needed from both the Charity and EMRTS to rebuild trust and confidence with rural communities specifically to ensure the future of this partnership service; and
(8) **Approved** recommendations 1 to 4 in line with the Review report and to approve recommendations 5 and 6 on implementation monitoring lessons learned on implementation monitoring lessons learned; and that a report to be brought back to May 2024 meeting outlining key milestones.

5. Legacy Statements
Members received a report presenting the legacy statements from the predecessor joint committees / teams that transitioned into the new NHS Wales Joint Commissioning Committee (JCC) on 1 April 2024 for assurance.

Members noted that JCC became operational on 1 April 2024 and in accordance with the Interim Operating Model Framework for the NHS Wales JCC for Quarter 2024-2025 received by the JCC on 9 April 2024, there was a requirement for the new JCC to receive the legacy statements from the predecessor joint committees/teams.

Members noted the legacy statements for the:

- Emergency Ambulance Services Committee (EASC)
- National Collaborative Commissioning Unit (NCCU)
- 111 Service
- Sexual Assault Referral Centre (SARC)
- Welsh Health Specialised Services Committee (WHSSC)

6. Other reports
Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC),
- Quality & Patient Safety Committee; and
- Welsh Kidney Network (WKN).

Agenda Item: 4.14b

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 May 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership Committee (NWSSP) Update Report – May 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Michelle Jones, Head of Board Business

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Shared Services Partnership Committee as a Joint Committee of the Board.

Cefndir / Background

NHS Wales Shared Services Partnership Committee (NWSSP) was established in November 2010 and became operational in April 2011 and through its work delivers economies of scale; efficiencies and consistency of quality and process for the business and professional services that are directly managed and delivered by local NHS bodies.

The membership is comprised of representatives from each NHS organisation that use the services and from Welsh Government in an observer capacity. The NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General / CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee).

The Partnership Committee meets bi-monthly and is chaired by an Independent Member, Professor Tracy Myhill OBE.

Asesiad / Assessment

The Joint Committee last met on 21st March 2024 and the papers for meetings are available at Committee Schedule and Papers - NHS Wales Shared Services Partnership . A summary of key matters discussed included:

- IMTP
- Update on the development of the BJC for Radiopharmacy Service
- Formal agreement to enable the continuation of the recruitment of qualified health care professionals from Kerala, India
- Decarbonisation Action Plan
- NHS Building for Wales Framework
- Nantgarw lease
- All Wales Energy arrangements
- Flu vaccination proposal
- Finance, People, Performance and Governance update

The assurance report from this meeting is shown at **Appendix 1.**

Argymhelliad / Recommendation

The Board is asked to RECEIVE this update report on NHS Wales Shared Services Partnership Committee activity.

Attachments

Appendix 1.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	21 March 2024

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Chair's Report

The Chair updated the Committee on her activities since the last meeting. This includes attending the Chairs' Peer Group and meeting with the Minister. The Welsh Risk Pool Committee was held the previous week with a full agenda and the Staff Awards Ceremony at the end of February was a very positive experience. The Chair also advised Committee members that there may be a need for an urgent Chair's Action before the May Committee. This is in respect of Radiopharmacy Isolators where approval is likely to be required in April to progress this urgent procurement.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Following the approval of the IMTP by the Committee in January, the two keeping in touch meetings, with the Finance Delivery Unit and the Planning Director at Welsh Government, produced no significant issues and the plan, has now been formally submitted;
- Work to finalise the Business Justification Case for the Radiopharmacy service to be located in IP5 is progressing well with all necessary appointments to relevant contractors having been made;
- The NWSSP People & OD Team have recently supported a further visit to Kerala in India which included attendance by the Minister for Health and Social Care from Welsh Government, who signed a formal agreement with the Kerala Government to continue the current co-operation arrangements which provides for a further 250 qualified healthcare professionals to be recruited into NHS Wales;

- The closure of the Laundry in Carmarthen is well underway and is on track for the end of March, with the new hub coming into operation in April. All affected staff have been given the opportunity to continue to work in the service at the Swansea Laundry or working in a suitable alternative role within Hywel Dda UHB;
- The recruitment process to replace the Director of Finance & Corporate Services has concluded and Alison Ramsey, the current Director of Planning, Performance, and Informatics was successful in being appointed to this post;
- Similarly, Nicola Phillips the current Deputy Director of Primary Care Services was successful in being appointed to the role of Director of Primary Care Services.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Decarbonisation Action Plan

The original Action Plan covered the period 2021-23 and there is now a need to update it. The plan is both externally and internally focused. External achievements to date include setting up a reporting template for all NHS Wales organisations to measure their progress against the 46 initiatives contained in the Welsh Government Plan and providing advice on achieving net zero in future construction projects. Internally we have invested in LED lighting across the estate, solar panels, and electric vehicles in our fleet. Going forward the plan continues to provide support to NHS Wales organisations and to take forward projects within NWSSP subject to the availability of capital. The plan is ambitious but is equally pragmatic, given the financial context to the years ahead. In the light of these challenges, a coordinated approach across NHS Wales is essential. Monitoring of progress against the plan at Committee is via the quarterly IMTP updates, albeit this is by exception, and it was agreed that a more detailed half-yearly report would be helpful.

The Committee **APPROVED** the Decarbonisation Action Plan.

NHS Building for Wales 2 Framework

The framework provides a number of specialist advisors to support major capital schemes across NHS Wales. The current framework expires in April and work has been undertaken over the last two years to prepare for a new framework, which will commence in May for a period of four years, with the option to extend for a further two years. There has been extensive consultation with Health Boards throughout the development of the new framework, and there has been proactive initiatives to support the Welsh economy wherever possible,

The Committee **ENDORSED** the Framework for formal approval by the Welsh Government.

Nantgarw 2 Lease

Due to low occupancy rates at both Companies House and the current Nantgarw HQ, NWSSP is taking the opportunity to consolidate staff into one new building on the Nantgarw estate. This will provide a better working environment and will release revenue savings The previous plan to move into Cathays Park was discounted due to increasing costs and restrictions on access, and it would also not have allowed the exit from the current HQ. The Committee was therefore asked to approve NWSSP entering into a 10-year lease for the new building.

The Committee **APPROVED** the signing of the lease for Nantgarw 2.

Items for Noting

All-Wales Energy Arrangements

The Committee were updated on developments with the implementation of new governance and contracting arrangements, and also the proposals for the supply of energy in the next few years.

The Welsh Energy Group, supported by the Welsh Energy Operating Group, were both established in March 2023, replacing the Energy Price Risk Management Group. Both of the new groups have performed well, with regular and well attended meetings, which has led to informed strategic decisions on energy supply. The governance arrangements were recently reviewed by Internal Audit and their report was rated as providing substantial assurance. NHS Trusts in England are considering the benefits of centralising their purchase of energy requirements and the Welsh Energy Group is similarly considering the benefit of joining this arrangement.

The Committee **NOTED** the update.

Flu Vaccination Proposal

The Central Procurement of Influenza project brief was approved by the Vaccination Programme Wales Transformation Board last July. The aim was to deploy centrally procured adult Influenza vaccine during the autumn of 2025. NWSSP have formed part of the Project Group to establish feasibility and design of a centrally procured Influenza model.

The next phase of implementation requires the Minister to direct General Practice to not purchase Influenza vaccine for Autumn 2025, which they would normally commence in September of this year. For this direction to be given, assurance needs to be provided that NHS Wales will be ready to provide GPs, Health Boards and Trusts with centrally procured adult Influenza vaccine. An Influenza vaccine tender process would run over the summer of 2024 to enable vaccine delivery commencing in September 2025.

NWSSP will procure the vaccines but there is the option of these being directly

delivered by the supplier or being held and distributed centrally via NWSSP. The paper provided to Committee focused in the latter option, but it is for Welsh Government to decide the preferred approach.

The Committee **NOTED** the proposal.

Staff Benefits Update

NWSSP currently provide administration services for several Staff Benefit Schemes for multiple NHS Wales organisations covering Salary Sacrifice Cars, Bicycles and Home Electronics. These services ensure that a fully procured supplier has been sourced, providing quality and value for money.

The Salary Sacrifice Car Scheme current fleet of vehicles stands at 3,736 at February 2024 which represents a 23% increase over the last 12 months. Additionally 94% of live fleet are electric/hybrid vehicles and 87% of cars on order are electric/hybrid vehicles. The car scheme deliver savings estimated at £750 per car per annum, resulting in a total annual saving of £2.8m across NHS Wales.

The Home Electronic scheme provides employees access to over 5000 items from Currys taken via salary sacrifice, allowing the employees to make savings through their salary.

The Cycle to Work scheme is supplied in conjunction with Halfords. The scheme provides employees access to bikes and accessories from Halfords and Tredz taken via salary sacrifice, allowing the employees to make savings on the cost of new bicycles.

The Committee **NOTED** the update.

Finance, Performance, People, Programme and Governance Updates

Finance – NWSSP reported a break-even Month 11 financial position with a year-to-date additional non-recurring savings of £2.277m. The 2023/24 distribution to NHS Wales is now finalised at £2m. In addition NWSSP anticipate being able to return £1m of funding to Welsh Government so that the total additional savings generated and distributed for 2023/24 is £3m.

People & OD Update – The sickness absence rate remains very low with the average for the last 12 months being 2.98%. Statutory and Mandatory training compliance is good at over 93% but PADR compliance needs to improve from the current level of 83%.

Performance – The in-month January performance was generally good with 38 KPIs achieving the target against the total of 41 KPIs. The three that missed the target were Recruitment, where performance has improved and the target was only marginally missed, and two for Audit & Assurance in respect of the issue of draft audit reports and the subsequent timeliness of management responses.

Project Management Office Update – Two projects are currently rated as red. These are the Primary Care Workforce Intelligence System and Transforming Access to Medicine (TrAMS). On the former there are issues with increasing costs and extremely tight implementation timescales and on the latter the lack of capital is the major issue although good progress is being made on the development of the Radiopharmacy Service.

Corporate Risk Register – There remain three red risks relating to the impact of industrial action and also of responding to the UK COVID Public Inquiry, and the development of the TrAMs project.

The Committee **NOTED** the above Reports.

Papers for Information

The following items were provided for information only:

- Finance Monitoring Returns (Months 10 and 11).
- Final Version of IMTP.
- PPE Dashboard
- Audit Committee Assurance Report.

AOB

N/a

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Matters referred to other Committees

N/A

Date of next meeting	16 May 2024