Aneurin Bevan University Health Board

Wed 23 March 2022, 09:30 - 12:30

Agenda

1. Opening Business / Governance Matters

1.1. Chair's Introductory Remarks

Verbal *Chair*

1.2. Apologies for Absence for Noting

Verbal *Chair*

1.3. Declarations of Interest for Noting

Verbal *Chair*

1.4. Draft Minutes of the Health Board Meeting held on 26th January 2022 for Approval

Attachment *Chair*

1.4 Draft Board Minutes 26 January 2022.pdf (13 pages)

1.5. Board Action Log for Review

Attachment *Chair*

1.5 Action Log 26.01.22.pdf (2 pages)

1.6. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

1.6 Report on Sealed Documents and Chair's Actions March 2022.pdf (10 pages)

1.7. Chair's Report

Verbal *Chair*

2. Patient Experience and Public Engagement

2.1. Report from Aneurin Bevan Community Health Council

Attachment *Chief Officer of the CHC*

2.1 Community Health Council Report for Aneurin Bevan University Health Board meeting Mar 2022.pdf (15 pages)

3. Items for Decision

3.1. Integrated Medium-Term Plan 2022-25

Attachment *Director of Planning, Performance, Digital and IT*

3.1 IMTP Cover Paper.pdf (4 pages)
3.1a IMTP 2022-2025.pdf (59 pages)

3.2. Delegation of Revenue Budgets 2022/23

Attachment *Interim Director of Finance, Procurement and VBHC*

3.2 Delegation of revenue budgets.march22.pdf (14 pages)

3.3. Capital Programme 2022/23

Attachment *Director of Planning, Performance, Digital and IT*

3.3 Capital Programme 2022-23 Cover Paper.pdf (11 pages)
3.3a Appendix 1 - Discretionary Capital Bids - DRAFT OPENING PROGRAMME 2022-23.pdf (1 pages)
3.3b Appendix 2 - Discretionary Capital Bids - NEXT PRIORITY BIDS - AWAITING FUNDING OPPORTUNITIES 2022-23.pdf (1 pages)

3.4. Endoscopy Business Justification Case

Attachment *Director of Planning, Performance, Digital and IT*

3.4 RGH Endoscopy Cover Paper.pdf (4 pages)
3.4a Endoscopy BJC redacted.pdf.pdf (36 pages)

3.5. Board and Committee Arrangements 2022/23

Attachment *Chair*

Committee ToRs can be viewed in the Technical Appendices pack

3.5 Board Committee Arrangements 2022-23_Draft.pdf (14 pages)

4. Items for Discussion / Assurance

4.1. Audit Wales Annual Report and Structured Assessment 2021

Attachment *Audit Wales*

4.1 a Structured Assessment and AAR.pdf (3 pages)
4.1 b ABUHB 2021 AAR_final .pdf (28 pages)
4.1 c ABUHB Structured Assessment 2021_final report.pdf (30 pages)
4.1 d SA 2021 - ABUHB Management Response.pdf (9 pages)

4.2. Grange University Hospital - Clinical Futures 12 Months Report

Attachment *Director of Planning, Performance, Digital and IT*

4.2 GUHCF 12 months Cover Paper.pdf (3 pages)
4.2 a GUHCF 12 Month Review.pdf (64 pages)

4.3. Annual Equality Report / Strategic Equality Objectives

Attachment *Director of Workforce and OD*

4.3_Annual Equality Report .pdf (3 pages)
4.3a Appendix 1_Annual Equality Report 2020-21 Employee Monitoring.pdf (30 pages)

4.4. Gwent Regional Partnership Board Population Needs Assessment, 2022-27, Consultation

Attachment *Director of Public Health and Strategic Partnerships*

4.4 Gwent PNA Cover Paper.pdf (1 pages)
4.4a DRAFT+PNA+21_22+DATE+DRAFT+CONSULTATION+Feb+2022 (1).pdf (60 pages)

4.5. Financial Performance: Month 10, 2021/22

Attachment *Interim Director of Finance, Procurement and VBHC*

- 4.5 Finance Report Month 10.pdf (21 pages)
- 4.5a Finance board report appendices M10 (Feb22) v2.pdf (19 pages)

4.6. Performance Report, March 2022

Attachment *Director of Planning, Performance, Digital and IT*

- 4.6 Performance Report March 2022.pdf (21 pages)

4.7. Strategic Risk Report, March 2022

Attachment *Interim Chief Executive*

- 4.7 Strategic Risk Report Board March 2022.pdf (11 pages)

4.8. Executive Team Report

Attachment *Interim Chief Executive*

- 4.8 Executive Team Report_March 2022 - Copy.pdf (5 pages)

4.9. Key Matter from committees

Attachment *Committee Chairs*

- 4.9 a Committee and Advisory Assurance Reports.pdf (11 pages)
- 4.9 b WHSSC JC Briefing (Public) 8 February 2022.pdf (2 pages)
- 4.9 c WHSSC JC Briefing (Public) 18 January 2022.pdf (5 pages)
- 4.9 d SSPC Assurance Report 20 January 2022.pdf (4 pages)

5. Closing Matters

Verbal *Chair*

5.1. Next Public Board Meeting - Wednesday 25th May 2022 at 09:30am

Verbal *Chair*

Aneurin Bevan University Health Board
Minutes of the Public Board Meeting held on Wednesday 26th January 2022, via MS Teams

Present:

Pippa Britton	-	Interim Vice Chair (Chair)
Glyn Jones	-	Interim Chief Executive
Dr Sarah Aitken	-	Director of Public Health & Strategic Partnerships/ Interim Director of Primary Care, Community and Mental Health
Sarah Simmonds	-	Director of Workforce and OD
Dr James Calvert	-	Medical Director
Peter Carr	-	Director of Therapies and Health Science
Rhiannon Jones	-	Director of Nursing
Shelley Bosson	-	Independent Member (Community)
Katija Dew	-	Independent Member (Third Sector)
Nicola Prygodzicz	-	Director of Planning, Performance Digital and IT
Rob Holcombe	-	Interim Director of Finance, Procurement and VBHC
Paul Deneen	-	Independent Member (Community)
Cllr Richard Clark	-	Independent Member (Local Government)
Louise Wright	-	Independent Member (Trade Union)
Prof Helen Sweetland	-	Independent Member (University)
Philip Robson	-	Special Adviser to the Board
Keith Sutcliffe	-	Associate Independent Member (Chair of the Stakeholder Reference Group)

In Attendance:

Rani Mallison	-	Board Secretary
Leanne Watkins	-	Interim Director of Operations
Dan Davies	-	Chief of Staff
Bryony Codd	-	Head of Corporate Governance
Jemma McHale	-	Aneurin Bevan Community Health Council
Neall Hollis	-	Audit Wales
Tracy Veale	-	Audit Wales
Gwen Kohler	-	Assistant Director of Finance
Andrew Walker	-	Strategic Capital and Estates Programme Director

Apologies:

Ann Lloyd	-	Chair

ABUHB 2601/01 Welcome and Introductions

The Chair welcomed members to the meeting. She explained that the meeting was being recorded and would be streamed on the Health Board's YouTube channel.

It was noted that the Vice Chair would be chairing the meeting in the absence of the Chair, however an update from the Chair was included in the papers for noting.

ABUHB 2601/02 Declarations of Interest

There were no Declarations of Interest raised relating to items on the agenda.

ABUHB 2601/03 Minutes of the previous meeting

The minutes of the meetings held on 24th November 2021 were agreed as a true and accurate record.

ABUHB 2601/04 Action Log and Matters Arising

It was noted that all the actions in the log were complete or in progress.

Shelley Bosson, Independent Member, asked if the HIW report referred to in item 2411/08, following the unannounced visits to the ED department at GUH had been received. It was confirmed that the full report was awaited and would be reported to the Patient Quality, Outcomes and Safety Committee once received.

ABUHB 2601/05 Governance Matters

The Board noted the use of the Health Board's common seal and RATIFIED the use of Chair's Actions, undertaken between 9th November 2021 and 12th February 2022, as set out within the paper.

ABUHB 2601/06 Chair's Report

The Board noted the written report provided in the absence of the Chair.

ABUHB 2601/07 Report from the Aneurin Bevan Community Health Council (CHC)

Jemma McHale, Chief Officer, CHC, provided an overview of recent issues of concern and positive observations or public feedback being addressed by the Community Health Council in relation to the planning and delivery of health services in Gwent.

It was acknowledged by the CHC that there continued to be whole system pressures and concerns regarding access to routine services due to staffing pressures, which were seen across the country. The CHC was therefore supportive of the

establishment of the Same Day Emergency Care (SDEC) as quickly as possible.

The CHC reported excellent feedback in relation to Minor Injury Units, with good feedback in relation to the approach of staff in GUH. The CHC have continued to receive feedback regarding long waits, communication and comfort in ED at GUH.

The CHC acknowledged the need to stand down face to face engagement events at the current time but would welcome an update on other options available to continue engagement activity wherever possible.

It was noted that a Winter Survey was underway with live feedback being provided to teams and a full report would be published at the end of April 2022. Jemma McHale also outlined upcoming and ongoing CHC activities, including in-hospital stroke survey, maternity services survey and out of hours/111 survey.

The outpatient diabetes survey had been completed and a report submitted to the Health Board. A particular area of focus is the support for parents with a child with diabetes.

The Board noted the virtual visits undertaken in November and the monthly feedback surveys.

Rhiannon Jones, Director of Nursing, commented that, in relation to issues regarding communication, the Board's Patient Quality, Safety and Outcomes Committee had received feedback regarding experience of families struggling to contact wards and the availability of staff to respond. The Board was pleased to learn that the Executive Team had approved the re-instigation of patient liaison officers which had brought a positive impact during the first wave of the pandemic.

Paul Deneen, Independent Member, thanked the CHC for a comprehensive report and asked if, in relation to GP services, there were specific areas/surgeries with particular issues. Jemma McHale explained that participants did not always identify the surgery however, there had been a small number of practices mentioned recently which the CHC had informed the Primary Care Team about in order to discuss further with the relevant practice manager.

In relation to concerns with increased risk to those waiting for cataract treatment, Glyn Jones, Interim Chief Executive, explained that the Health Board had been relatively successful in reinstating and maintaining elective work. The Health Board had continued a contract with Care UK, now Practice Plus Group, for ophthalmology treatment provided in Bristol. Rob Holcombe, Interim Director of Finance, Procurement and VBHC, confirmed

that approximately 1400 cataract procedures had been procured through this contract, with very positive feedback from patients.

Katija Dew, Independent Member, asked if the surveys undertaken identified any issues relating to the support that was being/could be provided by third sector organisations, particularly in relation to managing conditions closer to home. Jemma McHale explained that this had not been raised, but neither had there been a specific question regarding third sector access and would pick this up in the future.

The Board NOTED the update from the Community Health Council.

ABUHB 2601/08 Charitable Funds Annual Accounts and Annual Report 2020-21

The Board received an overview of the Annual Accounts and Annual Report for the year ending 31 March 2021 for Aneurin Bevan University Health Board Charitable Fund. Gwen Kohler, Assistant Director of Finance, presented the paper and highlighted the key issues contained in the accounts, as set out within the paper.

The Board was advised that the final Accounts and Annual Report for 2020/21 and Audit Wales report were presented to the Charitable Funds Committee on 11th January 2022. It was highlighted that there had been some minor changes following this meeting in relation to signatories and membership in the Annual Report and the final version was now recommended to the Board for approval.

The Board was pleased to note that Audit Wales intended to provide an unqualified audit opinion on the annual accounts.

Katija Dew, Chair of the Charitable Funds Committee, thanked all those involved in preparation of the Accounts and Annual Report 2020-21, and for the work undertaken throughout the year.

Shelley Bosson, Independent Member, asked if the relevant committee could receive an update on the use and implementation of PREMS and PROMS across the Health Board, as referenced in the Annual Report. Rob Holcombe agreed to take this work forward with the Value Based Healthcare Team. **Action: R. Holcombe**

Paul Deneen, Independent Member, thanked those who had generously donated to the Charitable Fund to enable additional facilities and services for patients and staff to be enhanced.

The Board, acting as Corporate Trustee, APPROVED the Annual Accounts and Annual Report 2020-21 and noted that they would be filed with the Charities Commission by 31 January 2022.

ABUHB 2601/09 Audit Plan 2021 and Audit of the Charitable Funds Financial Statements

The Board received and noted the Audit Plan 2021 in respect of Charitable Funds. This Plan set out the work the Auditor General for Wales intends to undertake during 2021 to discharge his statutory responsibilities as the Health Board's external auditor and to fulfil his obligations under the Code of Audit Practice.

The Board received the Audit Wales Audit of Accounts Report in respect of the Charitable Funds. The Board noted an unqualified opinion had been issued and whilst, there were initially misstatements in the accounts, these had been corrected by management and outlined within the report.

The Board RECEIVED the Audit of Accounts Report, Charitable Funds, 2020-21 and the Audit Plan for 2021.

ABUHB 2601/10 Newport East Health and Well Being Centre

Sarah Aitken, Interim Director of Primary Care, Community and Mental Health Services, presented the Full Business Case (FBC) to support the construction of a new Health and Well Being Centre in Newport East (Ringland). The estimated capital cost of the new Health & Wellbeing Centre is £27.461 million.

The FBC confirmed the case for change and a preferred option to develop Health and Well-being services in Newport East. It also confirmed the procurement strategy and the capital cost "not to be exceeded" that had been agreed with the Supply Chain Partner. The draft FBC had been considered by the Executive Team and the Board's Strategy, Planning, Partnerships and Wellbeing Group.

The planned facility will include a range of clinical services provided by Aneurin Bevan Health Board, General Practitioner, Community Pharmacist, Community Dental and General Dental Practice services together with Social Care and Third Sector provision.

It was noted that core benefits were clear but further work was required in relation to the wider benefits. It was agreed that the Benefits Realisation Plan would be circulated to Board Members. **Action: N. Prygodzicz/A. Walker**

Andrew Walker, Strategic Capital and Estates Programme Director, explained that the new building would be on the site of

the existing Health Centre and would be physically linked to the Newport Hub.

Katija Dew, Independent Member, commented that the development of this model was a testament to partnership working and asked if there was funding available to support Third Sector services in delivering the new model. Sarah Aitken explained that the building was an enabler for joint working and there was regional partnership support for sustainable funding for the Third Sector.

Jemma McHale confirmed that the CHC had requested that Park Surgery undertake its own 8-week consultation.

The Board noted that the Outline Business Case was approved by the Board in September 2020 and Welsh Government in March 2021.

The Board APPROVED the Newport East Health and Wellbeing Centre FBC for submission to Welsh Government.

ABUHB 2601/11 Gwent Public Service Board Wellbeing Assessment Consultation

Sarah Aitken, Director of Public Health and Strategic Partnerships, explained that the Well-being of Future Generations Act places a duty on Public Services Boards (PSBs) to produce a local assessment of well-being every five years. The five separate PSBs in the Gwent region agreed to produce a single Assessment for the whole of Gwent, with local assessments for each local authority area.

The Board was invited to consider and comment on the Draft Well-being Assessment, as set out in the circulated paper.

Katija Dew, Independent Member, welcomed the focus on alignment between inequalities and health outcomes and how this information would be used going forwards.

Phil Robson, Special Advisor, highlighted the importance of capturing the impact against this assessment in all policy work. The Board supported this point.

Pippa Britton, Vice Chair, suggested that data in respect of equalities, diversity and language could be strengthened. The Board supported this point. It was noted that inequalities as a result of COVID-19 would need to be included as the data became available.

ABUHB 2601/12 Financial Performance

Rob Holcombe, Interim Director of Finance, Procurement and VBHC, presented the previously circulated report outlining financial performance to the end of Month 8 (November 2021). It was noted that the Health Board continued to forecast a breakeven position for both revenue and capital.

Rob Holcombe outlined the following points being reported at Month 08, for the Board's information:

- A year-to-date underspend of £0.02m against delegated budgets;
- Income - included anticipated and confirmed Covid-19 funding;
- Pay Spend – had increased by circa £2m (excluding bonus payments adjustment in October), primarily due to medical and nursing agency costs,
- Non–Pay Spend (excluding capital adjustments) - had increased by £2m, due to additional funded WHSSC spend as well as increased costs for non-cash limited optometrist expenditure and ICF payments;
- Savings – expected achievement remained on plan & at the same levels as previously reported.

Rob Holcombe outlined key issues in respect of the forecast financial plan, which included:

- A remaining small risk with regards to finalising the income assumptions for Covid-19 with Welsh Government;
- Improving and achieving the level of savings and efficiency programmes on a recurrent basis to support long term financial sustainability, and•
- Ensuring that service and workforce solutions, in response to the challenging demands being faced, are achieved in the most cost-effective way.

Rob Holcombe emphasised to the Board that the underlying financial deficit (£20.9m) would need to be addressed to support financial sustainability and recurrent balance in future years. It was noted that this would form a key consideration of the IMTP Planning process, with a refreshed approach being considered by the Executive Team. The Board noted that a refreshed approach to efficiencies across the Health Board was required.

Shelley Bosson, Independent Member, noted the financial implications of the use of nurses for enhanced care and asked if it would be possible to assess the spend against patient outcomes and experience to be assured on the best use of resources. Rob Holcombe agreed to consider this outside of the meeting. Rhiannon Jones, Director of Nursing, agreed to work with Rob Holcombe, highlighting the work already undertaken to date in this area and the robust approach taken in relation to the Nurse

Staffing (Wales) Act and associated acuity audits. **Action: R. Holcombe/R.Jones**

Rob Holcombe advised the Board that the 2022/23 revenue allocation was received by the Health Board on the 21st December 2021. The revenue allocation letter identified the funding available for the Aneurin Bevan Health Board's 2022/23 Financial Plan. It was noted that the 2022/23 baseline funding had increased by £96.7m compared to the 2021/22 baseline and the net uplift to the Health Board i.e. excluding committed and directed funding, was £67.1m.

Phil Robson, Special Advisor, noted that there had been a significant amount of funding available to support the COVID-19 response, however the financial position for the next year was likely to be much more challenging and that staff would need to be informed of this. Phil Robson sought clarity on the financial priorities for the coming year. Rob Holcombe highlighted key cost pressures would likely include increasing utilities costs (a national issue), and workforce demand in response to system pressures and patient acuity.

Leanne Watkins, Interim Director of Operations, noted that the operational response required both a bottom up and strategic approach. The scale of the challenge required a full system transformation. Sustainability of staffing and a blended workforce model were likely to be key.

The Board NOTED, as set out in the paper, the:

- financial performance at the end of November 2021 and forecast for 2021/22 – against the statutory revenue and capital resource limits;
- revenue reserve position on the 30th of November 2021;
- Health Board's underlying financial position;
- Health Board's cash position and compliance with the public sector payment policy;
- financial assessment of the risks and opportunities which may impact on delivering the financial forecast for 2021/22, and
- 2022/23 financial allocation.

ABUHB 2601/12 Annual Operating Framework Delegation of Budgets – Quarter 4 Update

Rob Holcombe presented the previously circulated paper which provided an overview of the revenue funding allocations available to the Health Board for 2021/22 to be used to delegate budgets, including:

- Confirmed funding allocations;
- Anticipated allocations, supported by Welsh Government guidance or policy letters; and
- Anticipated Covid-19 allocations aligned to Welsh Government and Finance Delivery Unit financial planning

principles, where there remains a risk around securing this funding.

Rob Holcombe advised that the assumed income level (£1.6bn) was used to support allocation principles and the proposed approach to delegating funding for the 2021/22 financial year within total available resources, including a quarterly approach to setting and reviewing the delegation of budgets, recognising that a flexible and practical approach to financial planning and delivery is required.

The Board ENDORSED the proposed delegation of budgets for quarter 4, as set out within the paper, and noted the minimal ongoing risk associated with COVID-19 funding.

ABUHB 2601/13 Performance Report

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, presented the Board with the Performance Report, which provided a high level overview of activity and performance at the end of November 2021, with a focus on delivery against key national targets as included in the performance dashboard. The report focussed on the areas of Referral to Treatment (RTT), Diagnostics, Unscheduled Care access, Cancer, Stroke Care and Mental Health.

Nicola Prygodzicz outlined that the Health Board continued to manage: the COVID-19 pandemic, increasing demand across the urgent care system, increased pressure on primary care services, high walk-in demand at the emergency departments, significant pressures in social care and high levels of sickness across the workforce. All of which were in the context of the restart of many routine services, despite continued reduced capacity for elective surgery overall when compared to pre-COVID-19 activity levels during the same time period.

Nicola Prygodzicz provided a high-level overview of the position, which included:

- In terms of planned care and outpatients, the significant scale of the challenge, and the ability to make an impact over the coming year was highlighted. There had been significant work in the outpatient programme, to look at different ways of meeting the demand, with a balance of face to face and virtual appointments. The focus was on those waiting over 52 weeks, with all patients being contacted as part of the clinical assessment process.
- There was an increase in the number of elective treatments being undertaken, which were currently at approx. 80% of pre-pandemic levels. There had been a 12% reduction in those waiting over 36 weeks. Approx. 8000 people were waiting over 52 weeks.

- All diagnostic services continued to increase activity levels. Endoscopy and Cardiology were areas of particular concern, with an increase in demand in these areas. There were insourcing solutions in place for both.
- There were continued pressures in urgent care, in relation to demand, acuity, self-presentations and workforce challenges.
- Lengths of Stay were at the highest levels since June 2016. This was symptomatic of wider system challenges.
- Handover delays had remained static over the past year with a significant amount of work undertaken in this area, including cohorting vehicles, establishing the flow centre and ongoing work with Welsh Ambulance Services NHS Trust.
- In relation to stroke services, the Health Board was performing well in relation to access to a stroke consultant but less well in enabling access to a ward within 4 hours and to Speech and Language Therapy (SLT). It was noted that the Health Board was investing in Speech and Language Therapy at GUH.
- Cancer services remained a key priority with a reduction in referrals in November/December, however these were above pre-pandemic levels. Challenges in relation to some cancellations for high risk cancers as a result of pressures at GUH were noted.

Leanne Watkins, Interim Director of Operations, outlined the work undertaken to ensure patients were seen in the most appropriate setting with a risk based approach to delivering services.

Paul Deneen, Independent Member, asked if the Health Board had received assurances as to the timeliness and quality of those services commissioned and delivered by the Welsh Ambulance Services NHS Trust. Leanne Watkins explained that the Health Board had commissioned additional capacity as part of the GUH opening and this needed to be reviewed within the context of the wider contract.

Helen Sweetland, Independent Member, asked what happened to a patients place on the waiting list if they cancelled/declined their surgical appointment. It was confirmed that individual clinical assessments were undertaken to understand individual circumstances. If a patient did decide to be removed from the waiting list and subsequently wanted to be reinstated, an updated clinical assessment would need to be undertaken.

James Calvert, Medical Director, explained that there was a cohort of patients cancelling their own procedures and the CHC was working with the Health Board to understand the reasons for this and whether there was a socio-economic impact associated with this.

Shelley Bosson, Independent Member, queried whether there would be an Outcomes Framework to support delivery of the Annual Plan. Nicola Prygodzicz explained that Welsh Government was undertaking work to develop an Outcomes Framework and the Health Board would look to localise this once received.

The Board RECIEVED the Performance Report, NOTING performance at November 2021, including trends against the national performance measures and targets and progress on service recovery.

ABUHB 2601/14 Strategic Risk Report

Glyn Jones, Interim Chief Executive, presented the Board with the Strategic Risk Report which provided an overview of all 24 strategic risks described within the Corporate Risk Register. In addition, Glyn Jones set out recommendations, as set out within the paper, to de-escalate some risks which had been managed down to an acceptable risk appetite level or were no longer perceived to be strategic risks and could be managed operationally within respective risk registers.

The Board RECEIVED the Strategic Risk Report and APPROVED:

- the de-escalation of the risks outlined within the report subject to local monitoring and review;
- the removal of CRR029 and the re-framed position of CRR002, as set out within the paper; and
- the revised risk dashboard approach which would be used as a conduit to communicate all risks to the Board and its Committees with further detail of each risk to be received at each meeting, aligning to the Board Assurance Framework and Committee/Board work plans.

Sarah Simmonds, Director of Workforce and OD, noted that the change to the recruitment and retention risk (CRR002) was based on an assessment of the current recruitment market.

ABUHB 2601/15 Executive Team Report

Glyn Jones, Interim Chief Executive, presented the Executive Team report, which provided the Board with information on a range of work being undertaken by the Executive Team.

Glyn Jones highlighted that system pressures remained across Health and Social Care. COVID infection rates were reducing however the number of patients in hospital remained high. As a result, the Local Options Framework, issued by Welsh Government, had been applied including:

- Temporary centralisation of midwifery services - reinstated 17th January 2022.
- Temporary reduction in elective orthopaedic activity.

- Temporary redeployment of staff from Primary Care Mental Health Teams to support inpatient/crisis teams staffing levels.
- Temporary suspension of some routine outpatient activity to enable staff redeployment into urgent and emergency care services.

The Board congratulated Linda Alexander, Deputy Director of Nursing and Professor Euan Hails, Consultant Nurse, who had been awarded an Order of the British Empire (BEM) and Members of the Order of the British Empire (MBE) respectively, in the New Year's Honours 2022.

Sarah Aitken, Director of Public Health and Strategic Partnerships, informed the Board of a tuberculosis outbreak in the Health Board area, which the Health Board had been made aware of the previous week. An individual had attended a High School whilst unknowingly infectious. 200 students and staff had been identified as at potential risk of exposure to the infection. Screening had been offered, with a 92% uptake. A further update would be made available to the Board in due course.

Phil Robson, Special Advisor, requested a more detailed report on the establishment of the Step Closer to Home Unit, as an Integrated Care Facility, to be presented to the Board's Strategy, Planning, Partnerships and Wellbeing Group.
Action: R. Jones/S. Aitken

The Board RECEIVED the report of the Executive Team.

ABUHB 2601/16 Committee and Advisory Group Chair's Assurance Reports

The Board RECEIVED Assurance Reports from the following Committees:

- Audit, Finance and Risk Committee – 2nd December 2021
- Mental Health Act Monitoring Committee – 9th December 2021
- Patient Safety, Quality and Outcomes Committee – 21st December 2021
  Nicola Prygodzicz confirmed a rescheduled WCCIS implementation date of the end of March 2022.
- Strategy, Planning, Partnerships and Wellbeing Group – 13th January 2022

It was noted that the Assurance Report from the Charitable Funds Committee held on 11th January 2022 would be circulated to Board Members. **Action: R. Mallison**

ABUHB 2601/17 Date of Next Meeting

The next scheduled meeting of the Board, to be held in public, is to be held on Wednesday 23rd March 2022 at 09:30.

Aneurin Bevan University Health Board Meetings –
Wednesday 26th January 2022

ACTION SHEET

Minute Reference	Agreed Action	Lead	Progress/ Outcome
ABUHB 2601/08	**Charitable Funds Annual Accounts and Annual Report 2020-21:** Relevant Committee to receive an update on the use and implementation of PREMS and PROMS across the Health Board.	**R. Holcombe**	Board briefing report issued. Board briefing session to be arranged for further detail.
ABUHB 2601/10	**Newport East Health and Well Being Centre:** Benefits Realisation Plan to be circulated to Board Members.	**N. Prygodzicz/ A. Walker**	Complete. Circulated 10/2/22
ABUHB 2601/12	**Financial Performance:** Assessment of the financial implications of the use of nurses for enhanced care against patient outcomes and experience to be undertaken to provide assurance on the best use of resources.	**R. Holcombe/ R. Jones**	Joint work being progressed to develop triangulation of costs with operational impacts – briefing report to be issued during March.
ABUHB 2601/15	**Executive Team Report:** A more detailed report on the establishment of the Step Closer to Home Unit, as an Integrated Care Facility, to be presented to the Board's Strategy, Planning, Partnerships and Wellbeing Group.	**R. Jones/ S. Aitken**	Update to be provided to SPPWBG at the April meeting.

Minute Reference	Agreed Action	Lead	Progress/ Outcome
ABUHB 2601/16	**Committee and Advisory Group Chair's Assurance Reports:** Assurance Report from the Charitable Funds Committee held on 11th January 2022 would be circulated to Board Members.	**R. Mallison**	Complete. Circulated 9/2/22

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 23rd March 2022 Agenda Item:1.6

Aneurin Bevan University Health Board

Governance Matters:

Report of Sealed Documents and Chair's Actions

Purpose of the Report

This report is presented for compliance and assurance purposes to ensure the Health Board fulfils the requirements of its Standing Orders in respect of documents agreed under seal and also situations where Chair's Action has been used for decisions.

The Board is asked to: (please tick as appropriate)			
Approve/Ratify the Report			✓
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Rani Mallison, Board Secretary			
Report Author: Bryony Codd, Head of Corporate Governance			
Report Received consideration and supported by :			
Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**N/A**
Date of the Report: 7th March 2022			
Supplementary Papers Attached: None			

Executive Summary

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between the 13th January and 7th March 2022.

The Board is asked to note that there have been six (6) documents that required the use of the Health Board seal during the above period.

Chair's Action in Standing Orders requires approval by the Chair, Chief Executive and two Independent Members, with advice from the Board Secretary. This process has been undertaken virtually, with appropriate audit trails, for the period of adjusted governance and continues in the absence of the attendance of Independent Members at the office during this time. All Chair's Actions require ratification by the Board at its next meeting.

During the period between the 13th January and 7th March 2022, three (3) Chair's Actions have been agreed. This paper provides a summary of the Chair's Actions taken during this period, which are appended to this report.

Background and Context

1. Sealed Documents

The common seal of the Health Board is primarily used to seal legal documents such as transfers of land, lease agreements and other contracts. The seal may only be affixed to a document if the Board or Committee of the Board has determined it should be sealed, or if the transaction has been approved by the Board, a Committee of the Board or under delegated authority.

2. Chair's Action

Chair's Action is defined by the Health Board's Standing Orders as:

Chair's action on urgent matters: There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

3. Key Issues

3.1 Sealed Documents

Under the provisions of Standing Orders the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. Six documents were sealed between the between the 13th January and 7th March 2022, as outlined below. Those documents sealed in January and February were done so by the Vice Chair, in the absence of the Chair.

Date	Title
31/1/2022	Licence to underlet between Kintra Ltd (Landlord) and ABUHB (Tenant) and Oasis Dental (under tenant) the first floor at Chepstow Community Hospital for a dental premises
8/2/2022	ABUHB and Monmouth Creed Management Company Limited Deed of Covenant. Title no. WA745456 – Monmouthshire Hospital Site
14/2/2022	Kier Construction and Gleeds Management Services Ltd and ABUHB Tredegar Health and Wellbeing Centre Grouting (Terrafirma Wales Ltd) Collateral Warranty
14/2/2022	Framework Call Off Agreement ABUHB and QA Ltd
2/3/2022	TIR Lease (old building) relating to Markham Medical Centre and ABUHB, including maintenance management
8/3/2022	Licence for alterations relating to Markham Medical Centre

3.2 Chair's Action

All Chair's Actions undertaken between 13th January and 7th March 2022 are listed below. All of which were approved by the Vice Chair, in the absence of the Chair.

Date	Title
25/01/22	Endoscopy Equipment, Nevill Hall Hospital
16/02/22	Outpatient Transthoracic Echo's (TTE)
16/02/22	Replacement of Stacks and Scopes – NHH - Endoscopy

Assessment and Conclusion

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

Recommendation

The Board is asked to note the documents that have been sealed and to ratify the action taken by the Chair on behalf of the Board.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	Failure to report the sealing of documents to the Health Board would be in contravention of the Local Health Board's Standing Orders and Standing Financial Instructions.
Financial Assessment, including Value for Money	There are no financial implications for this report.
Quality, Safety and Patient Experience Assessment	There is no direct association to quality, safety and patient experience with this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality or child impact issues associated with this report as this is a required process for the purposes of legal authentication.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to Plan associated with this report.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Not applicable to this report
	Integration –Not applicable to this report
	Involvement –Not applicable to this report
	Collaboration – Not applicable to this report
	Prevention – Not applicable to this report

Glossary of New Terms	None
Public Interest	Report to be published in public domain

Description of Request:

To consider as Chairs Action a request for additional scopes and stacking systems to support the Endoscopy Service at Nevill Hall Hospital.

Financial Value £953.500.00

Situation

Approval request to provide additional scopes and stacking systems to ensure continuous high quality service provision for the Endoscopy Service at NHH.

Background

There is a potential operational impact on the Cancer Pathway and increased clinical risk due to many items of equipment being end of life and obsolete.

The service is currently being faced with regular interruptions due to machine failures resulting in lost activity due to cancellations that is causing urgent inpatients to wait longer. The cancellation of scheduled patients is impacting on RTT week diagnostic performance, and the 62-day cancer target.

Request:

This request is for Approval to provide additional scopes and stacking systems.

This replacement is essential to ensure the service remains accessible, effective and safe.

Accompanying documents:

Chairs Action - PPD 990 Endoscopy Equi

PPD 990 - Endoscopy Equipme

PPD 990- Endoscopy Equipme

Approval:

In accordance with the Delegated Limits set out within the Health Boards SFI's, the Chair is requested to approve the request.

Signatures: Chair / Vice Chair **Date:**

Pippa Britton, Vice-Chair – 28th January 2022

Signature: Chief Executive **Date:**

26/1/2022

Signature: Board Secretary

Date:

25th January 2022

Signature: Independent member

Please see separate email – Paul Deneen

Date:

28th January 2022

Signature: Independent member

Please see separate email – Shelley Bosson

Date:

28th January 2022

---- End ----

Description of Request:

To consider as Chairs Action the approval of a Single Tender Action (STA) to continue with outpatient Transthoracic Echo's (TTE).

Financial Value	£624,000.00 circa (circa 800 echos per month) £65.00 per Echo

Situation

Request to approve the Single Tender Action (STA) contract for the extension to continue the clearance of cardiology backlog numbers from 1st April 2022 to 31 March 2023.

Funded by Welsh Government Covid Recovery monies. Monies already agreed by ABUHB Executive Team (meeting of 3rd February 2022) available for use during contract term and equipment is in place.

Appointment bookings will be facilitated by the Health Board.

Background

The cardiology department has and continues to face significant challenges in meting the waiting times for cardiology diagnostics. These challenges relate to the backlog from Covid and an increase in service demand.

Request:

There remains an urgent need to continue to supplement the Cardiology diagnostic service capacity through the use of insourcing and by using IMC Healthcare Services Cardiology will be able to continue to make a significant impact on patient backlogs and help to reduce patient waiting times.

It is essential the contract continues, and the Single Tender Action (STA) is approved.

Accompanying documents:

ABU STA 129332A.pdf

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Approval:

In accordance with the Delegated Limits set out within the Health Boards SFI's, the Chair is requested to approve the request.

Signatures: Chair / Vice Chair

Date:

21st February 2022

Signature: Chief Executive

Date:

21/2/2022

Signature: Board Secretary

Date:

16th February 2022

Signature: Independent member

Paul Deneen - Approved by separate email

Date:

22/2/22

Signature: Independent member

Katija Dew - Approved by separate email

Date:

22/2/22

---- End ----

Description of Request:	
To consider as Chairs Action the approval of a Request for Approval (RFA) for replacement stacks and scopes for NHH Endoscopy.	
Financial Value	£746,309.52 annual value of new contract

Situation

Request to approve the Request for Approval (RFA) for a one off purchase of replacement stacks and scopes for NHH Endoscopy.

Background

There is currently a potential operational impact on the cancel pathway and increased clinical risk due to many items of equipment being at end of life and obsolete. The service is faced with regular interruptions due to machine failures resulting in loss of activity because of cancellations which is causing urgent inpatients to wait longer and in turn cause cancellation of scheduled patients – impacting on RTT, week diagnostic performance and the sixty-three-cancer target.

Request:

Providing the additional scopes and stacking systems will ensure continuous high quality service provision for the Endoscopy service at Nevill Hall Hospital (NHH).

The approval of this request is essential to ensure the service remains accessible, effective and safe.

Accompanying documents:

RFA933.pdf

Approval:

In accordance with the Delegated Limits set out within the Health Boards SFI's, the Chair is requested to approve the request.

Signatures: Chair / Vice Chair	Date:
Pippa Britton, Vice-Chair approved by separate email	4/3/22
Signature: Chief Executive	**Date:**
	04/03/2022
Signature: Board Secretary	**Date:**
	3rd March 2022
Signature: Independent member	**Date:**
Paul Denton - Approved by separate email	4/3/22
Signature: Independent member	**Date:**
Sheelagh Bosson - Approved by separate email	4/3/22

---- End ----

Aneurin Bevan Community Health Council (CHC)

CHC Report

For Aneurin Bevan University Health Board Meeting

March 2022

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

www.communityhealthcouncils.org.uk

Accessible formats

This report is also available in Welsh.

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

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

Contents

About the Community Health Councils (CHCs)

CHCs are the independent watchdog of the National Health Service (NHS) within Wales. CHCs encourage and support people to have a voice in the design and delivery of NHS services.

CHCs work with the NHS, inspection and regulatory bodies. CHCs provide an important link between those who plan and deliver NHS services, those who inspect and regulate it and those who use it.

CHCs hear from the public in many different ways. Before the coronavirus pandemic, CHCs regularly visited NHS services to hear from people while they were receiving care and treatment. CHCs also heard from people at local community events, and through community representatives and groups.

Since the coronavirus pandemic, CHCs have focused on engaging with people in different ways.

This includes surveys, apps, videoconferencing and social media to hear from people directly about their views and experiences of NHS services as well as through community groups.

There are 7 CHCs in Wales. Each one represents the "patient and public" voice in a different part of Wales.

Introduction

The purpose of this report is to inform Aneurin Bevan University Health Board of recent issues of concern and positive observations or public feedback being addressed by the Community Health Council in relation to the planning and delivery of health services in Gwent.

The CHC continues its work in respect of engaging with the population, scrutinising and offering independent challenge to the NHS, monitoring and considering routine and urgent service changes and continue to provide an independent Complaints Advocacy Service.

CHC update

1. Whole system pressures

As expressed during previous CHC reports, the whole system pressures remain to be seen and we hear from people frequently about all aspects of the system, the feedback repeatedly reflects:

1.1 People's frustrations with attempts to access primary care services. Many commenting that telephone access at peak times can be difficult, and sometimes a wait for a telephone appointment may result in a face-to-face consultation, seemingly lengthening the wait for treatment. We have however heard from others who have been very satisfied with timely telephone/face-to-face consultations and access to treatments or onward referral to specialist services. The feedback regarding Primary Care remains broadly mixed.

1.2 Waits for ambulances in the community, waits inside ambulances outside the Emergency Department and waits for people in the Emergency Department who have not arrived by ambulance. Over the last quarter, the CHC has observed Ambulance handover data to the Emergency Department and heard some feedback about care being delivered on the back of ambulance vehicles. The CHC recognises the whole system issue exacerbating this problem, which is preventing significant improvement in our area and across Wales. This issue continues to require significant attention and improvement.

1.3 Waits for discharge for the medically fit. We are aware that many people who are fit for discharge from hospital have been unable to go home for various reasons e.g. social care service or care home availability etc. and thus the urgent care system is unable to admit people in a timely way. The CHC again, recognises that collaborative working with local authority partners is required to improve discharge times and timely access to social care services.

1.4 Waits for planned care or operations. People have reflected their experiences and shared the negative impact on people's quality of life when waiting for planned operations. People waiting for Ophthalmology, Trauma and Orthopaedic or Gynaecology procedures feedback back to us mostly frequently. The CHC is aware that the Health Board has been able to maintain routine pathways at the Royal Gwent and Nevill Hospitals and that "dynamic planning" and activity projections are being scoped for the Health Board's expected Integrated Medium Term Plan (IMTP). The CHC recognises the efforts and work being undertaken by the Aneurin Bevan Univeristy Health Board to recover the long waiting times, but we remain concerned about people's quality of life and potential deterioration when waits are extremely extended. There remains a vital need for regular communication for people on waiting lists, so they do not feel forgotten or know where to turn when they are worried about their conditions worsening. The CHC continues to press for easier access

routes for people to be communicated with and updated about waiting times when people have worries and concerns about their particular condition.

The CHC remains keen to hear from the Health Board about improvement plans and new communication/engagement approaches.

2. Maternity Services Report

The CHC received concerns from the public regarding their experiences when accessing Maternity Services. Therefore, the CHC launched Maternity Services Survey on 8th October 2021 and the survey closed at the beginning of March 2022.

We heard from 48 people who provided us with feedback regarding their experience when accessing Maternity Services in the Aneurin Bevan area.

Some of the key feedback included:

2.1 Expectant mothers told us they felt isolated and alone during appointments and labour due to covid-19 visiting restrictions, meaning their birthing partners were unable to go into the appointment with them during the height of the restrictions.

2.2 It was positive to note that the majority of respondents felt that the ideas they had for their birthing plans were respected.

2.3 We did not hear from anyone who had suffered a loss during their pregnancy.

2.4 Unfortunately, we heard from a number of expectant mothers who did not feel involved about the decisions about their care, with one individual telling us that they were not given sufficient information about the induction process.

2.5 We received feedback from individuals who did not feel that the GP or practice nurse/midwife spend enough time talking to them about their own physical health and physical/mental recovery. One respondent told us that their post-natal check-up was carried over the phone, taking less than 5 minutes.

A response from the UHB is due in April.

3. NHS 111 Helpline/Out of Hours Services Report

In December 2021, the CHC launched a patient experience survey via our social media platforms and website. The purpose of the survey was to obtain patient experiences when accessing NHS 111 Helpline/Out of Hours Services. The survey closed at the beginning of March 2022.

The survey was also advertised in the South Wales Argus to gain as much feedback from individuals as possible.

We heard from 17 people. Some of the key feedback included:

3.1 It was positive to note that most respondents felt that the 111 Service Advisor and 111 medical professionals listened to them, the concerns they had and understood the situation.

3.2 We received mixed feedback regarding the satisfaction of the advice the individual received by the 111 Service Advisor and medical professionals. A small number of individuals who were dissatisfied with the advice received, sought advice from another NHS Service, such as GP Practices or the NHS website.

3.3 The majority of individuals who required a call back from a 111 Medical Professional only had to wait up to 1 hour.

3.4 We received feedback from an individual who noted that the NHS 111 app didn't appear to provide access for languages other than Welsh or English.

Report to be drafted March 2022

4. Monthly public feedback survey

Since May 2020, the Community Health Council has been hearing from people via a generic "Care during the Coronavirus" survey, to hear about people's positive and negative experiences in all NHS care areas.

4.1 To date we have heard from 1366 people. In January and February 2022, we heard from 69 people.

4.2 We have heard from several individuals who raised their concerns regarding the long waits at the Emergency Department at the Grange University Hospital. Even though feedback in relation to waiting times is still a common theme, however, the level of care provided by staff remains positive.

4.3 We have received some concerns from individuals who are experiencing difficulties when trying to register with an NHS Dentist.

4.4 We continue to receive mixed feedback from members of the public regarding GP Practices. Some individuals remain frustrated that they are unable to obtain a face-to-face appointment with their doctor, whilst others are satisfied to receive telephone appointments.

4.5 There is still a common theme of patients raising their concerns of having to wait a long time for procedures. The speciality of these procedures include Trauma and Orthopaedics, Urology and Ophthalmology.

5. Upcoming and ongoing CHC activities

5.1 The CHC wishes to thank the Health Board's Communication and Engagement team for welcoming CHC volunteer members to some of the Health Board's planned roadshow engagement events. The joint attendance at some roadshow events has been very positively received by CHC members and we have appreciated the opportunity to join members of the engagement team to speak directly to people at public events for the first time since the start of the pandemic.

5.2 The CHC launched our annual winter patient experience survey on Monday 10th January and provided the Emergency Department and all Minor Injuries Units with large posters and information to display, to encourage people attending to share their experience and feedback with the CHC, directly through an online survey and/or paper survey available from reception.

The CHC has provided the UHB with weekly/two-weekly bulletins that include the most recent patient experiences to support the CHC's and the UHB's continuous monitoring of patient comfort and holistic experiences throughout the winter months.

To date we have heard from 50 individuals who have shared their experience at the Emergency Department/local Minor Injuries Unit.

Some of the key feedback included so far:

- We have received positive feedback regarding staff across all Minor Injury Units and the Emergency Department providing an excellent service, despite the staffing pressures and the pandemic.

- It has been identified that members of the public seem to travel to all sites by car. This could be

because it is quicker to get to hospital by car, rather than facing potential waits for an ambulance.

- There have been concerns raised about the level of comfort whilst patients are waiting to be seen in the Emergency Department at the Grange University Hospital.

Report to be drafted April 2022.

5.3 In hospital Stroke Services survey – survey launched 1st November and was due to close 31st January 2022. However, due to not receiving a high number of responses, we have decided to extend the survey until 1st June 2022. We have also arranged to host two virtual focus groups in April 2022 via Microsoft Teams for Stroke Survivors to give their inpatient experiences. With the support of the UHB, the continuing surveys will be sent into hospitals for distribution, with our focus group poster attached. The surveys will be sent to the Health Board for distribution at the beginning of March.

Report to be drafted June 2022.

5.4 With the support of the UHB's person centred care team, the CHC can undertake virtual visits at the Grange University Hospital in March 2022. The virtual calls will be carried out via video calling and CHC members will speak to patients who are staying on the following wards:

- Cardiology C2
- Paediatrics C1
- General Surgery & Trauma and Orthopaedics B0

Report will be drafted in March 2022.

5.5 Dementia Care in the Community Survey will be launching on the 1st April for 3 months. The survey will be launched via our social media platforms, website and with the support from the UHB and Dementia Board, paper copies

will be sent to the dementia wards in the Aneurin Bevan area.

Report to be drafted June 2022.

5.6 In May 2022, the CHC are hoping to launch a Palliative Care Project. With the support from the Health Board, it is planned that CHC members will go into 4 hospitals in the Aneurin Bevan area, over a 2-week period, to speak with patients on palliative care wards to obtain feedback about the care that they receive whilst in hospital. CHC members will only speak with patients on the ward if medically appropriate. Surveys will also be sent to each of the 4 hospitals, to ensure that paper copies are available to be filled in.

Report to be drafted July 2022.

5.7 In April 2022, the CHC will be launching a cancelled operations survey. The aim is to identify if individuals felt the need to cancel or postpone their planned procedure for any socio-economic disadvantage that may have influenced their decision, i.e., financial implications, not being able to arrange/afford childcare, work commitments etc. The survey will be launched on our new Engagement HQ and paper copies will be sent to the UHB for distribution.

Report to be drafted June/July 2022.

Thanks

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

We hope the feedback people have taken time to share influences healthcare services to recognise and value what they do well – and take action where they need to as quickly as they can to make things better.

Feedback

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

Contact details

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CIC Aneurin Bevan CHC

Community Health Council

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 23rd March 2022 Agenda Item: 3.1

Aneurin Bevan University Health Board

Development of the Integrated Medium-Term Plan (IMTP) 2022/25

Executive Summary
The purpose of this paper is to provide the Board with a progress report on the finalisation of the Aneurin Bevan University Health Board Draft Integrated Medium-Term Plan (IMTP) 2022/25 and to seek approval for its submission by the 31st March 2022. The Health Board is asked to: • Note the progress achieved in finalising the Draft IMTP • Approve the Draft IMTP 2022/25 for Submission to the Welsh Government by the 31st March 2022.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Nicola Prygodzicz (Director of Planning, Digital and IT)			
Report Author: Christopher Dawson-Morris (Deputy Director of Planning)			
Report Received consideration and supported by :			
Executive Team	✓	**Committee of the Board []**	
Date of the Report: 15th March 2022			
Supplementary Papers Attached: Final Draft Integrated Medium Term Plan (IMTP) 2022/25. Supporting Minimum Data Set (MDS)			

Background and Context

The NHS Wales Finance Act 2006 requires the submission to Welsh Government of Integrated Medium-Term Plans (IMTP) for approval. In December 2021 Welsh Government confirmed the resumption of the formal IMTP process following the decision in 2020 to pause this requirement in the light of the COVID-19 pandemic.

At that time Welsh Government issued the NHS Wales Annual Planning Framework for 2022 to 2025. It recognised that this is the first NHS Planning Framework of the new Government term and it is published at a time of extreme pressure on the health and care system. The Framework requires us to look ahead to the next three years to deliver sustainable services for patients and improve population health.

The context within which the Health Board now operates is different from the one recognised in 2020/21, there is a renewed focus on sustainable recovery, which is characterised by a fundamental shift that encompasses the wider role of Health and Social Care in reducing health inequalities, delivering the foundational economy, and protecting the environment for future generations with the Net Zero 2030 ambition.

Our Integrated Medium-Term Plan 2022/25 is a natural progression from our Annual Plan 21/22. It builds on the life course approach, adopted last year, whilst recognising the current operational demand and being able to focus on realistic, sustainable recovery.

The Plan is purposefully short. It aims to provide a coherent story of the organisations ambition and priorities. It seeks to demonstrate an understanding of the system and sets out specific opportunities for change that will improve the health and wellbeing of the population materially and improve how the system operates.

Our approach to developing the Integrated Medium-Term Plan (IMTP)

In developing this plan, a scenario-based approach was adopted. Working with data partners and making assumptions within a reasonable planning range, a scenario of what is likely to happen across our system in the next year was developed. This scenario was tested and worked through with clinical teams by Specialty alongside workforce and finance partners to understand profiles for delivery, key risks, constraints and priorities for each clinical area. The planning tool allowed for real time pathway understanding and connected the data in order to understand the interdependencies of service provision, for example being able to demonstrate the links of urgent demand on planned care delivery, use of beds and theatre sessions. Utilising this system approach provides confidence of a realistic understanding of what the system can deliver in the context of current, backlog and unreferred demand within the constraints that the services are facing.

The supporting Minimum Data Sets which accompany this plan set out the profiles for next year and align delivery, workforce and finance information. In developing a dynamic approach to scenario planning, we will keep the profiles under review and undertake a formal review every quarter.

This understanding of the Health Board system has highlighted the areas where there must be a focus of attention to enable delivery of sustainable recovery. This has informed the Health Board Clinical Futures priorities for 2022 -2025, which have been reviewed and revised through workshops with our Board members, Executives and Trade Union Partnerships. They have also been shared with and shaped by Aneurin Bevan Community Health Council.

Partnership and collaboration across the system over the past 24 months has been exceptional and this approach is being harnessed to deliver the innovation and

improvements that we need at local, Regional Partnership Board, Public Service Board, South East Wales Region and National levels.

The plan describes financial balance for core budgets over the next three years, subject to the management of risk, and this has been subject to ongoing discussions with Welsh Government. The Clinical Futures Priority programmes will play an important role in supporting the system deliver sustainable balance through focussing on key areas of system change identified through the planning process.

The Health Board has been meeting regularly with Welsh Government in recent months, who have endorsed the approach that has been adopted.

Overall, this is a plan based on a realistic assessment of delivery in the next three years, it is optimistic in outlook, recognising the need to build on the transformation of services over the last few years, and it is focussed on sustainably making change to meet the long term needs of our communities.

Assessment, Conclusion and Recommendation
There has been a positive process in finalising the Integrated Medium-Term Plan (IMTP) 2022/25 and the Board is asked to: • Note the progress achieved in finalising the Draft IMTP • Approve the Draft IMTP 2022/25 for Submission to the Welsh Government by the 31st March 2022.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risk areas and mitigation plans are inherent throughout the Draft Plan and align to the Corporate Risk Register.
Financial Assessment, including Value for Money	Sets out the financial framework with key opportunities and risks. Areas of opportunities for improved efficiency and value for money are identified throughout the Plan.
Quality, Safety and Patient Experience Assessment	Quality, Patient Safety and Patient Experience underpins the whole Draft IMTP and runs as a theme throughout the plan. An enabling section on Quality and Patient Safety sets out the key headlines.
Equality and Diversity Impact Assessment (including child impact assessment)	Key issues are reflected within the Plan.
Health and Care Standards	The Health and Care Standards underpin the Draft IMTP.

Link to Integrated Medium Term Plan/Corporate Objectives	This is the Draft IMTP and sets out the key organisational priorities informed by our detailed understanding of how our system operates.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The Plan demonstrates an integrated approach to working across the Health Board and with partners and combines both short and long term goals
Glossary of New Terms	Any new terms are explained as they occur within the document.
Public Interest	This report has been written for the public domain.

Aneurin Bevan University Health Board

IMTP

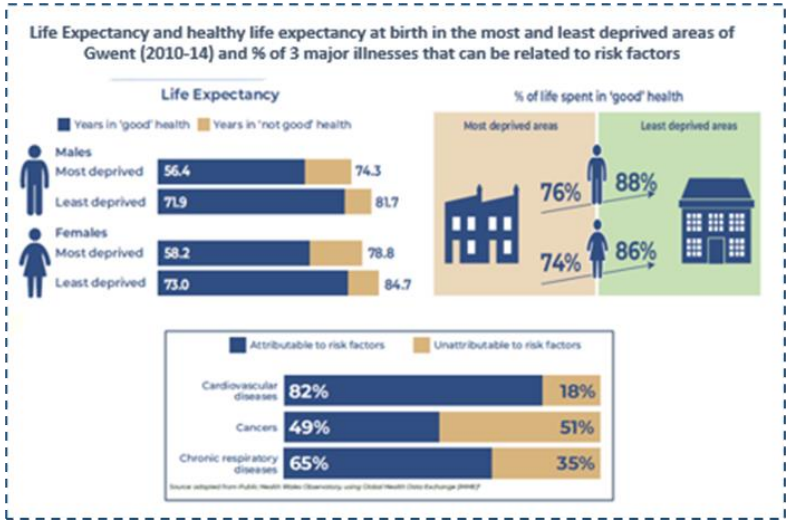
Integrated Medium-Term Plan

2022/25

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

INTRODUCTION

As an organisation our mission is to improve population health, and, through doing this, reduce the health inequality experienced by our communities. The current 18-year gap in healthy life expectancy between our wealthiest and poorest communities is significant. It is the consequences of inequality that mean a greater number of citizens require our services. Sadly, the pandemic has worsened the gap, therefore, as we look to the next three years, we must continue to relentlessly focus on improving population health in order to reduce health inequality.



This plan sets out our ambitions for the next three years, underpinned by three core themes: optimism, realism and sustainability. Optimism will be important as we enter the next three years; we will have to deal with the damaging consequences of the Covid 19 pandemic, remain alert to further waves and potential new variants, tackle backlogs of demand for planned care services, support people whose long-term conditions have deteriorated and importantly support our tired staff to recover from their experiences. However, the optimism in this plan stems from knowing and demonstrating that we can deliver change at pace to improve care; our growing understanding of our system means that we know where to focus our efforts and that strong foundations are in place across our system with renewed strength in partnership working, new facilities and digital, quality and workforce enablers in place.

The realism in this plan stems from its development by our teams. The priorities of this plan and the delivery profiles set out in the supporting Minimum Data Set have been developed by teams from clinical teams across our system. Given the scale of demand, we could have set out demanding delivery targets and challenged our teams to meet the task, however we chose to focus on understanding demand and capacity plans, understanding where we can together make improvements and supporting teams to understand their impact across our health system. In this way, we have developed a plan which is stretching but based on a realistic profile of delivery, owned by our frontline teams.

The final key theme is sustainability. This plan is not about recovery of waiting lists in the short term at the expense of a sustainable system. As a three-year plan, it is focussed on delivering the actions and focus needed to maximise sustainable capacity, support people in the most appropriate place of care, and take preventative actions to help people to live well in our communities. In focussing on sustainability, we can bring balance across workforce, finance and system challenges. We are also in a climate emergency and sustainability of health care services cannot be at the expense of environmental sustainability. This plan sets a renewed focus on driving forward our net zero and sustainability ambition.

The Clinical Futures Strategy, with tackling health inequality at its core, remains resilient as the direction of the organisation. This plan sets out our ambitions to deliver the strategy over the next three years. We are optimistic we are on course to deliver, have charted a realistic delivery approach and are confident our actions will support us in achieving sustainability in order to meet the needs of our communities.

Reflections on 2021/22

There has been substantial learning across the Health Board over the past twelve months which will guide how we respond in 2022/23. This does not simply relate to how we responded to the direct challenges of the changing variants of concern and successive waves of Covid-19, or the wider impact on the last two years on our population and services but also how crisis enables transformation to flourish across the system.

The past 12 months have seen increasing demand across our urgent care and our planned care systems, increased pressure on primary care and community services,

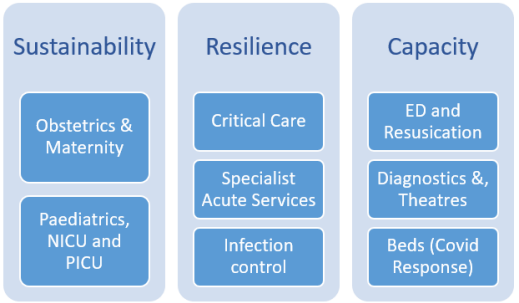
as well as mental health services. We have high walk-in demand at our emergency departments, significant pressures in social care and high levels of absence across our workforce. This is in the context of restarting many routine services despite continued constraints on capacity.

We are proud of the way in which our staff have responded, showing resilience, bravery, dynamism, resourcefulness and great skill over the last two years. In addition to the overwhelming challenges presented by Covid-19, our workforce has enabled our system to introduce new ways of working and to embed many of the clinical futures models that are transforming how we deliver services across our acute hospital network.

In 2021/22 we delivered

- ✓ Significant improvements in Urgent Care performance in a challenging climate
- ✓ Safe surgical zones created to maintain urgent and essential services
- ✓ Best performing Health Board for Referral to Treatment Times
- ✓ By February 2022, 95% of over fifty-year-olds had their first dose of the Covid vaccination, 94% their second dose and 86% have had their booster for Covid vaccinations
- ✓ Urgent Primary Care services established in all Enhanced Local General Hospital (ELGH) sites
- ✓ New ambulatory services established
- ✓ Reduced nurse vacancies by 85%
- ✓ Implemented the Mental Wellbeing Foundation Tier programme including Connect 5, SPACE (development of single point of access for children and young adults) and Melo

Our Clinical Futures Strategy has remained resilient and relevant for over a decade. The opening of the Grange University Hospital as part of a new hospital network was a fundamental milestone in the delivery of the broader strategy. Clinical Futures is about much more than one hospital; it seeks to improve population health, resilience and well-being and to deliver care closer to home, primarily thorough primary and community services, all supported by a hospital network.



One year on from the opening of the Grange University Hospital and moving to a new hospital model, six months early and in the middle of a pandemic, we are seeing benefits in terms of service sustainability, resilience, and capacity. In addition, recruitment has improved for specialist medical staff and registered nurses.

There is no doubt that our system has been under significant and relentless pressure. There are sicker patients needing urgent care, staff are adapting to new models of care and the consolidation of specialist services at the new hospital represents a culture shift.

As we approach 2022/23, we will continue to embed the new models of care that could not be fully implemented whilst our system responded to the pandemic. Notwithstanding this, our focus and key opportunities for achieving a sustainable system lie in delivering the broader strategy and strengthening the role of our Enhanced Local General Hospital network and the provision of more care closer to home.

We have reshaped our Clinical Futures Programme to support the delivery of the organisations key priorities which, based on our understanding of our system, will deliver the biggest impact on improving the sustainability of our system.

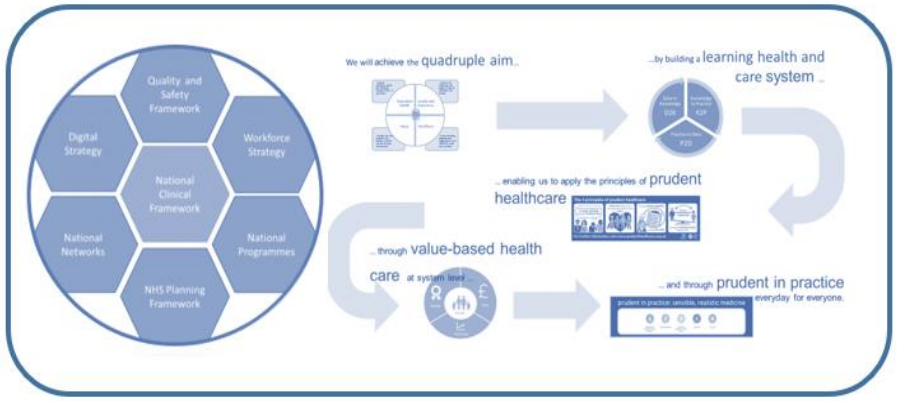
This Integrated Three Year Plan sets out the key priorities we will focus on over the life of this plan. It builds on what has already been achieved and provides the greatest opportunities to move further forward with the strategy in the Covid-19 recovery environment. We have also taken the opportunity to review and reflect on the Clinical Futures strategy in the context of A Healthier Gwent, National Clinical Framework and new opportunities for transformation and innovation possible in a post pandemic future, all of which will reform the refresh of our strategy.

Well-being of our Future Generations There are a range of policy drivers and tools which we can utilise to support how we plan to ensure that a person's chance of leading a healthy life will be the same wherever they live and whoever they are. The Wellbeing of Future Generations Act (WFGA) keeps us focused on preventative approaches, Value Based Healthcare and integrated decision making provides further tools to focus on the outcomes that matter to individuals and their families, the Quadruple Aim and Ten Design Principles in A Healthier Wales similarly provide a focus on ensuring wellbeing.

In this document, you will not find a separate section listing projects we are delivering to support the Wellbeing of Future Generations Act. The Act challenges us to fully embed the five ways of working. We fully share our four wellbeing objectives with our public sector partners, and they are enshrined in the 5 Public Service Board Well-being Plans that serve our citizens across Gwent.

We continue to work with partner organisations to embed the Act through our shared focus on prevention, reducing health inequalities, improving community and personal resilience. Our plan is not about a series of projects or specific pieces of work but an underpinning approach to the way we design and deliver services across our system, embedding the future generations principles throughout.

National Clinical Framework published in February 2021 sets out a coherent vision for the strategic, regional and local development of NHS Wales Clinical Services.



It is grounded in the life course approach to service delivery and aligned to the burden of disease facing the population. Its intention to improve patient outcomes and experience supporting the planning and delivery of Value-Based health care, doing what matters most to people through shared decision making, and creating sustainable and resilient clinical services.

We welcome this framework and are confident that the principles that underpin it resonate with our approach to planning and delivery of services across our system. We will contribute to and fully engage with national programmes to develop holistic pathways of care, service innovations and quality statements and be guided by the outcomes of this work as we transform services locally.

Our plan for 2022/23 is designed to capture our core intentions, give clarity on our priorities, be clear about how we are dealing with the incredibly difficult task of resuming 'normal' business in the context of the ongoing pandemic, and the direct and indirect harms of Covid-19 on the health and wellbeing of our population.

We all understand the consequences for our population are great and we need to focus on optimising every resource available to us as we strive to reduce ever widening health inequality and improve population health.

Our staff are exhausted, and we need to focus on their wellbeing. Asking staff to do more to tackle waiting list and to rise to the challenge of recovery is difficult. We need to focus on realistic and deliverable scenarios, being honest with the public, Welsh Government, and ourselves about what is possible. A single document can never capture the breadth of activity that takes place across the Health Board. Planning is not about a single document and this plan should be read alongside a range of plans and the annexes that accompany it.

Our plan is split into five broad sections:

1. **Our Organisational Priorities**
2. **Our planning landscape 2022 - 2025**
3. **Delivery of Whole System Transformation (Clinical Futures)**
4. **Our Core Enablers for delivery**
5. **Our Delivery Framework**

ORGANISATIONAL PRIORITIES

Our commitment to Care Aims Principles underpins our ambition to improve population health and reduce inequalities. Building resilience in our communities, embedding a person-centred approach to service provision and supporting the citizens and their families to take responsibility for their own lives in order to deliver the change communities need.

The main outcome of the approach to health is functional ability which is the sum of the individual and environmental attributes that enable a person to be or do what they have reason to value at every stage of their life-course. For a neonate or infant, functional ability could be manifested by feeding well and playing; for older adults, by the ability to function independently without dependence on care.

This approach requires holistic, long-term, policy and investment strategies and engagement that promote better health outcomes for individuals and greater health equity in the population. We are confident this approach can provide high returns for health and sustainable development, both by limiting ill health and the accumulation of risk throughout life and by contributing to social and economic development and the foundation economy.

PRIORITY 1 – EVERY CHILD HAS THE BEST START IN LIFE

We believe that every child deserves the opportunity to have the very best start in life.

Early childhood experiences, including before birth, are key to ensuring improved health outcomes, better learning, access to good work and a fulfilled life. To deliver this priority, we will challenge traditional practices, introduce new ways of working and forge greater alliances with Local Authorities and the Third Sector. We have already set out our ambition to become a Marmot Region focusing initially on early years. This will enable us to align our resources to promote early family-centred interventions, public education and improved long-term outcomes for all children.

Healthier Together was launched on 29th March 2021, this new online platform is dedicated to supporting families through the stages of maternity, early child health development, health and wellbeing for children and young adults.

The first of its kind in Wales, this is a self-care resource for both families, young people and health professionals and the public in the ABUHB area. As well as providing valuable information from pregnancy care, child development and mental health advice for young people, it's also anticipated to become the go-to

place for parents and young people to find support, resources and guidance while understanding and navigating key areas of childhood health.

Our medium-term plan identifies key areas that will have a positive impact on the first 1,000 days, and we are progressing a series of actions and initiatives against which we can measure how well we are doing. A summary of these are set out below:

Good Health in Pregnancy – a woman's health is essential to the good health of her baby. Women who eat well and exercise regularly along with regular prenatal care are less likely to have complications during pregnancy and are more likely to successfully give birth to a healthy baby. Making good lifestyle choices will directly impact on a baby. It is important to stop tobacco smoking, drug misuse and alcohol consumption during pregnancy. In 2021/22 smoking cessation advisors actively worked with pregnant women achieving cessation rates above the Welsh average. We also piloted a midwifery led weight service in Ebbw Vale through the appointment of a Public Health Midwife as recruitment of dietitians was not deliverable during the pandemic. This pilot is a precursor to implementing the Maternal Healthy Weight Pathway designed to reduce co-morbidities such as hypertension and gestational diabetes and to achieve improved birth choice outcomes with a reduction in Caesarean section and inductions. Key areas for delivery this year include:

Smoke free environments Maintaining formal smoking bans on all Health Board sites to ensure a smoke free environment for all pregnant women using our services
Support to stop smoking in pregnancy Extending smoking cessation support in pregnancy as part of routine ante natal care to reduce the incidence of smoking amongst pregnant women, reduce miscarriages, premature births, and low birth weights.
Weight management during pregnancy Expand the maternal healthy weight pathway to support all pregnant women with a BMI over 35. This programme provides brief interventions, dietary support, eating for one healthy for two, based on the Doncaster model.
Ante-natal Education Programme Our Maternity Service will continue to develop stronger alliances with PHW raising the public health messaging through ante natal education programmes.

Midwifery and Neonatal Services – support women with the knowledge, skills and confidence to make informed decisions regarding their care. We promote all options for birth, at home, in free standing midwifery led birth centres, the obstetric unit or the co-located midwifery birth centre. Through addressing key public health factors such as healthy eating, smoking cessation and exercise the health of future generations should be improved and interventions in the birthing process diminished. At the booking appointment all women are signposted to our 'Healthier Together Platform' by their named midwife. This provides a wealth of information to support women and their families through pregnancy, delivery, and parenthood.

Consultant cover for labour ward care has been improved by the consolidation of obstetric services at the Grange University Hospital supporting around 300 obstetric deliveries each month.

Sustainable Services We will maintain 'Birth-rate Plus' staffing standards, maintaining high quality and sustainable services for women within community and acute care settings. Working closely with HEIW to ensure ongoing recruitment of preceptor midwives.
Parental Accommodation There is a strong correlation between parental access to neonates and long term maternal /neonatal health outcomes. We will ensure that parents play an active role in their baby's nurture and care through the building of bespoke neonatal parents' accommodation, fully compliant with the latest national / 'BLISS' standards.

Healthy Child Wales Programme - we believe strongly that progressing the aims and objectives of the Healthy Child Wales Programme is critical to children's health, social and educational development and to optimising their longer-term potential. Our focus for delivery this year includes:

Increased support and encouragement of breast feeding for new mothers.
Increased emphasis on care closer to home, enhancing the role of the community team and supporting the pro-active management of conditions without the need for specialist paediatric intervention wherever possible.
Establishing fully integrated working between midwifery services and health visiting, school nursing and Flying Start teams. This is being delivered through the establishment of hubs within localities.

Increased support for the public health nursing, with midwives and health visitors able to extend the 'window of support' and respond to issues such as infant feeding difficulties, low mood and anxiety. We have established a responsive feeding team supporting women who breastfeed. Rates are not as high as we would want them to be, we recognise that some of this is culturally driven, however one of the biggest challenges to breastfeed is levels of obesity across our population.

Childhood Immunisation is a highly effective population health measure, second only to clean water, in reducing the burden of infectious diseases. It helps a child to become protected from diseases caused by bacteria or viruses. It also helps protect others around him or her. Without immunization, the only way to become immune is to get the disease. Our proposed Public Health Protection Service will be instrumental in driving uptake of immunisation and vaccination programmes, providing the skills and capacity to reach into our communities. We will continue to deliver our immunisation and vaccination programmes which include:

Children's Flu Programme Continue to deliver the Children's flu programme which was extended to cover all secondary school pupils. The School Nursing Service and Covid-19 mass vaccination team work together to deliver this expanded programme.
Human-papillomavirus Vaccination (HPV) HPV is a very common sexually transmitted infection that can cause genital warts or cancers. HPV protection is now extended to boys alongside girls this year and we are scheduled to immunise doses 1 & 2 totalling approximately 10,000 together with around 3,000 outstanding second doses (from 2020 cohort) due to recent school closures and absent children. We expect that additional staff resources will enable us to deliver an additional 5,000 HPV vaccines by March 2022.
Men ACWY booster This vaccine protects young people against four different types of meningococcal disease for 15 to 19-year-olds who are at more risk from disease than any other age group expect under 5s. We will undertake a catch-up programme of teenage meningitis vaccinations to recover disruption caused by the Covid-19 pandemic.
Measles, Mumps and Rubella (MMR) The MMR elimination plan has been disrupted by Covid-19. Uptake of first and second vaccinations as part of routine childhood immunisation programme has been maintained. We will offer a catch-up MMR programme to those who have missed having two doses during childhood.

Smoke Free Hospitals, Schools and Playgrounds the new Smoke Free Regulations are an important step towards achieving our ambition that 'all our children and young people live in smoke free environments and consider not smoking to be the norm'. We are actively managing the culture change needed to comply with the legal requirements to take reasonable steps to prevent smoking on hospital grounds. Our Public Health Team supports schools to provide a healthy setting for learners and staff.

PRIORITY 2 – GETTING IT RIGHT FOR CHILDREN AND YOUNG ADULTS

Young people are an important group, nurturing of future generations is crucial for our communities.

Evidence is emerging that brain structure is still developing and is not mature until the early 20s, and that after infancy, the brain's most dramatic growth spurt occurs in adolescence. The teenage years are thus a key stage for action to strengthen health behaviours, build resilience and ensure individuals reach their potential. Children and young people represent a third of the population in Wales, and their health and wellbeing will determine their future.

Adverse Childhood Experiences - stressors that impact on their future arise from the abuse and neglect of children but also from growing up in households

where children are routinely exposed to issues such as domestic violence or individuals with alcohol and other substance use problems. The effects can impact on the long-term physical and mental wellbeing of an individual, which in turn can be inter-generational. Therefore, preventing and mitigating the effects of Adverse Childhood Experiences (ACEs) can improve health across the whole life course, enhancing individuals' well-being and productivity while reducing pressures and costs on the health service.

Those experiencing four or more ACEs have increased risk of health harming and criminal behaviours. Thus, health, social, criminal justice and educational systems are all likely to see better results for the Welsh population if ACEs are prevented and mitigated. The impact of ACEs is everybody's business, preventing and mitigating ACEs is our common purpose across our systems' public sector. We have therefore developed a further series of initiatives to maintain momentum and ensure that our children grow up in the best possible supportive environment and are able to reach their potential in adulthood. A summary of our plans include: -

Mental Health Resilience in Children and Young adults - The Covid-19 pandemic has had measurable impact on the mental well-being of children and young people, exacerbated by the repeated closure of schools during successive pandemic waves. With schools now fully open again and restrictions being gradually lifted, it is imperative to take every opportunity to support the recovery of children and young people's mental well-being. Welsh Government recently launched its 'Framework for Embedding a Whole School Approach to Emotional and Mental Well-being'**.** This approach to emotional and mental well-being is the foundation of the 'Iceberg' model for Child and Adolescent Mental Health Services in Gwent which aims to ensure that the principle of children and families getting the right help, first time, at the right time informs service planning, delivery, and measures of success.

We have well established mechanisms in place across every state primary (195) and secondary (35) school through our school nursing teams and school in reach programmes. Within schools' students can use QR codes to access services and book discrete sessions with our school nurses, psychologists or school councillors. We piloted the school approach model in Blaenau Gwent and Torfaen supporting school communities to develop their thinking around whole school approaches to well-being. This year our plans reflect the mental health and resilience of children and young adults at one of the highest priorities for the Health Board over the coming year and beyond.

Iceberg Model

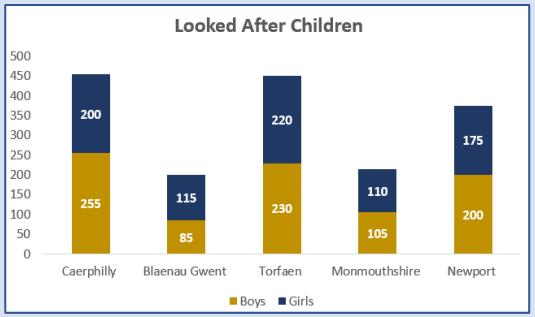
We are reviewing our priorities for delivery in the context of a post-Covid-19 needs assessment to enable us to determine the longer-term structure and functions of services that support children's mental health and emotional wellbeing. The outcome of this work is at present uncertain however partners are committed to progressing a programme of change over the 2022/23 period to embed key principles, values and practices that align with the 'Iceberg' model into how core services operate individually and in partnership. Our approach is consistent with and in transition to the NYTH|NEST Framework

Embedding and Expanding the Whole School Approach

Educational and Clinical Psychologists, skilled in working with complex systems to bring about system level change will work with partner agencies to support a cultural change in the way we think about well-being and mental health of young people. Working with individual schools, this team will help them identify the needs of young people considered the 'missing-middle', and together with partner agencies help schools access appropriate training/interventions to support specific young people and create school environments where all members of the community can flourish and thrive.

Looked After Children

There are currently nearly 2,000 children in the care system in our area, three-quarters of whom are aged 5-18. Torfaen is amongst the highest rate per head of population for Looked After Children in the UK. We will further integrate the Looked after Children service with the school nursing service to support the increased demand for places both locally and nationally.



Neurodevelopment Pathway

In April 2021 we launched a single point of access for Neurodevelopmental referrals. This has seen a doubling of referral rates and we anticipate that referrals will continue to rise as lock down measures are eased. This new needs-led, evidenced based service pathway for the assessment of neurodevelopmental conditions such as Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) will continue to be embedded this year. A key challenge for 2022/23 will be the backlog of assessments resulting from

school closures where in school observations which is a core part of assessment - had not been possible.

Welsh Government's Mental Health (Wales) Measure
Detailed proposals have been approved and will be implemented this year to integrate primary and secondary care CAMHS focusing on the provision of high quality, evidenced based specific interventions to young people and their families, who are requiring 'low to moderate' mental health and emotional wellbeing support under Part 1 of the MH measure; and who are experiencing 'moderate to severe' mental health difficulties under Part 2 of the MH measure.

Emergency Response Pathway
Windmill Farm will come on stream in Quarter 2 of 2022/23, providing a safe space/sanctuary for young people experiencing a psycho-social/mental health crisis to de-escalate for up to three months. Admission will be on a case-by-case basis, with CAMHS teams inputting directly into the therapeutic programme. This integrated approach is key to delivering a robust, sustainable seven-day service

Further work will be undertaken in conjunction with adult mental health and learning disabilities services for supporting section 136 assessments under the Mental Health Act.

Support being a Healthy Weight - it is important that children and young people can live in environments that support being a healthy weight and where they can be active in our shared open spaces and abundant natural environment. Implementation of the two-year Health Weight: Healthy Wales plan was delayed due to the pandemic response, this year we are redoubling our efforts and our focus for delivery includes:

New Initiatives to support healthy eating
- Level 1 Sustainable Food Communities Programme will deliver a whole system approach to food poverty, including education and skills to support healthy diets and greater equity in Blaenau Gwent, the Local Authority with highest levels of obesity.

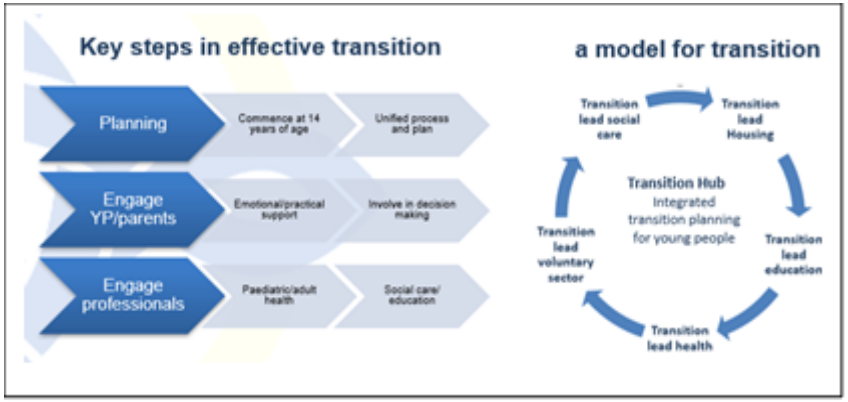
Obesity Pathway Development
- Implement planned Healthy Weight: Healthy Wales obesity pathway developments
- Level 1 Children and Families Programme will support good nutrition in the first 1,000 days of life and help children be a healthy weight by the time they start school

Eating Disorder Services
- Development and continued funding of an integrated Paediatric Avoidant/Restrictive Food Intake Disorder (AFRID) service
- A Health Board-wide review of eating disorder services with a view to designing a model that works 'upstream' to support early detection and intervention in relation to eating disorders.
- As part of Health Schools Programme in Gwent, provide training in schools for staff and pupils.

Transition pathway for 15-25 years - this is often a very difficult time for children and young people, where many stressful elements combine. Typically, a young person who has been under the care of paediatric services for an extended period can face a 'perfect storm' of circumstances, where transferring to unfamiliar adult patient pathways comes together with the loss of child-based third sector support, a series of social and economic challenges in their wider life and high risks of non-compliance with previous treatment routines. Often the shift from child to adult pathways is viewed simplistically as a transition point from one service delivery unit to another rather than the transition of the complex care needs of an individual.

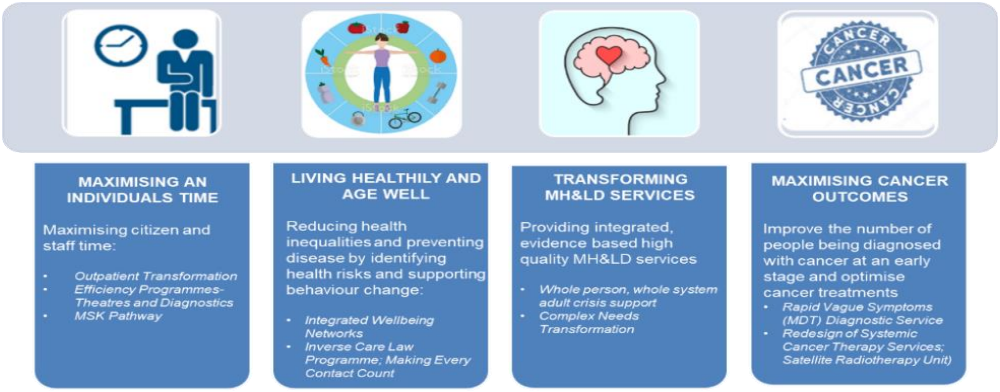
Transitioning care needs is multifactorial and multiagency often encompassing the educational, physical and mental health, social care, social (including third sector) and housing needs of the individual. It is our ambition to deliver and maintain an optimal model of transition from child to adult services.

Through our partnership mechanisms this year we will develop a shared understanding of the range of transition activities that exist for young people and develop transition pathways that are clear, gradual, supportive, user friendly and co-designed.



PRIORITY 3 – ADULTS IN GWENT LIVE HEALTHILY AND AGE WELL

We want our citizens to enjoy a high quality of life into old age we want them to be empowered to take more responsibility for their own health and care, so that they can retain independence.



Maximising an individual's time our Annual Plan 2021/22 recognised that our system still had work to do to become a value-led and efficient service, focused on doing what matters most for people and supporting them with high quality advice and guidance, and to reduce reliance on traditional models of care.

Pre-pandemic our system was out of balance, queues for urgent and emergency care, winter pressures that seeped further into Autumn and Spring created significant challenges for delivery of planned care services have been a feature of our system for some time. We have traditionally relied on waiting list initiatives, outsourcing, and insourcing to manage the longest waiting patients

Our dynamic planning, set out in the next section clearly illustrates the scale of the challenge that has accumulated since March 2020 across our system. Urgent and emergency presentations are increasing in real numbers and in acuity, unreferred demand has and will continue to reappear in different ways and at different times across our specialties, and the position is unlikely to stablise before the end of 2022/23.

PLANNED CARE

We welcome the recently published Planned Care Recovery Plan, 'Reset 2022' and the objectives it sets out, specifically:

- Focusing on those with greatest clinical needs first and supporting those who are waiting for treatment
- Increasing the capacity of the Health System, where possible delivering planned care away from urgent and emergency work to protect capacity
- Transform services to be sustainable in the longer run

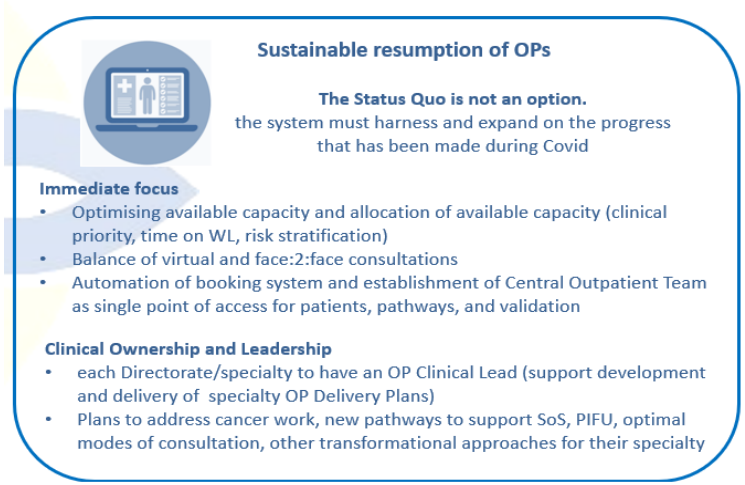
We know that our resources are finite, and that backlogs and unreferred demand for planned care has grown exponentially during successive pandemic waves. We do not have the capacity to meet this quantum of demand. We have an overwhelming duty to our population and to our clinicians to do the most good and least harm for the largest number of people within the resources available to us. We know that traditional models of outpatient services must change.

Over the coming year, as we reset services we think in terms of value and sustainability, harnessing the advances that have been made throughout the pandemic and building a more balanced system of care. Our focus for delivery this year is:

Outpatient Transformation – most patient interactions with secondary care are through outpatient clinics. Patients are referred predominantly by their General Practice for examinations, diagnostic tests, to undergo treatment or reviews. Pre-pandemic a National 3-year strategy and local action plan was in place focused on reducing OP attendances, with emphasis on a self-directed model of care (patient initiated, see-on-symptoms), adoption of digital technologies and ensuring the correct patients access secondary care services.

Covid-19 was a trigger for a more rapid adoption of change including the use of digital solutions such as virtual outpatients and widespread use of electronic communications. We learned the importance of liaising with patients referred to and/or waiting to safely access diagnostic and treatment in what was a very uncertain and frightening time for everyone. Embedding and expanding these new ways of working is key to delivering a sustainable service. We know that the status

quo is not an option and that we must transform outpatient services at scale and pace.



Our immediate plans to transform outpatient services are set out in this section. We will focus our efforts on those specialties that represent the greatest concern specifically Endocrine/ Diabetes Ophthalmology, ENT, Orthopaedics, Gastroenterology, and Maxillofacial specialties in the first instance

Optimising Capacity • Optimising the use of capacity (↓hospital cancellations, DNA rates, monitor utilisation, ↑ non- face2face activity) • Automated Booking System (↓ fallow clinic space, re-allocate space, ability to flex nursing staff)
New Ways of Working • Increase See-On-Symptom and Patient Initiated Follow-up, discharge at first appropriate opportunity • Increase advice only/specialist advice service (currently consultant connect) including triage of referrals • One Stop Treatment Centre RGH • Scope One Stop Treatment Centre NHH
Outpatients Clinical Leadership/Ownership/Risk • Directorate Outpatient Clinical leads supporting development and delivery of Directorate/specialty Outpatient Delivery Plans (factoring in Cancer work, transformation, new pathways, modes of consultation)
• Programme of validation of waiting lists - clerical and clinical (optimise automation and job plan clinical validation) • Risk stratification of new patients (re-evaluate those on waiting list for some time to ensure resources as aligned to most at risk cohorts)
Dynamic Planning • Consolidate specialty outpatient delivery plans with Outpatient Strategy and demand/capacity plans to inform a 3-year transformation plan with clear milestones and deliverables • Delivering Specialty Outpatient plans
Single Point of Contact, Communication and Co-ordination • Central Outpatient Team to be single point of contact for patients (queries, supporting SoS, PIFU, updating/informing) and ongoing validation). • This team will be responsible for maintaining ongoing communication, liaison and engagement with people while they remain on waiting lists to access services.

We continue to work with, benefit from and adopt the output from the National Planned Care Programme and the Planned Care Recovery Plan.

Diagnostics are an essential component of nearly all patient pathways and provide the evidence base upon which all clinical decisions of patients are made. Diagnostic capacity was already stretched before the pandemic as evidenced through the workforce plans for radiology to support the opening of the Grange University Hospital, together with our plans to restructure pathology services.

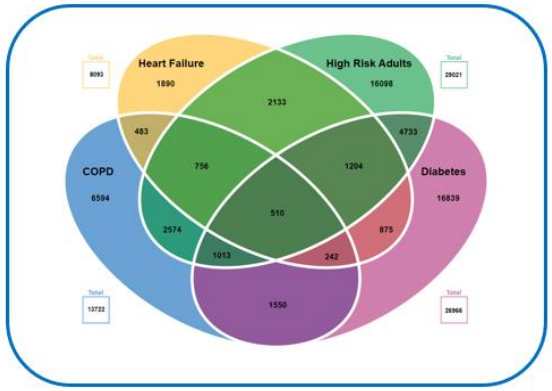
Covid-19 has acutely exacerbated pre-existing service frailties, most notably in respect of radiology reporting, endoscopy capacity, cellular pathology, neurophysiology and cardiac physiology diagnostics. Services continue to increase capacity for all patients however, the backlog in patients needing to be seen and consequently requiring diagnostics is putting pressure on services. In November 2021, just under 6,000 patients were waiting over 8 weeks for access to diagnostics.

Optimising Capacity • Insourcing procured for endoscopy and for echo capacity • Finalising a business case to support the expansion of JAG compliant endoscopy services delivered in the vacant Main Delivery Suite at the Royal Gwent site (with potential to support Regional Diagnostic Capacity • Identifying options to expand cellular pathology laboratory space to optimise throughout and facilitate expansion of workforce to increase capacity to meet current demand (including backlog)

• Supporting national neurophysiology service specification production and delivery
New Ways of Working • Developing an end-to-end Endoscopy Strategy for our system • Embark in a scoping exercise and plan for the adopting of Community Diagnostic Hubs

Pathway optimisation our dynamic planning tells us that 2% of our population occupy 60% of our bed base at any one time. This **High-Risk Adult Cohort (HRAC)** are people who often present to our system following falls, or an exacerbation of one or more of their co-existing conditions. Whilst many of these people will be older (65+ years), we recognise that our response needs to be in place for all adults to ensure that they are best placed to live well with their co-morbidities as they age.

We need to relook at how we are delivering care for these people. We must create a robust methodology that identifies high risk adults at NCN/Cluster and GP practice level. Provide health pathway tools that support delivery of a multimorbidity pathway and embed a culture of proactive support that enables people to remain in their homes and communities, reducing episodes of care that are delivered in hospital settings. Getting this new clinical pathway right is critical to the future sustainability of our system and it must be co-designed and based on integrated decision making.



In addition to the HRAC multi-morbidity pathway, we will continue to implement our **Musculoskeletal (MSK) Pathway** and our **Eye Care Pathway.** Through these we will reset the balance of care across our system providing more care close to home.

High Risk Adult Cohort • Multiagency approach in Blaenau Gwent, Monmouthshire and Torfaen that will extend from 'only frail' to incorporate COPD, Diabetes, Falls Prevention and Cardio arrythmias • Establish formal programme of work, to deliver methodology, pathway tools and cultural change for systematic implementation of HRAC pathway
Musculo-skeletal (MSK) Pathway • Establish end to end pathway programme to optimise and improve our current resources • Implementation of community physiotherapy service • Develop programme of work to support elective recovery and support patients on the waiting list
Eye Care Pathway • Virtual clinics to be embedded in cataract, glaucoma and retina services • Implement community cataract pilot
Regional Ophthalmology Programme (Southeast Wales) • High Flow Cataract hubs (to increase provision) and optimise/stablise cataract assessment and surgery provision within Health Boards • Develop strategy to support Regional Eye Care Services and address sustainability of key sub-specialties • Stabilisation of workforce, develop and deliver comprehensive regional training plan

These clinical pathways will be in line with best practice, the recommendations from Clinical Networks and consistent with the National Clinical Framework.

URGENT CARE SYSTEM (Urgent and Emergency Care)

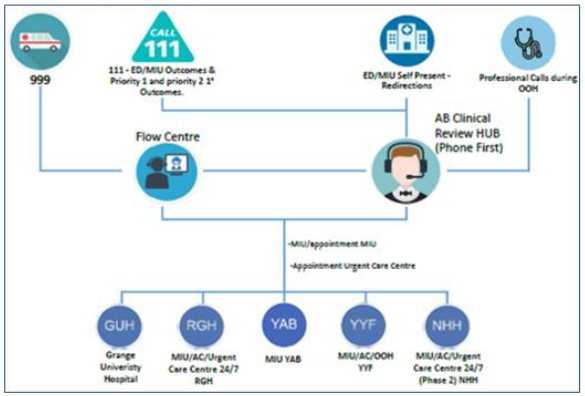
Urgent care encompasses any illness or injury that requires urgent attention but is not a life-threatening situation and may involve a range of existing services including phone consultations through the NHS111, pharmacy advice, same day and out-of-hours primary care appointments, and referral to an urgent care centre. However, a significant proportion of people with urgent care needs present in secondary care, our ongoing analysis of demand across the

system demonstrates that the needs of many of these patients could be delivered safely and effectively in other settings. We know that co-ordination, planning and support for populations at greatest risk of needing urgent and emergency care upstream could have a significant impact on our system, our pathway optimisation for high-risk adult cohort (HRAC) programme identifies 2% of our population driving 60% of our bed capacity.

Our ambition for our urgent and emergency care system is to deliver the right care, to the right patient, in the right way, at the right place by the right person(s). Not only is this best for the patient, but it is also a fundamental enabler for the rest of the system where urgent care flows place demands on the system that are inextricably linked to our ability to deliver emergency, urgent and non-urgent care.

Our new system seeks to simplify access for patients, providing clarity on the best route to care, with all access to urgent care services provided via the 111 or 999 contact numbers. This is supported by our social media campaign and our internet pages and other patient platforms that provides clear accessible advice on how to access urgent and emergency care including self-care.

Our new Urgent Care System



Three major work streams are driving the changes needed to develop and embed the new model namely the Urgent Primary Care/111, Flow Centre and Emergency Care Improvement.

Urgent Primary Care Centre - The introduction of the two Urgent Primary Care Centres, one at Royal Gwent Hospital (RGH) and one at Nevill Hall Hospital (NHH), has ensured a smooth transition of patients with urgent primary care needs from our four Minor Injury Units (Newport, Abergavenny, Ebbw Vale and Ystrad Mynach) and from ED at the Grange University Hospital. The Urgent Care Centres are currently staffed with a GP, Nurse Practitioner and Receptionist with plans in place to develop the multidisciplinary team this year. Data collection and initial demand and capacity work has been undertaken to inform the evaluation, alongside engagement with our population of the pacesetter initiative and share best practice across Wales.

This service has enabled patients to be seen on the same day for any urgent Primary Care need or to be re-directed to other services if more appropriate for their need, for example opticians. Work is ongoing to increase re-directions across all sites, especially our main ED at the Grange University Hospital with the support of clinical, managerial and non-clinical staff across ED, MIU and Urgent Primary Care. These centres receive an average of 1,600 call each week. The introduction of the Urgent Care Centres has already seen enhanced working relationships across all service areas, facilitating the availability of more streamlined pathways, thereby making changes system-wide.

We have sought to establish 'Think 111' as the first point of contact / entry into Urgent Primary Care, Emergency Department (ED) and Minor Injury Units (MIU) for all contacts other than a 999-emergency call. This is to ensure that:

Call volumes from our population remain low, around 90 calls/week.

Urgent Primary Care Centres • Introduction of physiotherapy support and additional mental health support to multi-disciplinary teams • Development of revised pathways (deep vein thrombosis) • Analysis of demand/capacity to determine the need for further UPCCs
Think 111 • Programme Oversight to ensure benefits are being delivered (people are signposted to the right place, first time according to their needs). • Engaging with our population, CHC and other stakeholders to increase uptake of Think 111 as first point of contact • Enhanced Management of Patients Waiting on Stack - remote support to 111 stack and GP support to WAST stack where primary care is required

Flow Centre - As a core feature of our reconfigured urgent care system the Flow Centre provides a single point of contact to optimise patient flow and ensures that appropriate transport arrangements are made to support all admissions, inter-site transfers and discharges across the hospital system, aligned to whole system flow. Initially established as a pre-hospital streaming service, we are building on our learning from the earlier opening of the Grange University Hospital and developing the Flow Centre to deliver a more comprehensive model that includes the development of a multidisciplinary workforce and incorporates redirection of patients to primary care, community services or ambulatory planned specialist care); single point of contact for all routes of referral into same day urgent care; robust information/data capture software and becomes a training hub to ensure consistent service provision. Key areas for delivery in 2022/23 include: -

Pathways development, implementation and embedding new pathways • Respiratory Ambulatory Care • Gastroenterology Ambulatory Care Development of revised pathways (deep vein thrombosis) • High volume pathways e.g., frailty, chest pain, minor injuries
Flow Centre– Embed sustainable flow centre as core service and developing and implementing direct admission pathways across the hospital network and wider system.

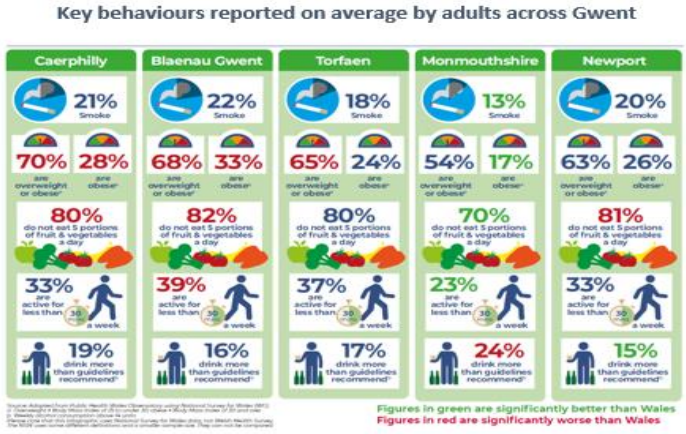
Emergency Care Improvements a significant number of people with urgent care needs present to secondary care. Through our flow centre work we are seeking to stream patients to the right place at the right time. Our Emergency Care Improvement work seeks to improve system performance by:

- developing and implementing a range of alternative ambulatory pathways using our wider hospital network to reduce congestion and improve flow through our Emergency Department at the Grange University Hospital
- developing an integrated front door across our acute hospital network (Urgent Primary Care, Minor Injuries, Ambulatory Services, Elderly Frail Units) expanding our offer for patients closer to home.
- developing a Same Day Emergency Care Unit at the Grange University Hospital
- continuation of process improvements in our Emergency Department
- improving discharge processes and ensuring evidence based approaches in partnership with Local Authorities and the Third Sector

Prevention of hospital admission and timely hospital discharge are integral to effective patient flow and optimising the use of available capacity to meet demand. The Health Board is committed to a specific programme of work to improve length of stay, reduce the time patients spend away from home and minimise the number of stranded patients, working with the Delivery Unit.

SUPPORTING WORKING AGED ADULTS TO LIVE HEALTHILY AND AGE WELL

We know health inequalities exist between our most and least deprived communities, we also know that a large proportion of the burden due to disease and premature death in the population are because of cardiovascular disease, musculoskeletal disorders, cancers, mental ill health and respiratory disease. The development of a large percentage of these illnesses can be attributed to preventable risk factors including smoking, unhealthy diets and physical inactivity.



The difference in key behaviours reported on average by adults across Gwent in relation to preventable risk factors explains the major part of the difference in the average number of years people live in good health and how long they live. People living in disadvantaged communities have a greater number of unhealthy behaviours. These are also the communities who have been disproportionately impacted by Covid-19, with an increase in many risk factors and been stressors that undermine the determinants of good health.

We are a population health organisation, reducing health inequalities and improving population health is at the core of everything we do. Our long-term ambition to reduce demand for healthcare is fundamental to a sustainable system of care. This can only be achieved through systematic, population scale interventions that target the underlying causes of poor health, such as lifestyle

choices and socio-economic deprivation, and the uptake of screening to improve early detection and optimum treatment of disease.

Although the Health Board entered 2021-22 with ambitious objectives to reduce health inequalities, we also began the year under the shroud of the developing Covid-19 pandemic. As a result, planned activities for example Living Well Living Longer were largely suspended or delayed while services reacted to the worsening situation with population health protection taking and continuing to take precedence. Lifestyle programmes including smoking cessation, weight management, early years and mental wellbeing were maintained.

There is a growing body of evidence and an acceptance that health inequalities in Wales were widening before the pandemic, and this has been made worse by the impact of the pandemic where people from our most deprived communities have disproportionate exposure to key stressor that impact negatively on health and well-being. Through our G10 Partnership we have agreed that the next step toward achieving 'A Healthier Gwent' will be a collective set of short-, medium- and long-term strategic objectives to reduce health inequalities across Gwent.

Our ambition is to become a Marmot Region which moves beyond access to services that support lifestyle change to tackling the determinants of health. Initially focusing on early years and young people, a sector of our population who have been impacted significantly by the pandemic.

We seek to adopt a set of Indicators to monitor our progress, challenge compliancy, put a spotlight on the issues that matter most and together reduce health inequalities. Our immediate focus will be on ensuring every child has the best start in life.

In the short to medium term (2-5 years), our objectives to reduce health inequalities will, by necessity, need to focus on measures of system transformation and reducing inequalities in uptake of preventative healthcare interventions. In the longer term (10 years) our ambition will be described in terms of population outcome measures.

Integrated Well-being Networks (IWNs) are at the core of our plans, providing a framework to support the establishment of integrated, place based, well-being systems across all 11 NCNs in Gwent. IWNs are not about creating more services that attempt to solve people's problems, instead they capitalise on what is already available locally and bring in the unique strengths and assets that are within individuals and communities. Wherever possible we want people to find the support they need to stay well within their communities, reducing the need to access support from the care system.

These IWB Networks will support Accelerated Cluster Development as we explore the most appropriate level (practice, NCN, pan cluster, Local Authority, Health Board wide) to deliver care and support to our citizens. We will contribute to creating healthy communities by:

Promote the well-being of the workforce across Gwent. (Public sector and beyond) We will ensure that the workforce is • Aware of the dangers of smoking and have access to NHS Stop Smoking services • Are supported for active travel • Have access to holistic workforce health and wellbeing programmes
Strengthening community well-being and resilience • Greater collaboration with agencies and communities to strengthen community assets for well-being (people, places and delivery) • Information on well-being assets and support is easily accessible and can be found in a timely way • Those working in communities see well-being as an important part of their role and have the knowledge and skills to signpost people and support behaviour change
Improving population mental well-being • Improve awareness of and access to self-help support for mental well-being and resilience by integrating and making visible services which build resilience in the fact of stress and community assets • Improving confidence, knowledge, and skills of the well-being workforce to respond to mental distress and support good mental well-being

The scale of the challenge has been heightened by Covid-19, it's legacy of unreferred demand, deteriorating health status for some of the most vulnerable in our communities and longer waiting times to access services gives us a further imperative to redouble our efforts. We now have a further imperative, to support people to maintain and optimise their health and wellbeing during their extended waits for interventions.

Transforming adult mental health services

We support a rights-based approach that explicitly promotes the recovery model, with the empowerment and involvement of service users throughout the life course. Our mental health and learning disability services have a long history of strong community focused services with a well-developed network of generic and specialist services across communities that are supported by specialist local inpatient services. Our services are delivered through multi-disciplinary teams in collaboration with our public and third sector partners.

Mental Health and Learning Disability model of care

The detrimental impact of Covid-19 on the mental health and well-being of the Welsh population has been significant (Wales Wellbeing Survey, 2020/21). Recent studies published by the Centre for Mental Health (2021 report) forecast that demand is likely to exceed capacity threefold over the next three to five years, with significant increases in conditions such as severe anxiety and depression and a disproportionate impact on individuals with existing mental health conditions. Even if the actual increase in demand is a fraction of that predicted, it means that mental health and learning disabilities services face a huge challenge in increasing the service capacity to meet this new demand at a time when significant backlogs for some services existed before the pandemic and have significantly increased over the last two years. Demand for mental health services is sharply increasing and we need to find ways of supporting people earlier within the community, to better support crisis prevention and recovery.

Headlines

- 9,200 PEOPLE ON WAITING LIST
- 4,600 ARE WAITING FOR PRIMARY CARE OR ADULT MENTAL HEALTH SERVICES
- AVERAGE DAYS TO FIRST CONTACT INCREASED BY 4 DAYS (29 – 33 DAYS
- PATIENT ACUITY INCREASING
- MENTAL HEALTH ACT ADMISSIONS INCREASING

We have made good progress in developing resources in the community to help individuals better support their own mental health and wellbeing. However, services are sometimes difficult to access, we must find ways to make it easier for people to access services when they need to and ensure there is enough capacity to meet demand at each part of the pathway. Workforce challenges persist, finding ways of attracting and retaining the right staff with the right skills will be key to a sustainable service. Providing the right environments for our patients and staff to feel safe and supported is key, we know that many of our buildings are no longer fit for purpose, and it is critical that services for people with the most complex needs are re-provided in more modern and purpose-built environments.

The pandemic has also provided opportunities to develop new ways of delivering our services using technology and we need to develop and embed some of these to enable more choice for our patients. As we emerge from the pandemic, our Mental Health and Learning Disabilities services aims to provide sustainable high quality, safe and person-centred services in a timely and responsive manner which promote and enable independence, recovery, and quality of life for the people of Gwent. Key components for 2022/23 include:

Improving Community Health and Wellbeing **-** helps individuals realise their full potential, cope with life challenges, work productively and contribute to family life and communities.

Raising Awareness – A sustained campaign raising awareness of available support, targeted at groups/ people at greatest risk of having poor mental health & wellbeing	**Effective Community Insight & Self-help resources** – Melo Cymru; Digital technology; Integrated well-being networks; Voluntary sector services; Sanctuary; National Helplines
A Branded and Trusted Website – Develop a branded and therefore trusted website with up-to-date information and resources signposting to local support.	**A Sustainable Training model** – Establish a Gwent Connect 5 Training Hub to support all front line workers feel confident and competent to talk about mental health and wellbeing and are able to support and signpost people to the information and services they need.

Care Closer to Home **-** we are committed to ensuring that all communities across Gwent have access to modern, high-quality care, based as close to home as possible. We know that there is variance in provision and access to primary care mental health support, and that there is a substantial backlog that has accumulated over successive pandemic waves. We will seek to enhance care by moving to a hub model of delivery, supporting a group of GP practices. A full range of individual and group therapies will be available through these hubs ensuring access for assessments and treatments will be the same across Gwent. Our key areas for delivery:

Establishing Locality (hub) based model - Standardised electronic GP referrals. Face-to-face activity, including mental health assessment, individual and group based therapeutic intervention. A dedicated email advice service will be introduced to provide timely support, consultation and advice to GPs. Patients will have the choice to attend appointments in person or 'virtually' using video technology or telephone.
Psychological Wellbeing Practitioners - A named practitioner will be allocated to each GP practice to support individuals whose needs cannot be fully met through core Primary Care services.

Service Transformation – Whole Person, Whole System Adult Crisis Support Programme the Gwent Regional Partnership is committed to crisis support and acute care within the context of a Whole Life, Whole System approach that meet the unique needs of people in crisis, recognising the social determinants of mental health and the need to address these as they relate to individual need. Practice, thinking, and culture needs to promote recovery and wherever possible the prevention or early intervention to crisis. We are moving from our hybrid model with assessment provided through locality-based team in-hours and centralised in the out-of-hours period to a single point of access, where assessments will focus on home first, with support from local community-based services wherever possible. Our key areas for delivery:

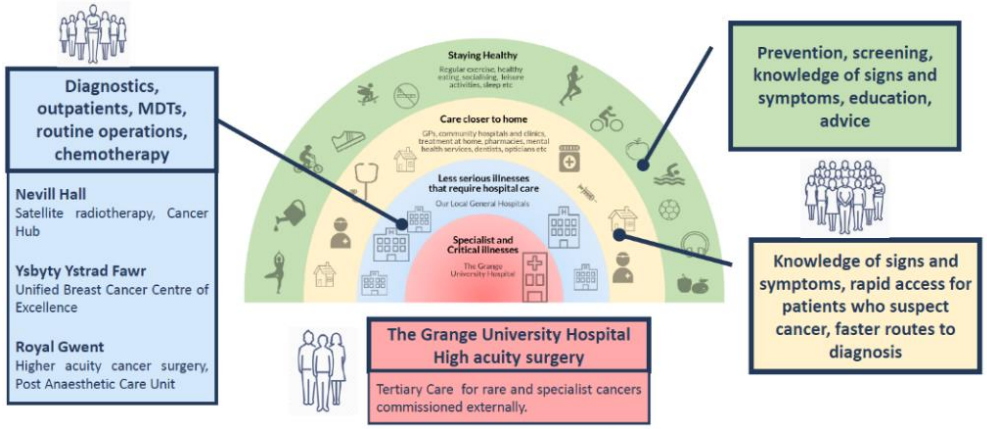
A centralised assessment unit with enhanced local home treatment teams - Single point of contact for crisis referrals 24 hours a day, 7 days a week. Local appointments offered to patients between the hours of 9am and 9pm.
Expansion of Shared Lives for Mental Health - Shared Lives provides an alternative to hospital care and facilitates discharge. It offers emergency placements with selected and trained families for people presenting to mental health crisis teams. Piloted in the Newport area it shows excellent patient-focussed outcomes, reduced admissions and re-admission to hospital compared with rates prior to the scheme. This year a business case will be developed to expand the scheme across our five Local Authorities in a partnership model with Caerphilly County Borough Council.
Older Adult Mental Health Memory Assessment Services - we are developing plans to improve support for older adults including increasing Speech and Language Therapy input to both inpatient wards and Memory Assessment Services (MAS) to assist with speech and language difficulties in the early stages of dementia.
Inpatient Care Model - individuals are admitted to hospital for a variety of reasons including crisis assessment, mental health act assessments, in addition to treatment and recovery. We are seeking to consolidate acute assessment and treatment providing a single point of admission for patients in crisis. This will enable a dedicated specialist multi-disciplinary team to undertake comprehensive assessment of all aspects of an individual's needs, irrespective of the day of the week or time of day. Patients will be able to step down after a short period of intensive care to recovery services (inpatient and community) that will be closer to home.
People with Complex Needs - we want all our citizens who have complex needs resulting from their mental health and/or learning disabilities to have access to compassionate, effective services that support and enable them to achieve their potential and lead fulfilling lives, in the least restrictive environment possible. We continue to progress the case for a New Specialist Inpatient Unit with a Full Business Case by July 2022 and we continue to enhance community support and pathways.
Psychiatric Liaison Services - half of all hospital inpatients have co-occurring mental health conditions such as depression and dementia. Identifying and managing these conditions quickly and effectively helps people to recover, improves outcomes and reduces their length of stay in hospital. We are reviewing our existing service model with a view to expanding liaison psychiatry across our system.

MAXIMISING CANCER OUTCOMES

We know that cancer outcomes need to be improved. Although we have made progress in recent years, we recognise the need to accelerate the rate of improvement. Through our local Cancer Strategy, Delivering a Vision 2020 - 2025 we have challenged ourselves to make enhancements in cancer outcomes through focusing on transformation right across the cancer system Whilst it is too early to be able to measure the impact of the Covid-19 pandemic on morbidity and mortality from cancers, we are concerned that a combination of reluctance by patients to attend primary care and hospital together with the temporary suspension of national screening programmes and longer waiting times for

diagnostic tests and treatment will result in increased morbidity and mortality from one of three diseases that contributes most to health inequalities for our population.

Model of Care for our Cancer Services



Despite the obvious challenges, the pandemic resulted in significant adaptations to our traditional ways of working, some of which will undoubtedly shape the future of services. We are proud of the efforts of our Cancer Services who have continued to provide diagnostic and treatment pathways throughout each phase of the pandemic and have established a Vague Symptom Assessment Service during this time. We are also proud of increased staff knowledge of cancer through training, including progressing a module embedded within ESR for all new starters.

Patients are now presenting with suspected cancer at higher rates than ever before, managing this sustained level of demand is the primary focus of our tumour site multidisciplinary teams. The Omicron variant has had a notable impact on Cancer Pathways with increasing numbers of patients unable to attend, increasing rates of staff absenteeism, together with a higher-than-normal drop in GP referral rates over this period. Despite these challenges, we have sustained cancer activity and treatment numbers continue to be higher than previous years.

Improving Cancer Outcomes – A Whole System Approach

Reducing the risk of cancer	Our approach to help our citizens find the support they need to stay well within their communities is set out at Priority # 3. We will also explore how this Integrated Wellbeing Network and our core services can capitalise on 'teachable moments' when a suspected cancer diagnosis is discounted.
Early Detection	For National Screening Programmes to reach their potential, uptake needs to improve and a combination of raising awareness and more acceptable testing is required. There needs to be targeted action in areas of high social deprivation where uptake of screening is at its lowest particularly in Newport East and West, and in Blaenau Gwent.
Timely Diagnosis	We know that there is variation across primary care in respect of their confidence and competence to spot signs and symptoms of cancer and refer appropriately in a timely manner. We will address this by doing as much as possible to prevent late diagnosis, using a new software tool called C the signs, as part of a pilot scheme, moving toward rapid roll out and adoption. This tool is designed by GPs for GPs and supports the early referral and diagnosis of suspected cancer. Although significant progress has been made, we continue to support and implement an improvement programme in our endoscopy and imaging services and patient pathways. We know we need to continue this work and maximise capacity to speed up the diagnostic process. Rapid Multi-disciplinary Diagnostic Centres for people with vague symptoms opened mid pandemic will consolidate, relocated within our own estate and options to expand will be explored.
RADIATION THERAPY	As part of Transforming Cancer Services Programme proposals are being progressed to develop a Full Business Case in close collaboration with Velindre NHS Trust for a 2 Linear Accelerator project to provide additional more local accessible radiotherapy capacity. The estimated capital cost is circa £16 million excluding enabling works and equipment. The FBC will be completed by May 2022. We are also preparing a Strategic Outline Context for a Cancer Services Hub at Nevill Hall Hospital, to sit alongside the Satellite Radiotherapy Unit. The Cancer services will consist of out-patient and chemotherapy facilities utilising vacant accommodation in Nevill Hall Hospital following relocation of services to the Grange University Hospital. The SOC will explore the optimum function of a Cancer Services Hub to support delivery of care closer to home, improving patient experience and outcomes.

	On 4th February 2022, Health Minister Eluned Morgan announced that nearly £11 million is being invested in a breast cancer 'centre of excellence' at Ysbyty Ystrad Fawr. Works are expected to start on site by March 2022, this facility will allow us to improve patient care, experiences, and outcomes.
 **Acute Oncology**	We continue to support and develop services to meet patients' needs who require acute admission as a result of their cancer treatment. Working closely with our stakeholders and partners across the South East Wales (SEW) region we have collectively developed and agreed an optimal service model. Our Board has approved Phase 1 investment of the Regional Acute Oncology Business Case which allows us to deliver a sustainable local AOS service across our system supported by specialist oncology services. We are seeking to clarify pathways for Phase 2 and 3 regional and specialist components of AOS to fully understand what that means for our population. This work will deliver detailed workforce plans to drive change, improved pathways for local, regional and specialist components of the model that ensure patients receive the right care, first time. These together with capacity, finance, benefits and delivery plans will form a further business case for investment that will be subject to the Health Boards Business Planning Process.

Suspected (Single) Cancer Pathway

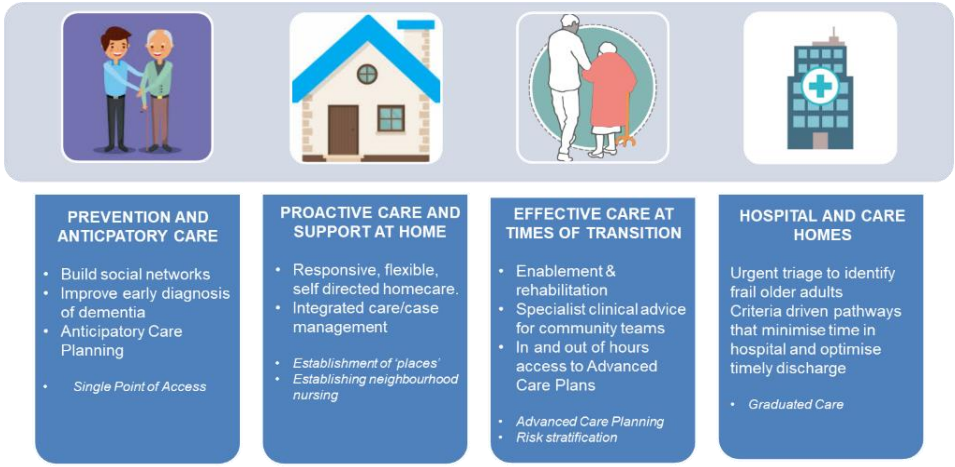
Cancer pathways are now being managed against the single cancer pathway target to ensure equity for all patients to timely treatment. Through our established Cancer Board structure, we continue to progress actions through a number of work streams to be able to more accurately report performance and to demonstrate continuous improvement against reported performance. To ensure successful implementation and delivery, the three key areas of focus for us continue to align to three key work streams:

- **Information and Intelligence** - leading on ensuring processes are in place to accurately capture relevant patient data across all stages of the pathway and ensuring our IT systems are integrated and fit for purpose for tracking and reporting. We have and continue to develop our Cancer Dashboard which supports each Tumour Site MDT to manage their caseloads. We are proactively managing our processes to ensure that delays and barriers are identified, escalated and resolved in order to optimise each patient's journey through their cancer pathway.
- **Demand and capacity** – working to identify the gap and implement solutions to balance demand and capacity in the short term and on a sustainable basis. We have further work to do to understand our demand and capacity profile and recognise that there will be local and regional challenges in terms of balancing capacity and demand.
- **Pathway Improvement** – in parallel with improving timeliness of access to outpatients and diagnostics, we also need to pursue pathway improvement and new ways of working. We are committed to implementing the nationally agreed optimal pathways for specific cancer disease groups, and deliver incremental improvements, with the ultimate goal of reducing variation and improving outcomes for our patients.

Our initial focus is on Breast, Urology and Colorectal tumour sites, where there are high referral rates together with specific delivery challenges, mostly workforce, that are having a disproportionate effect on delivering the SCP.

PRIORITY 4 – OLDER ADULTS ARE SUPPORTED TO LIVE WELL AND INDEPENDENTLY

We believe this to be a fundamental principle of social justice and is an important hallmark of a caring and compassionate community.



In recent years we have delivered significant transformation of services for older adults through our Frailty Programme. Many of our resources sit in communities, delivering integrated services jointly with our Local Authorities, Independent and third sector partners. Notably, in the past year we have strengthened the Home First programme and merged this with the hospital discharge service to provide a single point of discharge. We have also implemented Direct Admission and Transfer Pathways enabling older people to avoid or minimise the time spent in an acute care setting and worked with care homes that have the highest conveyance rates of residents to hospital.

We need to ensure that our system is as ageing friendly as possible. We know that as people age, their health needs tend to become more complex with a general trend towards declining capacity. We recognise that for many older people their general conditioning will have suffered during successive lockdowns, and they are presenting with higher acuity needs. There is a danger that care is over medicalised, particularly when an older person is admitted to hospital-based services that are designed to cure acute conditions or symptoms and tend to manage health issues in disconnected and fragmented ways that lack coordination across care providers, settings, and time. Consequently, older people experience extended stays in hospital environments which has a negative impact on their independence and wellbeing and on our ability to deliver planned care programmes sustainably, predictably, and reliably.

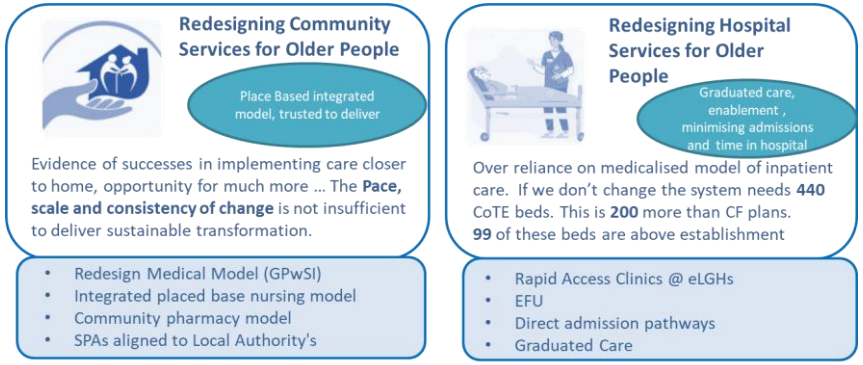
The importance of getting things right for older adults has been reinforced through our dynamic planning approach. It shows, in the starkest of terms, the cost to our system because our offer to older people falls short of what is needed to support them to live well and independently. As we emerge from the direct impacts of Covid-19 on our hospital system, older people including those receiving acute care, active treatment including rehabilitation and those who are waiting to move to the next phase of their pathways occupy 430 beds in our acute hospital system, up to 50% of these people are designated fit for discharge. One simple measure of the cost to our system is beds, if we continue as we are we will need to continue to provide an additional 99 beds or three wards above our core baseline for older people. We do not have staffing levels to support this additional capacity and rely heavily on bank and agency workforce. This position is neither desirable for patients nor sustainable for our system.

Notwithstanding the progress that has been made our approach to addressing the needs of older people could be better aligned as we have focused on discrete parts of the pathway rather than systematically wrapping a service model around older people.

Our system needs further transformation to ensure that older people can access evidence based clinical interventions that respond to their needs, in the context of what matters to them and ensuring that the care they receive helps prevent dependency now and later in life. Our priority is to create a single programme that consolidates all of the existing projects and activities that seek to improve the older people pathway.

This approach is essential for us firstly to develop an integrated strategy for older people, with unified leadership and services operating as a single team across our system. Secondly, to maintain a firm grip and focus on changing those parts of the system that will, individually and collectively, deliver material benefit for older people.

With respect to Prevention & Anticipatory Care we have already identified the actions we will take to develop and deliver a co-morbidity pathway for the High-Risk Adult Cohort (HRAC), many of whom will be older people. Here we have identified additional areas that we will pay close attention to during the life of this IMPT.



Redesigning Community Services for Older People we, together with our partners, are committed to implementing a model of 'placed based care' to foster greater integration across health, social care and third sector and reduce complexity for both patients and those who provide care. Our first order priority is to align existing services to provide a consistent model which provides health and social care staff, patients, and their carers with the confidence to remain in their usual place of residence for as long as possible.

Single Point of Access for each Borough combining all health & social care knowledge with decision maker at 'front door' to direct person to services that meet their needs
Establishing neighbourhood nursing through combining previously segmented nursing teams (District Nursing, Rapid Response, Chronic Conditions Management and Continuing Health Home Care Teams) local nursing provision will become more resilient and patients will experience greater continuity of care through dedicated key workers with fewer hand-offs between professionals
Workforce model for Community Services (Rapid Response/CRT) we are redesigning our workforce model for community (frailty) services with a strong focus on the General Practitioner with Special Interest workforce.
Pharmacy model we are reviewing the multiplicity of community pharmacy models that operate across our system and will design and delivery a single (optimal) model
Enhancing Capacity for Rapid Response/CRT to bolster admission avoidance capacity and reablement capacity to expedite discharge, reducing time spent in hospital

Redesigning Hospital Services for Older People our acute hospital network offers predominantly a traditional medicalised model of care focused on medical recovery and a strong adherence to the principles of responsible medical officer as patients are designated to a named physician or clinical team. This is in contrast to the community hospital network that aims to provide a graduated care model focused on enablement.

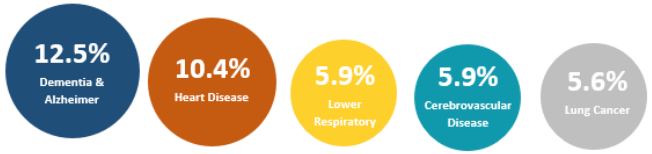
Our focus in respect of redesigning the acute hospital component of the older persons journey through our system seeks to reduce the need for admissions and to minimise the time spent in hospital settings.

Rapid Access Clinics for Older people at the Front Door aligned with Elderly Frail Units to provide assessment, diagnostic and treatment on an ambulatory basis where possible
Elderly Frail Units operational at each enhanced Local General Hospital providing short stay (up to 72 hours) for assessment, diagnosis, treatment/care plan where this cannot be done on an ambulatory basis.
Redirection and Direct Admission Pathways to ensure older people are admitted to the part of the system that best meets their needs, first time, every time.

PRIORITY 5 – DYING WELL AS A PART OF LIFE

Death and dying are inevitable. The quality and accessibility of end-of-life care will affect all of us and it must be made consistently better. We have embraced the principles of the 'A Compassionate Country – A Charter For Wales' and are committed to continuously improving what we do to ensure that the needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities are addressed, taking into account their priorities, preferences and wishes.

Each year around 6,000 people die in Gwent which equates to around 16 people a day. Around 90 of these are children and young people. It is predicted that the number of deaths in Gwent will increase by almost 10% to around 6,600 by 2039. Around 40% of deaths occur in people's usual place of residence, either a home (26%) or nursing/care home (14%). 56% of deaths occurring in NHS hospitals. The leading causes of death in Gwent include:



The Health Board has made excellent progress by focusing on promoting and embedding the principles of Advanced Care Planning (ACP) into practice. A focus has been on educating staff on serious illness conversations with the understanding that a healthy approach to dying, planning ahead and informing family and friends on their wishes can result in improved person-centred care at the end of life. We have implemented an ACP Primary Care pilot where GP practices piloted Vision 360 to capture ACP related outcome data. Additionally, there is a well-established priority work stream which is exploring outcome measures that reflect patient experience. We have been driving foundation and advanced communication skills across the Health Board and with partners to deliver communication training for staff.

Despite the achievements made, many challenges remain. We know that current trends in population ageing show that, in the near future, whilst more people live longer, more will also die at any one time. Our system will need to change its practice to manage the number of people dying in the coming years, many with multiple co-morbidities. Our plan is built on four key areas of focus:

Advanced Care Planning - is key in terms of improving care for people nearing the end of life and enabling better planning and provision of care, to help them die well in the place and manner of their choosing. People can discuss and record their future health and care wishes and also to appoint someone as an advocate, therefore making the likelihood of these wishes being known and respected at the end of life. We will build upon our Advanced Care Plan Facilitators programme, supported by a business case to ensure the sustainability of this role, recognising their importance in embedding Treatment Escalation Planning and improving information sharing between primary and secondary care. Additionally, we will continue to promote and raise awareness of ACP through our recruitment of ACP Champions training programme.

Implement Advanced Care Plan Facilitators across from Primary and Acute Care We will continue to implement ACP Facilitators across both primary and acute care in order to embed Treatment Escalation Plans across the organisation and improve information sharing between primary and acute settings. This will be supported with the development of a Business Case to ensure the sustainability of this role.
Promote suitability of ACP with recruitment of ACP Champions Through the identification of Clinical ACP Champions to facilitate ACP training, we aim to raise awareness of the benefits of ACP and in turn embed good practice across all settings.

Education Programme – ensuring a well-educated workforce has been and will remain a priority. Communication, including both foundation and advanced communication skills has remained a key component of the education work stream. Training is delivered in partnership with the third sector and feedback has already been evaluated positively. For example, over 90% of participants feel as though the training delivered will influence their practice.

Embed Advanced Care Planning across all settings in Gwent using the Triple E model We will continue to the roll out of the e-learning programme including the facilitation of workshops in order to raise public awareness of the benefits of ACP and increase the knowledge and skills to engage with ACP discussions
Continue delivery of foundation and advanced communication training We are committed to continuing the delivery of both foundation and advanced communication skills training for staff to support patients and families to make informed choices, embracing an integrated decision making approach.

Bereavement Services –Bereavement is associated with significant mental and physical health consequences, and risk factors for illness. The detrimental effects of long term, unresolved grief, are well-documented. Bereavement services help to reduce immediate physical and emotional distress while ameliorating long-term morbidities associated with unresolved grief. We recognise the importance of effectively supporting bereaved relatives from the initial time of death to improve experience. We will build upon the foundations of work already taking place across the Health Board to improve bereavement services across Gwent.

Review of existing Bereavement Services across Gwent
We are committed to improving both the equity and access to bereavement services in Gwent and will review the existing bereavement service offered across the Health Board and with third sector partners. Following on from the review, we will identify any gaps in provisions and determine what service change is required in order to provide a service that improves family and carer experience in compliance with NICE standards.

Value Based Outcome Measures – We are working at both a national and local level to identify a meaningful set of matrix, influenced by service reviews and audits for example National Audit of Care at the End of Life (NACEL). The aim is to develop an end-of-life performance dashboard that will provide meaningful, measurable data. This is a challenge that needs addressing in order to effectively evaluate the service. We will also continue the adoption, at pace and scale, of the 'Care Aims' model to truly embed 'what matters' principles and provide us with the evidence of feedback required to influence service plans and delivery. Additionally, we are committed to continuing with the participation in reviewing the options for Electronic Palliative Care Coordination Systems to improve information sharing.

Adoption of 'Care Aims' model
The Health Board will adopt, at scale, the Care Aims model across multi-disciplinary teams by truly embedding 'what matters' principles, improving patient experience, voice, value and choice. This will provide us with improved metrics for patience experience and evidence of feedback influencing service plans, delivery and improvement.

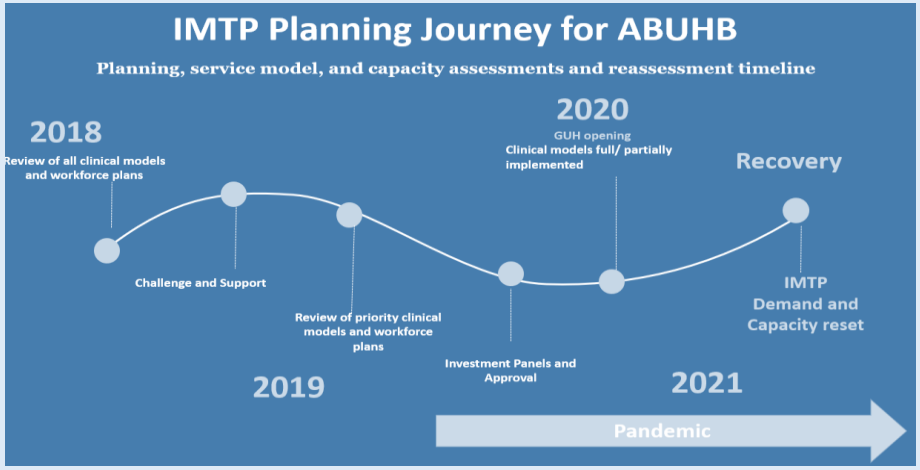
Continue engagement with the All Wales Advanced Care Plan (ACP) Strategic Group
We will continue to participate and review options for Electronic Palliative Care Coordination Systems. This aims to improve information sharing and improve patient choice to where they wish to be cared for and die through the completion of ACP.

OUR PLANNING LANDSCAPE 2022 - 2025

Consistent with Health and Social Care across Wales, our system has responded to the challenges of Covid -19. Uniquely at the same time we delivered substantial change to service models, workforce, the way we organise and delivery care consequent to opening the Grange University Hospital, a key enabler of our Clinical Futures Strategy.

As we learn to live with the virus and turn our attention to delivering a sustainable 'new normal' we recognise that the planning landscape has shifted. Traditional historic patterns of demand and capacity have changed therefore we need to understand what this means for our system consequently taking a scenario-based approach to how we plan services.

Last year our Annual Plan set out our ambition to deliver live, trusted, real-time data as the basis for planning and decision making. This year we are our building our IMTP on a better understanding of our system. Our organisational planning journey started in 2018 when clinical models were refreshed, regularly tested, and reviewed as part of implementing our new hospital system.
We have lived experience of how our system operates alongside learning from the pandemic and now is the time to undertake a reset of our demand and capacity system model.



Throughout successive pandemic waves the performance of our system has been volatile. By necessity, for much of the last 18 months, the NHS responded to the immediate Covid-19 challenges and maintained essential and urgent services, with routine and many of our population health programmes restricted or stood down. Consequently, we know: -

- the virus has taken a disproportionate toll on groups already facing the poorest health outcomes, economic and social consequences of measures to contain the virus has undoubtedly worsened these inequalities
- significant numbers of people are either waiting for or have yet to be referred for diagnosis and treatment for a wide range of conditions
- the pandemic hastening the widespread adoption of new technologies and innovative ways of delivering and receiving care
- public protection systems (across the UK and beyond) pre-pandemic lacked capacity, focus, ambition, and resilience, we had to build capacity and capability at pace early in the pandemic

The 'new normal' is unfolding, the full extent of what this will look like varies across individuals, communities, and services is unclear. When and how people will return to our system, their presenting health status (after months of inactivity, social isolation), acuity and stage of progression of their illness will vary.

Dynamic Planning – working with our data partner we have adopted a dynamic planning approach to understand the potential demand, risks, and capacity requirements of our system. Working with each clinical team by specialty using real time data, realistic workforce assumptions, emerging experience of how patients are returning to their services and known system constraints we have a clear understanding of:

- Our Starting point
- Predicted demand on our system (this includes known backlog, and a clinical assessment of unreferred needs in our communities)
- The capacity we need against what is available
- How much has changed and what is the new normal
- Most likely/realistic activity profiles in context of known constraints
- Potential impacts on population health
- A realistic 'most likely' scenario

Assumptions
• Clinical Prioritisation continues - this means focusing on the sickest patients first • Covid impact continues for first 6 months of this plan – this includes cleaning regimes, social distancing and PPE • Estate's capacity maintained at current level – this means the space available to us is constrained because of covid related measures • Workforce position will not improve substantially in short term – this means that the impact of recruitment challenges, staff wellbeing, sickness & absence rates, and returning workforce to their pre-pandemic duties will continue to be felt by our system • Impact of system changes are realised (e.g., urgent care programme) • Recovery activity will be sustained – this includes some insourcing solutions for Year 1 (2022/23)
Constraints
• Covid response continues – this includes provision of care for patients who are Covid^{+ve} (either as a primary or incidental presentation), Public Health Protection response TTP, vaccination and booster programmes • Infection Prevention and Control Measures, cleaning regimes, PPE, social distancing, Respiratory/non-Respiratory pathways remain in place • Reduced Social Care Capacity both domiciliary care packages and residential care • Workforce availability (health and social care) • Reliance on locum and agency and the impacts both +ve and -ve on system performance • Estates/infrastructure and capital for development

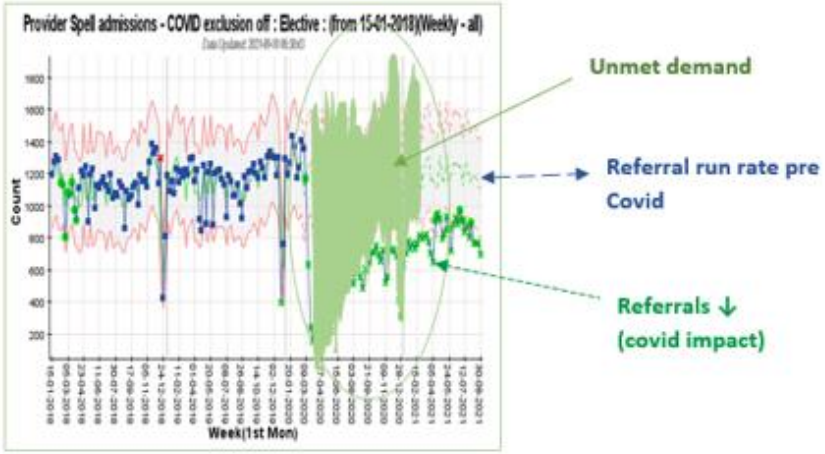
The outcome of this work has informed our Minimum Data Sets. Moreover, it is the baseline against which we will plan and review activity. We will do this for every specialty on a quarterly basis. This understanding of our system has allowed us to draw out our priorities for action.

Unreferred Demand It is important that the underderstanding of our system demand is not just built on historic profiles or our current waitng list profiles as we need to factor in the pandemic experience of potential unreferred demand. We have measured the patients who should have been referred to our system during the pandemic and calculated the gap as illustrated in Figure 1.

In order to understand the impact of unreferred demand on our system this data has been subject to clinical review (primary and secondary care) and enabled us to calculate the number of referrals that are likely to present to the system as underling health needs endure. Our scenario sees this unreferred demand

presenting during Year 1 of this planning cycle. We have factored this scenario into our demand and capacity assumptions on a specialty by specialty basis.

Figure 1 Unreferred Demand

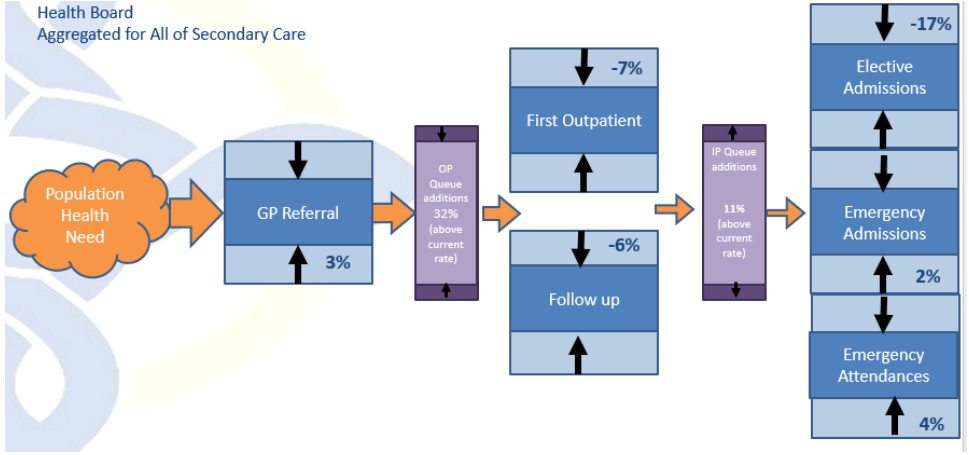


We have factored this scenario into our plans following consideration of two hypothesis;

Hypothesis	Consequence
1. Referral rates rise sharply as access to primary care eases for those people who had not presented over the past 18/24 months	Further increases in secondary care waiting lists and longer waiting times for patients as the gap between demand and capacity widens.
2. People do not access services, their health status deteriorates, they present later in their disease trajectories, with higher acutiy needs and often as emergencies	Population health worsens, the system is skewed toward reactive rather than planned and proactive (i.e., with capacity to focus on up-stream prevention and earlier interventions). This would perpetuate the cycle of widening health inequalities with consquences that will impact on our system for decades to come.

Whilst this hypothsis may not play out in this way it is important we plan for the totality of potential demand on our system. It is also an important reminder that we also need to ensure preventative services are in place to support further deterioration of health conditions.

Demand and Capacity from the clinical sessions we have developed a most likely activity scenario for 22/23, to understand the projected percentage difference in activity numbers compared to pre-Covid activity. This has informed our areas of transformation and work to restore activity levels and recovery. As these are implemented we will be able to measure the changes an understand the effect on our projections.

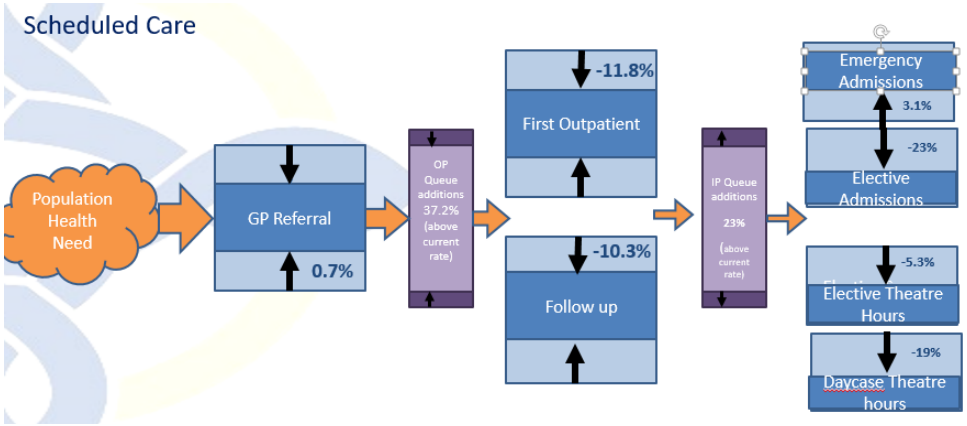


Overall GP referrals will return to or slightly above pre-Covid levels, although this will vary specialty by specialty. Demand for 2022/23 which includes referrals, backlogs that have deteriorated over the course of the pandemic and unreferred demand sees additions to the waiting lists for outpatients potentially growing by up to 32% at a time where outpatient capacity is constrained through a combination of estate, staffing and Covid 19 constraints.

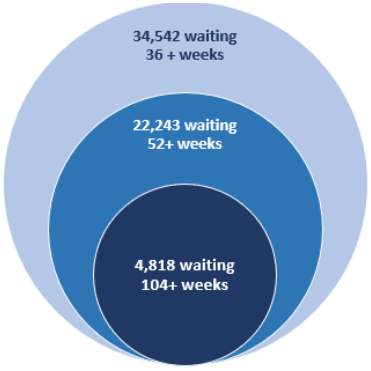
Already we are seeing patients presenting with higher acuity needs, more are presenting as emergency admissions for medical and surgical specialties. This presents significant challenges for our planned care capacity; we anticipate

additions to queues for inpatient treatments across our system will potentially grow by 11%.
This high-level aggregated overview masks differences across clinical services with summaries shown below for Medicine and Women and Children's Services.

Schedule Care or planned care services rely more heavily on face-to-face consultations than other services. Consequently, they are impacted significantly by constrained outpatient capacity resulting from limited physical space, workforce and sustained infection prevention and control measures as illustrated below. Reduced capacity will result in more additions to the outpatient waiting list.

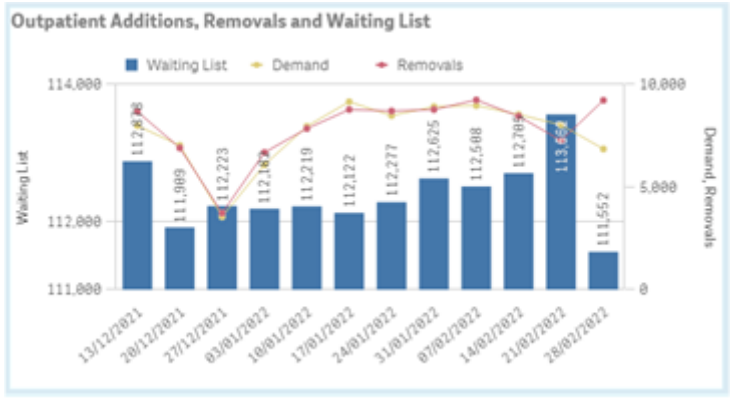


Inpatient and treatment elective/planned capacity is also constrained. We anticipate the increases in emergency surgery presentations will continue into 2022/23, with a 3.1% in emergency admissions compared with pre-Covid levels. The balance of planned to emergency has a material impact on inpatient capacity. This is compounded by further constraints in respect of elective theatre hours and day case theatre hours driven largely by workforce constraints. Reduced capacity for elective surgery will result in higher numbers of people waiting longer.

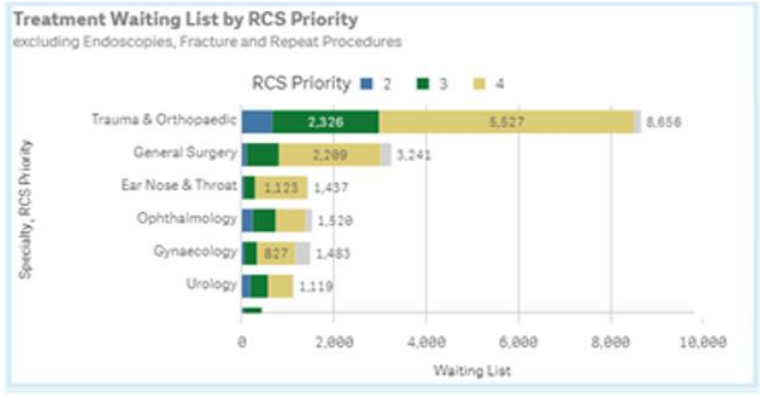


The RTT position coming into 2022/23 is shown opposite. As we seek to sustainably deliver routine elective care, we will deliver more activity in 2022/23, however, our backlog position together with the resurgence of unreferred demand presents a stark challenge that cannot realistically be addressed in the first year of this planning cycle.

The scale of the challenge is enormous, in January 2022, **111,552** people were on the outpatient waiting lists, with **17,703** on the waiting list for inpatient treatment.



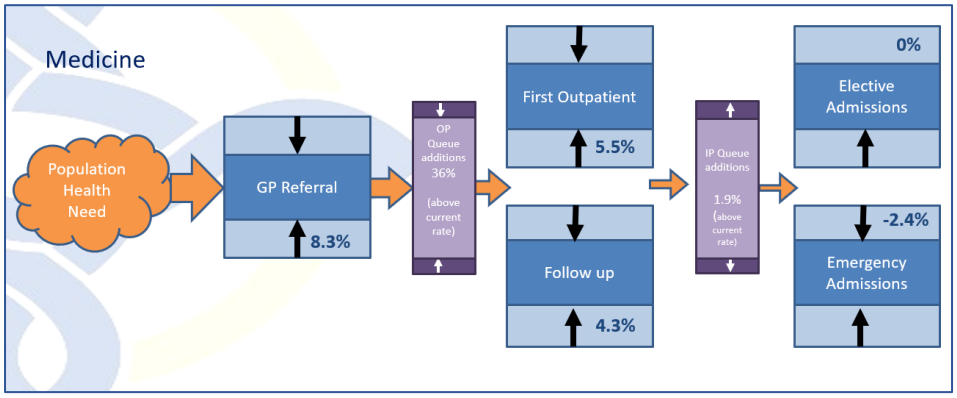
The current waiting list position for treatment for our most impacted specialties is shown opposite, categorised by clinical prioritisation.



Even if our system were able to 'turn-on' pre-pandemic capacity quickly it would not be sufficient to meet the backlog, 'business as usual' referral rates and unreferred demand. The reality is that waiting times will remain challenging, our system will need to have an offer for patients who are waiting for long period of time to access elective care.

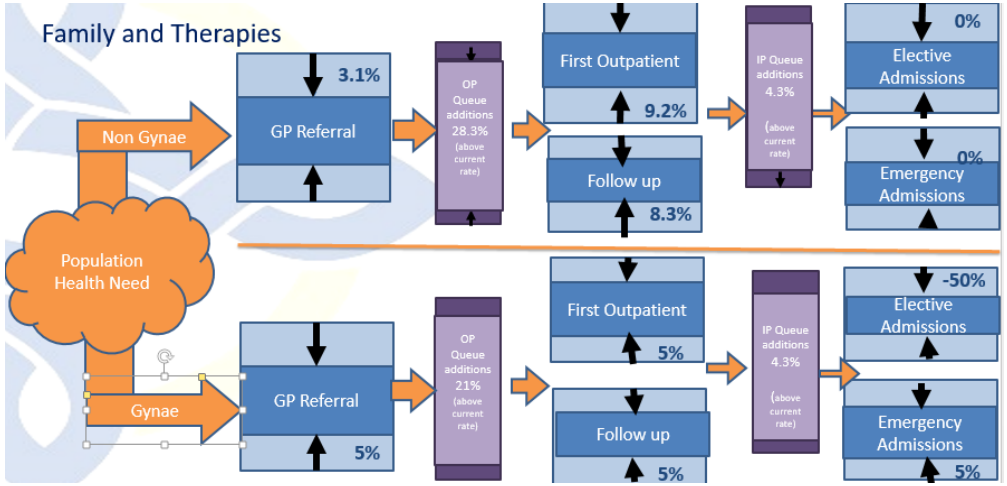
Outpatient and Inpatient waits need to be a key improvement platform for the Health Board, we cannot maintain the status quo in relation to how we organise, utilise, and deliver scheduled care services.

Medical specialties are already experiencing a return to pre-Covid referral rates and are anticipated to rise further by April 2022 (8.3% above pre-Covid levels). Many of our medical specialties have embraced new ways of working, which provides more outpatient capacity for new and follow-up. Despite increased outpatient capacity this will not be sufficient to address increased demand and waiting times will continue to rise.



We anticipate that Emergency Attendances will continue to grow by at least 4% compared to pre-Covid levels, the growth in numbers presents challenges on its own, however increasing acuity, late presentations, workforce availability (across the health and care system), together with infection prevention and control measures compound and heighten these.

Women and Children's services cover a wide range of services and is difficult to aggregate, nonetheless this overview demonstrates the impact of the transformation from inpatient to outpatient care that has been delivered over the past year. Gynaecology services are more akin to scheduled/planned care services and the impact that Covid-19 has had on service delivery is therefore different. This overview therefore illustrates non-gynaecology and gynaecology separately.



Referral rates will continue to grow with anticipated to increase of 5% next year. The assumptions anticipate clinical prioritisation continues for all or part of 2022/23, for gynaecology this would lead to a marked rise in additions to the inpatient additional queue (21%) as only a small number of service fall in the top clinical priority categories. The service is already taking action with the adoption of ambulatory approaches as alternatives to theatre, which will need to be optimised in this plan.

Mental Health. We have seen a lot of variability in referrals to our mental health services over the course of the last year. We anticipate substantial growth in referrals for children and young people, the effects of which are being experienced by our services now, and for our older adults including people with dementia.

Waiting lists have grown peaking at 9,800 in the autumn and now operating at 9,200. Over half of these people are waiting for a first contact with either Primary

Care or Adult Mental Health Services. We anticipate that most patients on this waiting list will require an intervention, this is the pattern that has been evident throughout the pandemic.

Our service model has developed over the past year to include The Sanctuary, Shared House, and Crisis House resulting in a reduction of inpatient admissions. However, in the same period the service has seen an increase in the acuity of patients admitted, as measured by the increase in MH Act referrals and enhanced care measures.

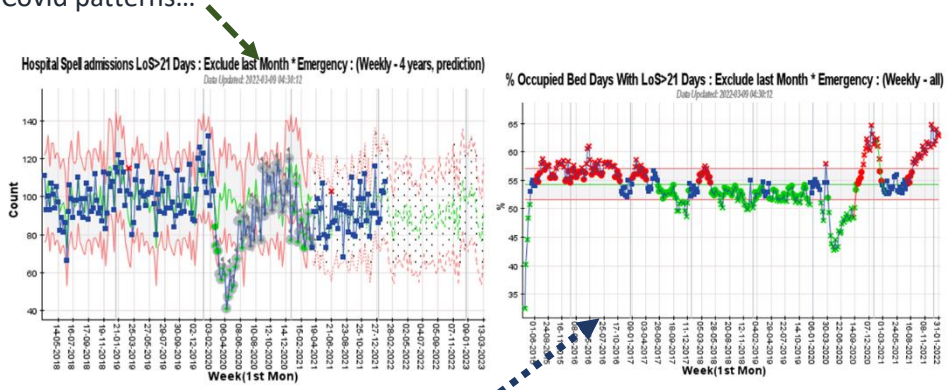
Bed Plan one of the advantages of developing our live demand and capacity tool is we can derive and align necessary capacity in our bed plan or theatre services. With each successive pandemic wave the Health Board has adapted its bed plan to meet the changing needs of patients in our system. The Annual Plan 2021/22 acknowledged that the intended Clinical Futures Bed Plan of **1,478** was not deliverable in year and agreed a transitional bed plan of 1,589 beds.

	2022/23 Draft Bed Plan	*2021/22 Bed Plan	Diff	Clinical Futures Bed Plan	Diff
Urgent Care*	54	54	0	66	-12
Medicine	731	758	-27	507	224
Scheduled Care	352	344	8	386	-34
Family & Therapies	185	179	6	184	1
Community	255	254	1	335	-80
Total	**1577**	**1589**	-12	**1478**	99

12 months later, we find patient acuity is increasing and system flow is and will continue to be constrained for some time. We recognise that the basis of our Clinical Futures Bed plan has changed, and the service transformation planned to support it (delivering more care in the community) not yet in place to meet the current needs of our population. Our system needs 99 additional (above CF baseline) staffed beds in 2022/23 to meet anticipated demand within our existing models of care.

We recognise the changes in how our beds are used post pandemic presents a further challenge with managing flow and the recovery agenda.

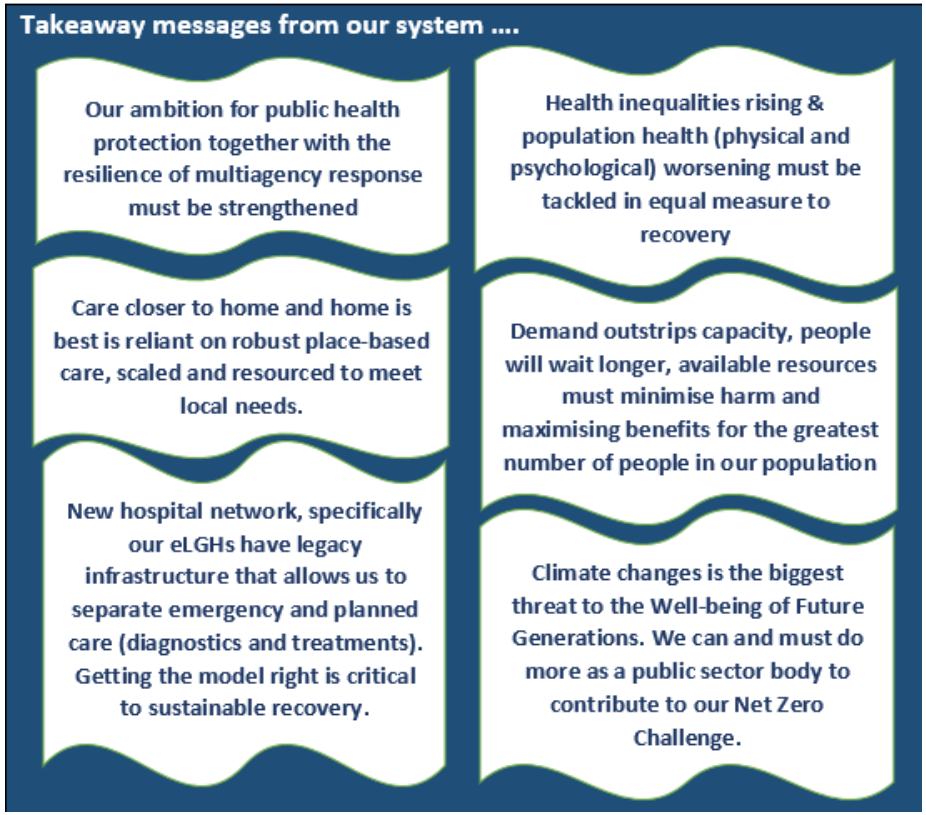
Whilst the numbers admitted who stay over 21 days is following the similar pre Covid patterns…



The percentage of beds these patients are using has significantly increased. This drives the focus of our discharge improvement work and the continued work with our Local Authority and Social Care partners.

Our Care of the Elderly service model is driving the need for additional inpatient capacity which present associated workforce challenges. Increasingly older people are presenting late, with more complex needs into a part of our system that 'medicalises' care. Our current medicalised model of service for these patients will need to develop to focus on reablement and care closer to home to deliver better benefits for our patients and our system.

Understanding our system through data has enabled us to identify specific areas where we need to make a concerted effort to change, both to better meet the needs of our population and create a more robust and sustainable system. Planned actions are based on a robust understanding of our system. This enables us to have a clear line of sight on the potential impacts of the approach and choices we make to address key challenges in our system on population health and has pointed us to a focused set of actions that, when addressed, will contribute most to optimising capacity, improving outcomes, experience and minimising harm. The next section of the plan sets out the Clinical Futures Programmes which will respond to these challenges.



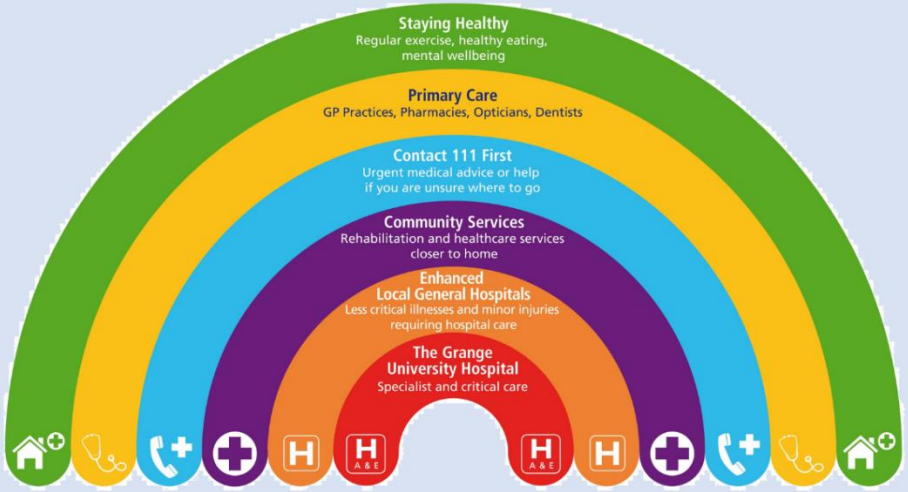
Delivery of Whole System Transformation

Dyfodol Clinigol Clinical Futures

Our Clinical Futures Strategy set out our ambition to transform our healthcare system and laid the foundations for change.

We have adopted a rigorous and systematic programme management approach to support the delivery of key components of our strategy. During the pandemic the focus was on the support and development of service models for our new hospital system, and the opening of the Grange University Hospital. Our learning from the Clinical Futures programme of work which allowed us to open the Grange University Hospital is that clear and consistent programme arrangements are important to supporting delivery.

For this planning cycle, we have refocused our Clinical Futures Team, to support the delivery of a finite number of organisational priorities in response to the challenges identified through the dynamic planning model.



These key priorities which, based on our understanding of our system, will deliver the biggest impact and improve the sustainability of our system, are:

1. Public Health Protection and Population Health Improvement
2. Accelerated Cluster Development
3. Redesigning Services for Older People
4. Mental Health Transformation
5. Planned Care Recovery
6. Transforming Cancer Services
7. Urgent Care Transformation
8. Enhanced local General Hospital Network
9. Net Zero – Decarbonisation

Many of these priorities are embedded in our Life Course Approach. However, as we move from a pandemic to an endemic scenario we are emerging as a very different system to the one we had planned as part of our Clinical Futures Strategy. Learning from the experience of the last 18 months we recognised that there are opportunities that will enable us to create a more resilient and sustainable system. Consequently, several our priorities transcend but are integral to our life-course approach, and form part of the Clinical Futures Programme for 2022/25.

Life Course Priorities	Pan Life-Course Priorities
❖ Population Health Improvement ❖ Redesigning Services for Older People ❖ Mental Health Transformation ❖ Planned Care Recovery ❖ Transforming Cancer Services ❖ Urgent Care Transformation	❖ Accelerated Cluster Development ❖ Public Health Protection ❖ Enhanced local General Hospital Network ❖ Net Zero – Decarbonisation

The culture, values and consistent approach to change are essential to delivery alongside consistent clinical and operational leadership. The Clinical Futures PMO team bring programme management expertise and rigour to above key priorities within our life course approach that if unchanged will have a detrimental impact on the sustainability of our systems.

PUBLIC HEALTH PROTECTION

Working together to respond to Covid-19 the maturity of relationships between public sector organisations has grown. The virus has shone a spotlight on the inadequate levels of preparedness (across the UK and much of the world) for the challenges faced by our population, our workforce, and our services. The Gwent Test, Trace, Protect Service (GTTPS) has been operational since June 2020, tracing over 155,000 positive Covid-19 cases across Gwent limiting the spread of Covid-19 and, ultimately, helping to save lives. Funding for this multi-agency service comes to an end on 30th June 2022.

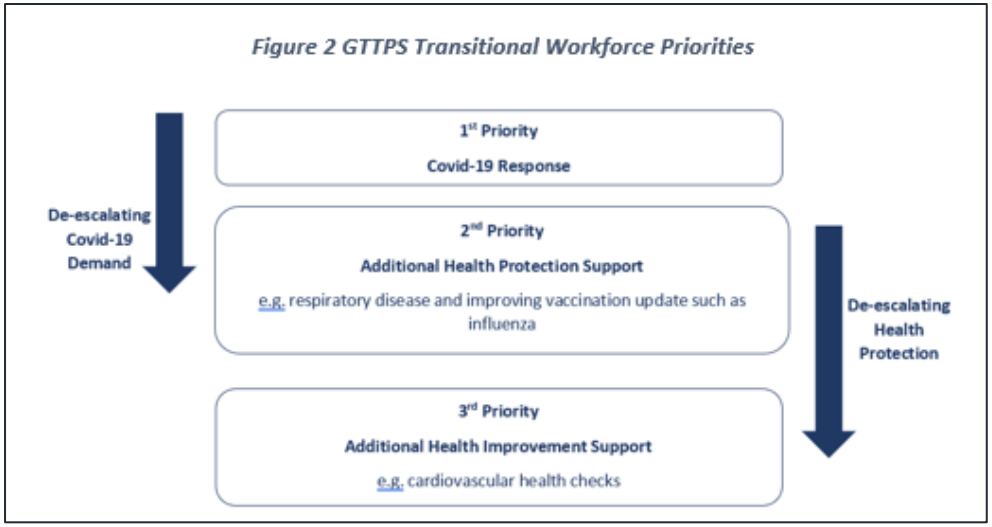
We recognised that within our system the level of ambition for Public Health Protection including preparedness for the management of infectious outbreaks, contact tracing, protecting most vulnerable populations and workforce, effective surveillance and higher vaccination uptake must be stronger.

The Health Board is working with Local Authority partners to develop a business case that will transition the GTTPS workforce to continue to protect population health and to contribute to the improvement of population health outcomes.

Whilst we anticipate a longer-term reduction in transmission of Covid-19, we recognise the need for ongoing resilience due to sustained, relatively lower levels of transmission including the capacity to respond to the possibility of hyper-endemic levels of the virus. At this stage, we simply do not know what the future holds with respect to Covid-19 and how we will need to respond, but the learning from TTP indicates that we can manage respiratory diseases more effectively in future through integrated working across Local Authorities and the Health Board.

Having to prioritise Covid-19 has come at the cost of having to redeploy resources away from programmed population health work. To help address this the flexible retained workforce would be trained over the course of Year 1 (March 2022-April 23) in a range of population health skills.

The priorities for the transitioned workforce are responding to Covid-19 as required, providing additional health protection support and providing additional health improvement programme support. The focus of the transitioned workforce priorities is illustrated in Figure 2.



As well as providing population health protection and supporting population health, the Service would also create entry level jobs whilst supporting a progression pathway as part of the foundation economy in our local communities.

Population Health Improvement (put in hyperlink) delivering a Healthier Gwent sets out our approach to reducing health inequalities and improving population health. Our ambition to become a Marmot Region and as a public sector collectively address the determinants of health will be incorporated into our long-term strategy.

ACCELERATED CLUSTER DEVELOPMENT

The Primary Care Model for Wales sets out how primary and community health care services will work within the whole system to deliver a place-based care. Cluster working is at the core of this bringing together local health and care services to ensure care is better co-ordinated to promote the wellbeing of people and communities.

Each of our Neighbourhood Care Networks (clusters) is developing individual integrated medium-term plans that set out priority areas for 2022/23 that will be delivered through a place-based care approach, with a focus on Covid Recovery, Immunisation and Vaccination, GMS Access, Psychological Wellbeing, Diabetes Prevention, Obesity Pathway and MSK**.** Strengthening our model for place-based care is at the heart of our plans to redesign community services for older people.

As the Primary Care Model for Wales has matured the focus has turned to the establishment of pan-cluster planning at Local Authority Level, responsible for population needs assessment, gap analysis, development of costed plans and commissioning services that should only be delivered at a Pan-Cluster Level (for example direct access physiotherapy or enhanced nursing home care as opposed to diabetes prevention that is place based care).

Our focus in 2022/23 will be establishing the foundations for pan cluster groups and we will:

Create pan cluster groups alignment with RPB/Integrated Care Networks/NCNs, agree the governance framework that underpins these arrangements
Identify and secure the substructure needed to support delivery of pan-cluster groups currently our substructure supporting our NCNs consists of 2 GP sessions/week to oversee the delivery of NCN plans and to link with specialties to improve patient pathways and process. They are supported by a small team within the Division. This will not be sufficient to support the new arrangements and functions (needs assessment, cluster level costed plans, commissioning) required from Pan-Cluster Groups.

NCNs at different stages of maturity, where ready to move on accelerated cluster development an agreed process/plan to make that happen needs to be in place.

E LGH HOSPITAL NETWORK

The opening of the Grange University Hospital has enabled us to deliver our planned new hospital network, that now offers opportunities for us optimise our recovery from the pandemic, modernise our hospital system and create a more resilient and sustainable system of care.

Our Clinical Futures Strategy set out to rebalance our system of care by delivering

most care close to home, creating a network of local hospitals providing routine diagnostic, treatment and rehabilitation services, and consolidating specialist and critical care services in a purpose build Specialist and Critical Care Centre (now the Grange University Hospital).

The pandemic has had a massive impact on our communities, our staff and our services. We have responded to patients suffering from Covid-19, maintained essential services, delivered mass vaccination and booster programmes, and kept providing as many services as possible. During this period, waiting lists for routine planned care have grown and waiting times increased markedly. As we have begun re-set referrals have increased and waiting times for some specialties are significantly higher than pre-pandemic rates. The impact on people waiting for diagnosis, or life impacting care and treatment is enormous.

One year on from the opening of the Grange University Hospital our attention is focused on the role of our wider hospital network. The legacy infrastructure from our District General Hospital estate supports the separation of emergency and planned patient flows between our hospitals. It gives us the opportunity to align our workforce to plan for and deliver a more sustainable re-start of services to meet the needs of our population.

Our Local General Hospital (eLGH) network sites will focus on planned surgical treatment with emergency services provided centrally and consistently at the Grange. This will enable us to protect elective capacity and allow us to re-focus, optimise and transform service models to protect planned care elective capacity. We are revisiting the original Clinical Futures eLGH model in the context of our system in 2022, and what our infrastructure will support in respect of increasing planned care capacity not only for our population, but for neighbouring populations too.

In addition to the provision of planned care our eLGHs also remain an important part of our urgent and emergency care system. They provide minor injuries, Urgent Primary Care services and medical assessment for lower acuity as part of an 'Integrated Front Door' to provide Same Day Emergency Care (SDEC) together with the Grange University Hospital Specialist and Emergency services. The Flow Centre is now a core part of our system, and we will enhance its role in facilitating non-GUH emergency care options for patients through our eLGH network.

We will confirm and/or redefine core and enhanced functions for each hospital and ensure that our population understand what this means for them, how they will access urgent/emergency care, diagnostics or planned care service, for recovery and for longer term sustainability of our system. Immediate Priorities that will impact in the short term on our capacity to make progress in post pandemic recovery are:

Protect and Optimise Elective Capacity • High volume day case centre of excellence @ NHH to increase capacity • Deliver more inpatient procedures @ RGH ▪ Robust hospital at night model ▪ Robust hospital transfer model ▪ Increase Post Operative Care Capacity (POCU) ▪ Anaesthetic Protocols (increase the number and type of procedures delivered (safely) at RGH where elective capacity can be protected) • Ambulatory Surgery (gynaecology, orthopaedics, and general surgery) • Endoscopy (insourcing and business case to support expansion of endoscopy capacity)
Breast Unit • Embed service models in readiness for the Breast Unit @ YYF.
Urgent Care/Flow ▪ Integrated Front door for eLGHs sits providing enhanced Same Day Emergency Care and links to our Flow Centre and GUH Emergency Department
Staffing ▪ Sustainable staffing models for eLGHs underpinning core and enhanced functions for our eLGH network

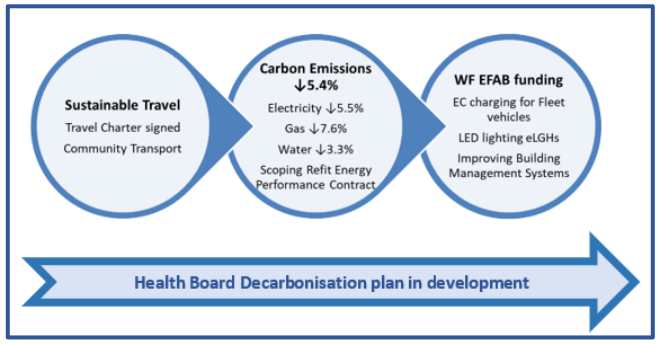
NET ZERO - DECARBONISATION

Welsh Government declared a 'Climate Emergency' in 2019 and set out their ambition that the public sectors in Wales should be in a carbon 'Net Zero' position by 2030. The response to the pandemic has demonstrated how significant and impactful changes can be enforced into the day-to-day life of the public and the approach to work, for example remote working. Our ambition, now, is for a sustainable and healthy recovery with concerted actions within and across our system to tackle the climate emergency.

Whilst we have made good progress over the past year as illustrated below the NHS Wales Decarbonisation Strategic Delivery Plan (2021) set out more opportunities

to look again at building and energy use as well as procurement, travel, and other emission sources across the NHS.

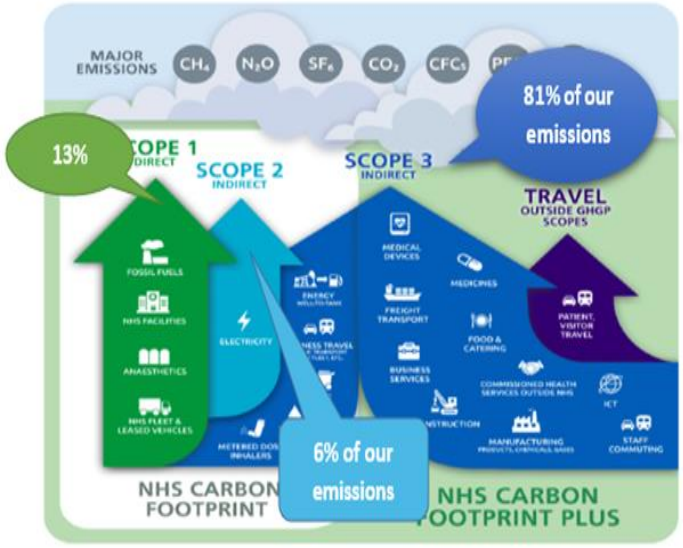
Environmental Sustainability Update ABUHB November 2021



Note: Our Decarbonisation – Net Zero Action Plan will supersede the Estates Energy Strategy and Energy Policy to align to national objectives and net zero carbon targets.

The Decarbonisation Strategic Plan clearly set out the enormity of the challenge, the unique context for action offered in Wales through The Wellbeing of Future Generations. Makes clear our commitment to reduce the environmental impact of climate change and our responsibility to drive the wider benefits of actions to reduction emissions and pollution to improve population health.

The Carbon Footprint for NHS Wales calculated for 2018/19 as 1 million tons of CO2 emissions, 14% of which is attributable to us in Aneurin Bevan University Health Board.



When we consider the proportion of our emissions due to direct, indirect (energy) and other indirect causes it becomes clear that we need to broaden our horizons moving beyond our estate's focus, to developing a systematic approach and a culture of sustainability that enables us to play our full part in tackling the wider determinants of climate change that are with our grasp.

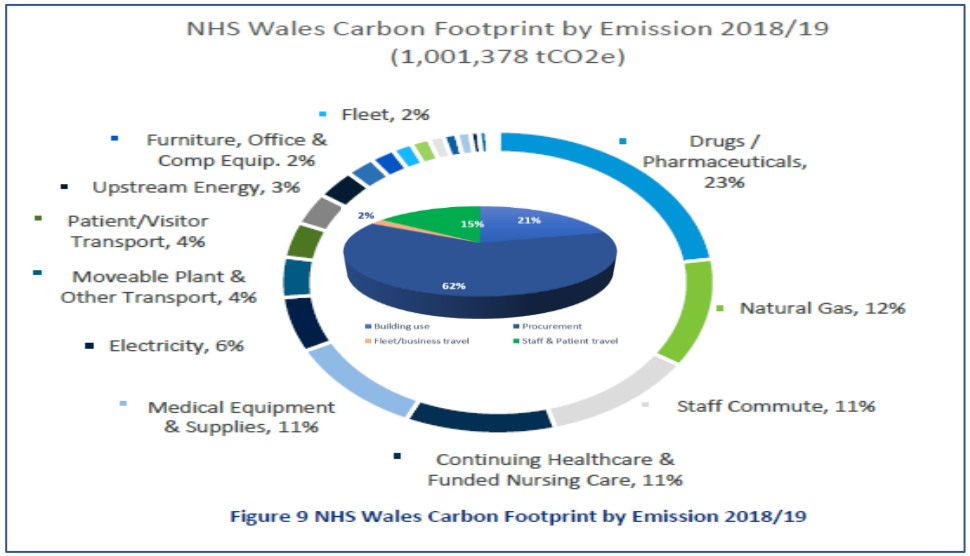


Figure 9 NHS Wales Carbon Footprint by Emission 2018/19

Scope 3, other indirect emissions associated with the supply chain are a good example, they choices we make about the drugs we use and how we procure them, and similarly medical equipment and supplies accounts for 34% of our emissions.

As part of the process to finalise our Strategic Decarbonisation and Net Zero Action Plan, we are seeking to establish firm foundations to support delivery, through our internal audit mechanisms we are evaluating the systems and control in place across the organisation including:

- Governance (accountability, training, communications to embed change)
- Localised strategies (aligns decarbonisation action plan with organisational and service strategies, supported by guidance/procedures)
- Monitoring and reporting (ranking feasible initiatives, target setting, sourcing data for accurate calculations, reporting progress)

- Collaboration (external resource, expertise, leadership, implement All Wales exemplars)
- Embedding Change (building and new builds; Transport, Procurement, adoption of new technology)

We are scoping how we are applying local conditions to the **46 initiatives** set out in the National Plan. This will be a **live Decarbonisation and Net Zero action plan** that can flex with changes to objectives, targets and progress.

We recognise that achieving net zero is everyone's business, touching all parts of our system, from the management of the estate to approaches to how we will sustainably organise, procure, and deliver healthcare.

KEY ENABLERS

Enablers are the factors which increase the probability of successful implementation of key priorities. We know that implementation is inseparable from context within the organisation, across our communities and the wider system. Our goal is to deliver sustainable changes to our system, this means that 'not only have the process and outcome changed, but the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed as well'.

1. EXPERIENCE, QUALITY AND SAFETY

Experience, quality, and safety is at the centre of our work to secure improvements in the quality of care and services we deliver and to improve outcomes for the population we serve. We aim to organise care around the individual, so that every person using our services, whether at home, in their community, or in a hospital has a positive experience. To do this experience, quality, and safety is a core component of all our plans, both for the service we provide now, and for the changes we are proposing to our models of care from small changes in one service to substantial redesign that necessary is to deliver a sustainable and resilient health and care system in the wake of the Covid-19 pandemic.

The Health and Social Care (Quality & Engagement) (Wales) Act 2020 embodies an enhanced legal duty not only to deliver quality care but to secure improvements in the quality of services provided and to deliver improved outcomes for the people of Wales. It strengthens the voice of the citizen and places a duty of candour on NHS organisations and Welsh Government. Through our Quality Assurance Framework (2021) we have firm foundations to support our adoption of these new duties as and when they are enacted.

Enabling a Safety Culture - developing a robust patient safety culture requires a systems wide approach that minimises preventable harm, improves outcomes and experience and eliminates variation and waste. Embedding a standardised clinical governance system that functions from operational level to the board, designed around the NHS Wales Health and Care Standards, and, aligned to the integrated decision making (Care Aims) Framework will provide the organisation with assurance around quality and risk. Key areas for delivery include:

• Set out the core evidence that will be considered by each Committee (service/division to sub-committee of board levels) to provide assurance on delivery of Health and Care Standards (by December 2023) • Developing a corporate clinical audit plan to address any gaps in assurance • Annual Report for each Health and Care Standard, scheduled for consideration by Patient Quality Safety and Outcomes Committee (PQSOC) • Strengthened assurance mechanisms for commission services
• Reviewing Quality Safety and Patient Experience structures within divisions/directorates, formalising lines of responsibility, accountability, escalation, and assurance by June 2022. • Standardising resources, role profiles and appraisal arrangements for QPS leads • Standardised PQS agendas (evidence and risk based)
• Clearly defining the support from corporate teams associated with the quality safety and patient experience agenda and setting the expectation.
• Preparedness for the Quality and Engagement Act including the Duty of Candour and Duty of Quality as they are published • Introducing the integrated decision framework with Board development and the identification of priority areas for implementation • Ensuring that the groups and committees across the Health Board are able to be responsive in promoting quality and patient safety at all levels of the organisation

A Learning Organisation - is one where people continually expand their capacity to develop and improve; this can be on an individual, team or organisational level. Quality, Safety and Patient Experience should be integral in informing a direction of travel in learning and education and should support a responsive approach in relation to emerging themes and trends. This should be undertaken through the principles of the integrated decision making and co-production. Key areas for delivery include:

Identification of key quality and patient safety priorities and sources of information, to inform the learning and education agenda guided by the views of service users
Collaboration between corporate and educational teams to support the development of health professionals around key quality and safety priorities
Facilitation of multi professional approaches to education aligned to quality, safety and patient experience
Representation of learning and education on key quality and patient safety groups across the organisation

To facilitate divisions and directorates to prepare a standardised annual improvement strategy based on information collated from review of complaints, incidents, surveys and audits
To build capacity within teams to develop co-produced digital patient stories to support listening and learning
Standardisation of training and education and competency records to avoid unwarranted variation in education approaches
Introducing a Covid Investigation Team to review cases of nosocomial transmission to identify breaches and ensure learning

A Just Culture - considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution or reprisal.

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by ensuring staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the risk of the same errors reoccurring can be minimised is a powerful tool in promoting cultural change.

Understanding the role of unconscious bias when making decisions will help ensure all staff are consistently treated equally and fairly no matter what their staff group, profession or background. Key areas for delivery include:

To embed the use of the NHS Just Culture Guide in parallel with patient safety investigations when there is suggestion that a member of staff requires support or management to work safely
To formalise an approach to supporting staff involved in patient safety incidents by June 2022
To further promulgate a safe reporting culture
To adopt national standards for consistent, high-quality reviews
To implement the Duty of Candour and Duty of Quality and to extrapolate learning from incidents and concerns • To develop a learning bulleting to share learning across the organisation • To develop and publish a quality report as set out by Welsh Government

Data for Quality and Improvement - both qualitative and quantitative data are critical in understanding the quality-of-care provision and in evaluating and guiding improvement. Increasing the availability of data and the capability and capacity to analyse, understand and utilise the data will ensure a focus on quality. Key areas for delivery include:

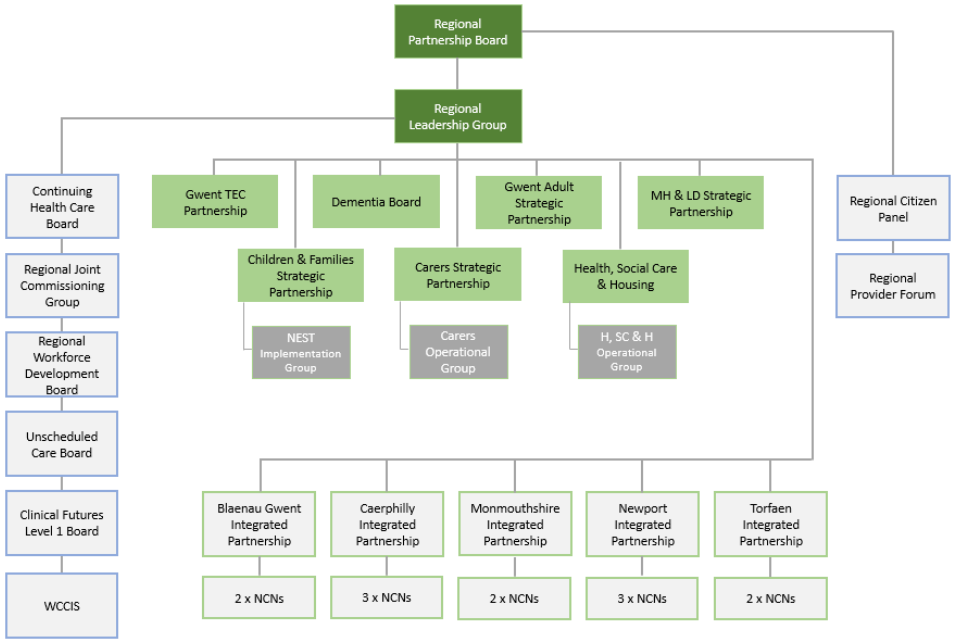
To increase the capacity and capability of divisions to utilise data that underpins quality and patient safety priorities
To increase the capacity and capability of the corporate Quality and Patient Safety Team to utilise data to support their agenda
To develop a quality and patient safety dashboard with meaningful quality indicators that drives improvement and provides assurance
To provide quantitative evidence that provides assurance in relation to the NHS Wales Health and Care Standards, this will be undertaken in line with the national review of Health and Care Standards.
To introduce the Once for Wales Concerns Management System (OFW) to capture accessible real time feedback from our service users.
To introduce an electronic patient feedback system to capture real time patient experience feedback from people accessing our services
To introduce and publish 'You Said, We Did' information to support the Duty of Candour

2. PARTNERSHIP FIRST

Delivering services in partnership across Gwent is a key enabler in this plan. Our partnership arrangements extend across multiple forums, with a range of supporting structures to enable collaborative and integrated approaches. Strategically aligned, we have seven thematic strategic partnerships, five Integrated Service Boards at a county level, and eleven Neighbourhood Care Networks. This sub-structure forms a foundation that will be strengthened through course of this IMTP delivery to respond to the needs identified within this plan and will see alignment of the Regional Partnership Board and the Accelerated Cluster Development activities to ensure a systematic approach to regional and place based delivery.

Within this partnership landscape we work with a wide range or organisations from health, social care, and social value sectors to support collaborative and integrated approaches and the delivery of the partnership. The statutory requirements of our Regional Partnership Board is a focus on early intervention and prevention, and the joint approaches for a number of our vulnerable population groups with care

needs. There are a range of policy drivers that shape our collaborative efforts, including the Wellbeing of Future Generations Act, the Social Services and Wellbeing Act, and the more recent A Healthier Wales national plan.

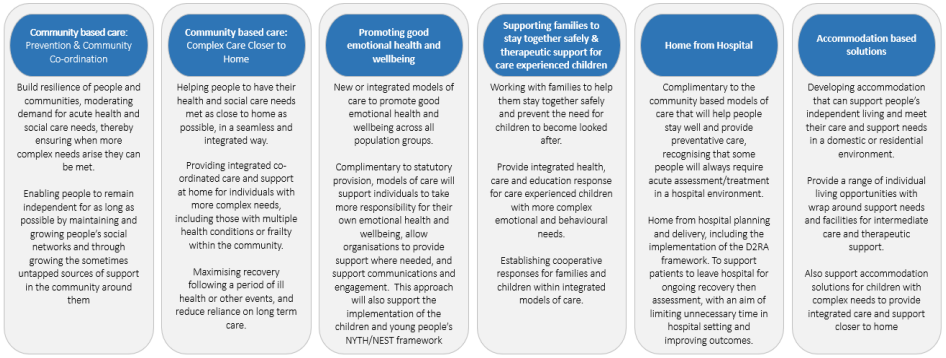


We will be working closely with our partners in developing and delivering solutions that support our vulnerable population groups, as identified within partnership guidance.

- Older people with complex needs
- People living with Dementia
- Unpaid carers, including young carers
- People with learning disabilities and neurodevelopmental conditions
- Children with complex needs
- People with emotional and mental health wellbeing needs

Refreshed guidance for Regional Partnership Boards introduces integrated models of care that will be developed and embedded throughout the period of the IMTP.

This approach will see our partnerships expand across Wales to share learning and best practice, facilitated by a range of facilitated Communities of Practice.



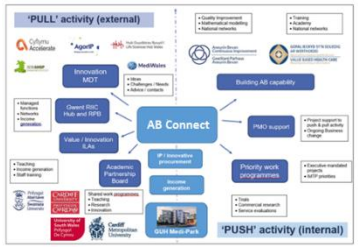
Aligned and complimentary to the Whole System programme approach via the clinical futures team, a range of RPB Strategic Programmes will contribute to the delivery of the priority areas identified within this plan, with particular emphasis on alignment as follows:

Priority 2: Getting it right for children and young adults	Building on the progress made to date, a key focus for our partnership is the implementation of the national NYTH/NEST framework: aligning our system to support children and families to remain together safely, provide emotional health and wellbeing support for children and young people with complex needs, and support seamless transition across our partnership organisations
Priority 3: Adults in Gwent Live Healthily and Age Well	Redefining a seamless connected communities model that embeds the Integrated Wellbeing Networks as a key asset-based development enabler. Supporting our population groups, to maintain independence and connect with their communities to reduce social isolation and improve wellbeing.
Priority 4: Older adults are support to live well and independently	Developing joint approaches to providing complex care close to home for individuals with complex needs to both avoid hospital admission where appropriate, and support rehabilitation and recovery close to home. Our dementia programme will also provide tailored support for people to live well with dementia and receive increased support as and when needed through their dementia journey.
Priority 5: Dying well as part of life	Working with partners across health, social care and care homes through our strategic programmes will support advanced care planning as early as possible in a person's journey, with a particular emphasis within our Dementia programme on this priority area. Our partnership dementia education programme will support workforce development and our ongoing collaboration with the third sector to provide bereavement and advocacy support.

As further enablers to partnership working, technology enabled care and integrated data systems will form a key consideration within our strategic

programmes to develop joint and integrated solutions for our patients and population groups.

3. RESEARCH, INNOVATION, IMPROVEMENT AND VALUE (RIIV)



building research, innovation, improvement, and value capacity within the Health Board

We have invested in and supported the development of Research, Improvement, Innovation and Value Based Healthcare to build firm foundations to enable the organisation to think and work in different and more effective ways. Until now, each of these functions had discrete portfolios, this year in response to recommendations set out in 'A Healthier Wales' and in line with the National Clinical Framework we have brough them together (**AB Connect**) with the shared purpose of supporting our system to develop new knowledge and understanding, continuously improve, think, and work in new and diverse ways, with the goal of increasing value across the range of healthcare activity provided to and for our population.

As a University Health Board, we have and continue to strengthen the links between research, innovation, improvement and value with education, organisational development and provision of health and care services. Our Triennial Review – University Health Board Status (March 2021) sets out what we had achieved through our University Status.

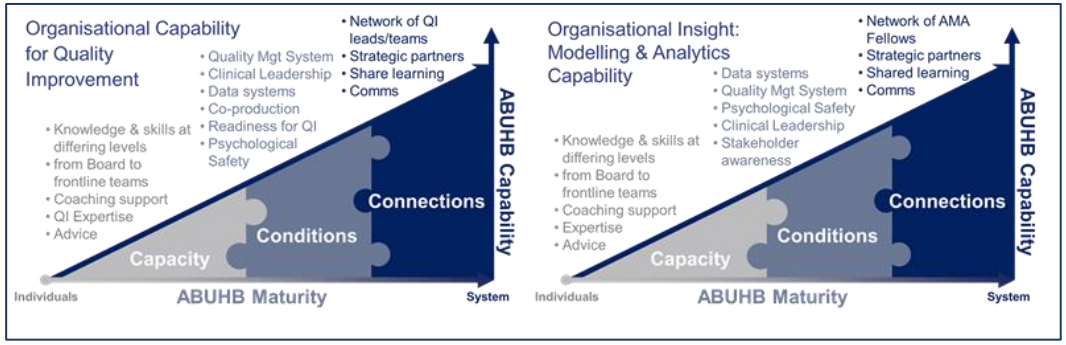
The everchanging landscape, not least as we emerge from the pandemic, heightens our ambition to collaborate and innovate with our partners and to capitalise on opportunities to translate new understandings that enable us to optimise how we use the resources available to us to improve health outcomes. We seek to do this through our Life Course Based Outcomes approach to delivering a sustainable system of care by

- driving value and improvement throughout our strategic priorities including service transformation and redesign, joint public sector (RPB); regional (SEW) and national change programmes.
- enabling frontline teams to take their ideas forward for the benefit of patients and staff; and,
- developing fruitful working partnerships with external bodies

We believe that an understanding and measurement of value should run through everything that we do, and Quality Improvement a day-to-day activity, part of how teams work and develop their services, with good data bringing insight to support decision making. This is the engine that drives a culture of learning and improvement.

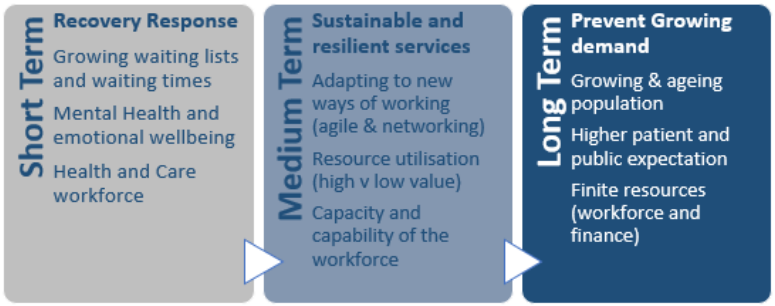
AB Connect is our mechanism to align an evidenced based strategy that delivers organisational capability for Value, Innovation, R&D (Research & Development) and Quality Improvement. AB Connect are developing a strategy that incorporates each of these functions.

The ABCi (Aneurin Bevan Continuous Improvement) team act as our hub for Quality Improvement (QI) and Mathematical Modelling (Insight). The team focusses on developing organisational capability for QI and Insight within services. In order to build Organisational Capability for these functions, by skilling our workforce (Capacity), creating an enabling environment (Conditions) and establishing peer networks that support spread and shared learning (Connections). Developing a quality management system will enable clinical teams to improve what matters to them and their patients.

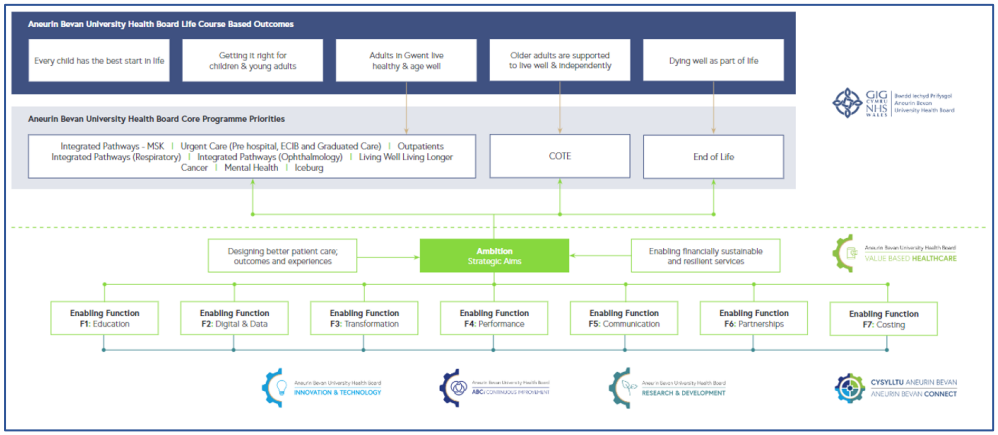


Our approach to value based and prudent health care is well established and embedded within the organisation. Value based healthcare, doing what matters

most to people is an essential enabler to address the challenges we now face in the short, medium, and longer term.



This key enabler underpins and supports our work to deliver Life Course Outcomes and core priority programmes.



Our Research and Development Team work in true partnership, locally, nationally, and internationally to design research projects and gain grant funding to meet the needs of our population. We have developed a research active workforce; our patients are routinely offered the opportunity to participate in research offering access to novel treatments that are not available outside of trials.

Research is delivered as part of core activity within our services across all aspects of the life course from midwifery and neonates to children, adults and older people.

We also support research in Social Care and the Third Sector. As we emerge from the pandemic, we see the alignment of R&D with ongoing service redesign as critical to delivering a sustainable system of care.
Notwithstanding the high levels of participation across our workforce, in the next year we will be seeking a review SPA (Supporting Professional Activities) policy in the context of R&D. We also recognise that in some clinical areas, including pharmacy, radiology and pathology manpower resources are particularly constrained and we will be seeking to address this shortfall from an R&D perspective. The outcome of research is important and impacts on the sustainability of our system, for instance Clinical Trials of an Investigational Medicinal Product (CTIMP) are material and deliver benefits in terms of patient outcomes, efficient and effective use of resources.

A new Clinical Research Centre opened in 2021 that will open doors and enable us to deliver more commercial and non-commercial phase 2 trials. A comprehensive overview of our R&D activities can be found here. Our immediate priorities for 2022/23 include a pharmacy workforce strategy that facilitates R&D, Population health and epidemiology; Mental Health; Rheumatology; Neurology; Long Covid; Cancer; and Surgery.

Going forward we will develop a five-year R&D Strategy that will ensure research becomes a core component of peoples' jobs, thus aligning the Health Board's R&D Strategy with the UK vision for clinical research delivery (Saving and Improving Lives: the future of UK clinical research delivery).

We have recognised that there are further benefits to derive from aligning RIIV functions to provide a joined-up offer for the organisation to think and work differently. This year we make our first steps on this journey to drive further value from our University Status through AB Connect. In the longer term, this integrated approach will underpin any Llanfrechfa Grange Campus Medi-Park, providing a significant and unique platform to engage externally with academia and industry.

4. WORKFORCE AND ORGANISATIONAL DEVELOPMENT

The Health Board employs 12,319 WTE and 15,763 people (January 2022) and is the largest employer in Gwent. There are 2013 people working in Primary Care GP practices an increase of 100 over the last 2 years. Over the last 12 months the number of staff within ABUHB has increased by 255 WTE (2.11%). There have been overall increases in all staff groups in line with our Clinical Futures plans and to support our continued responses to mass vaccination, Covid Testing and TTP. Supported by successful recruitment campaigns locally and overseas nurses, healthcare support workers and administration staff groups have seen the largest increases.

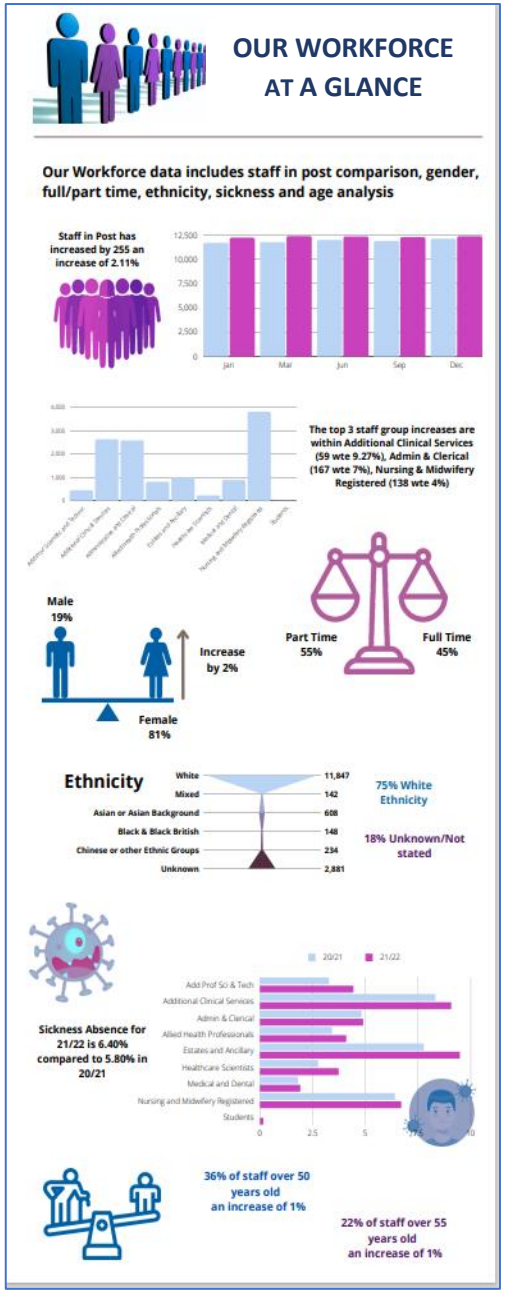
Whilst overall numbers of facilities staff on our workforce have increased, on the 1st April 2021, Laundry Services staff transferred to NHS Wales Shared Services Partnership (NWSSP) as part of nationally agreed process and this resulted in the TUPE transfer of 49.56 WTE facilities staff.

People Plan 2022 – 2025 - Putting People First

Our new People Plan, will reflect our current challenges, opportunities, and the changing context in which we now operate due to the impacts of the Covid-19 pandemic and of leaving the European Union.

The People Plan aligns with the themes of the Health and Social Care Workforce Strategy National Planning Framework and this IMTP, building on workforce data and intelligence together with the experience of our staff and partners. Collectively these inputs will shape our ambition and our priorities for 2022 to 2025.

The People Plan will outline a road-map that will help us improve the experience of our staff now and in the future. The plan is aligned with our organisational values and most importantly our belief that staff experience shapes patient experience. The plan addresses the short-term actions needed to stabilise our workforce following recent



times and the actions needed to establish and embed new ways of working in the medium to longer term. Much of what is set out in our plan is already underway, however, some developments are new and designed to creatively support longer term sustainability.

At its heart it will seek to develop seamless workforce models, ensuring people with the right skills, competencies and experience are in the right place at the right time across the health and social care system. A detailed action plan sets out what we will do to create sustainable and innovative solutions by connecting with our employees and our future workforce, to support new ways of working, developing new skills and capabilities with flexible and agile models, to widen access to training and employment and to develop stronger connections with our diverse communities. The People Plan 2022/2025 will focus on 3 core priority objectives:

People Plan Objective 1: Staff Health and Wellbeing

Supporting our people to feel valued, engaged with a positive sense of wellbeing at work is at the heart of our People Plan.

We will embed our innovative engagement programme "**Cynnal Cynefin / People First – Reconnecting with the Workforce**" and work through the 5-stage approach of addressing the key workforce biopsychosocial issues which were highlighted through a series of organisational surveys including the medical engagement scale, junior doctor report and wellbeing surveys.

The programme will, by re-connecting with our people, support our commitment to being a listening organisation and our commitment to ensuring people feel that their voices can be heard and their ideas acted upon.

Local teams will be supported to identify issues affecting staff's working experience and empowered to resolve matters or rapidly escalate to senior decision makers to unlock identified barriers. The programme will support local teams to self-sustain this approach and promote positive culture change, all of which is in line with our Values and Behaviours Framework, the Employee Experience Framework and our commitment to compassionate and inclusive leadership across the Health Board.

A Wellbeing Centre of Excellence will be established and will incorporate research, development and new approaches that will have benefits for all staff across NHS Wales. This will make a unique contribution to 'A Healthier Wales' by becoming the first Welsh NHS Employee Well-being Service to proactively address the complex psychosocial determinants of poor wellbeing at work. The Centre will work proactively and reach out to partners in the Public Sector to develop a partnership and population approach to our wellbeing offer.

Our staff have responded in the most incredible ways, particularly during the pandemic, and the Health Board recognises the impact on staff of increasing chronic fatigue, burnout, and mental health issues. The Health Board will continue to adopt a two-pronged approach to our emerging, evidence-based Wellbeing Strategy:

- Firstly, identifying and responding to the mental health needs of our staff by strengthening our well-being service; and,
- Secondly, developing a systematic way of supporting teams to identify and address symptomatic causes of poor wellbeing (as expressed by staff through regular wellbeing surveys).

We continue to implement new integrated psychological wellbeing roles and peer support networks within services. We will evaluate our innovative therapy trauma pathway, strengthen staff networks such as our Menopause Cafes and provide tangible measures to enhance the wellbeing of our staff. Additional support will be in place for long covid and staff absent from work due to chronic stress, anxiety, and depression.

Healthy Working Day describes the organisational development interventions to support the key areas of working life for all our staff. This will facilitate the creation of space, expertise and time for individuals and teams and our communities to grow, experience and deliver exceptional care.

We will facilitate the development and growth of multidisciplinary teams through the Health Board culture that is true to our values. Supported by a Prospectus for Training and Development, some examples of OD interventions are shown below:

OD Intervention	To ….
Talent Management Succession Plan	Purposefully attract, select, develop, and deploy the best people for key roles across our system
Business critical role identification	Consciously work with teams to anticipate and succession plan for business-critical roles (short, medium and long term)
Induction and Training Programmes	Deliver our development offer to staff through a wide range of programmes from entry level to senior management
Behaviour and Culture change	Lead the discovery and movement of critical behaviours and emerging cultures across the health board's teams
Core Leadership	Develop Health Board Leaders of the future (including bespoke programmes for Clinical Leaders, triumvirates, non-clinical leaders)

People Plan Objective 2: Employer of Choice

The Health Board's ambition is to maintain and build on its reputation for being a great place to work. We are operating in an increasingly competitive recruitment market we want to be an organisation that people choose to work in and one where they choose to stay. This will be supported by our existing strong Health Board identity and branding and enhancing our recruitment and retention strategies.

For registered and professional roles there are long standing and significant national recruitment difficulties. We will continue to work with recruitment partners including BAPIO, NHS Professionals and national and overseas campaigns to support safe staffing levels. Doing more to build on our flexible working offer

and innovative role profiles, which incorporate responsibilities such as research and education, to ensure we stand out in the market.

We will build on our connections with schools, education providers, third sector and community groups to promote the wide range of roles that we offer and the opportunities that exist to develop long term career pathways. By proactively reaching out to diverse groups we will strengthen our work with partners to create diverse and multiple pipelines of talent and extend our widening access agenda. We are thinking differently about how to train, attract, and create development pathways within the principles of the Foundational Economy. Our Action Plans will seek to deliver a sustainable workforce working in partnership with stakeholders to create a more diverse and inclusive workforce that represents our population and our communities.

As an 'Employer of Choice' we support retention and succession planning through the development of career pathways, helping staff to see their career journey within our Health Board both now and in the future. We will establish a Healthcare Support Worker Strategy and a Middle Grade Doctor Strategy, increase opportunities for Management Trainee Schemes, internally and by investing in joint graduate training programmes with Local Authorities. This will be supported by a programme of work for managers at all levels to identify talent and to proactively support staff who may not have previously "self-selected" for development, ensuring equality and diversity is at the heart of our career development and succession planning.

We will strengthen our staff retention framework which will focus on opportunities to support people to stay within our system. Doing more in terms of flexible working, internal career pathways that reach across services and staff engagement initiatives to address the complex needs of a multi-generational and diverse workforce.

These programmes of work will support our plans to reduce reliance on temporary staffing and high-cost variable pay which has a direct impact on the experience of our patients and people.

We will see additional cohorts of the new Aneurin Bevan Apprenticeship scheme being recruited bi-annually. We will work with employment schemes such as Kickstart and Restart to support widening access for school leavers and the unemployed and will do so across the health and social care sector. We are trialling new selection methods in place of traditional interviews to encourage applications from all parts of our population. We are working closely with the Gwent Regional Workforce Board and Career Consortium to develop ways to work together to develop training and employment routes that will support a longer term goal of a whole system workforce.

The Volunteer Strategy will also make an important contribution to the Health Board's implementation of the Wellbeing of Future Generations Act. We also see this as a route for people to consider careers in health and social care through collaborative working with our regional partners.

We will elevate and embed equality, diversity, and inclusion in all we do and align our work plans to our values with intersectionality threaded through. There will be open conversations with our staff across all protected areas and the establishment of staff networks, topic cafés and senior equality ambassadors to collectively drive forward equality, diversity and inclusion through our workforce areas and service delivery.

A new Equality Impact Assessment will adopt an integrated approach including the Well-Being of Future Generations, Welsh Language Standards, and socio-economic impact that is aligned with our values and provides a robust and transparent process to provide inclusive support and services.

We will develop a Welsh Language Strategy for the Health Board, centred on the needs of the local population, and providing a clear vision for the implementation of the Standards. We will continue to embed the 'Active Offer' principle and

developing our Partner IAITH network to support our Welsh speaking staff to maximise their linguistic skills

People Plan Objective 3: Workforce Sustainability and Transformation

Delivering our People Plan centres on having people with the right skills, expertise, in the right place and with the right capacity to deliver the health and care needs of our population. Core to this is our ability to develop strategic workforce planning across our system.

Workforce sustainability will require us to focus on skill mix, development of new roles, extended roles and maximising the contribution of the unregistered workforce. We will continue to utilise new workforce models and expand these to new services and settings. Sitting alongside this will be a new Health Care Support Worker Strategy addressing issues across both health and social care. Our work will focus on training, education and opportunities so there is seamless care, closer to home which supports admission avoidance. Learning from the pandemic we need to create an agile and flexible workforce that can respond to surges in demand of testing and/or vaccination and at other times skilled to support our efforts to reduce health inequalities and support population health improvement.

The Urgent Care Transformation programme will enable us to review our workforce models and implement an integrated workforce model for the acute hospital network.

Accelerated Cluster Plans are reviewing the services provided within their community, together with overall sustainability of the workforce. Redesigning community services will build on these plans ensuring prudent workforce models, reduce duplication or omissions and continue to grow graduated models of care.

The recent success of the Primary Care Transformation Programme will be extended to support and develop place-based care models throughout the Health Board area. Working closely with the Regional Partnership Board and stakeholders such as the Research, Innovation, Improvement and Communication Hub, we will work collaboratively to deliver the workforce dimensions to support new models of care and the outcome framework for the Regional Integration Fund. The Transformation Programme will also support the Foundational Economy Action Plan.

We will introduce a suite of workforce analytic dashboards to underpin and inform decision making. We will scope and plan to implement interoperable medical workforce E-Systems, which includes systems for job planning, rostering and locum and agency all of which supports safer staffing. The anticipated benefits will enable effective rostering, forecasting, better governance, resource utilisation and support robust workforce reporting and optimisation.

Agile and Hybrid Working/New Ways of Working will continue to build on areas of good practice in terms of agile working. This strategy will be considered alongside the Estate Strategy to create more agile working spaces based on a minimum standard which has been set from feedback we have received from our agile staff surveys. The work plan also recognises the cultural and leadership challenges and will require careful influencing and responding to the issues being raised by teams.

In addition, we will need to ensure all of our staff have the digital skills and technology that they need to work differently. Technology is paramount to enabling an agile, accessible way of working and will have a key role in recruitment and retention. We have updated the Agile Working Framework, with consideration of the Decarbonisation Strategic Delivery Plan, and ensure there is regular engagement with partners to explore options and identify and share good practice. We will research opportunities to work with partners for opportunities for community hubs especially where this will benefit the local community, for example, by supporting local high streets.

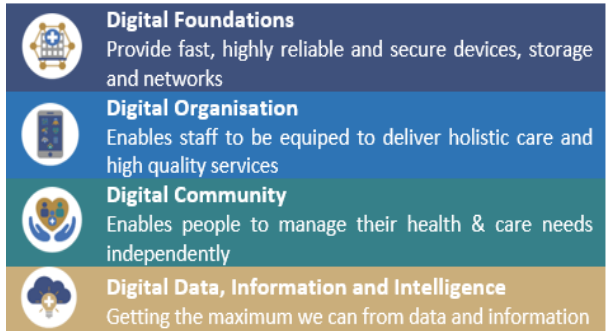
The past two years have had a significant impact on the way work is organised and delivered, and as we emerge from the pandemic we will constantly review our workforce plans. Our response will always be driven by our values where we take personal responsibility, demonstrate passion for improvement, take pride in what we do and in particular put people first.

5. TRANSFORMATION THROUGH DIGITAL

The Covid-19 pandemic demonstrated the critical role that digital technology plays in 21st century health care, it has also increased demand for and accelerated the pace of digital transformation across health care. Consequently, the planning imperative for Informatics is to make sense of a hugely expanded demand for services, to prioritise those requests within the context of Informatics and IT capacity and aligned to both the needs of operational services and supporting delivery of the Health Board's priorities.

Working Together we look forward to a renewed working relationship with Digital Health & Care Wales (DHCW), the successor to NHS Wales Informatics Service (NWIS), and will continue to play our part working with NHS Wales Collaborative and NHS Wales Shared Services Partnership (NWSSP) to deliver national programmes, tailored to meet local needs, and regional digital solutions supporting regional service redesign, for example Vascular Surgery.

Delivering our Strategy 'Transformation through Digital' (2019) provides the framework for setting out the areas for delivery. The development of Digital Data, Information & Intelligence is articulated throughout the IMTP, in the context of resetting baselines, developing minimum data sets, shaping of priorities and the delivery framework. The Health Board's imminent Information Strategy will provide a road map informing future needs and developments to support real time data use.



Digital Foundations

Digital investment equates to around 1% of the Health Boards' budget and is unlikely to meet the existing demand-capacity gap for some time. We understand the importance of investment to maintain infrastructure and ensure that our core digital platform that supports clinical services is robust and fit for purpose i.e. the basis for safe, secure, reliable, and compliant services. Equally, we need to invest in our informatics resources to ensure they can meet the growing demand from services and the public for digital solutions, to deliver and manage health care, and to keep the information that we capture and curate safe and secure.

There are four key areas for work in the year ahead:

Infrastructure Refresh – all digital equipment degrades over time and needs to be replaced and/or upgraded to meet changing standards be that the equipment we use in our daily work or the hidden systems and networks that support our front-line digital equipment. In light of growing demand for ICT, ensuring there is capacity to the manage the hardware refresh programme safely within a funded scheduled plan is increasingly important. Resources need to be deployed in a timely and effectively manner to avoid service failure, whilst supporting new programmes and projects as Digital Transformation matures. We will set out a roadmap to minimise the risks and issues associated with our current infrastructure and to ensure the service can meet the industry standards expected of it.

The Digital Platform – our in-house clinical portal 'Clinical Work Station' (CWS) is 25 years old in 2022. A radical refactoring of the platform that this sits upon is urgently needed to secure this service and to develop functionality to keep the Health Board's clinical applications operating within the context of the NHS Wales Digital Architecture Review recommendations, the rapidly evolving national open architecture, and the challenge to bring on new services in a timely manner to meet Health Board service needs. The service will present a proposal in early 2022 for a fully-fledged programme of work to meet this challenge.

The Informatics Directorate Target Operating Framework (TOF) - implementation of a new Target Operating Model in response to the review of Informatics undertaken in 2019 was delayed by the pandemic but remains essential to meet the digital transformation challenge. The Informatics new TOF service model will implement in 2022/23, following approval by the Health Board.

Information security - further to a review of the information security arrangements of the Health Board and recommendations made by Templar Consultancy an action plan will be delivered. This includes establishment of the Office of the Senior Information Risk Owner (SIRO) and work to improve the Health Board's Information Assets Register at a divisional and Directorate level.

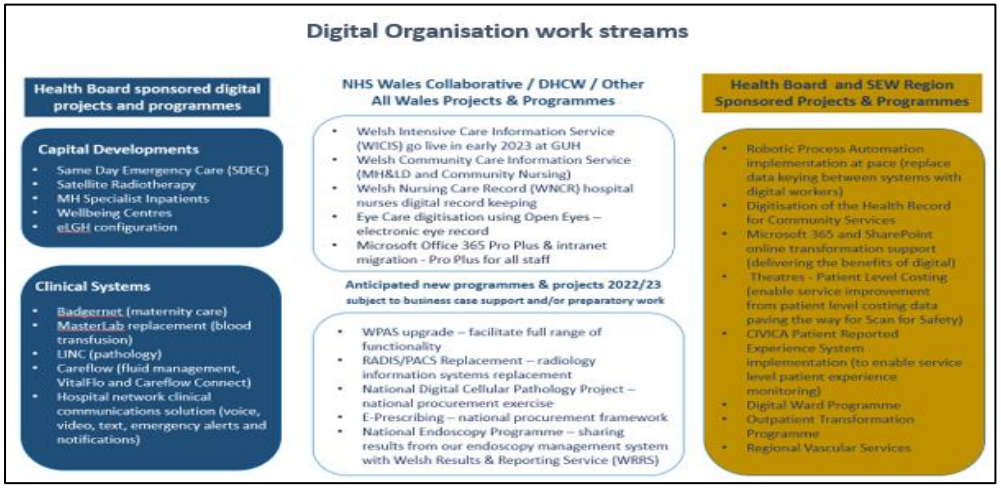
Digital Organisation

Digital Organisation covers the development and delivery of digital systems and services that our staff use in their everyday duties providing or supporting the provision of care. This is a complex and evolving picture with large numbers of projects being developed and delivered to better meet the needs that comply with quality standards and best practice for managing transformational change using digital technology.

The work covers two distinct streams: complex programmes and projects in progress in the Informatics Portfolio and new programmes and projects identified locally and/or nationally as part of digital enablement of service transformation. The key programmes and projects that are summarised opposite do not take account of emergent digital asks from within the organisation that will require informatic support or significant infrastructure work.

Digital Community

The next major development in NHS digital transformation is the empowerment of patients, parents and service users through the development and delivery of digital applications that enable self-assessment, self-management, self-referral, communication with clinicians and access to broader information relating to the production of personal health and well-being.



The National Picture over the next few years, all Wales Digital Services for Patients, and the Public (DSPP) programme will deliver a citizen platform based on a signature NHS Wales App that will provide a 'one stop shop' platform for accessing specific condition related apps. This programme is sponsored by the Planned Care Programme Board, and we are fully committed to supporting the development and delivery of the Citizen Platform.

The Health Board Picture

PSA Self-Management Application – our Health Board is undertaking a pilot, as part of the National Programme, using an existing digital platform designed and managed by University Hospitals Southampton called **My Health Record**. This work will see the local development and implementation of an application to support men and transgender women self-manage prostate cancer.

A Digital Record for Pregnancy - The Maternity Care System replacement project also includes a digital record held by pregnant women and transgender men. This will be the first digital health record held by service users in Gwent and Wales.

Support for TecCymru – we host and provide leadership for the TecCymru Programme, a national programme supporting technology enabled care. This has been instrumental in enabling video consultation where it was needed at the right time across primary, community and hospital care services and one of the significant digital successes to emerge during the Covid-19 crisis. The Programme is developing two additional national projects for telecare and telemedicine that will set the quality standards for implementing these technologies at local level.

We will continue to host and support the programme. Locally, our Informatics Directorate will support virtual consulting technology and will participate in national programme initiatives as they arise.

Digital Data, Information, and Intelligence

To be an intelligence led organisation requires three core elements, quality input of data through digital platforms, effective standards and management of information, and the ability to turn data into intelligence for the organisation. The benefits afforded by digitally captured and curated structured data, alongside tools to interpret and question are at the heart of service transformation.

These opportunities to make further effective use of our data will require planning and support to ensure the infrastructure is in place to pool and exploit our data and the organisational structures and processes in place to meet its information and intelligence aspirations.

- **ABUHB Data Warehouse** - In 2022/23 we will bring forward a proposal to renew its Data Warehouse to make sure that it is fit for purpose for the real-time curation and consumption of local and nationally available data by Health Board users. This is considered to be a Digital Foundations priority but given focus here.
- **ABUHB Information Strategy -** Alongside the renewal of the Data Warehouse, the organisation will develop an Information Strategy that will set out for the first time the principles and standards for digital data, information and intelligence development recognising the needs of stakeholders to create a coherent approach to the strategic development and use of Information for clinical and business purposes. This will include where data comes from, how we manage it and how we want to use it. We will also bring forward an Information and Data Transformation Plan against the Information Strategy to lay out its development roadmap.

These two developments will make sure that our information systems are safe, secure, reliable and compliant and that our services are well directed and focused to meet need. Our organisation is adopting a systems approach to planning which exemplifies the need for firm foundations in and around information management.

We will continue in the work we have developed to support our service with effective intelligence. We are moving away from traditional approaches to how we plan and deliver services to a new 'Always On' data rich system that allows us to understand how our system is behaving; to determine the potential impacts of changing circumstances on our demand/capacity profiles and enables us to plan how to respond to those challenges within the context of our system of care.

This is a core enabler to building a culture of support around teams and will support system planning through seeing systems together. This whole-system perspective translates our information into a facilitator for change ensuring we no longer plan in silos connecting services into coherent end-to-end pathways for sustainable change.

To plan for our IMPT, we have opted for a realistic and balanced approach to understanding our true demand and system capacity this has been set out in detail in Section 3. Through understanding our unreferred demand, and using our previous system behaviour as an indicator, scenarios have been run that take account of anticipated constraints on our system, how our services will come on back on stream (recognising that this will vary service by service) and what we can achieve.

This has enabled us to understand the realistic levels of activity and the key areas where new ways of working, partnership approaches and pathway changes will help us to address unreferred demand and improve patient experience and outcomes. This is only possible if quality data is inputted through digital systems and effective data standards, warehousing and management are in place.

Building on this in 2022/23:

- Dynamic Planning embedded as an approach to organisational scenario planning
- Process of quarterly reviews of the Dynamic Planning Model
- Development programme to support utilisation of the tool
- Additional feeds provided to the Dynamic Planning tool to enhance the data set

6. ENABLING ESTATES

Our Vision - a sustainable future focused, fit for purpose estate supporting delivery of patient outcomes and experience, which motivates and enables staff, with partners, to deliver safe, efficient, quality services that are financially viable and sustainable

Our 10 year Estate Strategy (2018-28) approved in January 2019, which was refreshed in 2021/22 contains twenty Strategic Objectives, organised around five sub-categories.

It seeks to support the implementation of the Clinical Futures Strategy where more care is delivered closer to home, requiring the development of 'hubs', both physical and virtual, at key locations across our communities together with a transformed

network of Local General Hospitals (LGHs) which together with the Grange University Hospital delivers a hub and spoke model of secondary care services.

The capital programme is a key enabler to delivering our strategy and maintaining our estate. £8.227m discretionary capital funding will support our plans for meeting statutory obligations, maintaining the fabric of our estate and the timely replacement of equipment.

Our approved Estate Strategy continues to inform our 10 year major capital programme the content of which is attached at Appendix y. This outlines all of the proposed strategic capital projects that either have, or will require, support from Welsh Government strategic capital in future years. It distinguishes between those projects that have some form of approval and those that are still in development, and some at very early concept stage. Regarding the former it is notable that the post completion works at the Grange University Hospital are nearing completion as is the Hospital Sterilisation and Disinfection Unit (HSDU) which should be fully functional in early March 2022.

Primary Care projects include the Tredegar Health and Well Being Centre which started on site in September 2021 and Newport East Health and Well Being Centre which should commence on site in April 2022 if and when the Full Business Case is approved. Three other projects are in the pipeline stage including projects in Monmouth, Ebbw Vale and Aber Valley.

Projects that improve access to cancer services figure prominently in the capital programme including the Satellite Radiotherapy Unit and Cancer Unit at Nevill Hall Hospital and the centralised Breast Unit planned for Ysbyty Ystrad Fawr. The former is being planned in collaboration with Velindre University NHS Trust with the FBC for the Radiotherapy Unit planned to be submitted in May 2022. The Breast Unit FBC has been approved and construction is expected to start in March 2022.

Projects in development include the Mental Health Specialist Services Inpatient Unit which is proposed to bring together several specialist services that are provided is disparate locations across the Health Board onto the Llanfrechfa Grange site and the redevelopment of County Hospital. It should also be noted that in the context of the wider estates' strategy funding will be required to improve estates infrastructure particularly at the Royal Gwent and Nevill Hall Hospitals and to facilitate the closure of the older estate at St Cadoc's and St Woolos Hospitals.

7. FINANCE

Financial Strategy

Our Financial Strategy is to achieve financial sustainability through the application of Value-Based health care principles, improving outcomes for patients within existing resources or reducing spend to deliver current outcome levels. Additionally, the application of Value-Based principles for population health to improve equity of access for the population we serve. Finance and funding is an enabler to achieve this strategic aim.

Strategic Context

We received circa £170m non-recurrently during 2021/22 to support Covid related service costs, this level of funding ends on the 31st March 2022 and health boards are expected to manage their financial position without additional Covid funding confirmed for 2022/23.

Our IMTP (2022 – 2025) see a return to the three-year planning process following a one-year Annual Operating Framework that was in operation for 2021/22. It assumes that ABUHB will continue to meet its statutory financial duties and deliver financial balance on a rolling 3 year basis. Strategic plans will be cognisant of the

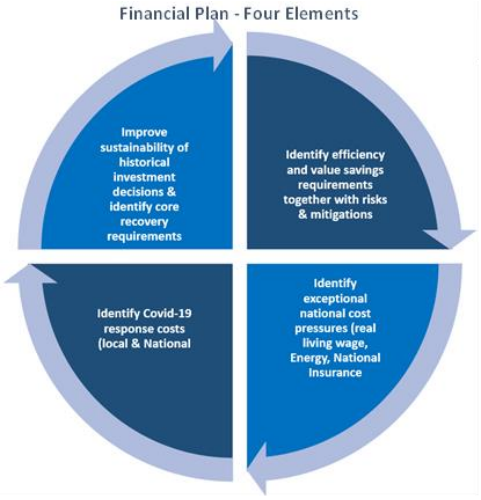
expectations and requirements of 'A Healthier Wales', 'Wellbeing and Future Generations Act', the 'Socio-economic duty', the 'Foundational Economy', the Decarbonisation agenda and delivering the ambitions set out in our 'Clinical Futures Strategy'.

The implications of the Covid-19 pandemic requires a dynamic response to resource and financial planning in the short term, while recognising that medium and long term financial, service and workforce sustainability remains the highest priority for patient care delivery.

The immediate focus is to ensure resources are available to respond to the underlying and historical cost pressures faced in the Health Board, deal with the uncertainties of the ongoing impact of the pandemic and drive transformative change through the delivery of the Clinical Futures Strategy.

IMTP Financial Plan: Our Approach

In line with the agreed Board approach to financial sustainability and expected improvement in the underlying financial position, the IMTP financial plan has been focussed on making historical investment decisions sustainable. As part of developing its service, workforce and financial plans the Health Board has developed a financial plan in 4 elements as shown opposite.



Welsh Government have set out the allocation for core service delivery and have confirmed national Covid-19 costs will be supported (TTP (test, track, protect), MVP (mass vaccination programme), PPE (personal protective equipment) during 2022/23. However, funding for exceptional national cost pressures and local Covid-19 response costs have not been confirmed. These unconfirmed cost pressures have been identified as areas that Welsh Government will consider and work with Health Boards to support financial balance.

Our IMTP assumes local Covid cost estimates and exceptional cost pressures will be managed during 2022/23 in partnership with Welsh Government, this is currently a risk due to its uncertainty.

Resources Available

The Health Board is allocated additional funding announced by Welsh Government, through the 2022/23 Allocation letter. Allocation movements consist of new allocations, consolidation of 2021/22 recurring in-year allocations and some previously anticipated allocations, resulting in a net uplift of £67.1m (4.6%) for ABUHB for the 2022/23 financial plan.

Net funding uplift	22/23 funding £
Core uplift 22/23	28,779,000
Planned and Unscheduled Care Sustainability	32,023,410
Value based Recovery	2,877,900
Mental Health Core uplift 22/23	3,785,000
Top sliced funding	
NHS Wales Shared Services	(21,739)
Paramedic banding (to ring fenced)	(299,000)
111 service (to directed)	(50,000)
Total Top sliced	**(370,739)**
TOTAL	**67,094,571**

We will apply the additional funding, along with agreed anticipated allocations and other income as part of the total core allocation of £1.4 billion, in line with the agreed resource allocation principles, to establish operational budgets.

We continue to strengthen collaborative working with regional partners, this includes incorporating the Regional Integration Fund (c£27m) which draws together the previous Transformation and Integrated Care (ICF) Funds.

Welsh Government is holding funding centrally for:	**Welsh Government have <u>not</u> confirmed additional funding for:**	
• 2022/23 Wage Award • National Covid-19 responses • Primary Care Contractor uplifts	• Local Covid -19 responses • Energy • National Insurance • Real Living Wage	There is an expectation, by our Health Board, that a mechanism to manage them will be agreed with Welsh Government

Financial Plan 2022/23

Our financial plan has considered and estimated the underlying costs, historical commitments, statutory requirements and new cost pressures likely to impact ABUHB during the year, these have been formed from both a bottom-up service

perspective and top-down corporate perspective. Service, workforce and transformational plans have been factored into the assessment, including identification of potential efficiency, value, cost containment and savings plans required to achieve financial balance.

This 'Core Plan' is our plan to achieve financial balance for 2022/23. This includes an assumption that £26m costs will be avoided. It also includes the utilisation of the £32m allocated for recovery and sustainability to support existing services to deliver greater levels of service going forward. The plan also includes utilisation of Value Based Recovery funding £2.9m for MSK and other Value-Based transformation schemes. Mental Health funding is included to support mental health CHC cost pressures.

Summary of our Financial Plan 2022/23

ABUHB IMTP	2022/23 £m
Additional Funding Expected	**68.26**
Recurrent positions	20.91
Clinical Futures Commitments	15.36
Non-achievement of Previous Savings targets	25.66
National Cost Pressures	9.13
Inflationary / Cost growth	9.86
Demand / Service Growth	11.78
Reserves	- 6.87
Executive approved decisions	8.67
Sub-total Net Cost Increase	**94.50**
2022/23 CORE Plan before Opportunities	26.24
OPPORTUNITIES	- 26.24
2022/23 CORE PLAN	-

In addition to the above the following costs and risks have been identified:

- Covid-19 national schemes £18m (assumed funded)
- Covid-19 Local Response cost estimates £36m (Welsh Government solution to be confirmed and currently represents a risk)
- Exceptional national cost pressures £12m (Welsh Government solution to be confirmed and currently represents a risk)
- Local cost pressures £19m to be mitigated (possible demand led pressures, pandemic uncertainty and currently represents a risk)

Local Covid-19 Response

In the short term, local Covid-19 responses and transitional costs remain and are necessary to ensure the safety of our patients and staff and to respond to the changes in health need as we emerge from the pandemic. Whilst we recognise that Wales returns to a level 0 there will be significant challenges because of the pandemic in the medium and longer term as demonstrated in the Dynamic Planning section of the plan.

Immediate costs (local Covid-19 response)	Medium- and long-term costs
• Increased requirements on facilities and estates • National cleaning standards • ED, Diagnostics & Urgent Care • Increased bed capacity • Patient flow, and • Delayed discharge and discharge support.	• Additional workforce capacity to support the significant pressure on the Emergency Department and other urgent care services • Workforce costs for covering increased sickness absence and self-isolation periods • Maintaining 'green' patient pathways to minimise infection • Additional hospital bed capacity to ensure the safe and timely flow of patients • Increased acuity of patients presenting and demand for enhanced care, and • Medically fit to discharge patients remaining in hospital beds.

Exceptional National Cost Pressures

Across NHS Wales there is recognition of the system wide impact of extreme cost pressures which need a system wide solution. Outside of any wage award, already agreed to be funded by Welsh Government, the significant pressures are:

- Energy and fuel – significant increases are expected with a continuing volatility in the market
- Employer National Insurance Contributions – an increase of 1.25%, and
- Real Living Wage – for NHS and areas contracted by the NHS, including Local Authority and private care providers.

These costs have been estimated but there is a risk that some of these areas are sensitive to market forces and that may increase the cost pressure. These pressures are currently excluded from our financial plan in anticipation of further discussions with Welsh Government on how to manage these exceptional items.

In order to achieve financial balance we have plans to re-engage the organisation in taking a prudent, value based approach to daily decision making and service planning and redesign.

3 Year Financial Plan

In relative terms the context of our three-year plan is one of greater certainty than the past year. Our plan is based on national Welsh Government budget publications and estimates of costs based on service and workforce plans, which may change in future.

IMTP 3 Year plan	2022/23	2023/24	2024/25
	£m	£m	£m
Opening Underlying Position	21	8	7
Forecast Expenditure (recurrent)	1478	1504	1526
Assumed Uplifts	2.80%	assume 1.5%	assume 1%
Estimated Allocations	-1465	-1486	-1503
recurrent savings	-18	-15	-18
Non recurrent savings	-8	-4	-5
Closing Underlying Position	**8**	**7**	**7**

Our estimates exclude	Our estimates assume
• Covid-19 costs and associated funding • Exceptional national costs for 2022/23 and future years • Non recurrent expenditure is excluded.	• Lower levels of allocation uplifts in years 2 and 3 as per WG budget plan • Similar levels of savings are achieved over the 3 year term.

Our 3-year financial plan presents an improving underlying position while demonstrating the intention to financially balance each year. There are significant service, workforce and environmental uncertainties leading to financial uncertainty in forecasting future financial consequences.

Budget Allocation 2022/23

Our resource allocation strategy is founded on the following Board agreed allocation principles to prioritise resources and delegate budgets and applies to the full revenue resource funding.

1	For established services, plans should demonstrate	• How service and workforce plans will be delivered within agreed resources? • How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales' and reduce socio-economic disadvantage? • Efficiency and productivity improvements which achieve (or aim to achieve) excellence
2	Addressing the underlying financial position – service and workforce plans which demonstrate 1. (above) should be funded appropriately before considering new investments	
3	Savings plans should demonstrate delivery before approving new funding or re-investment	
4	Where savings have been identified, for new service proposals plans should demonstrate	• Fit with the Clinical Futures strategic direction of ABUHB, • If they are approved priorities, • How service and workforce plans will be delivered within agreed resources? • How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales?', and • Efficiency and productivity improvements which achieve (or aim to achieve) excellence
5	The Board may choose to establish reserves which support key priorities and where plans require further development. This may include non-recurrent, tapered, or recurrent funding	
6	Pay awards to be funded in line with Welsh Government allocations	
7	If funding becomes available or there is a level of savings achievement greater than the IMTP then the Board should consider and establish an appropriate contingency reserve, considering the level of financial risk within the IMTP	

Exceptionally in 2021/22, a quarterly financial budget planning process was implemented, to ensure that the uncertainties of responding to the pandemic were appropriately mitigated, resourced and managed within our governance framework. It is recommended that this continues for the Covid-19 responses elements of expenditure for 2022/23.

Applying our resource allocation principles our 3 year financial plan has focused on developing a budget strategy that:

- Budget Delegation plan reconciles with Allocation Funding
- Budget Allocations prioritised to making historical/underlying commitments sustainable as part of 'Core' IMTP plan
- Budget Plan excludes local Covid-19 cost estimates and exceptional National Cost pressures – this is a risk but aligns with our plan and will be identified as a quarterly budget review
- All allocations delegated - Negligible central reserves held
- Need to operate and deliver within delegated budgets
- Out IMTP is only affordable if £26m savings are delivered to support some of the service costs identified – a budget cannot be allocated for a saving.

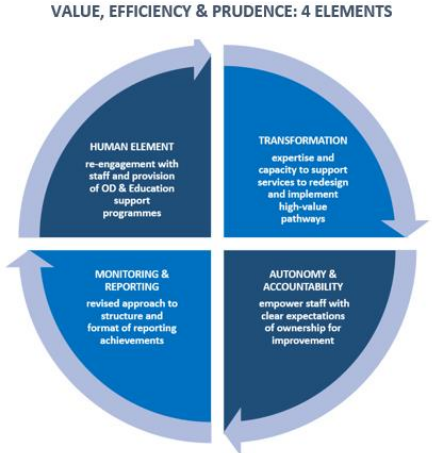
- All other risks & pressures will need to be pro-actively managed & mitigated.

The approach has had to balance the challenges of funding historical commitments with statutory requirements and national agreements.

Resource Efficiency - Value Based Health Care, Savings and Efficiency improvement for sustainability

A Value-Based care approach to decision making is embedded within our organisation, aligned to improving technical efficiency and allocative efficiency. This approach is consistent with national strategy, including the National Clinical Framework, the quadruple aims and prudent healthcare objectives.

The Covid-19 pandemic has driven a focus on responding to keep patients and staff safe, this has understandably reduced the focus on transformational change and efficiency improvement. We are now developing a refreshed approach to re-engage the whole organisation in re-focussing on efficiency and taking a prudent healthcare approach to both daily front line decisions and corporate programme level.



A Multi-disciplinary team approach (PMO, Planning, AB Connect (RIIV), Finance, Workforce, Information) will be developed and used to provide the headroom to services to allow them to drive transformation for sustainable service delivery, improved patient outcomes and efficiency.

We have received £2.9m to support the implementation of a Value Based Healthcare approach, with £5m retained centrally by Welsh Government to support development of VBHC within Trusts and across NHS Wales, and potentially further support for health boards.

We will invest the £2.9m, in addition to core funding plans, to drive Value-Based healthcare improvements in:

▪ MSK pathway ▪ Alcohol liaison ▪ Cardiology heart failure ▪ Diabetes ▪ Respiratory ▪ Ophthalmology ▪ Theatres ▪ Value team ▪

Improving care pathways in this way as part of implementing Clinical Futures and achieving efficiencies for fundamental for the long-term sustainability of our system.

Significant savings of £26.5m are planned for 2022/23. This is based on the opportunities identified within the various Efficiency Frameworks, both national and local, for both cash releasing and cost avoidance, to deliver improved value and break even. We will make efficiencies by:

- Implementing evidenced high value interventions that align to local population need and priorities
- Making significant progress in measuring cost and outcome data to inform future Value-Based health care decision making for priority condition areas
- Having a delivery programme of PREM & PROM collection and a mandate to sharing PROM data nationally to inform Value-Based decision making
- Making progress with allocating and distributing resources to maximise outcomes
- Reducing unwarranted variation and activity of limited value, and prioritise standardisation of best practice pathways which support delivering improved outcomes
- Ensuring that changes being implemented are monitored in terms of the improvement in outcomes being delivered and change in how resources are utilised to deliver value

We have made progress in outcome data capture across several service areas, improvements in productivity have been built into plans to deliver services based on improving outcomes for patients and ultimately improving the health of our population.

Priority Delivery

Key Service Investment decisions for our organisation include making underlying pressures and previous commitments sustainable including patient facing workforce commitments, premises facilties costs, digital investments, mental health services and specialised services.

Funding for recovery and sustainability (£32m) has been directed predominantly at acute solutions across scheduled care to support diagnostic and elective activity recovery and unscheduled care to support system pressures, including support function costs.

The allocation will need to deliver in excess of 1,500 beds across our hospital network and increase activity levels beyond 2021/22 activity for outpatients, treatments and diagnostics in the context of significant challenge in respect of workforce availability.

Regional and collaborative schemes include

▪ SEW Vascular centralisation ▪ SEW Ophthalmology & Endoscopy regional plans ▪ SEW Cancer Acute Oncology service & future regional Radiotherapy Satellite Centre at NHH▪ Diabetes Neurology redesign with C&VUHB ▪

Partnership working - Regional Integrated Funding

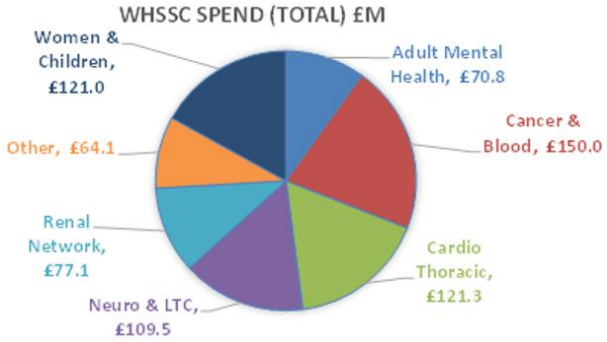
The Health & Social Care Regional Integration Fund (Revenue) is a five year fund designed to deliver a programme of change from April 2022 to March 2027. This new fund brings together some of the Regional Partnership Boards previous funding sources, including the Integrated Care Fund (I.C.F) and the Transformation Fund. The Revenue Funding for Gwent for 2022/23 totals £26.858m and covers the following areas:

▪ Community Based Care -Prevention & Community Coordination▪ Community Based Care - Complex Care Closer To Home ▪ Promoting Good Emotional Health & Wellbeing ▪ Supporting Families To Stay Together Safely and Therapeutic Support For Care Experienced Children ▪ Home From Hospital ▪ Accommodation Based Solutions ▪

Commissioned services

We commission specialist services for our population via the Welsh Health Specialist Services Committee, who work on behalf of all seven health boards to ensure equitable access to safe, effective and sustainable specialist services for the people of Wales. The Integrated Commissioning Plan (ICP) is developed in response to NHS planning guidance and takes account the wide range of National and ministerial priorities and makes commitments as to how it will ensure contribution to each of these.

The Specialist Services Integrated Commissioning Plan was approved by Joint Committee on the 11th January 2022. The plan outlines the commissioning priorities for the period 2022-2025 with associated financial requirements – the chart opposite presents an overview (21/22).



Other Agreements are in place with other NHS health boards, EASC and Trusts which are subject to review and revision annually. Due to Covid-19 implications the 2021/22 NHS agreements were operated as a block to avoid instability for providers and allow a focus on responding to the pandemic. The proposed approach for 2022/23 is to reinstate contractual terms, with an allowance for 'recovery' post covid to be factored into agreement. There is a significant reduction in the Powys tHB LTA, where there has been a reduction in the the level of services we provide to their population following the opening of the Grange University Hospital.

For 2022/23 some outsourcing contracts remain in place including cataract services, cardiology diagnostics and insourced endoscopy activity.

Underlying Position

The plan aims to significantly improve the underlying position of our organisation by funding previous commitments to make them sustainable, but recognises the

new cost presures, commitments and investments in 2022/23 may mean the underlying deficit reduces but is not removed.

Capital

We have received notification that the annual Discretionary budget allocation for 2022/23 has been reduced by 24% to £8.227m (expected allocation - £10.814m). The decrease results from a significant reduction in the Welsh Government Overall All Wales Capital Programme budget for 2022/23. When the brokerage of the All-Wales Capital Programme (AWCP) scheme slippage of £1.534m is deducted from the confirmed budget, only £6.693m remains to address existing Discretionary scheme commitments and new 2022/23 proposals.

Capital Projects with Approved Funding- National	£m
Primary care fees – Tredegar – main scheme	10.228
Radiotherapy satellite – FBC fees	0.120
Covide secovery funding - SDEC	1.200
National programme – imaging P2	4.765
Grange University Hospital- remaining works	-2.232
Total Approved AWCP	**14.081**
Forecast Capital Projects without Approved Funding	
Breast Centralisation YYF	9.000
Total Potential AWCP	**23.081**
Discretionary Capital	**8.227**
Total Capital Resource Limit	**31.308**

There will also be two sources of Capital available to the Regional Partnership Board from 2022/23:

- Housing With Care Fund - indicative allocation of £11.208m for Gwent in 2022/23
- Health & Social Care Integration & Rebalancing Capital Fund - £50m in 2022/23 across Wales growing to £70m in 0224/25

The Housing with Care Fund is a continuation of the previous ICF Capital Fund, and the Health & Social Care Integration & Rebalancing Capital Fund is a new fund focused on the development of integrated health and social care hubs and centres to support the rebalancing of the social care market.

Risks

- Uncertainty related to the Covid-19 pandemic and its service workforce and financial implications in the short, medium and long term.
  - Covid Local Response Plans, these costs are identified separately and excluded from the plan for further discussions with Welsh Government.
  - Covid National Response Plans, these costs are identified separately and excluded from the plan as the agreement is that these will be funded on actual costs by Welsh Government.
- Delivery of identified cash releasing savings plans and improvement in the underlying financial position of the organisation.
- Delivery of further cost avoidance savings and productivity improvements.
- Implementation of the wider Clinical Futures programme within available resources.
- Managing cost growth in line with or below assumed levels, whilst ensuring delivery of key priorities.
- IFRS16 - implementation of IFRS16 (lease accounting) in NHS Wales will go live in April 2022. The Board assumes that any revenue or capital resource implications of implementation will be managed by Welsh Government, with no financial impact to Health Boards or Trusts across Wales.
- NHS Pension Scheme Regulations - It is assumed that any increase in employers' pension contributions will be met from additional government funding including discount rate changes and medical staff specific incentives,
- Pay award and any new changes to Terms & Conditions will be funded by Welsh Government separately,
- Exceptional Cost Pressures for Energy, real living wage and National Insurance increases are funded by Welsh Government,
- Inability to reduce bed numbers to reach the opportunities target,
- Holiday pay (voluntary overtime) - the potential on-going costs of meeting this liability, have been assumed to be funded by Welsh Government.
- Enhanced Sick Pay – if there is a decision to continue funding this pay element, the impact has not been included within this plan.
- Annual Leave Provisions – exceptionally agreed for 2020/21 & 21/22 are sufficient for actual costs incurred.
- The implications of the Ukraine crisis have not been factored into this assessment

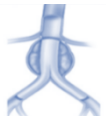
Conclusion

Our financial plan is a financial assessment of the service and workforce plans developed for the financial years 2022/23-2024/25 and assumes the delivery of financial balance within available funding, recognising the risk of savings achievement and income assumptions. The cost implications of financially managing the Covid -19 pandemic impacts on services, along with increasing energy costs and National Insurance increases will be further reviewed and discussed with Welsh Government as part of the 2022/23 financial management process.

8. REGIONAL SOLUTIONS (collaboration across NHS Wales)

We recognise that many services across Wales can be enhanced and optimised when Health Boards collaborate and plan on a joint basis to maximise benefit to the wider population. We remain committed to active collaboration where this delivers added value to clinical service delivery. Health Board planning teams meet on a regular basis to agree common approaches to strategic challenges, progress ongoing regional collaborative programmes, share experience / best practice and to consider future opportunities for closer working to mutual benefit.

This IMTP cycle sees an increase in the number of collaborative regional programmes that are being progressed in 2022/23 and beyond as set out in Table y. These programmes are not the only measure of Health Boards working together across the region, in the face of the impact of the pandemic on diagnostic and treatment services, collaboration to optimise capacity for the benefit of the people of Wales is becoming part of the 'new normal'.



Vascular Services 2021 saw the successful development, following formal engagement, of plans for launching the SEW Vascular Network culminating in regional business case (July 2021) approved by all four Health Boards in south-east Wales in July 2021. The programme now moves into its implementation phase during which several readiness assessments for all network components in February 2022. This process is overseen Medial Directors and Chief Operating Officers across the three provider Health Boards, with the aim of making a recommendation to launch of the service in April 22, consistent with the current plan.

Ophthalmology there is universal agreement that regional collaboration has a valuable role to play within ophthalmology to optimise our collective plans for short term service recovery and longer-term sustainability. Formal Programme Arrangements have been established, led by our Health Board, to oversee workstreams and deliver objectives and benefits.

Priorities for Regional Ophthalmology

- Regional Ophthalmology Strategy
- Sustainability of key sub-specialties (e.g., vitreoretinal services)
- High flow cataract centre
- Comprehensive Regional Training plan
- Develop vision, principles, and scope for a future Regional Care Centre (focused on specialist tertiary eye care)

At a recent regional clinical workshop, the following priorities were identified and workstreams are now in place to progress them with key milestones and timelines being finalised. This year, another major development within ophthalmology will be the operational implementation of a comprehensive electronic patient record. An extended period of quality assurance and system testing has taken place to ensure optimal efficiency and effectiveness, with rollout ongoing through the year.

Transforming Cancer Services we continue to play an active role in the Cancer Collaborative Leadership Group to drive, participate and support the transformation of cancer services. Collectively and within our own services we are seeking to deliver the single cancer pathway, continually improve standards by updating pathways, where appropriate integrating services and delivering more care closer to home. Our aim is to provide the highest standard of care for everyone with cancer. This year we have a specific focus on implementing phase 1 of the ***Regional Acute Oncology Service (AOS) model and*** work closely with AOS Implementation Board to finalise service models and their implementation for phases 2 and 3. We also continue to work collaboratively with Velindre University NHS Trust on a Full Business Care for the Satellite Radiotherapy unit at Nevill Hall Hospital planned for submission in May 2022.

Sexual Assault Referral Services (SARC) Police and Crime Commissioners, Police Forces and Health Boards, in partnership with the third sector, have agreed a service model for delivery of sexual assault referral services in South Wales, Dyfed Powys and Gwent.

Aims of Regional SARC service model

'To deliver sexual assault services that are person/victim centred; with health and wellbeing needs as the key priority and to ensure the best outcomes for victims of sexual violence, achieved through a health-led programme, working in partnership with policing and key stakeholders with the victim voice in the centre.'

This provides a more integrated service, driven by the needs of victims and patients and supports provision of services that meet clinical, forensic, quality and safety standards and guidance (including new ISO accreditation requirements) within robust governance arrangements.

An Assurance and Oversight Board accountable to NHS Wales Collaborative has been established. A series of workstreams are in place (accommodation, standards, clinical rotas, engagement, commissioning/financial arrangements). The programme will deliver the initial centralisation of acute/paediatric services within the Cardiif hub in the first half of 2022/23 and accreditation standards complete by end of 2023/24.

Thoracic Surgery following a comprehensive consultation exerise, a collaborative planning programme has been established by Swansea Bay University Health Board to reconfigure the delivery of thoracic surgery services and to create a single site thoracic surgery centre for South Wales at Morriston Hospital, Swansea.

Our Health Board is fully engaged with clinical, planning and finance participating in the programme. An Outline Business Case is being prepared for early 2022/23, subject to approval, physical construction will commence in 2023/24 and the thoracic surgery regional service fully operational in 2025/26.

Aims and benefits of Regional Thoracic Surgery

- 300 additional cases/annum (total 1,300)
- Dedicated thoracic surgery hybrid theatre supporting improved health outcomes
- Improved equity of care across Wales
- Sustainable workforce (medical and nursing)
- Capacity to address unmet need (benign work) and support MDTs.

Pathology and Precision Medicine work continues with key strategic partners across the region to create a precision medicine campus at the Cardiff Edge Business Park. A key driver of this work is to realise a South East Wales Regional Pathology Service aligned to the Strategic Direction set out in the National Pathology Statement of Intent (2019). This would bring our region in line with both the ARCH (A Regional Collaboration for Health) programme in South West Wales and the delivery of a single pathology service in North Wales.

Cardiff and Vale University Health Board are leading this work on behalf of the region and are seeking to to secure appropraite programme management resource to move into phase two planning, specifically the development of a multi-agency business case for a SEW Regional Pathology Facility.

Robotics this IMTP cycle sees the continued development of Robotic Assisted Surgery (RAS) as part of a bold strategy to improve outcomes for our patients. It is part of a wide range of health redesign principles in Wales seeking to optimise the utilisation of finite health resource.

The Robotics Assisted Surgery Programme (NRP), the first of its kind worldwide for Colorectal, Upper Gastrointestinal, Urological and Gynaecology Oncology, is well estabilised as an All Wales Programe. Cardiff & Vale, Aneurin Bevan, Betsi Calwaladr and Swansea Bay University Health Boards work closer under its auspices to support the rapid adoption of robotics. A business case to support the commissioning of RAS at the University Hosptial Wales using Welsh Government funding streams was agreed by their Board in December 2021.

In conjunction with diagnostic hubs, health pathways and systems to establish early diagnosis of disease the RAS programme will deliver cutting edge technology in our tertiary hospitals. The Royal College of Surgeons' Future of Surgery Commission has identified RAS as one of the key technologies that will deliver the greatest impact for our patients. It allows doctors to perform complex procedures with more precision, flexibility and control than is possible with conventional techniques. It is usually associated with minimally invasive surgery – procedures performed through small (keyhole) incisions.

Diagnostics (including Community Diagnostic Hubs and Endoscopy)

Before the pandemic, the need for radical improvement in diagnostic services was already clear-cut, the Covid-19 pandemic has exacerbated the pre-existing problems and major expansion and reform of diagnostic services is needed over the next five years to facilitate recovery from the Covid-19 pandemic and to meet rising demand across multiple aspects of diagnostics. New facilities and equipment will be needed, together with a significant increase in the diagnostic workforce, skill-mix initiatives and the establishment of new roles working across traditional boundaries.

The establihsment of Community Diagnostic Hubs away from acute sites and working collaboratively across the region and with National Programme Boards to improve diagnostics endoscopy capacity and performance.

Welsh Ambulance Services NHS Trust (WAST) / Emergency Ambulance Services Committee (EASC)

It is recognised that the emergency / urgent ambulance service continues to face severe pressures across South East Wales and we remain fully engaged with both WAST and EASC in respect of the commissioning, monitoring and utilisation of emergency and urgent ambulance services across the Health Board.

EASC's commissioning intentions for the service for the coming year were endorsed in October 2021, and we will continue to liaise closely with WAST colleagues and contribute to work streams to ensure service responsiveness and quality is optimised within existing constraints as we move into 2022/23 and beyond.

DELIVERY FRAMEWORK

The most important part of any plan is not the document but how it is implemented. Partnership is core to delivery. We will be working with our Regional Partnership Board to oversee implementation of the plan, in particular to ensure an integrated approach and oversight of each of our life course priorities. Within the Health Board we want to ensure we have a clear approach to how we deliver the core priority programmes from this plan. We have established a clear clinical led delivery arrangement, this year we are further strengthening these with dedicated programme management support to ensure delivery at scale and pace.

It is important we also have a clear methodology for understanding if we are delivering our strategy and plan. Therefore, we will be putting in place, in the first quarter of 2022/23 a new organisational Outcomes Framework. The Outcomes Framework will capture information and provide assurance on delivery, importantly demonstrating the linkages across our system with a focus on outcomes.

Our Understanding of delivery of will be drawn from our existing reporting framework on which we will build greater connections across domains:

Domain	Reporting/ Modelling	Board Committee
Activity	Monthly Report/ MDS Quarterly Refresh	Board
Utilisation	Dynamic Planning Tool	Strategy, Planning Partnerships and Well-being Group/ Board
Workforce	Monthly Reporting	People and Culture Committee
Finance	Month End Reporting	Audit Finance and Risk Committee
Quality & Experience	QPS Report/ Clinical Audit	Patient Quality, Safety and Outcomes Committee

The development of outcomes measures for each life course priority will draw on national work to develop a series of Ministerial measures. It is important to recognise the difference between system outcomes and individual outcomes, for example population outcomes measures such as percentage of adults reporting they smoke or percentage of adults reporting clinically significant weight loss are useful in understanding impact of schemes on population outcomes. We will also develop proxy outcomes measures related to our clinical futures programmes to understand their impact on outcomes such as performance in Home First services and the shift to community and virtual delivery. These measures will allow us to understand the impact of our plan on our population alongside traditional reporting domains.

Outcomes for individuals, such as PROMs and PREMS are valuable tool within individual patient pathways and our focus is about using more of these measures within clinical pathways. However, it is difficult to scale these measures to understanding system impact.

Effective Governance

We recognise the importance of governance in ensuring that the organisation fulfils its overall purpose, achieves its intended aims and outcomes for our population, and operates in an effective, efficient, and ethical manner. The effectiveness of our governance arrangements will therefore have a significant impact on how well we deliver our vision, aims and objectives as set out within this plan.

We are committed to continually reflecting upon, developing and maturing our governance systems to ensure that the organisation 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. In doing so, we aim to continuously ensure that Aneurin Bevan University Health Board is a well-led organisation with effective, agile and proportionate structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, which are clearly set out and understood.

Our system of internal control is informed by the work of Internal Auditors, Clinical Audit and the Directors within the organisation who have responsibility for the development and maintenance of risk assurance and internal control frameworks. Comments on this are made by External Auditors in their Annual Audit Report and other reports. In addition, the work of Healthcare Inspectorate Wales (HIW) in both their planned and unplanned work and other regulators is utilised.

In 2021, Audit Wales (External Audit) undertook a Structured Assessment which is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004. Audit Wales concluded that, in respect of governance, the

> "*Health Board has adequate arrangements in place to conduct Board and Committee business, however there are opportunities to assess the effectiveness of these arrangements. The Health Board is embedding its new governance structure and strengthening its assurance mechanisms, but it will need to continually monitor and review them to ensure they are functioning as intended. The Health Board has gone through a period of high turnover amongst its senior leaders at Board-level whilst also holding a number of Independent Member vacancies. It will need to manage the risks associated with this turnover; particularly given the significant operational challenges it is facing*".

Under Joint Escalation and Intervention Arrangements, the Welsh Government meets with Audit Wales and Healthcare Inspectorate Wales twice a year to discuss the overall assessment of each Health Board, Trust and Special Health Authority in relation to the arrangements. On the basis of a tripartite group discussion, regarding 2021/22, the escalation status of Aneurin Bevan University Health Board remains unchanged at 'routine arrangements'.

Risk Management and Mitigation

Effective risk management is integral to enabling the Health Board to achieve our aims and objectives and deliver safe, high-quality services and patient care. A key priority for the Health Board has been to refresh the approach to Risk Management. Significant work has been undertaken in the year to review the system of risk management including the establishment of a Risk Management Community of Practice. The Health Board has implemented a clear risk management process with appropriate escalation through to Board Committees, and a lead executive director is responsible for the management of each of the strategic risks. The Health Board risk register is regularly considered by the Board with a regular review of the risks now being used to develop agendas for board committees. During the development of the Integrated Medium-Term Plan 2022-25, the Health Board's risks were reviewed to ensure that the Plan addresses the risks and supports the mitigating actions.

The Board has also made good progress in the development of a Board Assurance Framework (BAF) which provides a strategic map of assurance on the Health Board's delivery against its objectives and annual priorities and enables the Health Board to identify and understand the principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks and where improvements are needed, action plans are in place and are being delivered; and provide an assessment of the risk to achieving the objectives based on the strength of controls and assurances in place. In essence, the BAF aligns principal risks, key controls, its risk appetite and assurances on controls alongside each objective following the three lines of defence model. Gaps are identified where key controls and assurances are insufficient to mitigate the risk of non-delivery of objectives. This enables the Board to develop and monitor action plans intended to close the gaps.

In conjunction with the development of the Board Assurance Framework, the Health Board has refreshed and is strengthening the risk management process and systems in the organisation.

The management of risk is a key priority for the Health Board in 2022/23 and beyond. The BAF will continue to provide a framework to inform the Board on principal risks threatening the delivery of the Health Board's objectives.

Governance Priorities 2022/23

A Governance Work Programme will be established for 2022/23, which focuses on further strengthening the Health Board's governance arrangements, ensuring they are robust and fit for purpose. This programme of work will address areas identified for improvement over recent months, informed by Internal and External Audit and the Board's reflections on its effectiveness.

The Governance Work Programme will be monitored by the Audit, Risk and Assurance Committee on a quarterly basis and updates provided to the Board periodically. The Governance Work Programme for 2022/23 will include the following priorities:

Ensuring Clarity of Purpose, Roles, Responsibilities and Systems of Accountability, by

- Establishing a Deployment and Accountability Framework to enable appropriate integrated-decision making at all levels of the organisation, along with strengthened internal control
- Developing a Partnership Governance Framework to support achievement of the Board's objectives, where the involvement of our key partners is critical
- Further strengthening mechanisms for recording and reporting declarations of interest, gifts, hospitality and sponsorship.

Ensuring Board Effectiveness, by

- Reviewing and strengthening the Board's Committee Structure, aligning the Board's needs with its assurance and advisory infrastructure
- Re-establishing the Board's Advisory Structure, i.e., the Healthcare Professionals' Forum and the Stakeholder Reference Group
- Ensuring openness and transparency in the conduct of board and committee business
- Further improving the quality of reports and information to the Board and its Committees
- Implementing an annual development programme for Board members, focussing on awareness sessions as well as training and learning to support the development of individual roles and the Board as a cohesive team;
- Ensuring a programme of comprehensive recruitment and induction for Board Member appointments
- Promoting Board Member visibility, openness and engagement
- Reviewing and implementing arrangements for the development, review, approval and publication of policies delegated by the Board
- Reviewing Board Champion Roles, ensuring clarity on purpose and responsibility.

Embedding an Effective System of Risk and Assurance, by

- Further implementation of the Risk Management Strategy, ensuring it continues to be fit for purpose and supports the organisation to navigate risk management processes in a simplified manner
- Review the Board's Risk Appetite Statement, ensuring it is reflective of the organisation's capacity and capability to manage risks
- Prepare for implementation of a revised risk register reporting system to ensure it is comprehensive and aligned to the Corporate Risk Register (via Once for Wales Complaints Management System [DATIX])
- Further Embedding of the Board's Assurance Framework, aligned to the Corporate Risk Register
- Introducing a system of Organisational Assurance Mapping at a divisional and directorate level to inform internal control arrangements.


Partnership First
Workforce and Culture
Data and Intelligence
Transformation through Digital
Quality, Patient Safety, Experience and Value
Urgent Care System
Research, Innovation, Improvement and Value
Enabling Estates
Finance
Regional Solutions
Priority 1
Giving every child the best start in life
Priority 2
Getting it right for children and young adults
Priority 3
Supporting adults in Gwent to live healthy and age well
Priority 4
Providing high quality care and support for older adults
Priority 5
Dying well as a part of life

Aneurin Bevan University Health Board

2022/23 Delegation of Revenue Budgets

Purpose of the Report

The Health Board is required to set budgets prior to the beginning of the financial year, which are in accordance with the aims and objectives of the Integrated Medium Term Plan for 2022/23 through to 2024/25. Specifically, this means preparing and setting budgets within available funds.

This paper proposes to the Board the setting of:

- Initial revenue budgets to be delegated for the 2022/23 financial year,
- A quarterly review for Covid funding delegations, and
- Those budgets to be held in reserve – both in terms of planned commitments and any contingency (uncommitted reserve).

The Committee is asked to: (please tick as appropriate)	
Approve the Report	√
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Rob Holcombe – Interim Director of Finance, Procurement & VBHC

Report Author: Suzanne Jones – Interim Assistant Director of Finance

Report Received consideration and supported by :

Executive Team	**X**	**Committee of the Board [Public Partnerships & Wellbeing Committee]**	

Date of the Report: March 2022

Supplementary Papers Attached:
Appendix 1- Statutory Financial Duties
Appendix 2 – Glossary

Executive Summary

This paper sets out the principles and proposed approach to delegating funding at the start of the 2022/23 financial year within total available resources (£1.47bn).

In line with the agreed Board approach to financial sustainability and expected improvement in the underlying financial position, the IMTP financial plan has been focussed on making historic investment decisions sustainable.

The IMTP financial plan is based on applying the above principles, thus the focus has been on developing a budget strategy that:

- Ensures budget delegation plan values reconcile with Allocation funding
- Budget allocations are prioritised to making historical/underlying commitments sustainable as part of the 'Core' IMTP plan
- Budget delegation excludes Covid cost estimates and exceptional National Cost pressures – this is a risk but aligns with IMTP assumptions and will be identified as a quarterly budget review
- All allocations are delegated to service delivery - negligible central reserves held
- Requires budget holders to operate & deliver within delegated budgets
- Reflects that the IMTP is only affordable if £26m savings are delivered to support some of the service costs identified – a budget cannot be allocated for a saving.
- All other risks & pressures will need to be pro-actively managed & mitigated.

The approach has had to balance the challenges of funding historical commitments with statutory requirements and national agreements.

In addition to this initial budget delegation plan a quarterly financial budget planning and approval process is recommended for any additional Covid funding. This will ensure that the uncertainties of responding to the pandemic are appropriately mitigated, resourced and managed within the health board's governance framework.

Background and Context

1.0 Financial Governance

The Health Board is required to set budgets, prior to the start of the financial year, and these should be in accordance with the aims and objectives of the Integrated Medium Term Plan for 2022/23 through to 2024/25. Specifically, this means preparing and setting budgets within available funds and delegating them in line with the Health Board's Standing Financial Instructions (SFIs) and financial policy on budgetary control.

The Health Board's intention in producing a financial plan for next financial year has been to take an approach that appreciates the on-going changing and uncertain environment with regards to Covid and exceptional cost pressures that have a national impact.

In line with the agreed Board approach to financial sustainability and expected improvement in the underlying financial position, the IMTP financial plan has been focussed on making historical investment decisions sustainable.

As part of developing its service, workforce and financial plans the Health Board has developed a financial plan in 4 elements:

- Improving sustainability of historical investment commitments & identifying core service requirements for recovery
- Identifying efficiency & value savings requirements & risks to mitigate
- Identifying exceptional national cost pressures (Real Living Wage, NI, Energy)
- Identifying estimated Covid response costs (local and national)

WG have confirmed the allocation for Core service delivery and have confirmed national Covid costs will be supported (TTP, MVP, PPE) during 2022/23.

However, funding for exceptional national cost pressures and local ABUHB Covid response costs have NOT been confirmed. These unconfirmed cost pressures have been identified as areas that WG will consider and work with health boards to support financial balance.

The IMTP assumes Local Covid cost estimates and exceptional cost pressures will be managed during 2022/23 in partnership with WG; this is currently a risk due to its uncertainty.

The Health Board received the revenue allocation letter on the 21st December 2021. The Welsh Government draft budget provides £150m of funding across Welsh Health Boards to meet core and inflationary cost pressures for 22/23, including National Finance Agreement costs for NHS Wales. The ABUHB's element of the core uplift equates to £28.8m. The 22/23 initial baseline allocations for the Health Board includes an additional £32m (£170m across Wales) to support planned and unscheduled care sustainability, and £2.9m (£15m across Wales) to support the implementation of a Value Based Healthcare approach.

It should be noted that the allocation letter does not include funding for any 2022/23 pay awards or contractor services uplifts; funding for these remains with WG and will be delegated to ABUHB once settlements are agreed.

In the context of the Covid-19 pandemic, National Covid-19 schemes of Test, Trace & Protect (TTP), Mass Vaccinations and PPE are to be funded on an actual cost basis by WG. Except for Tracing, values have not been confirmed by WG. It is proposed that once plans are confirmed this funding will be anticipated and delegated on a quarterly basis, which is reflective of the uncertainty of operating during the pandemic.

2.0 Budget setting principles

The Health Board has previously confirmed a resource allocation strategy, presented below:

To support the resource allocation process, the Health Board has set out the following resource allocation principles to prioritise resources and delegate budgets and applies to the full revenue resource funding:

1. For established services, plans should demonstrate:
   - How service and workforce plans will be delivered within agreed resources?
   - How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales' and reduce socio-economic disadvantage?
   - Efficiency and productivity improvements which achieve (or aim to achieve) excellence.
2. Addressing the underlying financial position – service and workforce plans which demonstrate 1. (above) should be funded appropriately before considering new investments,
3. Savings plans should demonstrate delivery before approving new funding or re-investment,

4. Where savings have been identified, for new service proposals plans should demonstrate:
   - Fit with the Clinical Futures strategic direction of ABUHB,
   - If they are approved priorities,
   - How service and workforce plans will be delivered within agreed resources?
   - How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales?', and
   - Efficiency and productivity improvements which achieve (or aim to achieve) excellence,
5. The Board may choose to establish reserves which support key priorities and where plans require further development. This may include non-recurrent, tapered, or recurrent funding,
6. Pay awards to be funded in line with Welsh Government allocations, and
7. If funding becomes available or there is a level of savings achievement greater than the IMTP then the Board should consider and establish an appropriate contingency reserve, considering the level of financial risk within the IMTP.

In addition to these principles the Health Board has a duty to consider the requirements of 'Wellbeing of Future Generations Act (Wales) 2015', the Socioeconomic Duty for Wales, the 'Foundational Economy' and the Decarbonisation agenda.

3.0 Allocations & Income

Based on the above principles, this paper sets out the proposed allocation of revenue resources in 2022/23. It also takes account of the nature of some of the funding allocations, including directions from Welsh Government on the use of some funding allocations. Table A outlines the total allocations and net expected income for 2022/23 totalling £1.47bn.

Table A – 2022/23 allocations and income

Funding	£'000's
Confirmed Allocations	1,419,788
Anticipated Allocations	23,104
Other 'Central' Income	22,445
Total	1,465,337

(anticipated allocations correct at point in time)

Anticipated allocations include items which are:

- funded every year,
- considered likely (low risk),
- have agreement by Welsh Government, including Policy leads

Welsh Government has confirmed that funding to support National Covid responses will be made available; however, only Tracing has had a confirmed an indicative value. This was anticipated and has been delegated for quarter one. The remaining areas will be shared once further confirmation is received from WG.

Table B – Anticipated allocations

22/23 Anticipated Allocation (as at February 2022)	£'000
(Provider) Substance Misuse & increase	2,853
(Provider) SPR's	112
(Provider) Clinical Excellence Awards (CDA's)	109
CAMHS In Reach Funding	257
Technology Enabled Care National Programme (ETTF)	1,250
Informatics - Virtual Consultations	3,628
Invest to Save DHR Phase 2	(143)
Invest to Save Omnicell	(425)
Carers Funding	191
National Nursing Lead Community & Primary Care	53
National Clinical Lead for Falls & Frailty	26
National Clinical Lead for Primary and Community Care	113
National Allied Health Professional (AHP) Lead for Primary and Community Care	85
AHW:Prevention & Early Years allocation 20/21	1,171
Clinical Consultant Services Mr S Wood Planned Care	18
Substance misuse uplift 21-22	139
Healthy Weight-Obesity Pathway funding 21-22	550
Community Infrastructure Programme	180
C19 Support for Post Anaesthetic Critical Care Units (PACU)	904
TTP Q1 22/23 (based on 25% of 21/22 forecast costs)	3,750
WHSSC - National Specialist CAMHS improvements	139
Same Day Emergency Care (SDEC)	1,500
PSA Self-management Programme (Phase 1 & 2)	114
OP Transformation-Dermatology Specialist Advice and Guidance	22
OP Transformation-Dermatology Nurses Surgical Skills Study Day	4
WHSSC All Wales Traumatic Stress Quality Improvement	159
Children & Young People Mental Health & Emotional Wellbeing	200
CAMHS in-reach funding	521
Funding to support all age Mental Health - Tier 0/1 provision	200
Memory Assessment Services - Gwent RPB	565
EASC/WAST Improvements in MH Emergency Calls	51
WHSSC - Implementation of National Specialist CAMHS Improv.	131
Additional R&D pay uplift 1pct	16
1pct non-consolidated pay award B1-5	0
Digital Priority investment fund	530
Strategic Primary Care - additional posts	113
Learning Disabilities-Improving Lives	64
GMS Refresh	1,603
Primary Care Improvement Grant	142
GMS - Agreement for Pay and Expenses 21-22	2,208
Total Anticipated Allocations 22/23	**23,104**

Other Central income relates to the services that the Health Board provides to other organisations through a range of contracts and healthcare agreements, including WHSSC and HEIW.

The following funding allocations have either been top sliced from the Health Board's initial allocation or directed by Welsh Government in their application.

Top sliced funding	
NHS Wales Shared Services	(21,739)
Paramedic banding (to ring fenced)	(299,000)
111 service (to directed)	(50,000)
Total Top sliced	**(370,739)**

In addition, there are elements of the Health Board's allocation which are ring-fenced or directed funding that should be used for those specified purposes. These include Primary Care Contractors, Mental Health & Learning Disabilities and Regional Integration Fund. This is approximately 29% of the Health Board's total 2022/23 baseline allocation letter (27% 2021/22, 26% in 2020/21 and 2019/20).

After allowing for top slices to the 2022/23 recurrent core allocation, the funding uplift available for additional discretionary spending is £28.4m, plus funding that has an element

of direction from Welsh Government of; £3.8m Mental Health core uplift, planned and unscheduled care sustainability funding of £32m and value based recovery monies of £2.9m.

At this stage, the resource allocation proposals only consider those funding allocations which have been confirmed by Welsh Government or where it is reasonable to anticipate funding allocations. Should further resources be made available, then these will be allocated in line with the principles agreed by the Board and the priorities set out in the Annual Plan / IMTP.

4.0 Value, Efficiency & Savings assumptions

ABUHB has initiated a value-based care approach to decision making, aligned to improving technical efficiency and allocative efficiency. This approach aligns with national strategy, the quadruple aims and prudent healthcare objectives. The Covid-19 pandemic has driven a focus on responding to keep patients and staff safe, this has understandably reduced the focus on transformational change and efficiency improvement.

ABUHB is now developing a refreshed approach to re-engage the whole organisation in re-focussing on efficiency and taking a prudent healthcare approach to both daily front line decisions and corporate programme level.

This will be developed in 4 elements:

- Human Factor – re-engagement with staff and provision of OD & Education support programmes.
- Transformational Change – Providing expertise and capacity to support services to redesign and implement improvement across pathways of care aligned to VBHC.
- Autonomy & Accountability – empowering staff with clear expectations of ownership for improvement.
- Monitoring & Reporting – revised approach to structure and format of reporting achievements.

A Multi-disciplinary team approach (PMO, Planning, Value, Finance, Workforce, Information, ABCi) will be developed and used to provide the headroom for services to allow them to drive transformation for sustainable service delivery, improved patient outcomes and efficiency.

The financial plan (as part of the IMTP) identifies a significant level of opportunities for 2022/23 which need to translate into financial savings plans across all Divisions.

At this stage, cash releasing opportunities for 2022/23 have been assessed as circa £26.5m. This assumes a level of cost avoidance and further Divisional 'house-keeping' plans to mitigate a wide range of lower level investments. Based on the opportunities identified within the national and local Efficiency Frameworks, there are further opportunities which could increase this; however all opportunities need to be analysed and progressed to increase cash releasing savings, productivity improvements and improve health outcomes within available resources.

These changes should contribute to the cost effectiveness of services, population outcomes and the wider well-being objectives of the Health Board.

Areas of focus in the Health Board plan will develop the following value and efficiency opportunities:

- MSK and Eye care pathways (IMTP 2020/21)
- Outpatient transformation,
- Theatre utilisation,
- Urgent care including SDEC,
- DOSA , Day case rates and appropriate lengths of stay in hospital,
- Value based procurement,
- Vascular Regionalisation,
- Agile working,
- Estates rationalisation,
- Digital enabled savings,
- Diabetes pathway, and
- Workforce variable pay.

5.0 Allocating resources – proposed delegations

The Health Boards financial plan has been presented in terms of a core plan, exceptional pressures and Covid. The budget proposals recommend delegating resources toward the core plan, as follows:

Core Uplift (£28.8m) & Sustainability Funding (£32m)

This funding has been allocated to improving the sustainability of services where historical investment decisions have been made, including Clinical Futures developments requiring a recurrent funding source and where previous recurrent savings expectations have not been achieved. Statutory requirements (nurse staffing act) and national/regional commitments are funded from this allocation.

It is recommended that this funding be directed towards:

- Underlying deficit including Medical & Nurse Staffing and Facilities pay and non pay,
- Clinical futures medical, nursing & clinical posts,
- Clinical futures facilities services,
- Mental Health (CHC), Nursing staffing, external commissioning including specialist services and IM&T Investment
- Inflationary uplifts of 2.8% for LTA's including WHSSC & EASC, and
- Signed off Specialised Services plans developments (WHSSC & EASC)
- Community Hospitals additional capacity
- Nurse safer staffing levels
- Medical safer staffing levels
- Inter-site transport service
- Birth rate plus staffing levels
- Digital ICU, RISP & LINC

Mental Health Core Uplift:

It is proposed that this funding (£3.8m) be delegated to Mental Health to fund the underlying cost pressures experienced by MH Continuing Healthcare.

Value Based Recovery:

Budget proposals for the Value Based Recovery £2.9m:

- MSK £1.2m – part year effect (Therapies Director)
- Alcohol Liaison Team £0.2m (Medicine Division)

- Heart Failure £0.23m (Medicine Division)
- Value Team £0.16m (Finance Director), and
- The balance to be delegated as final plans are agreed £1.1m.

Repatriation and Regionalisation
Budget proposals are included for services that have been repatriated to ABUHB or are due to become regionalised:

- Vascular Services – this service is due to be a regional service during 2022/23, therefore funding equalling three quarters of the savings included in Scheduled Care's plan are proposed to transfer to Commissioning to cover the increased cost of this service; the balance required is to come from the funding uplift
- Neurology Services – these have been repatriated to ABUHB, it is proposed that budget is transferred to Medicine from Commissioning to cover the costs of the new service.

Partnerships
A balance of the Regional Partnership Funding, £10m, it is proposed that this is transferred to the Chief Executive budget, to be further delegated as RPB plans are finalised.

NICE
The New Treatment Fund is received to fund early implementation costs of NICE approved drugs and therapies, in line with 2021/22 it is proposed to delegate to Commissioning for Velindre NICE drugs (£2m), Medicine (£1m) and Scheduled Care (£0.9m). This non recurrent funding continues to contribute to the underlying cost pressures of ABUHB.

Funding for wage award, covid National and Local responses and exceptional cost pressures will be delegated as further information is received and presented to the Board.

Local Health Board priorities
The level of allocation funding for 2022/23 needs to consider existing and emerging priorities. Where proposals are considered high priorities and require additional funding, resource plans and business cases will be required to demonstrate the case for further investment. These will need to be assessed against affordability, the resource allocation principles, set out previously, and the socio-economic duty.

Relative prioritisation will need to be considered over the whole service portfolio of the health board to ensure developments can be afforded within available resources.

2022/23 Underlying Financial Position

The Health Board's underlying deficit reported to Welsh Government is c£21m and this is reflected in the use of the core uplift, at the end 2022/23 it is expected to reflect new cost pressures and non-recurring savings levels resulting in a forecast underlying deficit of c.£8m. This level of underlying deficit is expected to remain for the 3 year IMTP period while annual financial balance is achieved through non-recurrent opportunities.

Risks & Opportunities

- Uncertainty related to the Covid-19 pandemic and its service workforce and financial implications in the short, medium and long term.
  - Covid Local Response Plans, these costs are identified separately and excluded from the plan for further discussions with WG.

- Covid National Response Plans, these costs are identified separately and excluded from the plan as the agreement is that these will be funded on actual costs by WG.
- Delivery of identified cash releasing savings plans and improvement in the underlying financial position of the organisation.
- Delivery of further cost avoidance savings and productivity improvements.
- Implementation of the wider Clinical Futures programme within available resources.
- Managing cost growth in line with or below assumed levels, whilst ensuring delivery of key priorities.
- IFRS16 - implementation of IFRS16 (lease accounting) in NHS Wales will go live in April 2022. The Board assumes that any revenue or capital resource implications of implementation will be managed by Welsh Government, with no financial impact to Health Boards or Trusts across Wales.
- NHS Pension Scheme Regulations - It is assumed that any increase in employers' pension contributions will be met from additional government funding including discount rate changes and medical staff specific incentives,
- Pay award and any new changes to Terms & Conditions will be funded by WG separately,
- Exceptional Cost Pressures for Energy, real living wage and National Insurance increases are funded by WG,
- Inability to reduce bed numbers to reach the opportunities target,
- Holiday pay (voluntary overtime) - the potential on-going costs of meeting this liability, have been assumed to be funded by WG.
- Enhanced Sick Pay – if there is a decision to continue funding this pay element, the impact has not been included within this plan.
- Annual Leave Provisions – exceptionally agreed for 2020/21 & 21/22 are sufficient for actual costs incurred.
- The implications of the Ukraine crisis have not been factored into this assessment.

Covid-19 Response

The Welsh Government has confirmed funding for the National Covid responses but have only confirmed a value for the Tracing element. It is therefore, recommended that a quarterly budget delegation process is followed as further information is received.

The Welsh Government has not confirmed funding for Local Covid responses but have expressed the expectation that these are time limited to reflect the changing covid status. It is however recognised that services still need to ensure the safety of staff and patients. An estimate of c£36m is the health board's current assessment for 2022/23 for local covid response costs. The health Board is expecting to work with WG to find a solution, hence, this is currently excluded from the budget delegation process.

Exceptional Cost Pressures

At this stage the Health Board has not included costs in the core plan nor the budget delegation for the volatile energy increases, the increase in the national Insurance contributions from employers and the real living wage costs for NHS and externally commissioned staff. These are estimated to be c. £12m and the health board is expecting to work with WG to find a solution to these costs, therefore these are excluded from the budget setting exercise.

6.0 Reserves

In line with the Health Board's resource allocation principles, the following reserve commitments, presented in Table F, will be released in line with agreed plans or arrangements. A small contingency is identified against income losses for provider services with Powys tHB.

The budget delegation plan essentially delegates all available funding to service delivery.

Table C – Reserve commitments 2022/23

Reserves	22/23 (£'000)	Notes
Junior Doctor Rota Management	39	Confirming delegation area
Wales Cancer Network support and SLAs	273	Confirming delegation area
Lymphoedema Network SLAs	47	Confirming delegation area
Value Based Recovery balance	1,083	To be delegated in line with plans as they are finalised
Vascular Centralisation commitment	388	To be delegated if required
Neurology repatriation reserve	38	25% to be delegated if required
Powys income reduction commitment	972	To increase with further opportunities
Total reserves as at March 2022	**2,839**	

7.0 Contingency

The Health Board annually considers the level of contingency (or uncommitted reserves) to support the organisation as part of delegating budgets. Evidence from other organisations indicates that a contingency of between 2% and 5% would be desirable.

The level of financial risk, including savings required, to deliver financial balance during 2022/23 is significant and greater than it has been previously, however, there is no contingency available. Given the level of risks involved in the IMTP, it is recommended that if funding becomes available a contingency reserve is established to manage cost risks to support financial balance in 2022/23.

8.0 Proposed Budget Delegation

Based on the principles and rationale, set out in this paper, including reserve commitments and contingency, the following initial budgets are proposed for the 2022/23 financial year:

Table D – Proposed Delegated Budgets

Division	TOTAL (£'000)
Primary Care and Community	252,977
Prescribing	99,190
Community CHC & FNC	63,346
Mental Health	100,867
Director of Primary Community and Mental Health	321
Total Primary Care, Community and Mental Health	**516,702**
Scheduled Care	219,616
Urgent Care	34,843
Medicine	98,602
Family & Therapies	112,787
Estates and Facilities	78,262
Director of Operations	3,950
Total Director of Operations	**548,061**
Corporate / Exec budgets:-	-
Finance & Performance	9,479
Workforce & OD	6,633
Nurse Director	8,750
Chief Executive and non officer members	44,502
ABCi	713
Planning & Digital/ICT	26,410
Therapies Director	2,337
Board Secretary	901
Public Health Director	8,140
Unallocated Corporate	-
Medical Director	4,612
Litigation	-
Total Corporate Divisions	**112,477**
Specialist Services	-
WHSSC	144,435
EASC	36,179
Total Specialist Services	**180,613**
External Contracts	-
External Commissioning - LTAs'	80,417
External Commissioning - Access Plans'	500
Total External Contracts	**80,917**
Capital Charges	23,725
Total Capital Charges	**23,725**
	-
Total Delegated Position	**1,462,496**
	-
Reserve funding	2,839
Total	**1,465,335**

Recommendation

This paper sets out the principles and proposed approach to delegating funding at the start of the 2022/23 financial year within total available resources (£1.47bn), including a hybrid of annual and quarterly, approach to setting and reviewing the delegation of budgets, recognising that a flexible and practical approach to financial planning and delivery is required.

The Board is asked to:

- Approve the delegation of revenue budgets to divisions and corporate directorates, as set out in the paper,
- Approve the funding provisions to be held in reserve and contingency, based on commitments identified in the Health Board's IMTP,
- Approve the approach for setting covid related budgets, and
- Note the further work required to translate opportunities into savings plans.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks to achievement of the Health Board's statutory financial duties are identified in this paper, of particular risks are the level of recurrent savings required to manage within allocated resources & the impact of Covid-19.
Financial Assessment, including Value for Money	This paper provides details of the proposed budget delegation for 2022/23 financial year, based on agreed principles and the Health Board's Annual plan.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	The delegation of budgets is based on the AOF priorities agreed by the Board. On the basis that relevant impact assessments have been undertaken in agreeing these priorities, then further assessments have not been considered necessary.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the budgetary framework and delegation proposal which supports and the Health Board's Financial Plan for 2022/23, including allocation of resources to support agreed priorities.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – note the IMTP 3-year 2022/23-2024/25. **Integration** – investment plan recognises Clinical Futures and wider Partnership arrangements and internal & external pathway system integration. **Involvement** – Board and Executive team have considered wider priorities. **Collaboration** – Board approved IMTP includes reference to partners and wider stakeholder initiatives and joint working initiatives. **Prevention** – Prevention initiatives are part of budget plans as a priority.
Glossary of New Terms	Provided
Public Interest	Written for the public domain

Appendix 1

Statutory Financial Duties

1. Expenditure should not exceed aggregate funding over a period of 3 financial years, and
2. Prepare a plan (in line with point 1) which improves the health of the population and is approved by Welsh Government Ministers.

Ref: NHS (Wales) Act 2014

Extract from the LHB's Standing Financial Instructions (SFIs)

"Prior to the start of the financial year, the Director of Finance will…prepare and submit budgets for approval and delegation by the Board. Such budgets will:

1. *Be in accordance with the aims and objectives set out in the Integrated Medium Term Plan and medium term financial plan…,*
2. *Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce Plans, and*
3. *Be prepared within the limits of available funds."*

Appendix 2

Glossary

IMTP	Integrated Medium Term Plan
SFI's	Standing Financial Instructions
EASC	Emergency Ambulance Services Committee
WHSSC	Welsh Health Specialised Services Committee
GMS	General Medical Services
GDS	General Dental Services
GUH	Grange University Hospital
CF	Clinical Futures
LD	Learning Disabilities
LTA	Long Term Agreement (contracts between NHS bodies)
ICF	Intermediate Care Fund
RAG	Red / Amber / Green Savings Rating
WG	Welsh Government
PIP	Health Board's Pre Investment Panel
CHC	Continuing Health Care
FNC	Funded Nursing Care
RTT	Referral to Treatment
WCCIS	Welsh Community Care Information System
NICE	National Institute for Clinical Excellence
AWMSG	All Wales Medicines Strategy Group
RPB	Regional Partnership Board
SLC	Speech, Language Communication
CAMHS	Children & Adolescent Mental Health Services
NCN	Neighbourhood Care Network
AOF	Annual Operating Framework
RGH	Royal Gwent Hospital
YYF	Ysbyty Ystrad Fawr
DOSA	Day Of Surgery Admission
COTE	Care of the Elderly

Aneurin Bevan University Health Board

Draft Capital Programme – 2022/2023

Executive Summary

Approval of the Annual Capital Programme is a key requirement and is made up of two components:

All Wales Capital Funded Projects: This includes significant sized projects supporting major strategic proposals of the Health Board, and those projects seen as an exception to the discretionary financial level.

Discretionary Capital Programme: This is generally allocated for the following priority areas:

- Meeting statutory obligations, such as Health and Safety and Firecode.
- Maintaining the fabric of the estate; and
- The timely replacement of equipment, including IT.

Following a comprehensive capital prioritisation exercise across the Health Board's Operational Divisions, the proposed capital programme shortlist of Discretionary schemes and equipment has been developed for consideration by the Board.

The proposed opening Discretionary Capital Programme (DCP) position is as follows:

2022/23 Discretionary Capital Resource Limit (CRL) Draft	**2022/23 £m**
1. Discretionary Capital Funding (CRL)	8.227
2. AWCP Scheme Brokerage	(1.534)
3. Planned Disposals	Nil
TOTAL Discretionary CRL Available for distribution	**6.693**

- Due to reductions in NHS Wales capital availability, Welsh Government has had to reduce discretionary capital allocations by 24% across Wales in addition to having reduced funding availability to support the All-Wales capital programme. The Health Board's original allocation of £10.814m has been reduced to £8.227m.

- The planned brokerage reduction of £1.534m is due to slippage on All Wales Capital schemes in 2021/22. In November 2021, the Health Board's Capital Resource Limit for all projects was fixed and thereafter any slippage against 2021/22 capital projects is required to either be returned to Welsh Government as a saving or be managed

by the Health Board through the acceleration of 2022/23 Discretionary Capital Schemes. The brokerage of £1.534m required in 2021/22 has therefore been deducted from the opening Discretionary Capital allocation leaving a balance of funding remaining of £6.693m. This slippage in 2021/22 did enable priority schemes, primarily relating to equipment to be accelerated.

- There are no planned property disposals for 2022/23.

Following discussions with Welsh Government, the opening approved All Wales Capital Programme (AWCP) allocated for financial year 2022/23 is £23.081m. The planned DCP brokerage of £1.534m will be added to the approved AWCP allocations to fund the slippage that occurred against the AWCP projects in 2021/22.

No allowance has been identified within the Discretionary Capital Programme 2022/23 relating to Covid-19. To date capital expenditure relating to the pandemic has been funded through the All-Wales Capital Funding Stream.

The capital outlook for 2022/23 is a challenging one in the context of a lower opening funding allocation than previously in place and significant demands on the discretionary capital programme which will not be without risk. The prioritisation process has attempted to best manage and mitigate risks associated with sustainability.

The Board is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Nicola Prygodzicz, Director of Planning, Digital and IT

Report Author: Mike Ellery, Head of Capital Planning, and Kelly Jones, Head of Capital Finance.

Report Received consideration and supported by: Nicola Prygodzicz, Director of Planning, Digital and IT

Executive Team		**Committee of the Board**	

Date of the Report: 16th March 2022

Supplementary Papers Attached
Appendix 1 – Proposed Draft Capital Programme 2022-23

Purpose of the Report

This paper reports on the proposed opening Capital Programme for 2022/23 for both the All-Wales Capital Funding and the Discretionary Allocation to obtain Board approval to progress the schemes early in 2022/23.

Background and Context

The Capital Programme is made up of two key components:

i) **All Wales Capital Funded Projects,** which includes significant sized projects supporting major strategic proposals of the Health Board, and those projects seen as an exception to the discretionary programme.

ii) **Discretionary Capital Programme,** which is generally allocated for the following priority areas:

- Meeting statutory obligations, such as Health and Safety and Firecode.
- Maintaining the fabric of the estate; and
- The timely replacement of equipment, including IT.

The Capital Programme 2022/23 has been developed in the context of the priorities set out in the Integrated Medium-Term Plan for 2022/23.

In addition, supporting and facilitating the Health Boards Service Strategy where appropriate, the capital programme is drafted in the context of the approved Estate Strategy for the Health Board alongside significant risk areas identified in the 'Six Facet Survey' within that Strategic Document.

Assessment and Conclusion

Funding Outlook 2022/23

The following section sets out the Capital funding available and the proposed allocation for the financial year 2022/23.

Table 1 below identifies the opening Capital Resource Limit (CRL) allocated by Welsh Government (WG) for the Aneurin Bevan University Health Board for the financial year 2022/23.

Table 1 – ABUHB Capital Resource Limit (CRL) 2022/2023

2022/23 Capital Resource Limit (CRL)	**2022/23 £m**
1. Discretionary Capital Funding	8.227
2. Major Capital Projects with Approved Funding	23.081
TOTAL CRL (Approved Funding)	**31.308**

As identified above, the Discretionary Capital allocated by WG amounts to £8.227m, a reduction of £2.6m from the previous levels of discretionary capital due to the pressures on the NHS Wales capital budget.

In November 2021 the Health Board's Capital Resource Limit for all projects was fixed and thereafter any slippage against 2021/22 capital projects is required to either be returned to Welsh Government as a saving or be managed by the Health Board through the acceleration of 2022/23 Discretionary Capital Schemes (brokerage). To manage the 2021/22 end of year position £1.534m of DCP schemes have been brought forward. This amount is required to be deducted from the opening 2022/23 Discretionary Capital allocation leaving a balance of funding remaining of £6.693m.

All Wales Capital Funding 2022/23

Following discussions with Welsh Government, the opening approved All Wales Capital Programme (AWCP) allocated for financial year 2022/23 is £23.081m. The planned DCP brokerage of £1.534m described above will be added to the approved AWCP allocations to fund the slippage that occurred against the AWCP projects in 2021/22. The breakdown of the approved funding and brokerage is identified in table 2 below.

Table 2 – All Wales Capital Funding

ABUHB ALL WALES CAPITAL PROGRAMME 2022-23	Approved CRL's £m	Brokerage £m	Total Revised Funding £m
1. Grange University Hospital	-2.232	0.824	-1.408
2. Tredegar Health & Well-being Centre	10.228	-0.205	10.023
3. Radiotherapy Satellite Centre at Nevill Hall Hospital Fees	0.120	0.078	0.198
4. Mental Health SISU Fees	0.000	0.258	0.258
5. Breast Centralisation YYF	9.000	-0.011	8.989
6. ICF NHH Children's Centre	0.000	0.043	0.043
7. Covid Recovery Funding (SDEC @ GUH)	1.200	0.200	1.400
8. National Programme Imaging	4.765		4.765
9. NHH SRU Enabling Works Ante Natal	0.000	0.400	0.400
10. Other anticipated brokerage and VAT Savings smaller schemes	0.000	-0.053	-0.053
Total AWCP Scheme Funding	**23.081**	**1.534**	**24.615**

Major Capital Projects (AWCP):

Major capital projects that have received funding from All Wales Capital include:

- **Grange University Hospital:** The 2021/22 allocation carried forward for the Grange University Hospital scheme will enable the Well-being and Admin provision works across the wider Llanfrechfa Grange site to be completed. The current approved allocation assumes that £2.232m of VAT and inflation savings will be refunded to Welsh Government. The Health Board has submitted a request to retain these funds to address the additional works identified in relation to the CAU Waiting Area, ED Resus and the provision of additional temporary car parking space. Whilst a decision is awaited these works will be progressed via the Discretionary Capital Programme.

- **Tredegar Health and Well Being Centre:** The project is on-site with completion of phase 1 expected by February 2023 and phase 2 by October 2023.

- **Newport East Health and Well Being Centre:** The Full Business Case has been submitted to Welsh Government. Approval is expected before the end of March to allow enabling works to commence in May 2022.

- **Nevill Hall Satellite Radiotherapy Unit:** The Full Business Case is expected to be submitted to the Board in May 2022 prior to submission to Welsh Government. If approved construction is expected to start in September 2022 with a "Beam On" date of July 2024.

- **GUH- HSDU:** The project achieved practical completion on 9th February 2022.

- **Mental Health Specialist Services Inpatient Unit (SISU):** Following SOC approval an Outline Business Case is being prepared for submission to the Board in

May 2022, this is proposed to include a Psychiatric Intensive Care Unit, a Crisis Assessment Unit, a Learning Disability Unit, and a Low Secure Facility.

- **Breast Unit YYF:** The Full Business Case was approved by Welsh Government in January 2022 and subsequent discussions regarding inflation have resulted in further funding being approved. Construction will begin in May and completion is expected in May 2023.

- **RGH Expansion of Endoscopy Services:** A Business Justification Case was submitted to Welsh Government at the end of February for the construction of 4 Endoscopy Suites utilising accommodation vacated following completion of GUH. If approved, construction could commence in early June with completion in May 2023. This scheme is a key enabler to achieving sustainability for endoscopy services.

Emerging Projects without Approved AWCP Funding:
In addition to the above 'funded' or "in progress" All Wales Capital Projects further projects that are recognised by WG that are in development, but do not have 'approved funding' or indicative allocations at this time are listed below. A 'Programme of Work' is being developed and will be submitted to Welsh Government for funding support as appropriate.

These emerging projects generally come under the banner of major strategic developments or infrastructure including:

- RGH Decontamination Unit,
- NHH Emergency Department,
- NHH Cancer Unit
- eLGH infrastructure projects aligned to St Woolos Hospital, RGH & NHH reconfiguration
- Further Primary Care Developments at Ebbw Vale, Monmouth and Aber Valley
- Redevelopment of County Hospital
- GUH Main ED Wait
- RGH Pharmacy Refurbishment and Robot Replacement

The above schemes will need to be considered in the context of significant competing priorities for All Wales capital from all NHS organisations across Wales which exceed annual funding available and exclude those already approved through the business case process.

National Informatics Programme
Welsh Government has advised that the Digital Priority Investment Fund (DPIF) for 2022-23 financial year is challenging. They have confirmed that their capital budget has been cut by 60% to £10m and this has resulted in the National Programme being over committed at the start of the financial year.
Informatics will endeavour to liaise with Welsh Government should there be any opportunity of funding later in the financial year due to slippage.
This presents a significant challenge nationally and for Health Boards given the scale of investment required and ambition for informatics and delivery of the digital agenda.

Imaging National Programme: Welsh Government approved a 2-year National Imaging allocation during 2021/22. The table below indicates the approved year two allocations. The CT Scanners will be purchased during the year with associated works

completed. The equipment in relation to the General X-Ray room projects has been purchased in 2021/22, therefore the allocation relates to installation costs only.

Table 3

National Diagnostics Programme – Bids 2022-23		
NHH	CT Scanner	2,120.0
RGH	CT Scanner	2,120.0
YYF	General X-Ray Room YF2 Upgrade	525.0
NHH	General X-Ray Room NG7 Upgrade	
YAB	General X-Ray Room Yab2 Upgrade	
	Total ABUHB Bids:	**4765.0**

Health and Social Care Integration and Rebalancing Capital Fund. (ICF)
Welsh Government has identified the opportunity to submit investment bids from the new Health and Social Care Integration and Rebalancing Capital Fund (ICF). The funding will be focused on the development of integrated health and social care hubs and centres and to support the rebalancing of the social care market.

This new Capital Fund has two distinct priority areas of investment to support implementation of A Healthier Wales and deliver against some of the current Programme for Government commitments. The overall value of this capital fund amounts to £50m in 2022/23 growing to £60m the following year and £70m the year after that.

It will be important to work in partnership and align Primary Care priorities towards possible funding opportunities.

Three projects currently in the early stages of formal bids include:

- **North Gwent Children's Centre** (£TBC) A feasibility Study has been commissioned to review the current service provision and optimum location.

- **Pontllanfraith Health Centre Pontllanfraith** (Est. £500.0k) is a Health Board building that is in need of major refurbishment and upgrade to meet current standards and 21st century accommodation. The centre currently incorporates Dentist, Pharmacy, Practice, and other Health Board services. The centre has the potential to expand its services and patient base to become a more integrated facility. This project is currently at feasibility stage, and it will be important to ensure the Health Board and other key stakeholders are heavily involved in the outcome of the feasibility proposal.

- **Trethomas Health Centre,** (Est. £500.0k) is a Health Board owned premises that, pre-COVID, accommodated several services within the Family & Therapies Division. Due to the COVID-19 pandemic the services vacated the site at short notice to allow for a Primary Care Covid Assessment Hub to be set up. However, the current footprint has since incorporated an additional 10 services and needs major

refurbishment and redesign to meet current and future needs of what is a growing service. This project is currently at feasibility stage, and it will be important to ensure the Health Board and other key stakeholders are heavily involved in the outcome of the feasibility proposal.

Three further proposals for Integrated Health and Well Being Hubs are also being developed in partnership that will be considered and may align to the criteria for this new fund.

Proposed Discretionary Capital Programme:
Following a comprehensive capital prioritisation exercise across the Health Board's Operational Divisions, the proposed opening capital programme shortlist has been developed for consideration and approval by the Board.

This shortlist has been developed from priority bids across divisions amounting to over £24million, clearly identifying the pressures on Discretionary funding. Therefore, the proposed opening position accounts for an anticipated discretionary allocation of £6.693m, after the deduction of end of year brokerage of £1.534m, which has been allocated in respect to risk and prioritisation within the organisation.

The expenditure within the Discretionary Capital Programme for 2022/2023 is identified by project in appendix 1 and is summarised in Table 4 below which also summarises Divisional allocations following the prioritisation assessment:

Table 4

Discretionary Capital Plan:	**Proposed 22/23 Programme £m**	**All Divisional 22/23 Priorities £m**
Discretionary Baseline Funding	8.227	8.227
AWCP Estimated Brokerage	-1.534	-1.534
Disposals	0	0
Available Discretionary Funding 2022/23	6.693	6.693
Statutory Allocations (including H&S)	0.576	1.648
B/f Commitments from 2021/22:	1.317	1.317
Divisional Priorities 2022/23:		
Mental Health & Learning Disabilities	0.260	0.950
Facilities	0.018	2.775
Scheduled Care	0.169	0.702
Family & Therapies	0.000	0.530
Primary Care & Community	0.110	1.302
Medicine	0.000	0.919
Urgent Care	0.030	0.030
Corporate Priorities:		
NHH Cancer Unit Fees	0.280	0.280
GUH Works (CEAU Wait, Temp Carparking, Resuscitation area.)	1.602	1.602

Internal Fees to support delivery of AWCP Projects	0.300	0.330
Fees to progress RGH decontamination Unit	0.000	0.114
Fees to progress NHH Front Door	0.000	0.051
NHH SRU Enabling Works	0.000	0.778
Informatics National Priority & Sustainability	1.800	10.764
Total Shortlisted Bids:	6.462	24.092
Contingency Sum:	0.231	0
Total Proposed Bid Approvals:	6.693	24.092
CRL Budget:	6.693	6.693
Balance:	0.000	17.399

Appendix 1 provides additional detailed information of the schemes/projects identified above and are summarised below:

Appendix 2 provides an extended schedule of bids totalling circa £5.8million that has been developed to ensure any opportunity of an All Wales Capital Programme slippage throughout the financial year is maximised and a potential increase in discretionary or new targeted funding. Even if additional £5.8million funding was made available there is still a shortfall of over £11.6million to deliver all requested bids.

Estates Statutory Compliance allocation (£576.0k), managing statutory backlog programme and compliance issues including issues with Electricity at Work Regulations, Legionella management, Disable Discrimination Act (DDA) requirements. An additional allocation has been proposed to enable the Health Board compliance with Statutory Asbestos Management Compliance £510.0K over a revised 4-year programme (£100.00k financial year 2022/23) and H&S fire allocation (£76.0k).

Commitments brought forward from 2021/22 amounting to £1.317m which includes, Duct Works (£175k), Refurbishment of Cordell for General Pre-Assessment Clinics & B6 for Sexual Health (£600k, Replacement Maternity System (£82.k), Viewpoint 6 system upgrade (£75k) and anticipated other slippage of various small schemes.

Divisional Priorities: These are sustainability schemes and planned Projects put forward by Divisions through planned divisional service strategies and regular assessment of service development/efficiency and safety requirements which support the IMTP process and include: Replacement of Maternity System (£82.0k), Compliance requirements for smoking areas Mental Health & Learning Disabilities (178.0k), Clinical Consulting Room Refurbishment Primary and Community Care (£110.0k).

Corporate Priorities: Generally, relate to major projects seeking funding through the All-Wales Capital Programme (AWCP). However, discretionary funding must be utilised 'at risk' to service the project developments until submitted to Welsh Government project funding award is received from the All-Wales Capital Programme. On approval the costs are replenished back into the Discretionary Capital Programme and Internal fees to support delivery of AWCP Schemes.

This also includes three schemes that relate to the GUH (Childrens assessment unit waiting area expansion, additional temporary parking, and increased resuscitation

isolation rooms) that were approved to be funded from the VAT savings referenced earlier.

Given the current plan by Welsh Government to recover this funding the schemes will need to be funded from discretionary allocation unless the funding is secured back into the Health Board allocation.

Informatics have identified priority bids amounting to £10.8million. However, given the reduced discretionary resources available an allocation amounting to £1.5m is recommended which includes WCCIS related schemes and other infrastructure priorities.

Risks of Capital Constraints 2022/23:

The significant pressures on the capital funding for 22/23 in the context of the high demands for capital there has required a more robust prioritisation and risk management approach.

- Statutory requirements in Asbestos Management and MH&LD smoking shelters/areas have been phased over a 2-year affordable period This ensures that the Health Board commits to commencing the works, meeting its obligation of compliance. It should be noted that plans were in place to increase funding for backlog maintenance to £820k which has not been possible for the opening programme due to the reduced funding available and therefore will delay addressing the risks associated with the existing condition of the estate.
- The delay in the replacement of equipment which is past its manufacturer's life expectancy will increases the risk of failure or breakdown with a possible impact or difficulties to efficient service provision.
- The lift replacement programme will need to be delayed requiring the lifts to work further past their expected life span. This will possibly impose delays to the efficiency of the service and additional cost to the day-to-day revenue costs depending on breakdown and maintenance callouts.
- The informatics programme will need to be prioritised based on maintaining a safe and reliable ICT service to the Health Board which includes cyber security risks/vulnerability, legal and regulatory compliance risks. This will result in reduced funding for the refresh of key infrastructure potentially reducing the reliability of IT across the Health Board. This also limits the opportunity for any further projects and transformation programmes that require capital investment. Alternative funding opportunities to help addressing the shortfall in capital will need to be reviewed to reduce the risk.
- This position also limits the opportunities for service improvement and transformation that support the Health Board strategic programmes.
- Increased capital availability later in the financial year whilst supporting the significant demand for capital is also restrictive in terms of addressing priorities due to lead times of key projects. Delays around the ICF capital decision making and approval processed has also been a key issue and will need to be improved to ensure optimisation of this increased funding source.

Contingency Sum

Following the reduction of Welsh Government Funding it has been agreed to maintain £230,700 contingency within the Capital Programme. The contingency commitment will be reviewed throughout the year and committed to projects as the year end gets closer.

Governance
All Capital will be managed in accordance to the Health Board's Capital Procedures, Standing Financial Instructions (SFIs) and to the Capital Investment Manual (Wales), for Major Projects.

Key Risks and Assumptions:

- Discretionary projects with estimated costs exceeding £1m, may require prioritisation and Ministerial Approval following further internal scrutiny and refinement.
- There is a possibility that additional funding may be made available from the All-Wales Capital Programme due to slippage later in the financial year.
- An extended schedule of bids has been developed to take any opportunity of All Wales Capital Programme slippage throughout the financial year.

Recommendation

The Health Board is requested to:

1. Note the content of this paper and the significant demands on the Capital Programme for 2022/23.
2. Approve the attached 'Draft Opening Capital Programme 2022/23' (Appendix 1).
3. Approve the Imaging National Programme Replacement Bids, and those over £500k (see table 3) NHH CT Scanner (£2.12million), RGH CT Scanner (£2.12million), General X-Ray Room Upgrades (£525.0k)
4. Approve New Projects/Equipment Over £500k. Statutory Compliance (£500.0k), Refurb of Cordell for General PAC & B6 for Sexual Health (£600.0k), CEAU waiting area extension (£740.0k), GUH - Temp Carpark (£600.0k)
5. Subject to award of additional Welsh Government Funding, approve the next set of priorities, as set out in Appendix 2, including those schemes over £500k: ECT Move to Nevill Hall (£600.0k), Patient and goods lifts in hospital sites - 3-year plan (£603.0k), Informatics (£1.5million)

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The paper provides the Proposed Draft Capital Plan for the financial year 2022/23. There will be a contingency sum that will be reviewed and maintained throughout the year.
Financial Assessment, including Value for Money	The financial implications of the Health Board's Capital Programme are fully described within the paper.
Quality, Safety and Patient Experience Assessment	Quality, safety, and patient experience are key elements of the risk-based assessments undertaken with Divisions and across the organisation.
Equality and Diversity Impact Assessment (including child impact assessment)	It is not considered that there are equality and diversity impacts of the Capital Programme.

Health and Care Standards	The two Business Justification Cases describe how the Health Board will meet health and care standards for the relevant services.
Link to Integrated Medium Term Plan/Corporate Objectives	The paper links to Section 5 of the Board's approved Integrated Medium-Term Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The paper demonstrated an integrated approach to working across the Health Board and combines both short- and long-term goals.
Glossary of Terms	None
Public Interest	None

Discretionary Capital Bids - DRAFT OPENING PROGRAMME 2022/2

APPENDIX 1

Line No.	PPD No.	Division	Description	Location/Site	Benefits	Estimated Value £000 (incl. VAT)	Comments
Health and Safety							
1	1141	Health & Safety	Direct Service Allocation for Statutory Compliance Regulatory Reform Order (Fire Safety 2005)	Various	Reduces risk to HB of legislative action, prosecution and adverse publicity. Supports business continuity by reducing risk of prohibition of use to all or part of HB premises.	76.0	Discretionary minor fire safety works spending to allow a working budget. In addition this includes a phased plan to rectify all means of escape risks over 3 years as well as a phased plan to replace alarm systems at lower risk premises.
					Total	**76.0**	
Mental Health and Learning Disabilities							
1	575	MH & LD	WIFI - Maindiff Court			23.0	Previous Year commitment
2	774	MH & LD	Monmouthshire Team relocation to			9.0	Previous Year commitment
3	890	MH & LD	Extend the Clinic Room on Talygarn – Infection Control recommendation			16.0	Previous Year commitment
4	676	MH & LD	Hi Lo Baths Ty Lafant and Ty Glas			55.0	Previous Year commitment
5	1130	MH & LD	Inpatient Ligature Works	Adult Wards, Ty Lafant and Hafen Deg	Continuation of the ongoing Anti Ligature programme. To ensure safer inpatient services and a reduction in the risk of self harm	50.0	This is an estimated cost - we wont know how much work is required and costings until the outcome of the yearly Ligature Risk Assessments in March 2022
6	1122	MH & LD	Conversion of Assisted Bathroom into a wet room	Hafen Deg Ward, County	Improved and safer access for older adult patients to shower facilities. This will allow improved assistance	30.0	Estimated Cost - awaiting costings
#REF!	1131	MH & LD	Designated Smoking Areas	All inpatient Sites	To comply with the recommendations set out in the Exec report. The Public Health (Wales) Act 2017 and the Smoke-free Premises and Vehicles (Wales)	180.0	In line with Option 1 outlined in the Recommendations of the Exec report. 2 year programme
					Total	**363.0**	
Estates and Facilities							
1	821	Estates and Facilities	Duct St Cadocs		Previous Year commitment	175.0	Previous Year commitment
2	1026	Estates and Facilities	Statutory Compliance	Various	statutory Allocation	500.0	**Separate Approval over £500.0k required**
3	469	Estates and Facilities	Asbestos Surveys (Year 3)	Various		100.0	£172.Bid Reduce & extend surveys over further 2 years.
4	1026	Estates and Facilities	Height Adjustable Sinks	RGH		18.3	
					Total	**793.3**	
Scheduled Care							
1	905	Scheduled Care	Refurb of Cordell for General PAC & B6 for Sexual Health			600.0	Previous Year commitment - **Separate Approval over £500.0k required**
2	871	Scheduled Care	CCTV for RGH Site			6.0	Previous Year commitment
3	1069	Estates and Facilities	RGH Main/ Bellevue Front Door Upgrade		Previous Year commitment	68.0	Previous Year commitment
4		Scheduled Care	Replacement Choledocopes		When Video choledoscopes were purchased for GUH it was acknowledged the existing flexible scopes were	81.0	
5	1143	Scheduled Care	Replacement Monitors for OSU		Current kit on ward dates to 2006 and are not compatible with new theatre monitors. Parts are also	88.0	
					Total	**843.0**	
Family and Therapies							
1	513	Family & Therapies	Replacement Maternity System			82.0	Previous Year commitment
2	833	Family & Therapies	Viewpoint 6 system upgrade			75.0	Previous Year commitment
					Total	**157.0**	
Primary Care and Community							
1	1073	Primary Care and Community	Clinical Rooms require essential refurbishemnet	Pengam HC Glan yr Afon Lane	The current patient experience on the site is that of poor building infrastructure and rooms that do not	110.0	PPD Complete
					Total	**110.0**	
Medicine							
1					Nil submission	0.0	
					Total	**0.0**	
Urgent Care							
1		Urgent Care	ED / MAU / SAU / Same Day Emergency Care (SDEC) IT requirement - **Symphony upgrade**	GUH		30.0	Initial upgrade until further work completed for version 3 - Cost to be confirmed
					Total	**30.0**	
Corporate							
1	865	Corporate	NHH Cancer Unit Fees	NHH		280.0	Previous Year commitment -
2	1078	Corporate	CEAU waiting area extension	GUH		740.0	Previous Year commitment - **Separate Approval over £500.0k required**
3	1074	Corporate	GUH - Temp Carpark	GUH		600.0	Previous Year commitment - **Separate Approval over £500.0k required**
4	1157	Corporate	Internal fees to support delivery of AWCP Schemes	Various		300.0	Total figure - need to work out how much can be funded from approved AWCP projects.
5		Corporate	Resusitation Works	GUH		262.0	Estimated Caost
					Total	**2,182.0**	
Informatics							
1	931	Informatics	Data Centre Move			22.0	Previous Year commitment
2		Informatics	Critical Server Refresh			86.0	Previous Year commitment
3		Informatics	Devices - Essential Replacements only	HB Wide		300.0	
4		Informatics	Accelerated Program Staff				£317.0k actual bid - Award to be bid against individual projects.
5		Informatics	Contact Centre	HB Wide			£145.0k actual bid - Unsupported Technology
6		Informatics	Critical Network Edge Refresh	HB Wide			£860.0k actual bid - Unsupported Technology Split into tranches
7		Informatics	Windows hardware refresh	HB Wide			£1,300.0k actual bid requested
8		Informatics	ECR and CCR Room Improvements	HB Wide			£499.0k bid requested
9		Informatics	Data Centre Move	Mamhilad		1500.0	£50.0k bid requested
10		Informatics	Microsoft Server Licencing - 3 year	HB Wide			£800.0k bid requested - Cyber contract end date September 2022
11		Informatics	Accelerated Program Staff	HB Wide			£217.0k bid requested
12		Informatics	WCCIS Staff	HB Wide			£420.0k bid requested
13		Informatics	Web Filtering	HB Wide			£250.0k bid requested - awaiting official quote - Current become unsupported dec 2022 - Note windows E5 MM
14		Informatics	Antivirus	HB Wide			£850.0k bid requested - awaiting official quote - Need by March 2023 Note windows E5 MM
					Total	**1,908.0**	
					Contingency:	**230.7**	
					Total Bids	**6,462**	
					Funding Available	**6,693**	
					Balance	**0.0**	

Note : **Separate Approval over £500.0k required**

Appendix 2

Discretionary Capital Bids - DRAFT NEXT PRIORITY BIDS - AWAITING FUNDING OPPORTUNITIES 2022/2023

Health and Safety							
1	1139	Health & Safety	Upgrade to the Fire Alarm and Detection System at The Royal Gwent Hospital	Royal Gwent Hospital	The replacement system will be in line with current British Standard 5839 Part 1, WHTM 05-02 & WHTM 05-03 Part B and will be more effective at fire detection the provision of early warning with the	205.0	£612.7k Bid requested - System must be replaced within/over next 3 years to maintain patient and staff safety. This is a complex project. It is important that we make progress this year to allow completion. while the existing system is still viable. **3 Year Programme of work:** Yr 1:
2	1142	Health & Safety	Essential Survey of Compartmentation at the Royal Gwent Hospital.	Royal Gwent Hospital	The proposed solution will provide 3rd party assurance of existing fire stopping and highlight deficiencies that can be recorded, risk evaluated and remedied on a risk based approach.	56.7	Although no survey has been completed to date there are known issues with compartmentation on site.
3	1140	Health & Safety	Essential refurbishment of Nevill Hall Hospital Fire Alarm System	NHH	The replacement system will be in line with current British Standard 5839 Part 1, WHTM 05-02 & WHTM 05-03 Part B and will be more effective at fire detection the provision of early warning and the	165.0	£326.7k phased approach This work will complete the transition of the alarm system at Nevill Hall to a stable modern system. All components within the main building will be up to date. A phased replacement of components in outlaying buildings will follow. **3 Year Programme of**
					Total	**426.7**	
Mental Health and Learning Disabilities							
1	966	MH & LD	Anti Climb for Ty Cyfannol and Carn y Cefn Courtyards	Carn y Cefn, YAB and Ty Cyfannol, YYF	Reduce risk of harm to patients via attempted absconsion from the unit via the courtyard wall and fence. There have been a number of incidents whereby pts have fallen from the courtyard wall/fence when trying to leave the unit	82.6	Estimated Cost - Will commence the Tender process with support from Procurement once monies are released
2	1123	MH & LD	ECT Move to Nevill Hall	Maindiff Court	To be co-located on a General Ward and close to physical interventions and a crash team	600.0	Awaiting confirmation of the plans and costings - PPD received with no confirmed costs - **Separate Approval over £500.0k required**
					Total	**682.6**	
Estates and Facilities							
1	805	Estates and Facilities	Urgent repairs/replacement are required to the roof of ABUHB HQ at SCH	SCH		913.5	
2	856	Estates and Facilities	Patient and goods lifts in hospital sites (3 year plan)	all		603.0	**Separate Approval over £500.0k required**
3	867	Estates and Facilities	Refurbishment of the restaurant staff toilets male/female at NHH	NHH		77.9	
4	868	Estates and Facilities	Upgrade coffee lounge/replacement of restaurant furnishings at NHH	NHH		40.6	
					Total	**1,635.0**	
Scheduled Care							
1	1041	Scheduled Care	Pentacam Scanners x 2		Pentacam Topography is a non-invasive imaging technique essential for diagnosis & treatment of cornea patients. ABUHB has long cornea waiting lists	106.0	
2	1070	Scheduled Care	Swipe Access to X 7 Wards on RGH site	RGH	Following site reconfiguration, swipe access is required for D7E, C7W, C7E, C6E, C6W, C5E & C5W	42.9	
					Total	**148.9**	
Family and Therapies							
1		Family & Therapies	Temporary Discharge Lounge and S.136 Provision	TBC	For a young person experiencing burgeoning emotional distress that is quickly becoming overwhelming, the idea of being able to quickly access a safe, non-judgmental professional with	TBC	Walkarounds ongoing before options/costings can be confirmed for both temporary and long term solution. Awaiting revised PPD - options for a temporary and permanent solution being explored by CAMHS service)
2	1158	Family & Therapies	Pollard's Well Roof replacement - phase 3 of works	Pollard's Well, St Cadoc's	Pollards Well is a building situated on the St Cadocs site and is used daily by staff within the S CAMHS Service. The building was originally purposed as a	229.09	Phase 3 of Pollard's Well refurbishment. Awaiting costings from W&Es
					Total	**229.1**	
Primary Care and Community							
1		Primary Care and Community	Building Refurbishment: The building is in a Poor condition, with significant costs required to bring to	Pontllanfraith Health Centre Blackwood Road,	Pontllanfraith is a ABHB building that has become run down over time. .There is an appetite to improve services at this centre and has currently	0.0	£500.0k - Planned funding stream new ICF model. Cost pending completion of feasibility study **- ASSUME ICF FUNDED**
2		Primary Care and Community	Trethomas Clinic is a ABUHB owned premise that pre-COVID accommodated a number of services within the Family &	Trethomas Health Centre, William St, Trethomas CF83 8FXT	Trethomas has the ability to function.. A Redesign of the interior of the building will allow expansion of service and add to the patient experience whilst enhancing the adherence infection control issues. A	0.0	£500.0k - Planned funding stream new ICF model. Cost pending completion of feasibility study - **ASSUME ICF FUNDED**
3	1132	Primary Care and Community	This space had been identified for refurbishment as part of an existing case to redevelop and upgrade the	RGH Pharmacy	Allows the Pharmacy Homecare team to expand to deliver the increasing demand for Homecare services. This facilitates the delivery of complex	12.0	PPD Complete
4		Primary Care and Community	Fit Safety Screens to Oak Ward stair well . Fly screens required on all windows, The ward experienced a	Code-y-Grid Rd, Griffithstown, Pontypool NP4 5YA	The stairwell has issues with both falls and possible se	30.0	Estimated Waiting Formal Costs
					Total	**42.0**	
Medicine							
1	1144	Medicine	Paediatric Colonoscope	YYF	To enable to endoscopy service to scope more inpatients and outpatients in YYF. This equipment will improve early cancer diagnosis, support the surveillance programme and ease the pressure at	49.0	
2	1146	Medicine	Mind ray endoscopy equipment	NHH	Replacement equipment but includes capnography which is not currently available on existing monitors.	16.0	
3	1145	Medicine	Refurbishment of toilet blocks on wards 3/1 & 3/2	NHH	Maintenance of privacy and dignity. Safety of staff and patients when transferring patients.	154.0	
					Total	**219.0**	
Urgent Care							
Corporate							
1	1133	Corporate	Decontamination Unit	RGH	A centralised Decontamination Unit to support the wider Endoscopy Project. The unit will service 4 Endoscopy Theatres, Urology, Urology Theatres, ENT and Cardiology	114.0	
2	1006	Corporate	NHH Front Door	NHH	To review the NHH Front Door model to provide an improved flow and more efficient facility for Minor Injuries	51.0	To support the wider clinical futures model.
3	NO PPD	Corporate	Provision for Enabling works in relation to NHH SRU (will be refunded once FBC is approved)	NHH	Enables the demolition to be progressed during the FBC approval period to maintain programme.	778.0	Supports the NHH Satellite Radiotherapy Scheme to progress.- **Separate Approval over £500.0k required**
					Total	**943.0**	
Informatics							
1		Informatics	Accelerated Program Staff				Bid submitted £317.0k - Award to be bid against individual projects.
2		Informatics	Contact Centre	HB Wide	Unsupported Technology		
3		Informatics	Critical Network Edge Refresh	HB Wide	Unsupported Technology		Split into tranches - request early approval
4		Informatics	Windows hardware refresh	HB Wide	Unsupported Technology		£1,300.0k bid requested
5		Informatics	ECR and CCR Room Improvements	HB Wide			£499.0k Bid
6		Informatics	Data Centre Move	Mamhilad			£50.0k bid
7		Informatics	Microsoft Server Licencing - 3 year	HB Wide			£800.0 bid - Cyber Contract end date September 2022
8		Informatics	Accelerated Program Staff	HB Wide			£217.0k bid
9		Informatics	WCCIS Staff	HB Wide			£420.0k bid
10		Informatics	Web Filtering	HB Wide	Unsupported Technology		£250.0k - awaiting official quote - Current become unsupported dec 2022 - Note windows E5 MM
11		Informatics	Antivirus	HB Wide			£850.0k bid - awaiting official quote - Need by March 2023 Note windows E5 MM
					Total bid to be reviewed against priorities	1,500.0	
					Total of all next priorities	**5,826.25**	

Note : **Separate Approval over £500.0k required**

Emerging Projects

Family and Therapies							
		Family & Therapies	Permanent Discharge Lounge and S.136 Provision	TBC	For a young person experiencing burgeoning emotional distress that is quickly becoming overwhelming, the idea of being able to quickly access a safe, non-judgmental professional with	TBC	Walkarounds ongoing before options/costings can be confirmed for both temporary and long term solution. Awaiting revised PPD - options for a temporary and permanent solution being explored by CAMHS service)
Urgent Care							
		Urgent Care	ED / MAU / SAU / Same Day Emergency Care (SDEC) IT requirement - Symphony 3	GUH		TBC	
SC RGH Site Capital Development Schemes							
		Scheduled Care	Refurb of theatres 15, 16 & 17 (Urology)	RGH	Theatres failing - Feasibility Required	TBC	
		Scheduled Care	NHH Day Surgery Unit - Feasibility Fees	NHH	As per CF and eLGH reconfiguration plan	TBC	
		Scheduled Care	NHH Day Surgery Unit - Refurb	NHH	As per CF and eLGH reconfiguration plan	TBC	
		Scheduled Care	Refurb of B6E for Orthopaedic PAC	RGH	As per eLGH reconfiguration plan . Allows service transfer from SWH	250.0	Estimated Cost
		Scheduled Care	NHH Llanwenarth Suite - Feasibility Fees	NHH	Ophthalmology Recovery and Regional Plan	TBC	
		Scheduled Care	NHH Llanwenarth Suite - Refurb	NHH	Ophthalmology Recovery and Regional Plan	TBC	
		Scheduled Care	Refurb B7 Infrastructure	RGH	Recovery plans	550.0	Estimated Cost
		Scheduled Care	Laminar flow to B7 theatres	RGH	Recovery plans	TBC	
		Scheduled Care	POCU refurb scheme	RGH	Toilet facilities for patients (accommodation previously ITU)	TBC	
		Scheduled Care	Complete refurbishment of D5W (Environmental Committee)	RGH	Anticipated circa £1.8m	TBC	
		Scheduled Care	Flexi Unit D2E	RGH	As per eLGH reconfiguration plan	365.0	Estimated Cost
		Scheduled Care	Refurb of blocks 4/5	RGH	Circa £2m. Supports eLGH reconfiguration plans - transfer of staff from SWH	TBC	
					Total	**TBC**	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 23rd March 2022 Agenda Item: 3.4

Aneurin Bevan University Health Board

Royal Gwent Hospital - Redevelopment and Expansion of Endoscopy Services - Business Case Submission

Executive Summary			
The attached Business Justification Case (BJC) has been prepared to support the proposed redevelopment and expansion of Endoscopy services at Royal Gwent Hospital (RGH). The estimated capital cost of the development is £9.145 million.			
The Board is asked to: (please tick as appropriate)			
Approve the Report	√		
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Nicola Prygodzicz, Director of Planning, Performance, Digital & IT			
Report Author: Andrew Walker			
Report Received consideration and supported by :			
Executive Team	√	**Committee of the Board [Committee Name]**	
Date of the Report:			
Supplementary Papers Attached: BJC plus Appendices			

Purpose of the Report

The purpose of this report is to request Health Board approval of the BJC so that it can be formally submitted to Welsh Government for full and final approval. Approval of the BJC will allow construction to commence.

Background and Context

The purpose of this BJC is to seek Welsh Government approval for a total capital investment of £9.145 million to support the proposed redevelopment and expansion of Endoscopy services at the Royal Gwent Hospital.

The existing two suite Endoscopy unit does not meet the requirements of JAG accreditation as there is no clear separation of flows and insufficient facilities for both patients and staff. The existing unit also does not have the capacity to support current and future demand for endoscopy services therefore requiring significant additional out-of-hours activity and outsourcing.

It is therefore proposed that a new JAG compliant unit with four endoscopy procedure rooms and associated support spaces is developed within vacated accommodation at RGH.

The Investment Objectives for the project are set out below:

Investment Objective 1	To improve and increase Endoscopy infrastructure at RGH and achieve JAG accreditation
Investment Objective 2	To eliminate / reduce the need for waiting list initiatives and private sector out-sourcing
Investment Objective 3	To improve access to Endoscopy diagnosis and treatment services

The preferred option utilises space that has become vacant as a result of the vast majority of Maternity Services moving from Royal Gwent to the Grange University Hospital. The Maternity Unit occupied an irregular shaped area to the north of the ward block adjacent to the lift and stair core which provided access from Belle Vue Lane. The space houses two maternity theatres and associated recovery beds, seven delivery rooms, a small inpatient area and associated support accommodation in approximately 1,140sqm.

As the revenue consequences of the project are significant the Pre-Investment Panel has been reviewing the emerging revenue costs alongside the development of the capital project. The Executive Team has subsequently received a report on the outcome of this process on 3rd February 2022 and were requested to:

> **"Approve formally the required recurrent investment (totalling £4,429,000 in year 2 through to £4,689,000 in year 5) from the health board's revenue reserves"**

Section 5.13 of the BJC has subsequently provided a statement on revenue affordability.

Key project milestones are as follows:

Milestone	Completion Date
Sign off of Draft BJC by the Executive Team	17th February 2022
Submission of Draft BJC to WG	21st February 2022
Submission of Draft BJC to Health Board	30th March 2022
Anticipated WG approval of BJC	29th April 2022
Contractor appointment/start on site	27th May 2022
Construction work completion / Occupation	May 2023

The case is also consistent and aligned with national and regional endoscopy planning work that has now been accelerated in the context of covid recovery challenges.

Assessment and Conclusion

As noted above the BJC requests capital funding from Welsh Government in the sum of £9.145million. Ordinarily the BJC would be submitted via the Executive Team to the Health Board before it is submitted to Welsh Government. On this occasion, as there was not a Health Board in February and so as to delay the project, it was agreed that Welsh Government would commence the scrutiny of the BJC as a draft case after Executive Team approval whilst awaiting full Board approval in March 2022.

Recommendation

The Board is asked to:

- APPROVE the BJC for submission to Welsh Government.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The BJC includes an assessment of all risks, service, revenue and capital.
Financial Assessment, including Value for Money	The BJC includes a Financial and Economic Appraisal
Quality, Safety and Patient Experience Assessment	The BJC includes three Investment Objectives and a range of associated Benefits the majority of which are targeted at improving quality, safety and the patient experience
Equality and Diversity Impact Assessment (including child impact assessment)	WG have not requested this.
Health and Care Standards	The BJC has been prepared in the context of the relevant Health Care Standards
Link to Integrated Medium Term Plan/Corporate Objectives	The development is identified in the IMTP and in the associated capital programme
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** This project will significantly influence the longer term delivery and sustainability of endoscopy services
	Integration – The project has been planned and designed as a fully integrated unit
	Involvement – There has been extensive engagement with other public sector bodies, staff, users and the wider public.
	Collaboration – The project has been planned and designed in the context of the wider Endoscopy National Programme
	Prevention – The project will provide additional capacity to support the early detection and treatment of cancer and other health conditions
Glossary of New Terms	BJC – Business Justification Case, is a single "one stop shop" case that is used to support the development of smaller capital projects.
Public Interest	There is local, public and political interest in this project. There has been extensive engagement

Royal Gwent Hospital
Redevelopment and Expansion of Endoscopy Services
Business Justification Case

Version No: 5
Issue Date: 23rd February 2022

Contents

APPENDICES

1.0 Introduction

1.1 The purpose of this Business Justification Case (BJC) is to seek approval for a total capital investment of £9.115 million to support the proposed redevelopment and expansion of Endoscopy services at the Royal Gwent Hospital (RGH), Newport.

1.2 The existing two suite Endoscopy unit does not meet the requirements of JAG accreditation as there is no clear separation of flows and insufficient facilities for both patients and staff. The existing unit also does not have the capacity to support current and future demand for endoscopy services therefore requiring additional out-of-hours activity and outsourcing.

1.3 It is therefore proposed that a new JAG compliant unit with four endoscopy procedure rooms and associated support spaces is developed within vacated accommodation at RGH.

1.4 The additional recurrent revenue investment required to support the proposed increase in Endoscopy provision is £4,429,000 in year 2 of operation through to £4,689,000 in year 5.

Structure of Document

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

- HM Treasury Guide to Developing the Project Business Case 2018
- NHS Wales Infrastructure Planning Guidance (2015)
- HM Treasury, the Green Book: Appraisal and Evaluation in Central Government: Treasury Guidance (2003).
- Public Sector Business Cases using the Five Case Model: A Toolkit Guidance and Templates (2007)

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

- The **Strategic Case** which sets out the Strategic Context and the Case for Change, together with the supporting investment objectives for the Scheme.
- The **Economic Case** which demonstrates that ABUHB has selected a *preferred way forward,* following evaluation of a number of alternative solutions, which best meets the existing and future needs of the Service and is likely to optimise Value for Money (VFM).
- The **Commercial Case** which outlines the potential procurement strategy.
- The **Financial Case** which addresses the capital and revenue implications and the issue of affordability.
- The **Management Case** which demonstrates that the scheme is achievable and can be successfully delivered in accordance with accepted best practice.

2.0 Strategic Case

Part A Strategic Context

2.1 Organisational Overview

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

2.1.2 We serve an estimated population of over 639,000, approximately 21% of the total Welsh population. Approximately 30 per cent of the population live in the Caerphilly local authority area and 25 per cent live in the Newport local authority area.

2.1.3 With a budget of circa £1.4 billion we deliver healthcare services to people in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen and also provide some services to the people of South Powys.

2.1.4 The Health Board covers diverse geographical areas and had to take account of a mix of rural, urban and valley communities. The valleys experience high levels of social deprivation, including low incomes, poor housing stock and high unemployment.

2.1.5 The Health Board employs 11,252 staff (October 18) and is the largest employer in Gwent. The staff group has remained relatively unchanged in the last year. The largest staff group are Nursing & Midwifery at 30% of the total workforce followed by additional Clinical services at 20%.

Services

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

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

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

2.1.8 There are 281 WTE General Practitioners and Salaried GPs providing general medical services from 72 General Practices. Supporting these are 194.8 WTE

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

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

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

2.2 National Policy /Service Context

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

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

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

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

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

2.2.5 In the context of A Healthier Wales, Welsh Government announced in September 2018 a new nationally directed approach for Endoscopy service improvement in recognition of the fact that Endoscopy services play an essential part in investigating suspected cancer, as well as providing follow-up for people with prior diagnoses and delivering interventional treatment. The service covers several modalities of diagnosis and treatment with waiting lists being subject to an 8-week diagnostic target:

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

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

2.2.7 Demand was significantly out of balance with the available core capacity and Health Boards had struggled to develop sustainable solutions. The subsequent ***National Endoscopy Programme Action Plan*** provided a framework to deliver improvement against four key work streams by 2023. The four work streams are:

1. Demand and Capacity
   Aim to ensure HB have embedded, balanced and responsive, demand and capacity planning through a standardised approach
2. Clinical Pathways
   Aim to develop a national overview of clinical pathways to standardise pathways according to the evidence and to achieve optimisation and equity
3. Workforce, training and development
   Aim to support local workforce analysis, job planning, recruitment and retention and development of National training and development opportunities
4. Facilities and Infrastructure
   Aim to develop a national overview of the physical estate to achieve JAG accreditation of the units and to improve the IT infrastructure to enable a world class endoscopy service

2.3 Regional Context

2.3.1 This proposed development is being taken forward in the context of the regional response to the aforementioned National Action Plan and with the support of the National Programme Lead. It should be noted however that the proposal does not present a regional solution it only addresses capacity and environmental issues within ABUHB.

2.4 Local Policy Context

2.4.1 The Health Board's approved ***Integrated Medium-Term Plan*** for the next three years April 2020 – March 2023 is a statement of the Health Boards' ambition, working with partners, to improve the health and wellbeing of the population through services delivered closer to home. At the same time, the plan sets out how safe, timely and efficient hospital care will be maintained, in the most appropriate location, delivering the best possible outcomes to patients, by well trained staff who feel supported and valued. Informed by the Welsh Government's ambition for future generations, and the strategic direction described in "A Healthier Wales", the Health Board has devoted time and effort in the last year to strengthening collaborative working across the public and voluntary sectors as a key enabler in achieving change.

2.4.2 During the last year the Health Board has continued to progress the Clinical Futures plan ***"Caring for You and Your Future"***. More services are provided in the community and closer to the people who need to use them, and the Grange University Hospital has opened. This new hospital, a centre of excellence for specialist and critical care, will help to deliver the long-standing clinical strategy designed to provide 21st century health care; a sustainable, value driven system of care designed to meet the needs of our population.

2.4.3 The Health Board's ***"Cancer Service Strategy Delivering a Vision 2020 2025"*** outlines the Health Board's commitment to improve prevention, optimise cancer treatments, patient outcomes and reduce health inequalities for our population. This will be delivered through a focus on the following core themes:

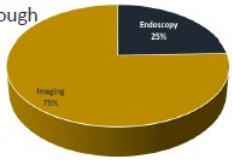
- Prevention
- Early detection
- Timely diagnosis
- Improved and standardised cancer care
- Living with and beyond cancer
- Improving our knowledge of cancer

2.4.4 The extracts below from the Cancer Service Strategy relating to the single cancer pathway identifies the importance of rapid diagnosis in that pathway and timely endoscopy provision is obviously a key element within that.

Gwent - Beneath the surface each month …

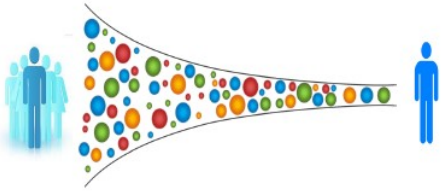
Referrals to Single Cancer Pathway[5]	Investigations (endoscopy & imaging)	Confirmed Cancer YES	Confirmed Cancer NO	Treatments
2,601	1,276	295	2,306	311

0% referred as urgent suspected through primary care. The remainder through
- Screening programmes
- Vague symptoms or
- Non-specific but worrying symptoms (incidental findings)



13% conversion rate on single cancer pathway

Think of the Single Cancer Pathway as a funnel – large (and growing) numbers of patients with suspected cancers referred to the system. Considerably more capacity for "yes/no" investigations required to confirm or eliminate cancer. The majority of patients will not have cancer, those that do must receive definitive treatment within 62 days of suspicion of cancer.



Timely Diagnosis

Our Performance

Metric	Single Cancer	Urgent Suspected
2 week from referral to 1st Outpatient	42.80%	45.70%
28 day diagnostic pathway	76.00%	56.10%

Source: Cancer Dashboard April - August 2019

Where should we be today?

Day 0 | Day 14 | Day 28

Cancer Suspected → GP consultation & refer for urgent investigation → Investigation (first definitive test) → Reporting (0 - 5 days) → 1st OP with specialist → Staging (furtner investigations) → Diagnosis Pathway (complete)

Where are we today?

The average waiting time to see a GP for a non-urgent appointment is **14 days**.

Each month our services provide 344 endoscopy and 930 imaging investigations. The average waiting time from request to test is **14 days** (range 7 to 18 days).

Reporting the results can take an additional **5 days** for imaging .

To deliver the 28 day diagnostic pathway diagnostic capacity would need to increase by 23%.

Where do we need to be?

To deliver the Single Cancer Pathway first definitive investigations would need to be completed and reported within **7 days.**

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

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Part B: The Case for Change

2.5 Investment Objectives

2.5.1 The agreed Investment Objectives for this project are as follows:

Investment Objective 1	To improve and increase Endoscopy infrastructure at RGH and achieve JAG accreditation
Investment Objective 2	To eliminate / reduce the need for waiting list initiatives and private sector out-sourcing
Investment Objective 3	To improve access to Endoscopy diagnosis and treatment services

2.6 Business Needs

Current Service Provision and Impact of Covid 19

2.6.1 Whilst this business case focuses on Endoscopy services at the Royal Gwent Hospital the Health Board as a whole provides services from four locations reflecting the need for local service provision. The following is a summary of existing provision:

Site	Days Operational	No. of theatres	No. of Sessions	Comments
RGH	Mon-Fri	2 Theatres	4 sessions per day	1 session per week used by Respiratory
YYF	Mon-Fri	2 Theatres	4 sessions per day	3.5 sessions per week used by Bowel Screening Wales. 0.5 session per week used by Urology
NHH	Mon-Fri	2 Theatres	4 sessions per day	1 unfunded session per week 2 sessions per week used by respiratory 1 session per week used by Urology
GUH	Mon- Sun	1 Theatre	2 sessions per day 1 session per day Sat/Sun	1 session per week is used by respiratory For emergency inpatients and high-risk outpatient ERCP/Stents only

2.6.2 Endoscopy services are provided for routine, urgent and emergency referrals. Management of referrals is based on priority and utilisation of risk stratification tools alongside clinical triage. Activity for these procedures is shared between Gastroenterologists, General Surgeons, Advance Care Practitioners and Clinical Endoscopists.

2.6.3 The service works to agreed National RTT and pathway targets as below:

- >8-week diagnostic
- 26-week RTT
- Compliance with and achievement of Cancer Pathways
- Eradication of delayed follow ups
- Bowel Screening Wales are currently re-modelling existing plan, Health Board will be notified of changes later in the year

2.6.4 For several years endoscopy services have carried a residual gap of c6000 procedures per annum which has been met through the use of weekend WLI's and "Backfill". In 2017, c2700 procedures were outsourced to Care UK. During 2019/20 the service remained on track meeting the 8week diagnostic target despite demand continuing to rise but this was only achieved via a cycle of weekend WLI's and "Backfill". It should be noted that this only addressed the 8-week diagnostic target; routine and surveillance/repeat waiting list targets were not achieved.

2.6.5 As the Health Board responded to Covid-19, Endoscopy Services were affected due to:

- The units being used for Covid-19 surge capacity
- Patients refusing to attend
- BSG and Royal College of Surgeons guidance
- PPE and social distancing

2.6.6 The service communicated with all patients with the aim to prioritise all Urgent Suspected Cancer (USC) referrals before targeting urgent and then routine referrals. All booked routine appointments were postponed and replaced with USCs. USC referrals, on average, were booked within 3 weeks, allowing the service to manage new referrals 'live' as they were received.

2.6.7 Following BSG and Royal College of Surgeons guidance published on 27th March 2020, the endoscopy service postponed all outpatient diagnostics, including the booked USC patients.

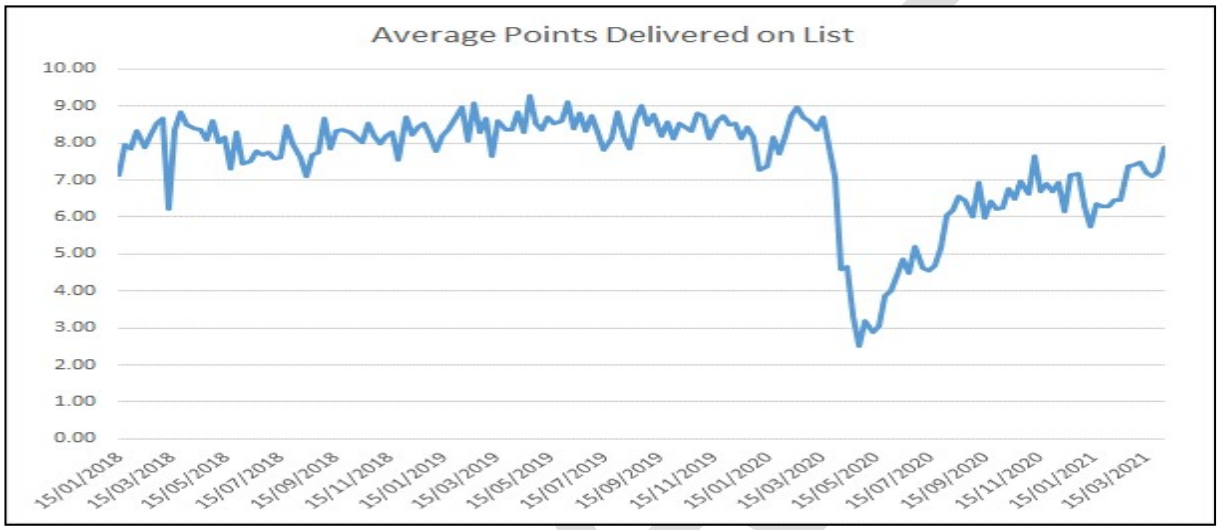
2.6.8 The use of Symptomatic FIT10 test has been pivotal to the risk stratification process for referrals and waiting list prioritisation for lower GI procedures during Covid-19. All Upper GI diagnostic referrals are clinically validated, prioritising USCs and urgent referrals:

- All Upper GI patients reviewed as urgent P1 are for immediate booking, less urgent patients are prioritised again as P2 or P3, and booked into available slots
- All Lower GI, P1 and P2 are reviewed and re-prioritised ensuring there is sufficient clinical information on the referral. These are then regraded appropriately, with those needing further clinical information the recommended FIT test or CT are being used.
- Routine referrals:
    - All added to the waiting list
    - Review dates for re-vetting and prioritisation once urgent backlog reviewed and all patients booked
    - Referrals will be upgraded if required or telephone assessed by CNS staff for ongoing monitoring or treatment until routine patients can be booked

2.6.9 The impact of the changes implemented due to Covid-19, i.e. the number of patients booked and average points per sessions, can be seen from the table below:

Year	2018/19	2019/20	2020/21
Booked Points	24018	26472	19380
Average Points per List	8.7	9.2	6.9

2.6.10 The number of sessions currently being delivered are higher than pre COVID levels, but the number of points is lower as per graph below. The average number of points on list is at 7.5 points as opposed to 8.4 pre-Covid-19 with list utilisation approx. 10% lower.



2.6.11 As the service moves into the post pandemic recovery phase the demand and current backlog outstrips capacity which will not be met by the current preCovid-19 delivery model. The current waiting list, as of 17th January 2022, is:

Backlog as at 17/01/2022	Backlog Patients	Current Backlog in Points
WG 8 Week Target	3888	5673
Repeats over 8 Weeks	1827	3246
Total	**5715**	**8919**

Demand and Capacity

2.6.12 The table below is based on a points system as each endoscopy procedure is allocated a set number of points, i.e. Flexi 1.5, Gastro 2.0 and Colon 2.5. It provides a forecast position in points for the next 5 years, including a 5% population growth and the proposed increase in activity via Bowel Screening Wales:

Baseline Recurring Demand in Points (Excludes Backlog Removal)

Demand	Year 1 2021/22	Year 2 2022/23	Year 3 2023/24	Year 4 2024/25	Year 5 2025/26
Demand brought forward	22,676	27,562	30,150	32,107	36,368
Percentage increase	5%	5%	5%	5%	5%
Demand Increase	1134	1378	1507	1605	1818
BSW Increase	3752	1210	450	2655	
Total Recurring Demand	27,562	30,150	32,107	36,368	38,186

2.6.13 Utilising the above data the next table maps current capacity against the assessed demand and quantifies the anticipated shortfall in both points and patient numbers per year:

Current Demand and Capacity Points (Weeks Exc BH and Downtime)	Year 1 2021/22	Year 2 2022/23	Year 3 2023/24	Year 4 2024/25	Year 5 2025/26
Total Recurring Demand	27,562	30,150	32,107	36,368	38,186
Current Capacity	22,078	22,078	22,078	22,078	22,078
Surplus / (Gap) Points	-5,484	-8,072	-10,030	-14,290	-16,108
Average Weekly Surplus / (Gap) Points	-105	-155	-193	-275	-310

Current Demand and Capacity Patients (Weeks Exc BH and Downtime)	Year 1 2021/22	Year 2 2022/23	Year 3 2023/24	Year 4 2024/25	Year 5 2025/26
Total Recurring Demand	18,919	20,696	22,039	24,964	26,212
Current Capacity	15,155	15,155	15,155	15,155	15,155
Surplus / (Gap) Patients	-3,764	-5,541	-6,885	-9,809	-11,057
Average Weekly Surplus / (Gap) Patients	-72	-107	-132	-189	-213

*49 productive theatre weeks including backfill, excludes BH and session downtime

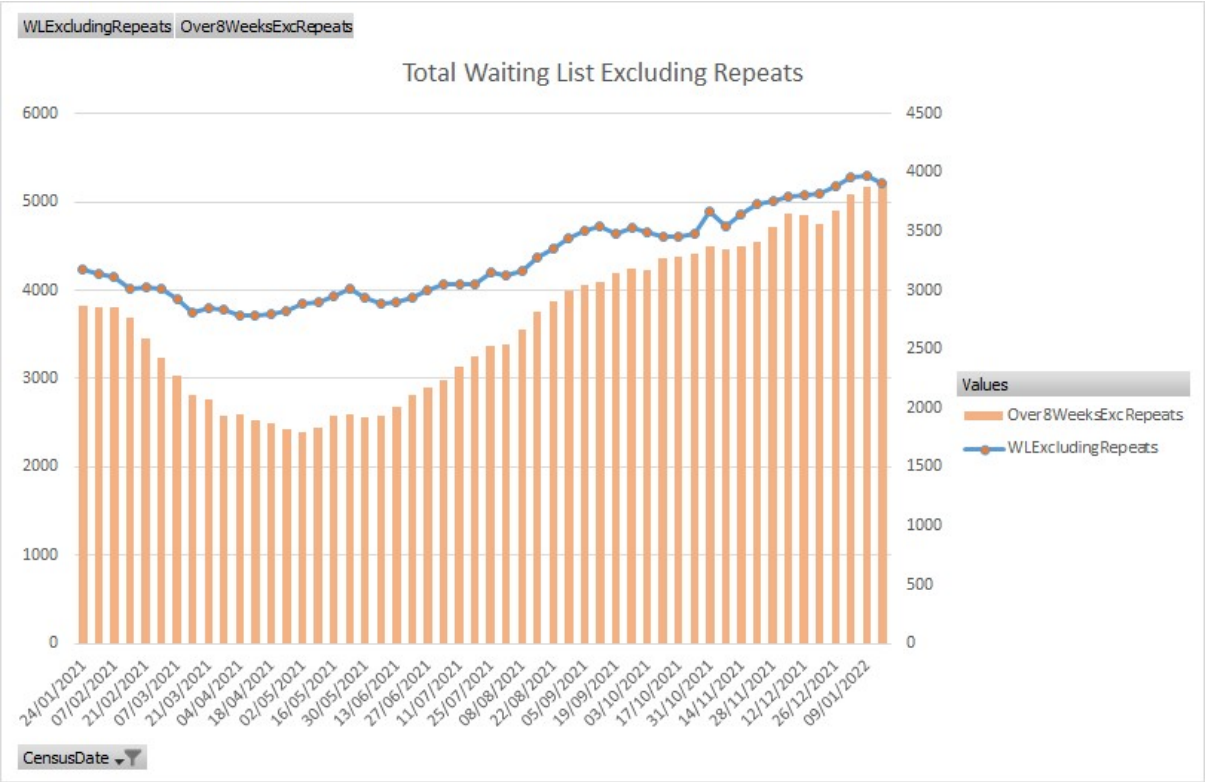
2.6.14 It is clear from the above analysis that service capacity at 22,078 points per annum is not sufficient to meet the current 2021/22 demand of 27,562 points leaving a gap of 5,484 points which equates to 3,764 patients; this gap will increase year on year.

2.6.15 The current capacity includes what can be delivered by 6 theatres across YYF, RGH & NHH over 5 days a week. GUH capacity is utilised to manage In Patient Demand. The modelling is based on 73% utilisation which incorporates list downtime for Audit and Training days, machine servicing and essential safety checks, DNA's and procedures cancelled on the day this can be due to multiple factors such as prep procedure advice not being followed, patient not fit for procedure and last-minute cancellation by patient and effects of hospital cancellations.

2.6.16 The capacity has been modelled based on scheduling 12 points per list and delivering an average of 8.7 points per list, this is in line with recent JAG Assessments.

Waiting Times

2.6.17 The charts below give a waiting list position for 8 week and repeats as of 17th January 2022


WLExcludingRepeats
Over8WeeksExcRepeats
Total Waiting List Excluding Repeats
6000
5000
4000
3000
2000
1000
0
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Values
Over8WeeksExcRepeats
WLExcludingRepeats
24/01/2021
07/02/2021
21/02/2021
07/03/2021
21/03/2021
04/04/2021
18/04/2021
02/05/2021
16/05/2021
30/05/2021
13/06/2021
27/06/2021
11/07/2021
25/07/2021
08/08/2021
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03/10/2021
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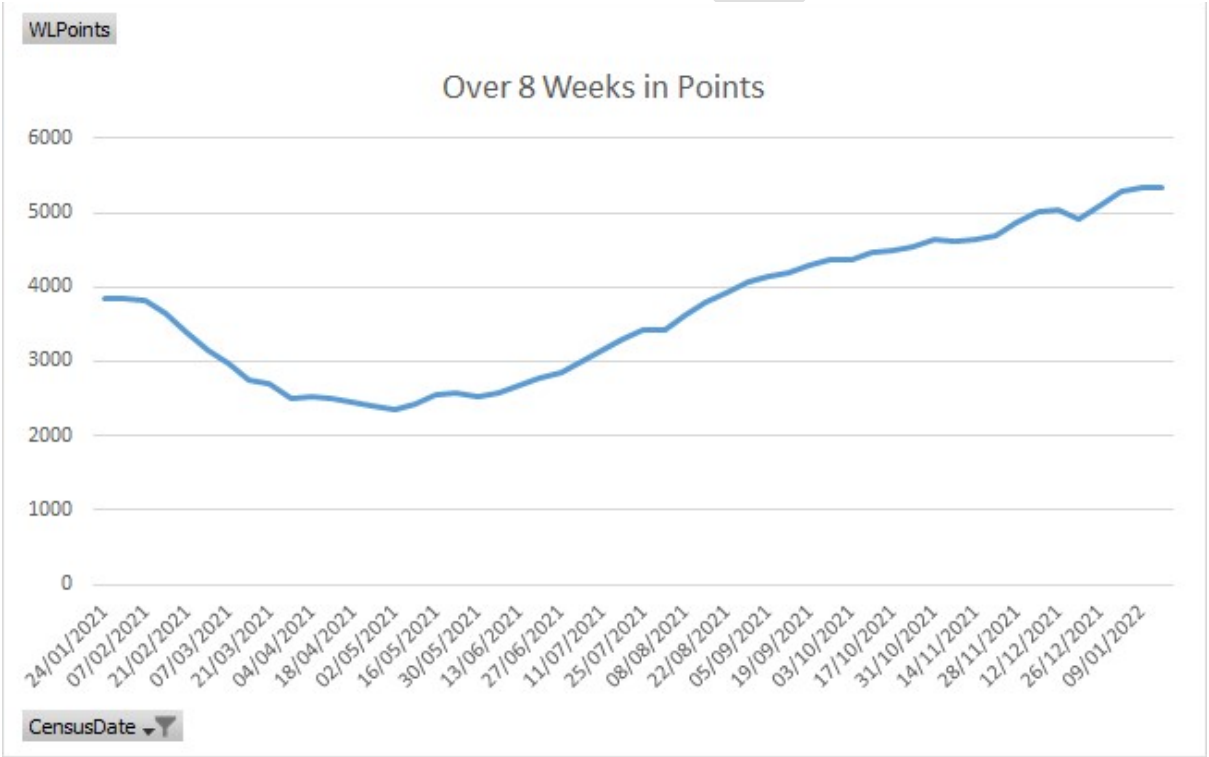
09/01/2022
CensusDate


WLPoints
Over 8 Weeks in Points
6000
5000
4000
3000
2000
1000
0
24/01/2021
07/02/2021
21/02/2021
07/03/2021
21/03/2021
04/04/2021
18/04/2021
02/05/2021
16/05/2021
30/05/2021
13/06/2021
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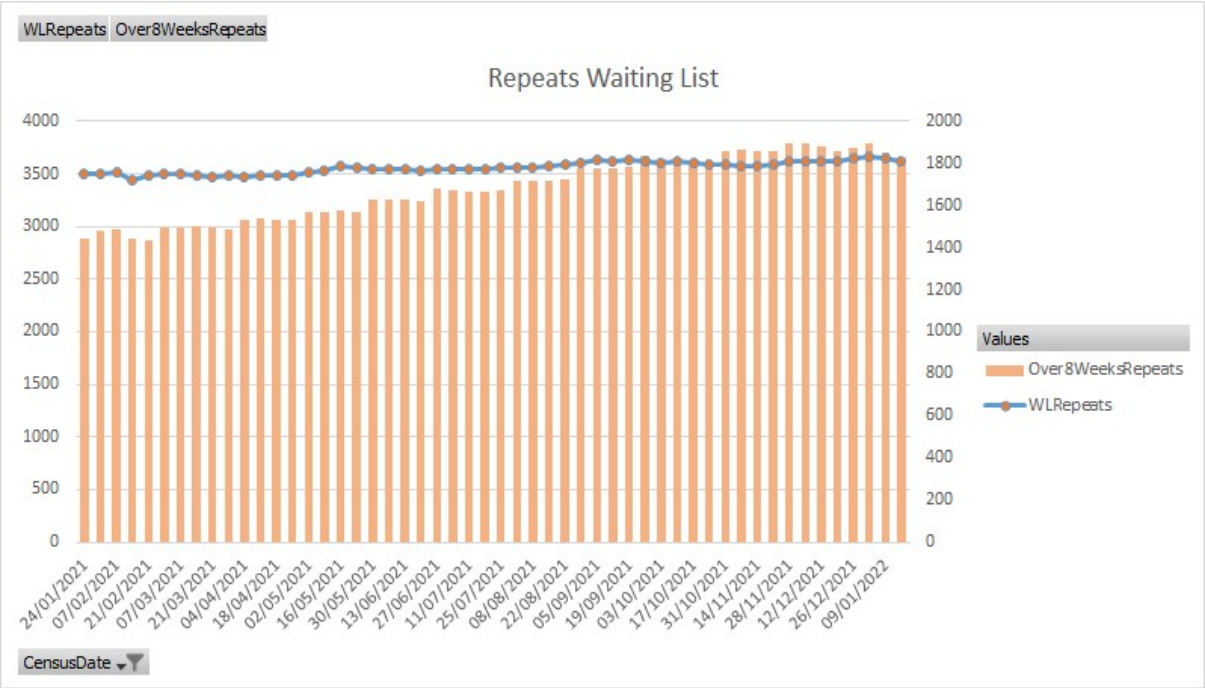
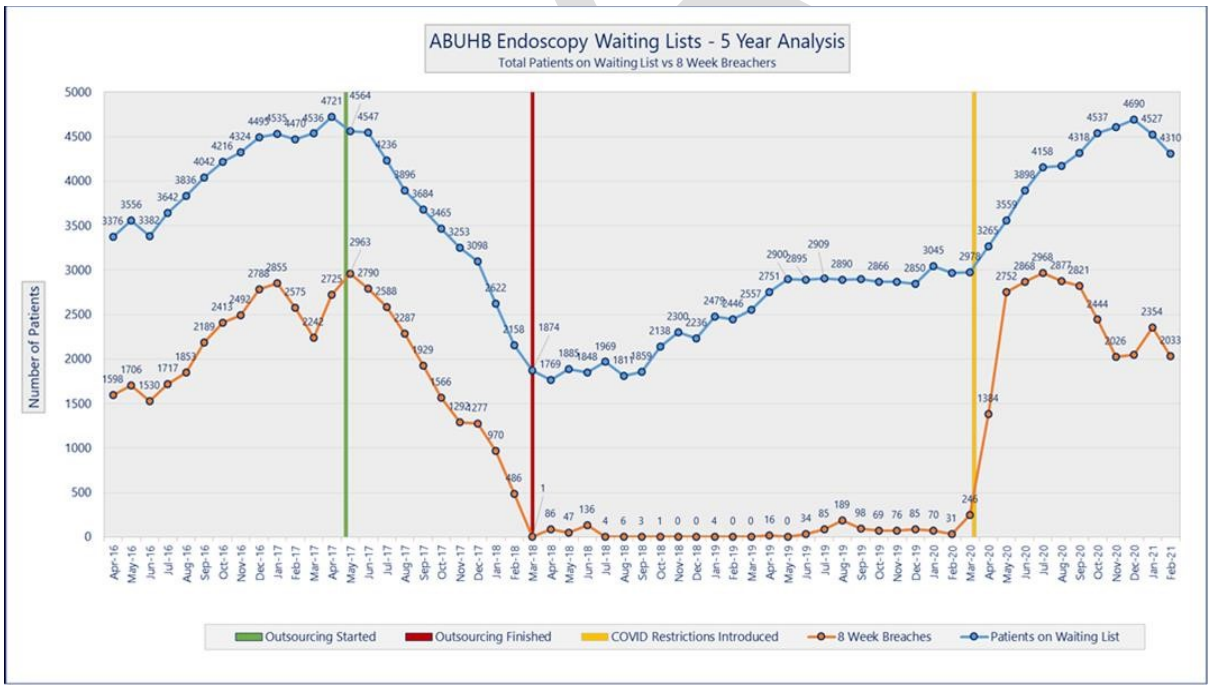
12/12/2021
26/12/2021
09/01/2022
CensusDate



2.6.18 The graph below demonstrates activity for 8-week diagnostic procedures over the last 4 years, giving context to the impact of outsourcing and Covid-19. The current demand on endoscopy services is equivalent to the demand seen in 2016 when outsourcing was introduced; outsourcing was only ever intended to be a short-term fix.



2.6.19 The Surveillance/Repeat Waiting List has continued to grow year on year, demand cannot be met within current service capacity therefore this list will continue to increase. The overdue procedure list for March 2021 is broken down per procedure below:

Gastro repeats overdue by procedure

	2018	2019	2020	2021
Colon	174	282	457	468
Gastro	19	82	268	347
Flexi	2	12	54	42

Workforce

2.6.20 There are 11 Gastroenterologists, 15 General Surgeons and 6 clinical endoscopists that deliver 51 endoscopy sessions per week across RGH, NHH and YYF plus 11 inpatient sessions per week at GUH.

2.6.21 There is a requirement for 4 RNs/ODPs and 1 HCSW to support an endoscopy list, with an additional HCSW required to support the pre/post endoscopy care ward area.

2.6.22 There are 4 Trainee Nurse Endoscopists, 2 specialising in lower procedures (colonoscopy) alongside BSW & STT teams and 2 specialising in upper procedures (gastroscopy) the 2 'upper' trainees are also undertaking training to become specialist in Nutritional/PEG procedures to support the need to supply PEG replacement and insertions.

Revenue Costs

2.6.23 The information below outlines expenditure on endoscopy provision in 2021/22 including existing recurrent funded costs, and non-recurrent funding to address capacity deficits associated with increasing demand:

	2021/22 spend £'000
Workforce	1,102
Non-pay	809
Facilities	30
Histopathology	635
Non-Recurrent Capacity	3,435
Total Expenditure	**6,011**

The Estate

2.6.24 The unit at RGH is currently located on the west wing at the third floor of C-block, accessed from the central lift core and staircase and adjacent to the existing day-surgery unit and main operating theatres. The existing suite has two endoscopy rooms with associated pre-operative assessment and post-operative recovery.

2.6.25 In November 2019 RGH received a pre-JAG compliance visit from the National Endoscopy Programme. A post-visit report was received by the service outlining areas for improvement against the domains that were reviewed. Progress was made during 2019/20 however once Covid-19 hit further development ceased as the service concentrated effort on addressing the effects of the pandemic.

2.6.26 The RGH Endoscopy unit does not meet the requirements of JAG accreditation as there is no clear separation of flows and insufficient facilities for both patients and staff. Some remedial works had been carried out however these have not been sufficient to be compliant with JAG accreditation standards.

Summary and Conclusion of Business Needs

2.6.27 It should be clear from the above information that the key issues that need to be addressed within the Health Board to offer quality, sustainable and efficient Endoscopy diagnostic and treatment services, include:

- Historical mismatch, worsened by Covid-19, between capacity and demand resulting in the need to outsource activity and undertake regular WLIs
- The inability of the Health Board to manage the future projected demand without additional capacity
- The manifestation of this mismatch in the growing waiting lists and the high number of patients that are breaching the 8-week referral to diagnosis target, some of whom will have cancer
- The inadequacy of the current estate at RGH both in terms of capacity and compliance with JAG accreditation standards.

2.7 Potential Scope

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

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

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

Minimum	**Intermediate**	**Maximum**
Retain existing services and upgrade existing estate to Condition B / JAG compliant. Continue	Redevelop existing estate at RGH to provide 4 JAG compliant endoscopy suites	New build endoscopy unit on the RGH site to provide 4 new JAG compliant endoscopy suites.
Minimum	**Intermediate**	**Maximum**
with WLIs and outsourcing		

2.8 Benefits

2.8.1 This section describes the main outcomes and benefits associated with the implementation of the potential scope in relation to business needs. Satisfying the potential scope for this investment will deliver the following high level strategic and operational benefits. By investment objectives these are as follows:

Objective	Benefit
Investment Objective 1: To improve and increase Endoscopy infrastructure at RGH and achieve JAG accreditation	• Increase in overall capacity • Improved utilisation • Reduced cancellations • Increased activity as a result of pooling and consolidation of referrals and cross cover of clinicians • Improved infection control and reduced infection rates • Improved recruitment and retention
Investment Objective 2: To eliminate / reduce the need for waiting list initiatives and private sector out-sourcing	• Improved patient satisfaction • Improved levels of staff satisfaction, and morale • More efficient and effective use of existing resources • Reduced revenue costs
Investment Objective 3: To improve access to Endoscopy diagnostic and treatment services	• Compliance with Welsh cancer waiting times targets • Delivery of Nice Guidance for recognition and referral of suspected cancer • Improved cancer survival rates • Reduction in patient DNA/ CNA • Reduced complaints

2.9 Risks

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

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

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

Risk Category	Risk Description	Consequence 1-5	Likelihood 1-5	Risk Score	Mitigating Action Undertaken
Funding risk - Reduced availability of capital funding	May lead to a delay or reduction in scope of project	5	2	10	No contractual commitments will be made until affordability and availability of capital is assured
Planning risk - planning constraints or issues	May impede progression of preferred option	3	3	9	Planning permission is not required but building regulations are, and will be adhered to at all stages
Demand and usage risk	The size and capacity is not appropriate for eventual need of the user group.	4	3	12	The preferred option will take into consideration future flexibility and the opportunity to 'right size' at a later date to adapt to emerging and changing needs
Implementation Risk	Working adjacent to clinical areas, potential disruption / delay	4	4	16	Engagement with clinical services on programme of works, on-site communication
Recruitment of additional staff	May prevent full utilisation of capacity	4	4	16	Strategy to address current and future workforce needs required from service
Revenue Affordability	May prevent full utilisation of capacity	4	3	12	Clear assessment of revenue affordability offset by reductions in WLIs

2.10 Constraints

2.10.1 The project is subject to following constraints:

- **Availability of capital** - The availability of capital funding is an obvious constraint which may hinder project progression.

- **Site Constraints** – The development of new services on an existing hospital site and adjacent to clinical services will require careful planning and ongoing communication with relevant stakeholders.

- **Revenue affordability** - The project must demonstrate revenue affordability and that sufficient savings will be achieved to justify any investment.

- **Ability to future proof against changing needs** - the design of any new facilities must be flexible and adaptable to take into account the changing needs of the organisation and future service delivery.

- **Timescale** – New services must be in place as soon as possible to address a number of adverse service impacts including recruitment and patient waiting times.
- **Workforce** - Ability to recruit additional staff and the mobility of the current workforce to change current working patterns. Potential need to remodel services within anticipated levels of resources and without the need for revenue investment.

2.11 Dependencies

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

- **Stakeholder Consultation** - The introduction of a new model of services will require consultation with existing staff and key users of the service. It is essential therefore to ensure a clear communication and engagement plan is in place so that stakeholders have a clear understanding of the model and can influence the way the new working environment is designed.

- **Leadership** - A commitment from the Board and within the Division is required to implement a shift to the agreed model of service delivery. Commitment to drive through the required changes is paramount.

- **Transition** - A possible requirement for transitional costs in moving from one model of care to another.

3.0 Option Appraisal

3.1 This section of the business case outlines:

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

Critical Success factors

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

Critical Success Factor	Description
CSF1: Strategic Fit	• Consistent with national and regional strategies • Consistent with Clinical Futures strategy • Meets national standards and guidance
CSF2: Acceptability	• Supported by key stakeholders, service users, other Health Boards, CHC and staff • Meets expectations in terms of patient safety, quality and accessibility • Compliance with legislation • Improved environment
CSF3: Sustainability	• Sustained delivery of reduced cancer waiting times targets • Allows for flexibility of use and adaptable to future changes • Improves recruitment and retention of clinical staff
CSF4: Efficiency	• Facilitates one stop diagnostic assessment and investigation • Diagnosis to treatment time minimised through streamlined pathways which are in line with current evidence and best practice • Facilitates economies of scale
CSF5: Achievability	• Ability to keep existing services running during development • Likelihood to gain planning approval • Likelihood to be completed in line with project timescales • Minimises disruption to other services.

Options Framework

3.3 An Options Framework is required to demonstrate a robust analysis of a number of possible options and this review has been carried out with careful reference to the Five Case Model Guidance as part of the Business Case Toolkit. The Options framework was used by the project delivery team to first generate and secondly evaluate a range of possible solutions. This was undertaken using a SWOT analysis and a simple scoring mechanism to record how well each option satisfied the critical success factors (CSFs):

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

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

Framework of Strategic Options (or Potential Solutions)

Category of Choice	1	2	3	4	5	6
Service Scoping Option	**SO1** Continue to maintain the existing Endoscopy service at RGH at current physical capacity levels.	**SO2** As option 1 but rely on WLIs and Outsourcing to meet demand	**SO3** As option 1 but expand services at YYF to meet demand	**SO4** As option 1 but expand services at NHH to meet demand	**SO5** Expand the Endoscopy service at RGH	**SO6** As option 1 but rely on a regional solution to meet demand
Estate Solutions	**ES1** Utilise existing unit with no investment	**ES2 Redevelop** and expand existing unit at YYF	**ES3** Redevelop and expand existing unit at NHH	**ES4 Redevelop** vacant accommodation at RGH	**ES5** New Build on the RGH site	**ES6** New Build Regional Unit
Service Delivery	**SD1** Total service provision by ABUHB	**SD2** Some clinical services are outsourced	**SD3** All services are outsourced			
Impleme-ntation Options	**IO1** Single Phase	**IO2** Phased				
Funding	**F1** Public Sector Capital	**F2** Private Sector Capital -				

Long List

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

Options	Finding
1.0 Scoping Options	
SO1 - Continue to maintain existing service at current capacity levels	This option would **not** meet the majority of the critical success factors. It offers no opportunity to sustain the service, support the growth in demand or address current infrastructure issues. ***This option is rejected but is retained as a benchmark for cost comparison against other shortlisted options.***
SO2 - As option 1 but rely on WLIs and Outsourcing to meet demand	This option does not meet all of critical success factors, but it does provide the opportunity to address the increase in endoscopy demand. ***This option is possible and is carried forward to the shortlist.***
SO3 – As option 1 but expand services at YYF	This option would potentially meet many of critical success factors, but it would however require that a new build facility be created on the YYF site. The existing unit cannot be expanded. ***This option is discounted***
SO4 – As option 1 but expand services at NHH	This option would potentially meet many of critical success factors, but it would however require that the existing private sector owned building, which houses 2 suites, be closed to allow it to be redeveloped for 3 suites. 4 JAG compliant suites are not possible. A mobile twin suite unit would be required for the duration of the redevelopment. ***This option is discounted***
SO5 – Expand the Endoscopy services at RGH	This option would potentially meet the vast majority of the critical success factors via the utilisation of existing vacant space. ***This option is possible and is carried forward to the shortlist.***
SO6 - As option 1 but rely on a regional solution to meet demand	This option would potentially meet many of the critical success factors but at the time of writing this appraisal there is little or no evidence of a forthcoming regional solution. **This option is discounted at this point in time**

2.0 Estate Options	
ES1 - Utilise existing unit	This option does not meet any of the investment objectives or critical success factors. ***This option is discounted, but is retained as a benchmark for cost comparison as part of the Do-Nothing option***

ES2 - Redevelop and expand existing unit at YYF	***This option is discounted from being carried forward to the shortlist as outlined above***
ES3 - Redevelop and expand existing unit at NHH	***This option is discounted from being carried forward to the shortlist as outlined above***
ES4 - Redevelop vacant accommodation at RGH	There is vacant accommodation at RGH as a result of services moving to the Grange University Hospital. This option would meet the vast majority of the critical success factors. ***This option is possible and is carried forward to the shortlist.***
ES5 - New Build on the RGH site	Space at RGH is potentially available. This option would meet the vast majority of the critical success factors. ***This option is possible and is carried forward to the shortlist.***
ES6 - New Build Regional Unit	***This option is discounted from being carried forward to the shortlist as outlined above***
3.0 Service Delivery Options	
SD1 – Total provision by ABUHB	This option meets all of the investment objectives and critical success factors. ***This option is recommended as the preferred*** service ***delivery option***
SD2 – Some Clinical services are outsourced	This option is akin to the business-as-usual option and has happened before ***This option is possible and is carried forward to the shortlist.***
SD3 -	This option does not offer any significant advantages and does not comply with current NHS Wales's policy**.** ***This option is discounted***
4.0 Implementation Options	
IO1 - Single Phase	This option meets all of the investment objectives and critical success factors. ***This option is possible and is carried forward to the shortlist.***
IO2 - Phased development	This option meets some of the investment objectives and critical success factors although it might not create the most efficient solution, could take longer to deliver all the benefits, may not align with programme milestones and may cost more. ***This option is discounted***
5.0 Funding Options	
F1 - Public Sector Capital	**Possible -** This is likely to present the most cost-effective solution ***This option is retained as the preferred funding solution***

F2 - Private Sector Capital	**Discounted -** Not viable from a policy perspective. ***This option is discounted***

Short-listed Options

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

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

Service Options	Estate Solution	Service Delivery	Implementation	Funding
Option 1 – Business as Usual - Continue to maintain existing Endoscopy service at current capacity levels with no investment for improvement	Utilise existing unit	Total provision by ABUHB	N/A	N/A
Option 2 - Do Minimum As Option 1 but shortfall in demand is met via WLIs and Outsourcing. Backlog maintenance is addressed.	Utilise existing unit	Some provision via private sector	Phased Development	Public Sector Capital
Option 3 - Utilise existing vacant accommodation at RGH to provide additional capacity and JAG compliance	Redevelop vacant Obstetric Unit / Delivery Suite at RGH	Total provision by ABUHB	Single Phase	Public Sector Capital
Option 4 – New build on the RGH site to provide additional capacity and JAG compliance	New build unit on the RGH site	Total provision by ABUHB	Single Phase	Public Sector Capital

Qualitative Benefits Appraisal of the Shortlisted Options

3.8 As required by the Five Case Model the short list was then appraised using the Critical Success Factors in section 3.2. These have been discussed and weighted for use in appraising the options as shown in the table below:

Critical Success Factor	Weighting
CSF1: Strategic Fit	10
CSF2: Acceptability	20
CSF3: Sustainability	30
CSF4: Efficiency	25
CSF5: Achievability	15

3.9 The ranking and weighting exercise would have been carried out by a group of relevant stakeholders but due to the Covid 19 restrictions this has had to be done remotely.

3.10 The criteria used to score the non-financial options is shown in the table below:

Assessment	Score
Does not meet criteria in any way	**1**
Does not meet significant element of the criteria	**2**
Goes some way to meeting the criteria	**3**
Goes a long way to meeting the criteria but some remain unresolved	**4**
Meets criteria in full	**5**

3.11 All the individual score sheets have been aggregated to give an overall result for the options the outcome of which is shown below:

CSFs		Option 1		Option 2		Option 3		Option 4	
	W	S	T	S	T	S	T	S	T
Strategic Fit	10	2	20	2	20	5	50	5	50
Acceptability	20	1	20	1	20	4	80	5	100
Sustainability	30	1	30	2	60	4	120	4	120
Efficiency	25	2	50	2	50	5	125	4	100
Achievability	15	5	75	3	45	5	75	3	45
Totals			100		195		450		415
Ranking			4		3		1		2

Option 1 – Business as Usual, this option is being carried forward as the benchmark for value for money. It was considered that it did not satisfy the investment objectives agreed for the project. Consequently, it does not provide additional public value in terms of delivering additional benefits in relation to existing costs. It is however by definition an achievable and currently affordable option.

Option 2 - Do Minimum. This option would provide the minimum improvement to meet demand and compliance with waiting time targets. There would little

improvement to the environment and JAG compliance would not be met. This might be considered to be an achievable and affordable option in terms of existing budget and anticipated timescales. However, in terms of the associated benefits this option does not offer the opportunity of increasing capacity and there would continue to be reliance on WLIs and outsourcing which may not be sustainable. This option therefore scores less favourably than options 3 and 4.

Option 3 and 4 rank closely in non-financial terms in terms of providing strategic fit, acceptability and sustainability. Option 3 is however marginally ahead in the context of efficiency and achievability. Option 3 is therefore the preferred option from a non-financial perspective.

Capital Cost Comparison

3.12 A summary of the capital cost of the options is provided in the following table:

	Option 1 Do Nothing	Option 2 Do Minimum (Backlog only) £000	Option 3 Redevelop existing estate £000	Option 4 New Build £000
Works Cost		0.156	4.431	6.683
Fees		0.025	0.727	1.203
Non-Works		0.120	0.336	0.276
Equipment		0	1.522	1.522
Contingency		0.030	0.701	0.968
Sub Total Costs excl. VAT		**0.331**	**7.717**	**10.652**
VAT (excl. Recoverable)		0.061	1.398	1.990
Total Costs	**N/A**	**0.392**	**9.115**	**12.542**

3.13 Whilst Option 3 and 4 rank closely in the non-financial appraisal it is clear from the above capital cost analysis that Option 3 presents the best option in terms of value for money as it can deliver the same benefits as Option 4 but at a significantly lower capital cost.

Preferred Option

3.14 Based on the non-financial appraisal and the capital cost comparison, the preferred option to be carried forward is Option 3 i.e. the redevelopment of the vacant Obstetric / Delivery Unit at RGH to provide a JAG compliant four suite Endoscopy Unit.

3.15 The preferred option utilises space that has become vacant as a result of the vast majority of Maternity Services moving from Royal Gwent to the Grange

University Hospital. The Maternity Unit occupied an irregular shaped area to the north of the ward block adjacent to the lift and stair core which provided access from Belle Vue Lane. The space houses two maternity theatres and associated recovery beds, seven delivery rooms, a small inpatient area and associated support accommodation in approximately 1,140sqm.

3.16 The functional requirements for the proposed four suite Endoscopy unit based on JAG recommendations and feedback from stakeholders is:

- 12 Pre-Assessment rooms - (including one bariatric with en-suite)
- 12 post-Operative recovery bays -(3 per Procedure Room)
- Capsule endoscopy facilities
- Inpatient bed holding area
- Separate discharge facilities –adjacent to recovery areas
- Support accommodation: Offices (Scheduling and Sister's offices)
- WC's x 13 (2 x staff / 11 x patient -including 6 accessible)
- Staff Rest Room
- Dedicated Reception & Waiting Room
- Separate Male & Female Changing
- Separation of flows

3.17 The configuration of the unit is as proposed below:

3.18 The proposed preferred option will provide an additional two procedure rooms. In the context of the previous demand and capacity calculations a detailed assessment has been done on the capacity that will be generated by the total complement of four rooms using different levels of utilisation which has in turn informed the revenue costs. The capacity calculations are attached at ***Appendix 1***. Three levels of utilisation have been assessed:

Option 3a - 4 rooms operating 5 days a week

At Year 3 (2023/24) there is a demand for 32,107 points. Service capacity at year 3 on a Mon-Fri model is 30,144 points, this leaves a gap of 1964 points or 1348 patients. This shortfall could increase due to potential backlog from year 2

Option 3b - 4 rooms operating 5 days a week, 2 rooms operating weekends

At Year 3 (2023/24) there is a demand for 32,107 points. Service capacity at year 3 on a 7-day model operating 4 theatres Mon-Fri and 2 theatres sat/sun is 33,536 leaving surplus capacity of 1429 points or 981 patients. This capacity could be used as there is likely to be a backlog from year 2.

Option 3c – 4 rooms operating 7 days per week

At Year 3 (2023/24) there is a demand for 32,107 points. Service capacity at year 3 on a 7-day model operating 4 theatres Monday-Sunday is 36,929 leaving surplus capacity of 4,822 points or 3,310 patients. The surplus could be utilised as there is likely to be a backlog from year 2.

3.19 The differing capacity levels of each option are summarised in the below table, detailed calculations are included at ***Appendix 1***:

Phased Capacity

Demand and Capacity Points (49 Week:	Year 1 2021/22	Year 2 2022/23	Year 3 2023/24	Year 4 2024/25	Year 5 2025/26
Total Recurring Demand	27,562	30,150	32,107	36,368	38,186
Capacity					
Current	22,078	22,078	22,078	22,078	22,078
Proposed 5 Day Working			28,799	28,799	28,799
Proposed 7 Day Working (2 Theatres W/E)			31,627	31,627	31,627
Proposed 7 Day Working (4 Theatres W/E)				36,364	36,929
Surplus / (Gap) Points					
Current	-5,484	-8,072	-10,030	-14,290	-16,108
Proposed 5 Day Working			-3,308	-7,568	-9,387
Proposed 7 Day Working (2 Theatres W/E)			-481	-4,741	-6,560
Proposed 7 Day Working (4 Theatres W/E)				-4	-1,257
Surplus / (Gap) Patients					
Current	-3,764	-5,541	-6,885	-9,809	-11,057
Proposed 5 Day Working			-2,271	-5,195	-6,443
Proposed 7 Day Working (2 Theatres W/E)			-330	-3,254	-4,503
Proposed 7 Day Working (4 Theatres W/E)				-3	-863

Preferred Model

3.20 The preferred Option is 3b progressing to Option 3c in 2024/25. The phased options mirror the Demand & Capacity modelling therefore would ensure there is sufficient capacity to meet increasing demand by Year 4 (2024/25). In the preferred model, the new unit will initially deliver a 7-day service, operating a 4-theatre model Monday-Friday and a 2-theatre model Saturday and Sunday when it opens, progressing to a full 7-day service, 4 theatres Monday – Sunday at a later date.

3.21 A phased approach will support the workforce / recruitment plan, the details of which are attached at ***Appendix 2,*** allow for familiarisation with the new environment, and training and education.

4.0 PROCUREMENT ROUTE

Tender Process

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

4.2 The proposed refurbishment works required at Royal Gwent Hospital to provide four JAG complaint Endoscopy suites is proposed to be procured via the NHS 'traditional tendering procurement route'. This takes into consideration the relatively small capital value requirement and short timescale of the scheme and seeks to take advantage of local expertise and value for money for this one-off project.

4.3 Tenders have been invited and returned and the resultant tender evaluation report prepared by [redacted], project Cost Advisors, and is attached at ***Appendix 3*** to this BJC

4.4 This recommends the appointment of [redacted] as the project Main Contractor based on a planned acceptance of their tender in the sum of £4.431 million excluding VAT.

Risk

4.5 A risk register has been prepared and has been included in the Estates Annex.

Agreed Length of Contract

4.6 The recommended tender, if approved, is based on for the construction/refurbishment works taking 45 weeks.

Procurement Strategy and Implementation Timescales.

4.7 If the BJC is approved within 2 months from its submission to Welsh Government at the end of February 2022 it has been assumed that the redevelopment would commence in early May 2022 and would be complete by March 2023. These dates will be confirmed if and when the BJC is approved, and the tender has been awarded.

4.8 The BJC has been prepared on the assumption that capital funding will be available in financial year 2022/23 and 2023/24.

4.9 It is assumed that Ministerial consent will be required for the main building contract.

5.0 FUNDING & AFFORDABILITY

Introduction

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

Capital Costs

5.2 The preferred option is Option 3 the redevelopment of the vacant Obstetric / Delivery Unit at Royal Gwent Hospital to provide four JAG compliant Endoscopy Suites. The estimated outturn costs for the preferred option is £9.115 million, the detail of which is set out below:

	Option 3 – Redevelopment of vacant accommodation (£000)
Works Cost	4.431
Fees	0.727
Non-Works	0.336
Equipment	1.522
Contingency	0.701
Total Option Costs	**7.717**
VAT (net of reclaim)	1.398
Total Option Costs (including VAT)	**9.115**

5.3 A more detailed breakdown of the capital cost calculations is contained within the BJC Forms attached at ***Appendix 4.***

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

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

5.6 Submission of the BJC to Welsh Government is currently programmed for the end of February 2022. On the assumption that the BJC is approved within 2 months of submission it has been assumed that the project will commence in May 2022 and will be completed by the end of March 2023.

5.7 The detailed cash flows for the preferred option is contained with the BJC forms attached at ***Appendix 4*** and is summarised below:

2019/20	**2020/21**	**2021/22**	**2022/23**	**2023/24**
£65,614	£140,969	£150,731	£6,750,180	£2,007,230

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

- Costs included for Fees are based on typical rates
- Non-Works Costs are based on estimated capital costs that will be incurred in developing the scheme through to Operational Completion and include Planning Fees, IT infrastructure and Commissioning costs
- Equipment costs are based on a schedule of equipment taking into account a level of transfers from existing shared premises.

- A Contingency allowance of £701k has been included based on a quantified Risk Register. The Risk Register is included in the Estate Annex.
- VAT has been applied at the rate of 20% to all relevant cost components has been assumed. Further advice on the potential VAT reclaim will be sought as the project progresses.

Revenue Costs

5.9 The table below summarises the revenue costs associated with the preferred option (Option 3) compared to the baseline costs that the service is incurring in the delivery of the existing service (Option 1), and the costs that will be incurred to meet demand if there is no capital investment (Option 2). The detailed revenue calculations are attached at ***Appendix 5.***

Options Appraisal Costings per annum	Current	Options 1 and 2 (Do Nothing)	Option 3a	Option 3b	Option 3c
	£'000	£'000	£'000	£'000	£'000
Endoscopy Workforce	1,102	1,102	2,081	2,517	2,866
Non-Pay	809	809	1,278	1,460	1,641
Non-Recurrent Capacity	3,435	4,490	1,300	1,069	600
Facilities	30	30	178	230	256
Decontamination	0	0	658	848	974
Histopathology	635	933	1,130	1,329	1,527
Set Up costs*	0	0	0	0	0
Total Cost	**6,011**	**7,364**	**6,625**	**7,453**	**7,865**
Option - Do nothing	0	0	7,364	7,364	7,364
Additional insourcing required	0	0	(584)	400	1,384
Cost of Additional Insourcing to Match Capacity	-	-	**6,780**	**7,764**	**8,748**

Current Expenditure

5.10 Costs are based on the following:

- All costs are at 2021/22 price levels
- VAT is included where appropriate

Option 3 Expenditure

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

- Clinical and service models
- Workforce requirements
- Estate and Non-pay implications

5.12 They assume that:

- The new model (Option 3) will be operational in May 2023, the endoscopy unit will have 4 suites operating 7 days per week, Monday – Friday utilising 4 theatres: Saturday/Sunday utilising 2 theatres.

- At that point there will be projected demand for 32,107 points. Service capacity based on the above operating model will be 31,627 leaving surplus capacity of 481 points or 336 patients. Surplus capacity will be used to address the likely backlog that will exist at that point. The detailed capacity and demand

calculations are attached at ***Appendix 1*** which include other potential capacity scenarios.

- In the Do Minimum model (Option 2) an assessment has been made of the costs of the additional WLIs and / or outsourcing required to achieve the same level of activity as Option 3.

- The existing services delivered from existing RGH Endoscopy suite will cease and that facility will be converted to a central Decontamination Unit for RGH.

Affordability

5.13 The additional recurrent revenue investment required to support the proposed increase in Endoscopy provision is £4,429,000 in year 2 of operation through to £4,689,000 in year 5. This investment presents a major improvement in delivering sustainable healthcare to both ABUHB and the wider regional patient population. The revenue funding will be considered as a priority for the IMTP for ABUHB as the service will support long term recovery for diagnostics, cancer and treatment for patients, improving equity of access.

5.14 The demand for endoscopy has grown since the pandemic and additional capacity will be required regardless of delivery model. This case supports delivery of an efficient, high quality JAG accredited delivery option, for optimum patient benefit.

5.15 Additionally, the Health Board would appreciate Welsh Government considering this development as an opportunity to support regional working and provide additional revenue support, as available, as part of the national priority for regional endoscopy programme.

Preferred Option Depreciation and Impairment

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

	2023/24		2024/25 Recurring	
	Buildings	Equipment	Buildings	Equipment
Option 3	£000	£000	£000	£000
Depreciation	106	242	141	323
Impairment	5,719	0	0	0
Total Costs	**5,825**	**242**	**141**	**323**

5.17 Impairment has been calculated based on advice from the District Valuer. The asset value post impairment has been depreciated over the estimates of useful economic life provided by the District Valuer.

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

Impact on the Organisations Statement of Financial Position (SoFP)

	2021/22	2022/23	2023/24	2024/25
Option 3	£000	£000	£000	£000
Non-Current Assets b/f:	279	454	9,115	3,048
Non-Current Assets Additions:				
Equipment	0	1,928	0	0
Assets Under Construction / Buildings	175	6,733	0	0
Total Additions	175	8,661	0	0
Non-Current Assets Impairment:				
Assets Under Construction / Buildings	0	0	(5,719)	0
Total Impairments	0	0	(5,719)	0
Non-Current Assets Depreciation:				
Buildings	0	0	(106)	(141)
Equipment	0	0	(242)	(323)
Total Depreciation	0	0	(348)	(464)
Closing NBV Impact on SoFP	**454**	**9,115**	**3,048**	**(2,584)**

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

6.0 MANAGEMENT ARRANGEMENTS

Introduction

6.1 This section sets out information on the management arrangements for the RGH Endoscopy Redevelopment project.

Project Management Arrangements

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

6.3. The project is being managed in the context of the Clinical Futures programme management structure and via a Project Board that has been established to oversee

the transition of Royal Gwent and Nevill Hall Hospitals to Local General Hospital. The project also has a dedicated Project Team.

Project Roles and Responsibilities

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

6.5. The Project Director – Andrew Walker Strategic Capital and Estates Programme Director is accountable to the Director of Planning and has specific responsibility for the project management structures and organisation of the project, including appropriate controls and monitoring mechanisms. The Project Director is ultimately responsible for the Risk Register but delegate's day to day management to identified risk leads. The Project Director is supported by an External procurement for the day-to-day planning and design phases of the project as well the technical, procurement and construction phases.

6.6 The Service / Clinical Lead – Andrew Yeomans, is accountable for the effective co-ordination of clinical and user professional input to the project both from the perspective of the service / clinical provision and the internal allocation and utilisation of space within the UBU.

6.7 Other key project team members include key internal ABUHB estates and operational service managers and input from finance, personnel, information and procurement.

Outline Project Plan

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

Milestone	Completion Date
Sign off of Draft BJC by the Executive Team	17th February 2022
Submission of Draft BJC to WG	21st February 2022
Submission of Draft BJC to Health Board	30th March 2022
Anticipated WG approval of BJC	29th April 2022
Contractor appointment/start on site	27th May 2022
Construction work completion / Occupation	May 2023

Assurance

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

Benefits Realisation

6.10 The Benefits Realisation plan is attached at ***Appendix 6.*** This sets out the potential benefits and the framework for monitoring the realisation of the benefits.

Risk Management

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

6.12 The current project risk register for the project is found in the Estates Annex.

Communications and Engagement

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

Post Project Evaluation

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

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

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 23rd March 2022 Agenda Item: 3.5

Aneurin Bevan University Health Board

Board & Committee Arrangements 2022/23

Executive Summary

At its meeting in December 2020, in response to the on-going pandemic, the Board approved a revised Committee Structure as part of 'Resetting Governance' which promoted a leaner structure whilst maintaining effective scrutiny and assurance around the Health Boards strategic decision making, financial accountability and patient outcomes. The revised arrangements were implemented from 1st April 2021.

Throughout the COVID-19 pandemic, the Board has continued to review its governance arrangements to ensure that they remain appropriate whilst agile enough to meet the demands placed upon the organisation. The Board is aware of the increasing pressures that have been placed on the health and social care system, as a direct and indirect result of the pandemic, and the significant ongoing challenges that the organisation faces in responding to these. It is therefore essential that the Board's business, and that of its committees, remains focussed on its key priorities and strategic risks, ensuring an appropriate balance between strategy, delivery and performance, and culture.

The Board's committee structure therefore needs to support the Board in gaining assurance on the extent to which the organisation is operating effectively, delivering its strategic vision and meeting the strategic objectives it has set by managing strategic risks – maximising opportunities and mitigating threats – in a manner that upholds the highest standards of public sector delivery and in accordance with all legal and other requirements.

In recognition of the Board's strategic priorities for 2022/23 and the strategic risks it currently holds, a revised committee structure is proposed for the new financial year. The proposed structure (**figure 3**) will enable an appropriate balance between strategy, delivery and performance, and culture and takes into consideration feedback from Board Members and Audit Wales in respect of effectiveness.

The Board is asked to:	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	
Executive Sponsor: Ann Lloyd, Chair	
Report Author: Rani Mallison, Board Secretary	
Report Received consideration and supported by:	

Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**Shared with Board Members for comment**

Date of the Report: 23rd March 2022

Purpose of the Report

The purpose of this report is to set out proposed Board and Committee arrangements for 2022/23, for the Board's consideration and approval, if deemed appropriate.

This paper does not focus attention on the Board's Advisory Fora (Stakeholder Reference Group, Healthcare Professionals' Forum and Local Partnership Forum) which will be subject to a separate paper at a later meeting.

Background and Context

Aneurin Bevan University Health Board's Standing Orders[1] state that: "*The Board may and, where directed by the Welsh Ministers must, appoint Committees of ABUHB 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 shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business: Quality and Safety; Audit; Information governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements*."

There is scope to bring committees together so long as the Board can be assured that in doing so these areas can be addressed effectively. Conversely, the Board may increase the number of committees as deemed necessary to provide assurance. There is also scope to establish sub committees and joint committees with other NHS bodies.

At its meeting in December 2020, in response to the on-going pandemic, the Board approved a revised Committee Structure as part of 'Resetting Governance' which promoted a leaner structure whilst maintaining effective scrutiny and assurance around the Health Boards strategic decision making, financial accountability and patient outcomes. The revised arrangements were implemented from 1st April 2021.

In 2021, Audit Wales (External Audit) undertook a Structured Assessment[2], which considered the effectiveness of the Board's governance arrangements. In respect of the Board's committee arrangements, Audit Wales concluded that "*Whilst Board members are supportive of the new governance structure, some have expressed concerns about the volume of work now undertaken by some of the committees (such as the Audit, Finance and Risk Committee), and the robustness of the arrangements for ensuring flows of assurance. The Health Board, therefore, needs to assess the effectiveness of its new governance structure to ensure it is operating as intended*." Audit Wales also identified areas for strengthening in respect of the conduct of committee business, which included: adopting a consistent approach to agenda setting to provide focus and enable scrutiny where it is needed most; and opportunities to improve the quality and use of cover reports through training, guidance and regularly reviewing the quality of agenda content.

[1] LHB Model Standing Orders Reservation and Delegation of Powers - 25 March 2021 v5 Final (nhs.wales)
[2] Aneurin Bevan University Health Board – Structured Assessment 2021 | Audit Wales

In-line with Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. In March 2022, the Board undertook an assessment of its effectiveness, including its committee structure, and identified areas for strengthening and improvement. These included, but are not limited to:

- Establishment of a Board Development Programme
- Establishment of a Board Member Induction Programme
- The need for dedicated time for the Board to undertake horizon scanning and discuss strategic development
- The need for a strengthened focus on outcomes, using intelligence and analytics
- The need for a strengthened focus on the work delivered through partnerships and joint committees
- The development of an Organisational Accountability Framework
- Ongoing development of risk management and assurance mapping.

Throughout the COVID-19 pandemic, the Board has continued to review its governance arrangements to ensure that they remain appropriate whilst agile enough to meet the demands placed upon the organisation. The Board is aware of the increasing pressures that have been placed on the health and social care system, as a direct and indirect result of the pandemic, and the significant ongoing challenges that the organisation faces in responding to these. It is therefore essential that the Board's business, and that of its committees, remains focussed on its key priorities and strategic risks, ensuring an appropriate balance between strategy, delivery and performance, and culture.

Assessment

The three key roles through which the Board demonstrates its leadership within the Health Board are:

1. Shaping a positive culture for the Board and the organisation;
2. Formulating strategy; and
3. Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; and

The Board's committee structure therefore needs to support the Board in gaining assurance on the extent to which the organisation is operating effectively, delivering its strategic vision and meeting the strategic objectives it has set by managing strategic risks – maximising opportunities and mitigating threats – in a manner that upholds the highest standards of public sector delivery and in accordance with all legal and other requirements.

The Board has confirmed its strategic intent via its Integrated Medium-Term Plan 2022-25 (**figure 1**). It will therefore remain imperative that the Board Assurance Framework, as the key document used to record and report the organisation's key strategic objectives, risks, controls and assurances to the Board, is aligned to enable the Board to focus its attention and that of its committees by seeking assurances on the risks identified.

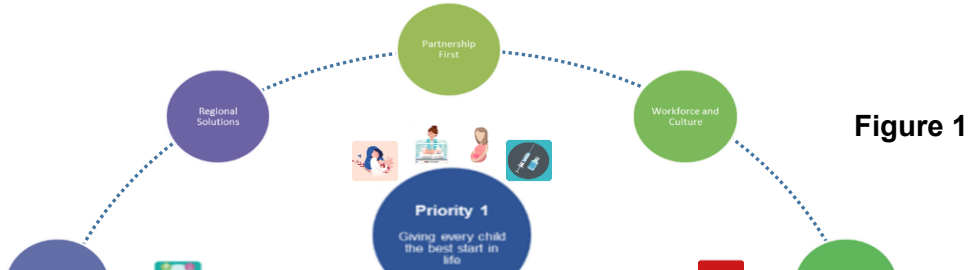


Figure 1

The Board received a mid-year review of its Board Assurance Framework in November 2021 (based on 2021/22 strategic priorities), which confirmed 12 principal risks (scored 15 or above [high]) to the Health Board's delivery of its strategic priorities. The risks were in relation to:

- Health Care Acquired Infections (HCAIs) to include COVID 19
- High levels of emergency supportive care
- The demands of an increasingly aging population with complex healthcare needs and requirements
- Implementation of the Welsh Community Care Information System (WCCIS)
- Population health in relation to non - COVID harm
- Patient falls whilst using the Heath Board's Services
- Recruitment and Retention of staff
- Stability of ICT Systems
- The effectiveness of the COVID-19 Vaccination and Booster
- Inappropriate admissions of children aged under 18 to acute adult mental health wards
- The Health Board's duties in respect of Safeguarding
- Financial Performance.

Current Committee Structure (2021/22)

The committee structure approved by the Board in December 2020 (**figure 2**), established three major Committees:

- The Audit, Finance and Risk, established to scrutinise financial issues and risk management and some information governance risks (FOIA requests);
- The Quality, Patient Safety and Outcomes Committees, established to oversee the quality of patient services and system measures as well as some information governance requirements (SARs and incidents) as well as staff well-being and development issues; and

- The Strategy, Planning, Partnerships and Wellbeing Group, established to consider strategy, planning and partnership working including the scrutiny of collective outcome measures for services delivered with partner agencies.

In addition, in light of the increased risk in respect of the workforce and its well-being, the Board agreed that the People and Culture Committee would continue to meet for 2021/22, to review the effectiveness of the plans and measures to consolidate the proposals for all staff and their well-being and development. It was agreed that the longer-term need for this Committee (as a separate entity) would be reviewed after this time.

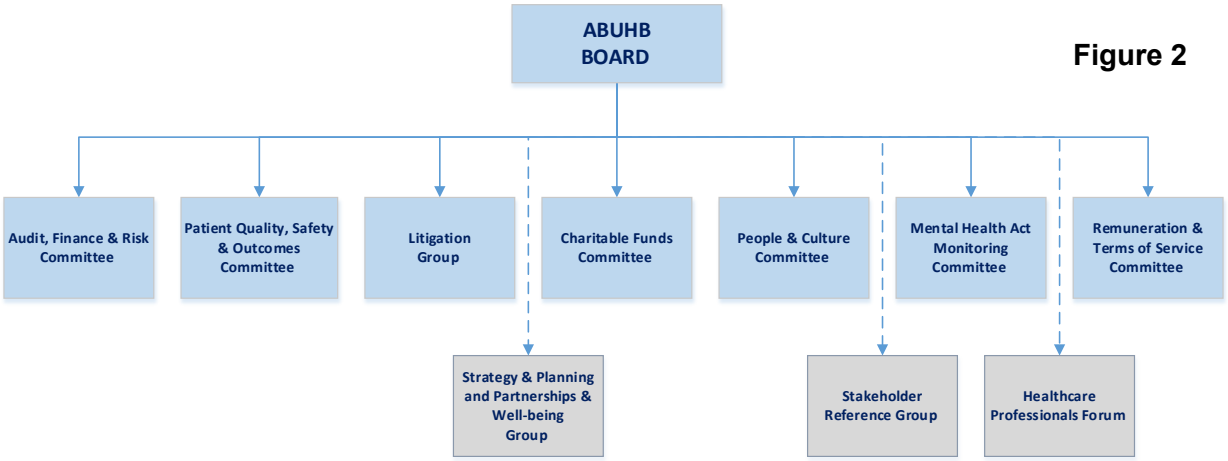


Figure 2

Proposed Committee Structure 2022/23)

In recognition of the Board's strategic priorities for 2022/23 and the strategic risks it currently holds, a revised committee structure is proposed for the new financial year. The proposed structure (**figure 3**) will enable an appropriate balance between strategy, delivery and performance, and culture and takes into consideration feedback from Board Members and Audit Wales in respect of effectiveness.

In addition to the Board's formal meetings and formal Committee meetings, the following informal arrangements would be established to support the Board to fulfil its responsibilities:

- Board Development Sessions, held bi-monthly (6 times yearly), to focus on the development and effectiveness of the Board as a cohesive and unitary Board;
- Board Briefing Sessions, held bi-monthly (6 times yearly), to focus on key matters where informal discussion is required and to raise awareness of matters such as changes in policy or legislation; and
- Board Strategic Planning Sessions, held quarterly, to allow the Board informal development time to discuss collectively strategic developments and horizon planning.

This paper therefore proposes that the following committees are constituted for 2022/23:

a) Audit, Risk & Assurance Committee
b) Patient Quality, Safety & Outcomes Committee
c) People & Culture Committee
d) Finance & Performance Committee
e) Partnerships, Population Health and Planning Committee

f) Mental Health Act Monitoring Committee
g) Remuneration and Terms of Service Committee
h) Charitable Funds Committee
i) Litigation Group (subject to ongoing review)

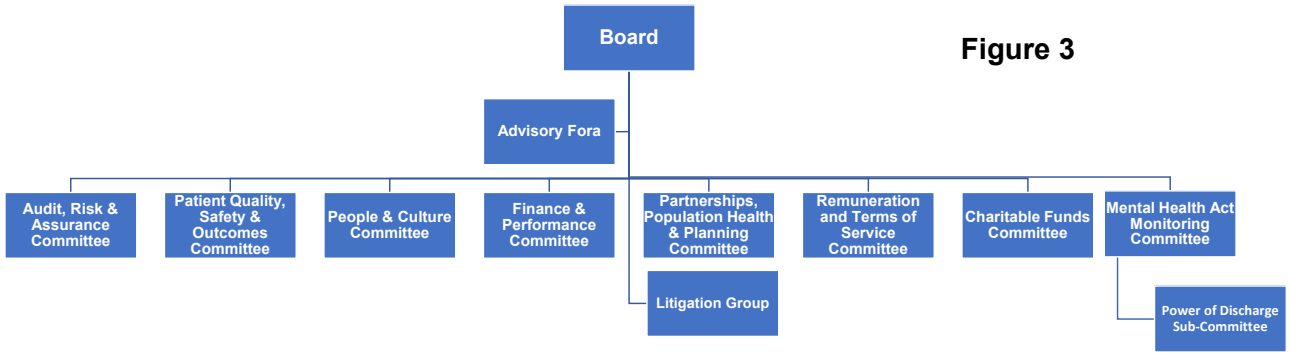


Figure 3

a) Audit, Risk & Assurance Committee

The purpose of the Audit, Risk and Assurance Committee will be 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 Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix A**. The Committee will meet on a bi-monthly (6 times yearly) basis.

Committee membership for 2022/23, is proposed as currently constituted:

Chair (Independent)	Shelley Bosson
Vice Chair (Independent)	Richard Clark
Member (Independent)	Paul Deneen
Member (Independent)	Katija Dew
Executive Support (Not a formal member)	*Director of Finance, Procurement and VBHC Board Secretary*

b) Patient Quality, Safety & Outcomes Committee

The purpose of the Patient Quality, Safety & Outcomes Committee will be 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.

The Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix B**. The Committee will meet on a bi-monthly (6 times yearly) basis.

Committee membership for 2022/23, is proposed as currently constituted:

Chair	Pippa Britton
Vice Chair	Louise Wright
Member (Independent)	Paul Deneen
Member (Independent)	Helen Sweetland
Member (Independent)	Shelley Bosson

Executive Support (Not a formal member)	*Medical Director* *Director of Nursing* *Director of Therapies and Health Sciences*

c) People & Culture Committee

The purpose of the People and Culture Committee will be to advise the Board on all matters relating to staff and workforce planning of the Health Board; and plans to enhance the environment that supports and values staff in order to engage the talent and nurture the leadership capability of individuals and teams working together to drive the desired culture throughout the Health Board to deliver safer better healthcare. The Committee will also provide advice and assurance to the Board in relation to the direction and delivery of Organisational Development and other related frameworks to drive continuous improvement and to achieve the objectives of the Health Board.

The Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix C**. The Committee will meet three times a year.

Committee membership for 2022/23, is proposed as currently constituted:

Chair	Louise Wright
Vice Chair	Paul Deneen
Member (Independent)	Helen Sweetland
Member (Independent)	Vacant (pending public appointments)
Executive Support (Not a formal member)	*Director of Workforce & OD*

d) Finance & Performance Committee

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. Included within this, the Committee will seek assurance that arrangements for financial management and financial performance are sufficient, effective and robust.

The Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix D**. The Committee will meet on a quarterly basis.

Committee membership for 2022/23, is proposed as:

Chair	Richard Clark
Vice Chair	Pippa Britton
Member (Independent)	Shelley Bosson
Member (Independent)	Vacant (pending public appointments)
Executive Support (Not a formal member)	*Director of Finance, Procurement and VBHC* *Director of Planning, Performance, Digital & IT*

e) Partnerships, Population Health and Planning Committee

The purpose of the Partnerships, Population Health and Planning Committee will be to provide the Board with advice and assurance on arrangements for: ensuring that strategic collaboration and effective partnership arrangements are in place; and that there are effective mechanisms in place in respect of improving population health and reducing health inequalities. The Committee will also provide the Board with advice and assurance on the robustness of the Health Board's approach, systems and processes for developing strategies and plans, including those developed in partnership.

It is important to note that this Committee will not be responsible for the development of strategy, which is a collective Board responsibility and therefore reserved for full Board discussions. In addition, it will be important for the full Board to remain apprised of the work of its statutory partnerships.

The Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix E**. The Committee will meet three times a year.

Committee membership for 2022/23, is proposed as:

Chair	Ann Lloyd
Vice Chair	Katija Dew
Member (Independent)	Richard Clark
Member (Independent)	Vacant (pending public appointments)
Executive Support (Not a formal member)	*Director of Planning, Performance, Digital & IT* *Director of Public Health & Strategic Partnerships*

f) Mental Health Act Monitoring Committee

The purpose of the Mental Health Act Monitoring Committee is to provide advice and assurance to 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. 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. This will include the Power of Discharge sub-Committee, constituted by Associate Hospital Managers.

The Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix F**. The Committee will meet on a quarterly basis.

Committee membership for 2022/23, is proposed as current constituted:

Chair	Pippa Britton
Vice Chair	Katija Dew
Member (Independent)	Paul Deneen
Executive Support (Not a formal member)	*Director of Primary, Community Care and Mental Health*

The Mental Health Act Monitoring Committee has established a ***Hospital Managers Power of Discharge Sub-Committee***. The principal remit of the Hospital Managers Power of Discharge Sub-Committee is to satisfy the board that the processes employed by the committee, tasked with considering whether the power of discharge should be used, are fair, reasonable, and exercised lawfully. The Sub-Committee will report routinely to the Mental Health Act Committee for assurance and developmental purposes

g) Remuneration and Terms of Service Committee

The purpose of the Remuneration and Terms of Service Committee is to consider and approve the remuneration and terms of service for the Chief Executive, Executive Directors and other very senior staff within the framework set by the Welsh Government, on behalf of the Board. The Committee will seek assurance in respect of objectives for Executive Directors and other VSMs and the associated performance assessment; agreeing actions on behalf of the Board where required.

The Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix G**. The Committee will meet on a quarterly basis.

Committee membership for 2022/23, is proposed as currently constituted:

Chair	Ann Lloyd
Vice Chair	Pippa Britton
Member (Independent)	Louise Wright
Member (Independent)	Shelley Bosson
Executive Support (Not a formal member)	*Chief Executive* *Director of Workforce & OD* *Board Secretary*

h) Charitable Funds Committee

The purpose of the Charitable Funds Committee is to make and monitor arrangements for the control and management of charitable funds, on behalf of the Board, as corporate trustees of the charitable funds held and administered by the Health Board.

The Terms of Reference and Operating Arrangements for this Committee are attached at **Appendix H**. The Committee will meet on a quarterly basis.

Committee membership for 2022/23, is proposed as currently constituted:

Chair	Katija Dew
Vice Chair	Louise Wright
Member (Independent)	Keith Sutcliffe
Member (Executive)	Chief Executive
Member (Executive)	Director of Finance, Procurement and VBHC
Executive Support	*Director of Finance, Procurement and VBHC*

i) Litigation Group

The Board previously established a Litigation Group, in the context of the Health Board's Policy for the Management of Clinical Negligence and Personal Injury Litigation. The purpose of the Litigation Group is to make decisions on claims where: there is a value of above £100,000; cases may be taken to trial; and for cases which significantly risk the

reputation of the Health Board. The Terms of Reference state that, although a Group of the Board, the Litigation Group will report routinely for assurance purposes to the Quality, Patient Safety and Outcomes Committee.

Discussions are underway to review the Litigation Group's role, purpose and operating arrangements to ensure it remains appropriate and fit for purpose. An update will be brought forward to the Board at a future meeting.

Committee Operating Arrangements
In line with the proposed committee arrangements, a Schedule of Board and Committee meetings will be issued to Board Members based on the agreed frequency of respective committee meetings, once agreed.

2022/23 Annual Workplans for each committee are under development and will be aligned to priority areas identified through the Integrated Medium-Term Plan 2022-25, the Board Assurance Framework and Corporate Risk Register. These workplans will be key in ensuring that the Board's overall assurance arrangements are focussed on strategic priorities, strategic risks and assurance needs.

An initial committee assurance map, based on the proposed committee structure and associated terms of reference, is attached at **Annex 1**. This will need to remain a dynamic document, updated in-line with the development of committee workplans. It is important to note that, whilst items of business are mapped to the relevant committee, committee workplans will only focus on those matters which are deemed as strategic priority, a strategic risk or as an assurance need. This will ensure the work of the board and its committees remains proportionate and balanced.

Compliance with Standing Orders
As mentioned earlier in the paper, the Health Board's Standing Orders state that, "as a minimum, it must establish committees which cover the following aspects of Board business: Quality and Safety; Audit; Information Governance; Charitable Funds; Remuneration and Terms of Service; and Mental Health Act requirements." The table below confirms that the proposed committee arrangements have taken into consideration the requirements placed upon the Health Board:

Requirement of Standing Orders	**Assurance Committee**				
	Patient Quality, Safety & Outcomes	**Finance & Performance**	**Audit, Risk & Assurance**	**Remuneration & Terms of Service**	**Mental Health Act Monitoring**
Quality & Safety	✓				

Audit			✓		
Information Governance		✓			
Remuneration & Terms of Service				✓	
Mental Health Act					✓

Conclusion and Recommendation

Throughout the COVID-19 pandemic, the Board has continued to review its governance arrangements to ensure that they remain appropriate whilst agile enough to meet the demands placed upon the organisation. The Board is aware of the increasing pressures that have been placed on the health and social care system, as a direct and indirect result of the pandemic, and the significant ongoing challenges that the organisation faces in responding to these. It is therefore essential that the Board's business, and that of its committees, remains focussed on its key priorities and strategic risks, ensuring an appropriate balance between strategy, delivery and performance, and culture.

In recognition of the Board's strategic priorities for 2022/23 and the strategic risks it currently holds, a revised committee structure is proposed for the new financial year.

The Board is asked to:

1) AGREES the following board committees being constituted for the financial year 2022/23, including proposed Terms of Reference and Operating Arrangements and Membership:
   - **a.** Audit, Risk & Assurance Committee
   - **b.** Patient Quality, Safety & Outcomes Committee
   - **c.** People & Culture Committee
   - **d.** Finance & Performance Committee
   - **e.** Partnerships, Population Health and Planning Committee
   - **f.** Mental Health Act Monitoring Committee
   - **g.** Remuneration and Terms of Service Committee
   - **h.** Charitable Funds Committee
   - **i.** Litigation Group (subject to ongoing review)

2) NOTES that Annual Workplans for each committee are under development and will be aligned to priority areas identified through the Integrated Medium-Term Plan 2022-25, the Board Assurance Framework and Corporate Risk Register; and

3) NOTES the arrangements to established in addition to formal Board and Committee meetings to support the Board in fulfilling its responsibilities:
   - **a.** Board Development Sessions, held bi-monthly (6 times yearly), to focus on the development and effectiveness of the Board as a cohesive and unitary Board;
   - **b.** Board Briefing Sessions, held bi-monthly (6 times yearly), to focus on key matters where informal discussion is required and to raise awareness of matters such as changes in policy or legislation; and

c. Board Strategic Planning Sessions, held quarterly, to allow the Board informal development time to discuss collectively strategic developments and horizon planning.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework and this proposal should enhance the risk management process.
Financial Assessment, including Value for Money	There is no direct financial detrimental impact associated with this report.
Quality, Safety and Patient Experience Assessment	Impact on quality, safety and patient experience are believed to be improved.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no specific equality issues associated with this report.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The risks against delivery of key priorities in the IMTP, will be better monitored and assessed.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are included within the review of the structure
Glossary of New Terms	None
Public Interest	Report to be published.

ANNEX 1

COMMITTEE MAPPING				
Audit, Risk & Assurance	**Patient Quality, Safety & Outcomes**	**People & Culture**	**Finance & Performance**	**Partnerships, Population Health & Planning Committee**

• Risk Management Strategy and Implementation
• Board Assurance Framework System and Co-ordination
• Annual Accountability Report, including Annual Governance Statement
• Financial Control Procedures
• Budgetary Control
• Single Tender Action
• Losses & Special Payments
• Annual Financial Statements & Remuneration Report
• Internal Audit
• External Audit
• Counter Fraud
• Post Payment Verification
• Audit Recommendation Tracking
• Standing Orders
• Standing Financial Instructions
	• Health & Care Standards
	• Patient Quality & Safety Framework
	• Quality Performance and Outcomes Reporting
	• Internal and External Reviews and Inspections relating to the provision of care
	• Maternity Services
	• COVID-19 Quality Reviews
	<u>Safe Care</u>
	• Health & Safety
	• Fire Safety
	• Radiation Protection
	• Medical Exposure
	• Violence & Aggression
	• Manual Handling
	• Report of the Controlled Drugs Officer
	• Medication Safety
	• Mortality and Harm Reviews/Medical Examiner
		• People Plan
		• People First/Staff engagement
		• Values and Behaviours Framework
		• Arrangements for testing culture/Staff Surveys
		• Staff Voice (Social Partnership)
		• Staff Wellbeing and attendance at work
		• Compassionate Leadership
		• Learning, Training and Development
		• Equality & Diversity
		• Welsh Language
		• Staff Raising Concerns/Whistleblowing
		• Dignity at Work
		• Respect & Resolution
		• Employee Relations Matters
		• Organisational Development/Design
		• Workforce Planning
		• Recruitment and Retention
		• Talent Management & Succession Planning
			<u>Financial Management and Performance</u>
			• Allocation of revenue budgets
			• Financial performance monitoring against
			  ○ revenue budgets and statutory financial duties
			  ○ Capital budgets, incl discretionary
			  ○ Savings plans and cost improvement plans
			• Efficiency Framework
			• Procurement Framework
			<u>Performance Management</u>
			• Performance Management Framework
			• Delivery of strategic plans and priorities as set out in IMTP
			• Delivery of enabling plans
			  ○ Digital
			  ○ Estates
			  ○ Information Governance
				<u>Strategic Planning</u>
				• Planning Framework
				• Engagement and Consultation Framework
				• Review of Service Change Proposals
				• Capital Plan and Business Case Review
				• Business Continuity and Major Incident Planning
				• Wellbeing of Future Generations Act (Wales) 2015
				• Socio-economic Duty for Wales
				• Strategic and Commissioning Plans of WHSSC and EASC
				• Regional Planning
				• Cluster/NCN Planning
				<u>Strategic Partnerships</u>
				• Public Service Board
				• Regional Partnership Board
				<u>Population Health</u>
				• Population/

• Covid-19 Inquiry Preparedness	• Nutrition and Hydration
	• Safeguarding
	• Liberty Protection Safeguards
	• Cleaning Standards
	• Infection Control
	• Falls
	
	<u>Effective Care</u>
	• Clinical Effectiveness
	• National and Local Clinical Audit
	• Quality Improvement
	• Research & Development
	• Medical Devices
	• Point of Care Testing
	<u>Dignified Care and Individual Care</u>
	• Patient Experience
	• Dementia
	• Putting Things Right, including
	  ○ Complaints
	  ○ Compliments
	  ○ Redress
	• Claims
	• Incidents
	• Coroner Inquests
	• Patient Safety Incidents
		• Foundation Economy
		• Workforce Performance Measures
			○ Intelligence and Data
			• Performance against national and local outcome measures
			• NWSSP Performance
			• EASC Performance
			• WHSSC Performance
				Wellbeing Assessments
				• Health Inequalities
				• Health Promotion

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 23rd March 2020 Agenda Item: 4.1

Aneurin Bevan University Health Board

Audit Wales – Annual Audit Report and Structured Assessment 2021

Executive Summary

The Health Board receives an Annual Audit Report from Audit Wales (AW) each year, which covers the work undertaken by the AW with the Health Board during the previous year. This provides an overview of the key audits undertaken and a general opinion in respect of the Audit of the Health Board's Accounts, the programme of performance audits and the comprehensive Structured Assessment.

A key element of Audit Wales' annual programme of work is the Structured Assessment. This examines the arrangements the Health Board has in place to support good governance across key areas of the Health Board's business and the efficient, effective and economic use of resources.

This paper presents the final Annual Audit Report and Structured Assessment Report for 2021 and the Management Response, which has been completed by the Executive Team and reviewed by the Audit, Finance and Risk Committee.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Glyn Jones, Interim Chief Executive

Report Author: Rani Mallison, Board Secretary

Report Received consideration and supported by :

Executive Team	**x**	**Committee of the Board**	**Audit, Finance and Risk Committee – 03/02/22**

Date of the Report: 9th March 2022

Supplementary Papers Attached:

- Annual Audit Report 2021
- Structured Assessment Report 2021
- Management Response

Purpose of the Report

In line with usual governance monitoring and annual reporting, the Health Board has received the 2021 Structured Assessment from Audit Wales. The report sets out the findings from the Auditor General's 2021 Structured Assessment at the Health Board. The Structured Assessment is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure

economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.

Background and Context

In line with External Audit's Programme of work and the duties of the Auditor General for Wales, the Health Board received the final Structured Assessment report from Audit Wales in January 2022. Comments were invited from the Health Board in the first instance to be considered by Audit Wales prior to a final report being issued and presented to the Audit, Finance and Risk Committee in February 2022.

This report provides the management response to each recommendation received for 2021 and an update against previous recommendations received in 2020 which remain outstanding (contained within the main report).

Assessment and Conclusion

Five recommendations were concluded as a result of the Structured Assessment and the Health Board has agreed appropriate actions and implementation dates to progress these.

Recommendation

The Board is asked to receive this report for compliance purposes, note the assessments made and the actions that are being or are planned to be taken in order to respond.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report highlights key risks and issues for the Health Board if they are not effectively responded to during the next year. Therefore, the Health Board will respond to these matters through its improvement plan.
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report, however, key financial issues are covered by the report with regard to the Health Board's statutory duties.
Quality, Safety and Patient Experience Assessment	The report highlights key issues for the Health Board in relation to quality and patient safety, if these issues are not effectively responded to during the next year. Therefore, the Health Board will respond to these issues through its comprehensive improvement plan.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality or child impact issues associated with this report.
Health and Care Standards	This report will contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to Plan associated with this report.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Not applicable to this report
	Integration –Not applicable to this report
	Involvement –Not applicable to this report
	Collaboration – Not applicable to this report
	Prevention – Not applicable to this report

Glossary of New Terms	None
Public Interest	Report to be published in public domain

Archwilio Cymru
Audit Wales

Annual Audit Report 2021 – Aneurin Bevan University Health Board

Audit year: 2020-21

Date issued: January 2022

Document reference: 2812A2022

This document has been prepared for the internal use of Aneurin Bevan University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

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

Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report summarises the findings from my 2021 audit work at Aneurin Bevan University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when public bodies continued responding to the unprecedented challenges presented by the COVID-19 pandemic, whilst at the same time recovering services. My work programme was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services. I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. On-site audit work continues to be restricted, and we continued to work and engage remotely where possible through the use of technology. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

4 As was the case in 2020, the delivery of my audit of accounts work was not without its challenges, not only in how and where we undertook the work, but also in taking account of considerations for financial statements arising directly from the pandemic. The success in delivering it reflects a great collective effort by both my staff and the Health Board's officers to embrace and enable new ways of working and remain flexible to and considerate of the many issues arising.

5 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. My programme of work has provided focus on themes, lessons and opportunities relating to NHS governance and NHS staff wellbeing. I have reviewed the Test, Trace, Protect programme and the rollout of the COVID-19 vaccine. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery. I have also reviewed the governance arrangements of the Welsh Health Specialised Services Committee.

6 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of planned work currently being re-scoped.

7 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2021 Audit Plan.

8 **Appendix 3** sets out the financial audit risks set out in my 2021 Audit Plan and how they were addressed through the audit.

9 The Chief Executive and the Director of Finance have agreed the factual accuracy of this report. My team are presenting it to the Audit, Finance and Risk Committee on 3rd February 2022. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Health Board to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

10 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

11 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit. However, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts in note 21 relating to the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government.

12 The Health Board achieved financial balance for the three-year period ending 31 March 2021 and had no other material financial transactions that were not in accordance with authorities nor used for the purposes intended, so I have issued an unqualified opinion on the regularity of the financial transactions within the Health Board's 2020-21 accounts.

13 Alongside my audit opinion, I placed a substantive report on the Health Board's financial statements to set out further detail on the Emphasis of Matter paragraph that I included in my audit opinion.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

14 My programme of Performance Audit work has led me to draw the following conclusions:

- the Test, Trace, Protect programme is making an important contribution to the management of COVID-19 in Wales. Whilst the programme struggled to cope with earlier peaks in virus transmission, it has demonstrated an ability to rapidly learn and evolve in response to the challenges it has faced.
- in relation to the Welsh Health Specialised Services Committee Governance Arrangements: since the previous reviews in 2015, governance, management and planning arrangements have improved, but the impact of COVID-19 will now require a clear strategy to recover services and there would still be benefits in reviewing the wider governance arrangements for specialised services in line with the commitments within 'A Healthier Wales'.
- the COVID-19 vaccination programme in Wales has been delivered at significant pace with local, national and UK partners working together to vaccinate a significant proportion of the Welsh population. A clear plan is now needed for the challenges which lie ahead.
- all NHS bodies have maintained a clear focus on staff wellbeing throughout the pandemic and implemented a wide range of measures to support the physical health and mental wellbeing of their staff during the crisis. It is vital that these activities are built upon, and that staff wellbeing remains a central priority for NHS bodies as they deal with the combined challenges of recovering services, continuing to respond to the COVID-19 pandemic, and managing seasonal pressures.
- The Health Board has gone through a period of high turnover amongst its senior leaders at Board-level whilst also holding a number of Independent Member vacancies. The Health Board needs to manage the risks associated with this turnover, particularly given the significant operational challenges it is facing
- the Health Board has adequate arrangements in place to conduct Board and Committee business, however, there are opportunities to improve these arrangements
- The Health Board is embedding its new governance structure and strengthening its assurance mechanisms, but it will need to continually monitor and review them to ensure they are functioning as intended.
- the Health Board has achieved its financial objectives and has generally effective financial controls and monitoring and reporting arrangements in place. However, it will need to manage its underlying deficit to ensure its financial sustainability going forward.

- the Health Board has reasonable planning arrangements in place which align to wider corporate and regional strategies. The Annual Plan, while providing clarity around the Health Board's strategic objectives, lacks the target milestones needed to enable effective monitoring. Plans to introduce a monitoring and outcomes framework have been delayed due to the pandemic. As a result, the Health Board has been unable to provide assurance on overall delivery against the priorities outlined in the Annual Plan.
- the Health Board has significantly improved the way it plans and delivers radiology services through strong leadership and using demand and capacity modelling to identify and implement solutions to respond to increasing demand and changes to service delivery and patient pathways.

15 These findings are considered further in the following sections.

Detailed report

Audit of accounts

16 This section of the report summarises the findings from my audit of the Health Board's financial statements for 2020-21. These statements are how the organisation shows its financial performance and sets out its net assets, net operating costs, recognised gains and losses, and cash flows. Preparing the statements is an essential element in demonstrating the appropriate stewardship of public money.

17 My 2021 Audit Plan set out the financial audit risks for the audit of the Health Board's 2020-21 financial statements. **Exhibit 4** in **Appendix 3** lists these risks and sets out how they were addressed as part of the audit.

18 My responsibilities in auditing the Health Board's financial statements are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2020-21 financial statements

19 I concluded that the Health Board's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in the Health Board's internal controls (as relevant to my audit). However, I placed an Emphasis of Matter paragraph in my report to draw attention to disclosures in the accounts relating to a Ministerial Direction to fund NHS clinicians' pension tax liabilities in respect of the 2019-20 financial year.

20 We acknowledge the significant achievement of the Finance team in preparing the financial statements to a good standard, in the face of the challenges posed by the pandemic.

21 I must report issues arising from my work to those charged with governance before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues to the Health Board's Audit Committee on 8 June 2021. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues identified in the Audit of Financial Statements Report

Issue	Auditors' comments
Uncorrected misstatements	There were no uncorrected misstatements.
Corrected misstatements	There were several corrected misstatements which corrected classification errors or provided additional narrative disclosure.
Other significant issues	We requested that the Health Board sets out in Note 21.1 - Contingent liabilities- additional narrative to disclose the potential liability resulting from the Ministerial Direction to the Welsh Government to fund pensions tax liabilities above the pension savings annual allowance threshold. The Health Board has included the additional contingent liability.

22 I will also review the Whole of Government Accounts return once the National Audit Office has issued relevant guidance for auditing this return.

23 My separate audit of the Charitable Funds financial statements is currently ongoing, and I anticipate that the accounts will be approved by the Charitable Funds Committee on 12 January 2021 and signed, following consideration of my report on the financial statements, by the Trustees following the Board meeting on 26 January 2021. The audit opinion will be issued shortly afterwards.

Regularity of financial transactions

24 The Health Board achieved financial balance for the three-year period ending 31 March 2021 and had no other material financial transactions that were not in accordance with authorities nor used for the purposes intended, so I have issued an unqualified opinion on the regularity of the financial transactions within the Health Board's 2020-21 accounts.

25 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

26 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion. For the three-year period ending 31 March 2021, the Health Board achieved financial balance with a cumulative surplus of £0.512 million for revenue expenditure. The Health Board also met its duty to break-even in relation to capital expenditure with a surplus of £0.082 million over the same three-year period.

27 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. I placed a substantive report on the Health Board's financial statements to set out further detail on the Emphasis of Matter paragraph that I included in my audit opinion. The Emphasis of Matter paragraph drew attention to disclosures in the accounts in note 21.1 relating to the impact of a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

28 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- examining how NHS bodies have responded to the challenges of delivering the Test, Trace, Protect programme.
- reviewing the governance arrangements of the Welsh Health Specialised Services Committee.
- reviewing how well the rollout of the COVID-19 vaccination programme was progressing.
- reviewing how NHS bodies supported staff wellbeing during the COVID-19 pandemic.
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.
- reviewing the Health Board's Radiology Services and the progress made to address recommendations from our 2017 local and 2018 national reports on radiology services.

29 My conclusions based on this work are set out below.

Test, Trace, Protect programme

30 My work examined how public services responded to the challenges of delivering the Welsh Government's Test, Trace, Protect Programme (TTP). As well as commenting on the delivery of TTP up to and including December 2020, my report set out some key challenges and opportunities that will present themselves as part of the ongoing battle to control COVID-19.

31 I found that the different parts of the Welsh public and third sector had worked together well together to rapidly build the TTP programme. The configuration of the system blended national oversight and technical expertise with local and regional ownership of the programme, and the ability to use local intelligence and knowledge to shape responses.

32 Arrangements for testing and contact tracing have evolved as the pandemic has progressed. But maintaining the required performance in these arrangements proved challenging in the face of increasing demand.

33 Despite increased testing and tracing activity, the virus continued to spread, and as in other parts of the UK and internationally, testing and tracing have needed to be supplemented with local and national lockdown restrictions in an attempt to reduce transmission rates.

34 While a range of support mechanisms exist, it remains difficult to know how well the 'protect' element of TTP has been working in supporting people to self-isolate.

Welsh Health Specialised Services Committee governance arrangements

35 In May 2021, I published my review on the governance arrangements of the Welsh Health Specialised Services Committee (WHSSC). WHSSC is a joint committee made up of, and funded by, the seven local health boards in Wales. On a day-to-day basis, the Joint Committee delegates operational responsibility for commissioning to Welsh Health Specialised Services officers, through the management team. WHSSC, which is hosted by Cwm Taf Morgannwg University Health Board, has an annual budget of £680 million and makes collective decisions on the review, planning, procurement, and performance monitoring of specialised services for the population of Wales on behalf of health boards.

36 In 2015, two separate reviews highlighted issues with WHSSC's governance arrangements. Considering the time passed since the two reviews, together with increasing service and financial pressures and the changing landscape of collaborative commissioning, I felt it was timely to review WHSSC's governance arrangements.

37 My review found a number of improvements have been made to the overall governance arrangements in WHSCC since 2015. Good progress has been made to strengthen arrangements for quality assurance of specialised services, although scope still exists to increase the attention given to finance, performance, and

quality reporting at Joint Committee. There is also a need to review the arrangements for recruiting and remunerating independent members that sit on the Joint Committee given some of the challenges in filling these roles. Current Joint Committee members have a healthy working relationship and operate well together. However, the current model creates potential conflicts of interest due to the fact some Joint Committee members are also the Chief Officers of the health bodies commissioned to provide specialised services.

38 My review found that arrangements for planning commissioned services are generally good and there is an improving focus on value. However, some key new services such as new service models for major trauma and thoracic surgery have taken a long time to agree and implement. My review also found that the COVID-19 pandemic has significantly affected the delivery of specialised services, and that the development of a plan for the recovery of specialised services should now be a priority. The Welsh Government's long-term plan for health and social care, A Healthier Wales, signals the intention to review a number of hosted national functions, including WHSSC, with the aim of 'consolidating national activity and clarifying governance and accountability'.

39 Whilst the governance arrangements for WHSSC have continued to improve, my report shows that there are still a number of facets of the WHSSC model that merit further attention.

Vaccination programme

40 My audit focused on the rollout of the COVID-19 programme in Wales up to June 2021, the factors that affected the rollout and future challenges and opportunities.

41 The vaccine programme has delivered at significant pace. At the time of reporting, vaccination rates in Wales were the highest of the four UK nations, and some of the highest in the world. The milestones in the Welsh Government's vaccination strategy provided a strong impetus to drive the programme and up to the time of reporting, the key milestones had been met.

42 The UK's Joint Committee on Vaccination and Immunisation guidance on priority groups was adopted but the process of identifying people within some of those groups has been challenging.

43 The organisations involved in the rollout have worked well to set up a range of vaccination models which make the best use of the vaccines available, while also providing opportunities to deliver vaccines close to the communities they serve.

44 Overall vaccine uptake to the time of reporting was high, but there was a lower uptake for some ethnic groups and in the most deprived communities. At the time of the audit, vaccine wastage was minimal, but concerns were emerging about non-attendance at booked appointments.

45 The international supply chain is the most significant factor affecting the rollout, with limited vaccine stock held in Wales. However, increasing awareness of future supply levels was allowing health boards to manage the vaccine rollout effectively.

46 As the programme moved into the second half of 2021, challenges presented themselves around encouraging take-up amongst some groups, vaccine workforce resilience and venue availability. A longer-term plan is needed to address these and other elements of the ongoing vaccination programme.

How NHS bodies supported staff wellbeing during the COVID-19 pandemic

47 My review considered how NHS bodies have supported the wellbeing of their staff during the pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19.

48 NHS staff have shown tremendous resilience and dedication throughout the pandemic, despite facing huge strains to their mental and physical health.

49 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic, and the crisis has highlighted the importance of supporting the mental and physical health of the NHS workforce. Through my Structured Assessment work, I found that NHS bodies moved quickly at the beginning of the pandemic to enhance wellbeing initiatives to support staff through unprecedented times. As the pandemic unfolded, I found that NHS bodies in Wales implemented a range of measures to improve staff wellbeing, such as creating dedicated rest spaces, increasing mental health and psychological wellbeing provision, enhancing infection and prevention control measures, and enabling remote working.

50 My work also looked at how NHS bodies in Wales protected staff at higher risk from COVID-19. Amongst other safeguarding initiatives, I found that all bodies rolled out the All-Wales COVID-19 Workforce Risk Assessment Tool which identifies those at a higher risk and encourages a conversation about additional measures to be put in place to ensure staff are adequately protected. Although NHS bodies promoted and encouraged staff to complete the assessment tool, completion rates varied between NHS bodies.

51 While the crisis has undoubtedly had a considerable impact on the wellbeing of staff in the short term, the longer-term impacts cannot be underestimated.

52 With a more emotionally and physically exhausted workforce than ever, NHS bodies in Wales must maintain a focus on staff wellbeing and staff engagement to navigate through the longer-term impacts of the crisis. My report, therefore, is accompanied by a checklist which sets out some of the questions NHS Board members should be asking to ensure their health bodies have good arrangements in place to support staff wellbeing.

Structured assessment

53 My structured assessment work was designed in the context of the ongoing response to the pandemic. I ensured a suitably pragmatic and relevant approach to help me discharge my statutory responsibilities, whilst minimising the impact on NHS bodies as they continue to respond to the pandemic.

54 My team considered how corporate governance and financial management arrangements adapted over the year, as well as the operational planning arrangements underpinning the development and delivery of the Annual Plan for 2021-22. Auditors also paid attention to progress made to address previous recommendations.

Governance arrangements

55 My work considered the Health Board's ability to maintain sound governance arrangements while having to respond to the unprecedented challenges presented by the pandemic. The key focus of the work has been the corporate arrangements for ensuring that resources are used efficiently, effectively, and economically. We also considered how business deferred in 2020 was reinstated and how learning from the pandemic is shaping future arrangements for ensuring continued good governance and recovery.

56 My work found that **the Health Board has adequate arrangements in place to conduct Board and Committee business, however there are opportunities to assess the effectiveness of these arrangements. It is embedding its new governance structure and strengthening its assurance mechanisms, but it will need to continually monitor and review them to ensure they are functioning as intended**.

The Health Board has gone through a period of high turnover amongst its senior leaders at Board-level whilst also holding a number of Independent Member vacancies. It will need to manage the risks associated with this turnover; particularly given the significant operational challenges it is facing.

57 The Health Board has experienced significant changes to Board membership during the year, which will need to be managed carefully to provide leadership stability and ensure Board cohesion at a time when the Health Board is facing significant operational pressures.

58 The Health Board has adequate Board and Committee arrangements in place but needs to address issues around its website content, and the capacity and resilience of its Corporate Governance Support Team. It is embedding its new governance structure and intends to review its effectiveness by April 2022. The Health Board has further revised its Board Assurance Framework, and risk management strategy and approach. However, embedding the new approach will take time. The Health Board is strengthening its arrangements for supporting employee wellbeing, However, there are opportunities to strengthen quality and patient safety reporting and tracking internal and external audit recommendations.

Managing financial resources

59 I considered the Health Board's financial performance, financial controls and arrangements for monitoring and reporting financial performance. I found that **the Health Board has achieved its financial objectives and has generally effective financial controls and monitoring and reporting arrangements in place. However, it will need to manage its underlying deficit to ensure its financial sustainability going forward**.

60 The Health Board has successfully met its financial duties over the past three years and achieved its revised savings target despite the pandemic. It is also predicting to break-even during 2021-22. The Health Board has effective financial planning arrangements, and the 2021-22 financial plan reflects the exceptional nature of the pandemic and the uncertainties in response and recovery.

61 The continuing impact of the COVID-19 pandemic has led the Health Board to revise its initial savings target of £33 million to £16.6 million. As a result, the underlying financial deficit brought forward from 2020-21 of £20.8 million remains and will not improve during 2021-22 due to in-year cost pressures and continuing financial pressure. This represents a risk to the financial sustainability of the Health Board as savings will need to be achieved in future years to reduce the underlying deficit.

62 The Health Board has generally effective financial controls, monitoring, and reporting arrangements.

Planning arrangements

63 My work considered the Health Board's planning arrangements underpinning the Annual Plan for 2021-22.

64 I found that **the Health Board has reasonable planning arrangements in place which align to wider corporate and regional strategies. The Annual Plan, while providing clarity around the Health Board's strategic objectives, lacks the target milestones needed to enable effective monitoring. Plans to introduce a monitoring and outcomes framework have been delayed due to the pandemic. As a result, the Health Board has been unable to provide assurance on overall delivery against the priorities outlined in the Annual Plan.**

65 The Health Board has reasonably effective arrangements for developing and submitting its Annual Plan. The Annual Plan for 2021-22 incorporates learning from the pandemic and outlines a strategic approach to providing healthcare in the

region. It contains clear strategic objectives underpinned by a set of outcomes and measures to achieve them.

66 However, it lacks target / dates and milestones to enable the Health Board to monitor and track progress against the various measures and ensure intended priorities and outcomes are achieved. Whilst the Health Board is developing a monitoring and outcomes framework, this work has not been finalised due to the pandemic. As a result, the Health Board has been unable to provide assurance to the Board on overall delivery against the priorities outlined in its Annual Plan. However, we note that the Annual Plan has been used to inform Board and Committee business, with assurance on individual strategic objectives provided at different points of the year.

Radiology Services: Update on Progress

67 As part of my local audit programme, I have reported on the Health Board's Radiology Services and the progress made to address recommendations from our 2017 local and 2018 national reports on radiology services.

68 I found that **the Health Board has significantly improved the way it plans and delivers radiology services through strong leadership and using demand and capacity modelling to identify and implement solutions to respond to increasing demand and changes to service delivery and patient pathways**.

69 I judged the Health Board to have made good progress in addressing my previous recommendations because:

- the new Grange University Hospital has resulted in increased radiology equipment and imaging capacity. Prior to the opening of the hospital, the Health Board reduced waiting times by making use of additional capacity provided by outsourced services and continues to make use of these services in response to increased waiting times caused by COVID-19.
- the service has developed supporting plans to implement the changes to service delivery and patient pathways resulting from the opening of the Grange University Hospital.
- the is a strong leadership team within the radiology directorate with a clear vision to drive forward innovative solutions and improvements.
- the radiology directorate has been successful in recruiting to radiographer posts, and changes to staff working patterns and increased radiology operating hours have improved the sustainability of imaging services.
- where challenges remain in recruiting radiologists, the Health Board has sought to partly close the resource gap with advanced radiographer practitioner roles.
- the radiology directorate has good relationships and regular communication with other directorates to inform demand and capacity, and to ensure appropriate prioritisation of patient referrals for diagnostic imaging.

- there are appropriate arrangements to ensure operational monitoring of performance.

However, as wider services now start to recover from the pandemic, suppressed demand as a result of delayed access to treatment has the potential to create challenges in radiology services. The Health Board, therefore, will need to make sure that it maintains oversight of this risk and that its radiology services are able to make the necessary contribution to service recovery and meeting demand.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2021.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	June 2021
Opinion on the Financial Statements	June 2021
Audit of Accounts Report Addendum	December 2021
Charitable Funds Audit of Financial Statements Report	January 2022
Performance audit reports	
Doing it Differently, Doing it Right? (Structured Assessment 2020 All-Wales themes, lessons and opportunities relating to NHS governance during COVID-19)	January 2021
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021
Welsh Health Specialised Services Committee Governance Arrangements	May 2021
Rollout of the COVID-19 vaccination programme in Wales	June 2021

Report	Date
Radiology Services: Update on Progress	October 2021
Taking care of the carers? (Structured Assessment 2020 All-Wales themes, lessons and opportunities relating to NHS staff wellbeing during COVID-19)	October 2021
Structured Assessment 2021	January 2022
Other	
2021 Audit Plan	March 2021
2021 Charitable Funds Audit Plan	January 2022

My wider programme of national value for money studies in 2021 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are a number of performance audits that are still underway at the Health Board These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Unscheduled care	Phase 1 – February 2022 Timing of further work included as part of the 2022 plan still to be confirmed.
Orthopaedics	March 2022
Quality Governance	February 2022
Review of Efficiency Arrangements	April 2022

Appendix 2

Audit fee

The 2021 Audit Plan set out the proposed audit fee of £373,146 (excluding VAT). My latest estimate of the actual fee, on the basis that some work remains in progress, is in keeping with the fee set out in the outline.

Appendix 3

Financial audit risks

Exhibit 4: financial audit risks

My 2021 Audit Plan set out the financial audit risks for the audit of the Health Board's 2020-21 financial statements. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business;	On a sample basis we tested both journal entries and accounting estimates and found no evidence of the management override of controls. We were satisfied that the accounts were free from material error.
There is a significant risk that you will fail to meet your first financial duty to break even over a three- year period. Following a core 'Financial Stability' funding allocation for COVID-19 from Welsh Government of £70m and further COVID-19 allocations of £52m, coupled with the	The audit team will focus its testing on areas of the financial statements which could contain reporting bias.	We undertook a range of audit work to provide assurance over the risk of bias to ensure that the actual year end position was true and fair. This included: • detailed sample testing of transactions either side of the year-end to ensure that they were recorded in the correct accounting period. This was

Audit risk	Proposed audit response	Work done and outcome
avoidance of certain costs due to COVID-19, the position at month 11 shows a year-to-date surplus of £0.176 million and a forecast break-even yearend position. This combined with the outturns for 2018-19 and 2019-20, predicts a three-year surplus of £0.267 million. Where you were to fail this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion. Your current financial pressures increase the risk that management judgements and estimates could be biased in an effort to achieve the financial duty		focussed on the areas of greatest risk. • ensuring that accounting estimates were prepared on a reasonable basis and were supported by appropriate accounting judgements. We were satisfied that the accounts were free from material error.
The COVID-19 national emergency continues and the pressures on staff resource and of remote working may impact on the preparation and audit of accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors.	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.	We maintained constant contact with the Finance Team so to understand the accounts preparation process, and any changes made to this process due to the COVID-19 Pandemic. We satisfied ourselves that the Finance Team had made good arrangements in order to provide an accurate and high-quality set of financial statements.

Audit risk	Proposed audit response	Work done and outcome
Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.		
The increased funding streams and expenditure in 2020-21 to deal with the COVID-19 pandemic will have a significant impact on the risks of material misstatement and the shape and approach to our audit. Examples of issues include accounting for the early opening of the Grange University Hospital; regularity risks of additional spend; valuation of year-end inventory including PPE; and estimation of annual leave balances.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.	We carried out a range of audit work to identify all additional funding and expenditure streams expected within the accounts through liaison with the Finance Team and Welsh Government. Central guidance was provided to assist in the audit of this complex area. We satisfied ourselves that the additional income and expenditure was free from material error and correctly classified in the accounts.
Where year-end stock balances are material to the financial statements, ISA501 – Audit Evidence – Specific considerations for selected items, requires auditors to attend the physical year-end stock count. Due to Audit Wales' policy in response to the pandemic, audit staff are unable to work at client sites and	We will maintain ongoing discussions with the finance team to monitor the forecast year- end stock balances and plan our work to obtain the assurance needed for our audit. Where the year-end stock balance is material and we are unable to comply with the requirements of ISA501, we will determine the impact on the audit report and	We obtained appropriate audit evidence to confirm the year-end stock balances and satisfied ourselves that the year-end stock balances were not material.

Audit risk	Proposed audit response	Work done and outcome
therefore are unable to attend physical stock takes. As a result, where year-end stock balances are material and auditors are unable to attend the physical year-end stock count, the auditor shall modify the opinion in the auditor's report in accordance with ISA701– Communicating key matters in the independent auditor's report.	discuss our proposed modified audit opinion with officers/management.	
A phased deployment of the new WellSky Hospital Pharmacy System was commenced by NWIS from November 2020 across Welsh health bodies and is planned to be completed in July 2021 (COVID pandemic disruptions allowing). The Wellsky system was implemented in the Aneurin Bevan UHB in November 2020. The financial expenditure balances for hospital drugs, medicines and other pharmaceutical items flowing through the Wellsky system will be material to the Health Board. The data transfer from the old hospital pharmacy	We will review the process for transferring the data to the Wellsky system and the controls in place, to ensure the opening balances are an accurate starting point to continue calculating the financial throughput of expenditure in the new WellSky system	We satisfied ourselves that the process for transferring the data to the Wellsky system and the controls in place, to ensure the opening balances are an accurate starting point to continue calculating the financial throughput of expenditure in the new WellSky system was appropriate.

Audit risk	Proposed audit response	Work done and outcome
system to Wellsky was completed manually by the Health Board before the system went live on 9 November 2020, and responsibility for the design and implementation of effective controls over the transfer process rested with the Health Board.		
The implementation of the 'scheme pays' initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. However, if any expenditure is made in year, we would consider it to be irregular as it contravenes the requirements of Managing Public Monies.	We will review the evidence one year on around the take up of the scheme and the need for a provision, and the consequential impact on the regularity opinion.	We satisfied ourselves that the contingent liability disclosure made in the accounts was appropriate. An Emphasis of Matter in respect of this matter was contained in the audit report.
Due to the COVID 19 pandemic and in light of the Coronavirus Act 2020, health bodies across Wales are required to accrue for	The audit team will: • assess the appropriateness of the proposed methodology for	We satisfied ourselves that the methodology proposed to calculate the annual leave accrual was appropriate and the accrual estimate was

Audit risk	Proposed audit response	Work done and outcome
untaken annual leave as at 31 March 2021. The All Wales Technical Accounting Group has met to agree a common methodology to be applied, and the calculations based on this for each health body will be submitted to Welsh Government. It is anticipated that the annual leave accrual will be funded although this has not been confirmed. The accrued annual leave balance will be material to the Health Board's accounts for 2020-21 and as at 31 January 2021, the Health Board has estimated the accrual to be £20.3million.	calculating the accrual • test to ensure the estimate has been calculated in line with agreed methodology	calculated in accordance with the proposed methodology.
Introduction of IFRS 16 Leases has been deferred until 1 April 2022 and may pose implementation risks. There is considerable work required to identify leases and the COVID-19 national emergency may pose implementation risks.	The audit team will undertake some early work to review preparedness for the introduction of IFRS 16 Leases.	As a result of the COVID-19 pandemic, the implementation of IFRS 16 was delayed into 2021-22. We will undertake this work next year. We did however carry out preliminary discussions on the progress of IFRS16 preparedness

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Structured Assessment 2021 – Aneurin Bevan University Health Board

Audit year: 2021

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Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2021 Structured Assessment at Aneurin Bevan University Health Board (the Health Board). Our Structured Assessment is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.

2 The COVID-19 pandemic required NHS bodies to quickly adapt their arrangements in respect of governance, planning and decision making to ensure timely action was taken to respond to the predicted surge in emergency COVID-19 demand and ensure the safety of staff and patients. Our 2020 structured assessment report considered the Health Board's revised governance arrangements and was published in November 2020.

3 NHS bodies have continued to respond to the ongoing challenges presented by COVID-19, whilst also starting to take forward plans for resetting and recovering services affected by the pandemic. Our 2021 structured assessment work considered how arrangements for corporate governance, financial management and strategic planning have continued to adapt since the initial response stage of the pandemic. We also considered how business deferred in 2020 has been reinstated and how learning from the pandemic is shaping future arrangements for good governance and delivering value for money.

4 Our work was designed in the context of the ongoing response to the pandemic, by ensuring a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they continued to respond to the COVID-19 pandemic.

5 Where appropriate, we have provided updates on progress against any issues and recommendations identified in previous structured assessment reports, where these related to important aspects of governance, financial management, and operational planning.

Key messages

6 Overall, we found **the Health Board maintains adequate Board and Committee arrangements and is embedding its new governance structure alongside its assurance mechanisms, but there are opportunities to assess the effectiveness of these arrangements. The Health Board has gone through a period of high turnover amongst its senior leaders at Board-level whilst also holding a number of Independent Member vacancies. The Health Board has effective financial management arrangements enabling it to meet its financial duties over the last three years. However, its underlying deficit presents a risk to financial sustainability going forward. Arrangements for developing**

and submitting the Annual Plan are effective. Whilst the Annual Plan provides clarity on strategic objectives and has informed Board and Committee business, there has been limited oversight and scrutiny on overall delivery of the Annual Plan at Board-level.

7 The Health Board has adequate Board and Committee arrangements but needs to address issues around its website content and capacity and resilience in its Corporate Governance Support Team. It is embedding its new governance structure and intends to review its effectiveness by April 2022. The Health Board has gone through a period of high turnover amongst its senior leaders at Board-level whilst also holding a number of Independent Member vacancies. The Health Board will need to manage the risks associated with this turnover; particularly given the significant operational challenges it is facing. It has further revised its Board Assurance Framework, and risk management strategy and approach. However, embedding the new approach will take time. The Health Board is strengthening its arrangements for employee wellbeing, However, there are opportunities to strengthen quality and patient safety reporting around services the Health Board commissions and arrangements for tracking internal and external audit recommendations.

8 The Health Board has successfully met its financial duties over the past three years and achieved its revised savings target despite the pandemic. It is also predicting to break-even during 2021-22. The Health Board has effective financial planning arrangements and the 2021-22 plan reflects the exceptional nature of the pandemic and the uncertainties in response and recovery. The continuing impact of the COVID-19 pandemic has led the Health Board to revise its initial savings target of £33 million to £16.6 million. As a result, the underlying financial deficit brought forward from 2020-21 of £20.8 million remains and will not improve during 2021-22 due to in-year cost pressures and continuing financial pressure. This represents a risk to the financial sustainability of the Health Board as savings will need to be achieved in future years to reduce the underlying deficit. The Health Board has generally effective financial controls, monitoring and reporting arrangements.

9 The Health Board's arrangements for developing and submitting its annual plan are reasonable. The plan incorporates learning from the pandemic and outlines a strategic approach to providing healthcare in the region. There are clear strategic objectives underpinned by a set of outcomes and measures to achieve them. However, it lacks target / dates and milestones to enable the Health Board to monitor and track progress against the various measures and ensure intended priorities and outcomes are achieved. The Health Board is developing a monitoring and outcomes framework; however, this work has not been finalised, due to the impact of the pandemic, resulting in limited oversight and scrutiny on overall delivery against priorities outlined in its Annual Plan at Board-level. However, the Annual Plan has been used to inform Board and Committee business, with assurance on individual strategic objectives provided at different points of the year.

Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: 2021 recommendations

Recommendations
Website Content and Information R1 The Health Board's website contains some outdated information relating to its governance arrangements and incomplete performance data which is not supported by appropriate explanatory information. The Health Board, therefore, should take immediate action to ensure: • Content is well-organised, easy to navigate, clear and concise, and • Key information / data is up-to-date and in a format that the public and stakeholders can interpret and understand.
Reviewing the new Governance Structure R2 Some Board members have expressed concerns about the volume of work now undertaken by some of the committees and the robustness of the arrangements for ensuring flows of assurance. The Health Board, therefore, should complete its review of the new governance structure by its intended deadline of April 2022 to be assured that it is operating as intended.
Corporate Governance Support Team resilience and capacity R3 Recent staff turnover within the Corporate Governance Support Team has impacted on the quality of service it is able to provide to the Board and its Committees. The Health Board, therefore, should review the effectiveness of its Corporate Governance Support Team as soon as possible to ensure that it has sufficient resilience and capacity to support all governance functions. Arrangements should also be put in place to ensure staff are able to access suitable training / learning opportunities to develop their knowledge and skills within their respective roles.
Stability of the Board R4 The Health Board has experienced significant changes in its Executive Team and cadre of Independent Members resulting in several interim Executive

Recommendations

Director appointments and is currently recruiting to two independent member vacancies. However, maintaining these temporary arrangements indefinitely alongside the turnover of Independent Members present risks at a time of significant operational pressures. The Health Board, therefore, should seek to make permanent appointments to these key Executive Director roles at the earliest possible opportunity. In addition, there remains a need for the Health Board to strengthen its induction and training for new Independent Members in line with our recommendation in 2019.

Monitoring delivery of Strategic Priorities

R5 The Health Board has not finalised its monitoring framework due to the pandemic, subsequently there continues to be limited oversight and scrutiny at Board-level on overall delivery against priorities outlined in the 2021/22 Annual Plan. The Health Board, therefore, should complete the development of its monitoring framework as soon as possible to allow the Board to review and if necessary, challenge delivery of its strategic priorities and progress against the Annual Plan and future Integrated Medium-Term Plans.

Governance arrangements

11 Our work considered the Health Board's governance arrangements while continuing to respond to the challenges presented by the pandemic.

12 We found that the **Health Board has adequate arrangements in place to conduct Board and Committee business, however there are opportunities to assess the effectiveness of these arrangements. The Health Board is embedding its new governance structure and strengthening its assurance mechanisms, but it will need to continually monitor and review them to ensure they are functioning as intended. The Health Board has gone through a period of high turnover amongst its senior leaders at Board-level whilst also holding a number of Independent Member vacancies. It will need to manage the risks associated with this turnover, particularly given the significant operational challenges it is facing**

Conducting business effectively

13 We found that **the Health Board has adequate arrangements in place to conduct Board and Committee business. There are opportunities for improvement including reviewing the effectiveness of the new governance structure and ensuring that there is continuity of executive and independent member leadership during this period of board member change. This is critical at a time when the Health Board is facing significant operational pressures.**

Public transparency of Board business

14 Board and Committee meetings continue to be held virtually, with some members attending remotely and some attending from socially distanced meeting rooms. The use of technology and the etiquette around virtual meetings is well embedded. Some Board members have indicated that they would like to see the current arrangements continue as the Health Board moves into recovery.

15 Board meetings are livestreamed with recordings made available on the Health Board's YouTube channel. Signposting to upcoming Board meetings is provided via the Health Board's social media channels and website homepage. Weblinks for previous meetings are accessible through its website. However, they direct the public to the Health Board's YouTube channel homepage as opposed to specific meetings.

16 The Health Board does not livestream any Committee meetings. The Health Board has indicated it does not have the resources to provide this service. However, meetings are recorded for minuting purposes. The Health Board, therefore, may wish to consider making these recordings available on its YouTube channel to further enhance public transparency of Board business.

17 The Health Board aims to publish meeting agendas and papers on its website a week in advance. However, the impact of the pandemic has placed significant and sustained pressure on the Corporate Governance Support Team resulting in delays in issuing some Committee papers. Some Board members have indicated to us that this has affected their ability to review these papers in detail to enable effective scrutiny and challenge. The Health Board does not have arrangements in place to monitor timescales for submitting and publishing Board and Committee papers. It may, therefore, want to consider establishing a breaches log to monitor and improve compliance with timescales for submitting and publishing papers.

18 Our review of the Health Board's website between September and November 2021 identified:

- outdated information relating to the Health Board's new Committee structure;
- outdated information on Executive Team membership;
- incorrect meeting dates; and
- incomplete meeting packs for some Committee meetings[1].

19 Furthermore, some of the performance data published on the website is incomplete and not supported by appropriate explanatory information[2]. The Health Board, therefore, should take steps to ensure the content relating to its governance arrangements is well-organised, easy to navigate, clear and concise, and performance data is up-to-date and presented in a format that the public and stakeholders can interpret and understand **(Recommendation R1)**.

20 The Health Board continues to invite Community Health Council (CHC) representatives to participate in virtual Board meetings. The Health Board also makes extensive use of social media to engage with the public by, for example, providing information on service provision and changes, and its ongoing response to the pandemic. It is also expanding the way it communicates to the public and stakeholders by developing a WhatsApp messaging service which will provide subscribers with frequent Health Board updates on a variety of topics.

Board and committee arrangements

21 At its December 2020 meeting, the Board agreed to introduce and implement a leaner governance structure in April 2021 to reflect learning from its revised governance arrangements introduced at the outset of the pandemic and to recognise the need for a more proportionate governance model going forward. The aim of the new governance structure is to allow the Board to maintain greater strategic oversight of the organisation and to strengthen the role of the Committees

[1] Some papers were unavailable for the Patient, Quality, Safety and Outcomes Committee meeting in September 2021, and the People and Culture Committee meeting in November 2021.

[2] Data published in relation to mortality figures across the Health Board's hospital sites during the pandemic and more recently hospital handovers at the Grange University Hospital (GUH) have either been incomplete or not supported by appropriate explanatory information.

in terms of providing more detailed scrutiny and assurance on Health Board business.

22 Some of the Committees in the new structure have taken responsibility for wider elements of Health Board business, with some functions spanning several committees, for example:

- The Finance and Performance Committee has been disbanded, with oversight of finance allocated to the new Audit, Finance and Risk Committee ('AFR Committee').
- Performance is now overseen by two Committees - the new AFR Committee, and the Patient, Quality, Safety, and Outcomes Committee ('PQSO Committee').
- The Information Governance Committee has been disbanded with the AFR Committee, the PQSO Committee, and the Strategy, Planning, Partnerships, and Wellbeing Committee (SPPW Committee) now responsible for overseeing different aspects of information governance and ICT programmes.
- The SPPW Committee now includes partnership working which was previously covered by the Partnerships and Wellbeing Committee. However, this is not an assurance committee of the Board.

23 Whilst Board members are supportive of the new governance structure, some have expressed concerns about the volume of work now undertaken by some of the committees (such as the AFR Committee), and the robustness of the arrangements for ensuring flows of assurance. The Health Board, therefore, needs to assess the effectiveness of its new governance structure to ensure it is operating as intended. **(Recommendation R2)**.

24 There is a degree of variability in the way agendas for Board and Committee meetings are configured. Some Board members have expressed concern that the length and configuration of some agendas limit their ability to provide detailed scrutiny and questioning. The Health Board, therefore, may want to consider adopting a consistent approach to agenda setting to provide focus and enable scrutiny where it is needed most by placing items for review and assurance first, followed by items for consideration, and finally items for noting and information. This would also help manage time and energy levels across all meetings.

25 Our observations of Board and Committee meetings found them to be generally well managed, with Chairs ensuring focussed discussions on key issues and encouraging contributions from all. Board members engage and participate fully in meetings with good scrutiny and questioning of the information presented. Chairs still invite Independent Members to submit questions in advance, which is continuing to increase the breadth and depth of scrutiny.

26 The Corporate Governance Support Team continues to provide administrative support to the Board and its Committees. However, our work identified some concerns amongst Board Members regarding the capacity and resilience of the

Corporate Governance Support Team, indicating that recent staff turnover is impacting on the level of knowledge and experience within the team. With the appointment of a new permanent Board Secretary, there are opportunities for the Health Board to review the capacity and resilience of the Corporate Governance Support Team to ensure the Board and its Committees are supported effectively **(Recommendation R3)**.

Board and committee information

27 We found evidence of positive practice, with some Board and Committee papers becoming more succinct, clearer, and outcomes focussed, for example:

- Information included in the Patient, Quality, Safety and Outcomes Report has reduced significantly and is beginning to provide more clarity around emerging themes, areas of concern, mitigation, and good practice.
- Independent Members have also commented positively on the quality of the update paper on National Clinical Audit which give clearer assessments of the Health Board's position against several national clinical audit actions.

28 Whilst all cover reports follow a SBAR[3] format, our work found slight differences in their use, for example:

- Executive summaries are either not completed or include information that is more appropriate in a different section of the report.
- Some cover reports are unclear on the overall purpose of the report with multiple options selected rather than one (approve the report, discuss, and provide views, or receive the report for assurance / compliance); and
- The quality of information contained within cover reports are variable, with some cover reports containing limited information and others containing too much detail rather than focussing on the key issues set out in the main report.
- We have also identified instances where broadly similar reports were presented to Committees and the Board, thus missing opportunities to summarise and synthesise the information to provide focus on key matters.

29 Overall, we found that information provided to the Board and its committees is improving and there is evidence of good practice. However, there are opportunities to improve the quality and use of cover reports through training, guidance and also regularly reviewing the quality of agenda content.

30 In addition, in 2018, we highlighted improvements needed in the areas relating to information governance and informatics. Progress against the recommendations is outlined in **Exhibit 2**.

[3] Situation, Background, Assessment, and Recommendation.

Exhibit 2: progress made on previous year recommendations

Recommendation	Description of progress
Information Governance Arrangements 2018 R3 The Health Board should improve its information governance arrangements by: a. Improving compliance with the information governance training programme to reach the national rate of 85%; b. Improving performance against information access targets for the Freedom of Information Act to reach the statutory targets.	**In Progress** The pandemic has hindered progress against achieving the national rate of 85% with compliance for the organisation currently reported at 74%. The Information Governance (IG) Unit has extended the range of learning options available: - The E-Learning package available via the intranet for staff. - Working with the National ESR team to add the Health Boards IG E learning on to ESR for ease of access (work in progress). - A YouTube video is now available for staff for easier access to the information by staff e.g. Facilities /bank/ agency staff - Bespoke training sessions provided on request - Information Governance Development Groups held with Divisions to report and inform of their compliance rates. A reduction in compliance for FOI requests has been noted from 100% in May 2021 to 67% in September 2021. This occurred due to workforce absences, along with a significant increase in requests which has impacted the ability to respond in a timely manner. A review of capacity requirements is underway.
Informatics 2018 R4 The Health Board should address areas for improvement in relation to informatics, specifically updating ICT disaster recovery plans and test these to ensure they worked as intended.	**In Progress** Progress has continued across the informatics agenda throughout 2021 with a new interim management structure in place to help drive progress and focus on key priorities. A new Digital Delivery Oversight

Recommendation	Description of progress
	Board has been established to improve the decision making, risk management and accountability of progress at Executive level. This will be strengthened further into 2022. Progress has also been made with ICT business continuity plans with many services, albeit further work is still required in some areas due to the staffing pressures of some clinical teams. This will be a priority to be completed in 2022.

Arrangements to improve the Board and its committees

31 The Health Board has continued to hold development and briefing sessions for Board Members, which cover a range of topics such as risk management and measuring and reporting outcomes, and Board Members have indicated to us that the sessions are helpful in terms of raising awareness of key issues prior to discussion at Committee or Board meetings.

32 Last year, we reported that the Committees did not review their effectiveness or prepare annual reports for the Board. The Health Board's intention was to reinstate annual reports from early 2021 using a more consistent approach for self-assessment. However, the ongoing impact of the pandemic and the introduction of the new governance structure has delayed this work. The Board intends to undertake a review of its effectiveness in February 2022 and also review the effectiveness of its new governance structure in April 2022.

33 Our work found that the impact of the pandemic has delayed the delivery of a local induction for new Independent Members. Given the recent and upcoming changes within the Health Board's cadre of Independent Members (see **paragraph 37**), the Health Board should ensure it has appropriate arrangements in place for providing an effective local induction for new Independent Members as soon as possible into their tenure (see **Exhibit 3 2018 R1**).

Ensuring organisational design and leadership capacity supports effective governance

34 Last year, we reported that the Health Board established emergency command and control structures across all levels of the organisation and adjusted its governance framework to respond to the pandemic. These arrangements were reviewed by the Board in December 2020 where it was agreed that they continue

until March 2021. The command-and-control structures established in February 2020 were also adjusted with the strategic (gold) and tactical (silver) command groups stood down, with reporting reverting to the Executive Team. The operational (bronze) groups continued to operate and report to the Executive Team until the end of March 2021.

35 The Health Board has seen significant changes within the Executive Team. A new Medical Director, Executive Director of Workforce and Organisational Development, and Board Secretary joined the Health Board in the last year. However, the Director of Operations, Chief Executive Officer, and Director of Primary, Community, and Mental Health have departed. Whilst the Health Board moved swiftly to appoint interim replacements to these key roles, maintaining these temporary arrangements indefinitely may present risks during a time where the organisation is facing significant operational pressures **(Recommendation R4)**.

36 There are also recent, current and expected changes to Independent Members including:

- The new Independent Member (University) joined the Board in January 2021.
- The Vice Chair began a temporary role as Chair of Cwm Taf Morgannwg University Health Board in October 2021. Whilst interim arrangements have been put in place, the Health Board has been advised by Welsh Government not to appoint a permanent replacement for 18 months.
- The Health Board is currently seeking to recruit a new Independent Member (Finance) and a new Independent Member (Digital), with interviews due to be held during December 2021 and January 2022 respectively.
- A fourth vacancy will become available in March 2022 when the tenure of the Independent Member (Third Sector) comes to an end.

37 This turnover will need to be managed carefully supported by an induction and development programme. We highlighted this requirement in 2019, but action against the recommendation remains incomplete (**Exhibit 3**).

Exhibit 3: progress made on previous year recommendations

Recommendation	Description of progress
Board Member Induction and Training 2018 R1 The Health Board should ensure Board member induction and training meets the needs of independent members.	**Incomplete** The Health Board does not have local induction arrangements for Independent Members.

Systems of assurance

38 We found that the **Health Board has further revised its risk management approach but embedding the new arrangements and developing an organisational risk culture will take time. Whilst the Health Board has enhanced its staff wellbeing arrangements, the Board should seek regular assurance around their effectiveness, particularly in relation to the Grange University Hospital. Opportunities to further strengthen the Health Board's arrangements for tracking recommendation remain.**

Managing risk

39 We found that **the Health Board has further revised its Board Assurance Framework, and risk management strategy and approach, however it will take time to embed the new arrangements.**

40 Last year, we reported that the Health Board finalised and approved its Board Assurance Framework (BAF) in March 2020 along with a revised risk management strategy. At the time, the BAF captured a small number of principal risks, predating the pandemic. Principal risks were updated to reflect the impact of the pandemic and the adjustments to the Health Board's governance framework.

41 The Health Board has further developed its risk management strategy, approach, and BAF during 2021. The Health Board's revised risk approach provides a greater focus on the risk escalation process and how it assists in achieving the Health Board's strategic objectives. It also places responsibility on operational areas to take more ownership for managing and escalating risks to the delivery of local objectives (see **Exhibit 4 2019 R1**).

42 The Health Board maintains a corporate risk register which clearly articulates cause and effect along with timescales to deliver mitigating action. However, there is scope to enhance the register further by:

- reducing overlaps between actions and controls,
- clearly aligning assurances to controls, and
- providing more information around the effectiveness of mitigating actions. (see **Exhibit 4 2019 R2**).

43 The Health Board's intention is to transition to a new approach of completing a thematic analysis of escalated risks and using this information to generate risk profiles for the organisation. The Executive Team are also considering proposals for bi-monthly risk management development sessions to enable them to receive assurance and endorse progress from divisions on the management of their risks, facilitate horizon scanning of new risks, and consider risk profiles **(see Exhibit 4 2017 R3)**

44 Our overall assessment of the risks on the BAF and corporate risk register reflects our understanding of the Health Board's key issues and the actions that it is taking to resolve them.

45 The Health Board has established a delivery framework to embed the new arrangements across the organisation and ensure organisational buy-in and commitment. The introduction of a Risk Managers Community of Practice, which held its first meeting during November 2021, is a positive development and will support efforts to improve knowledge and understanding of risk management across the organisation by creating opportunities to share learning and good practice. Whilst the Health Board has appointed a Head of Corporate Services, Risk and Assurance to lead this work, there has been no further investment in this function. The Health Board, therefore, may want to consider investing further in its risk management function to provide the necessary expertise and support to the Head of Corporate Services, Risk and Assurance and ensure the new arrangements are rolled-out and embedded at pace.

Exhibit 4: progress made on previous year recommendations

Recommendation	Description of progress
Board Assurance and Risk 2019 R1 The Risks to delivering the IMTP service change plans (SCPs) and the high impact priorities have not been clearly articulated in a board assurance framework (BAF). The Health Board should: a. Complete the development of a BAF by March 2020 and in doing so look to see how other NHS Organisations in Wales construct theirs and consider whether the approach can be adapted. b. Clearly articulate and document risks to delivering SCPs and high-impact priorities as part of the IMTP refresh for 2020-21 in a BAF.	**Complete** The Health Board has revised its BAF which now clearly articulates the organisation's principal risks and strategic priorities outlined in its Annual Plan. Whilst the Board reviews the BAF bi-annually, the arrangements should be kept under constant review to ensure they remain fit for purpose and support effective governance.
Board Assurance and Risk 2019 R2 There is scope to improve the quality of the corporate risk register (CRR). The Health Board should review the CRR by the end of March 2020 to ensure it clearly articulates cause and effect, reduced overlap between controls and mitigating actions, specifies controls	**In Progress** The corporate risk register clearly articulates cause and effect along with timescales to deliver mitigating action. However, there is scope to enhance the register further (see **paragraph 43**). The Health Board is

Recommendation	Description of progress
such as policies and procedures, aligns assurances to controls, indicates whether mitigating action is effective and includes timescales to monitor progress.	transitioning to a new 'risk profile approach' but will need to maintain a corporate risk register until the new arrangements are embedded.
Risk Management 2017 R3 The Health Board should review risk management arrangements to ensure that corporate risks are appropriately escalated and managed by: a. Developing upon its current risk reports to ensure that the context of the risk and progress in managing it are clearly set out; and b. revising the risk rating based on the mitigating actions.	**In Progress** The Health Board has reviewed its risk management arrangements and is currently introducing a new approach for escalating risks across the organisation and onto the BAF.

Quality and safety assurance[4]

46 We found that **whilst Health Board is taking steps to strength its employee wellbeing arrangements, it will need to continually monitor their impact, particularly in the Grange University Hospital. Reporting on patient experience has continued, but further work is required to develop quality and safety reporting in relation to services the Health Board commissions.**

47 The Health Board has identified employee wellbeing as an organisational priority in its Annual Plan, recognising the continuing impact of the pandemic and the changes brought about through the early opening of the Grange University Hospital on its staff. In response to these challenges, the Health Board has taken a range of actions, including:

- developing a wellbeing strategy and workplan focussing on strengthening its current wellbeing service and providing support to operational areas in identifying and addressing causes of poor wellbeing.

[4] We have limited the work we have undertaken on quality governance arrangements as part of our 2021 structured assessment as we are undertaking a separate review of quality governance arrangements at the Health Board. The review will consider whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We will report our findings in 2022.

- developing plans for a Wellbeing Centre of Excellence that will encourage research and development.
- prioritising wellbeing support for individuals and teams moving to the Grange University Hospital.
- issuing quarterly wellbeing surveys to staff that will help focus support in the correct areas.
- increasing the capacity of its occupational health and psychological wellbeing teams.
- introducing its 'People First Programme' to engage with staff across the organisation enabling them to share their feelings and concerns.

48 Staff safety and wellbeing is reported to the Health Board's People and Culture Committee. Key messages around workforce performance and activity are communicated through the COVID-19 workforce wellbeing and occupational health dashboards. The Board gains some assurance on 'wellbeing' from the People and Culture Committee's assurance report and other papers, such as the nurse staffing assurance and winter planning reports. There isn't however a regular dedicated update on this key area of risk at the Board, this could leave some members less than fully sighted on pressures currently being faced by staff and any potential consequence to service delivery.

49 Despite the Health Board's efforts to improve employee wellbeing and the quality and safety of services it provides patients; we note the serious concerns raised by the Royal College of Physicians (RCP) following a visit to the Grange University Hospital. The RCP received positive views from medical staff regarding opportunities for medical education and support, the strong working relationships between professional colleagues, the model of care for single specialty conditions, and the wellbeing and mental health support services provided during the pandemic. However, they identified serious concerns around excessive workloads and chronic understaffing, lack of support from Health Board managers, inappropriate responsibilities of the medical registrar role, and lack of clinical engagement and action from the Health Board. The Health Board has worked in partnership with the RCP and Health Education and Improvement Wales (HEIW) to develop an action plan to address these findings and wider wellbeing actions. The Health Board is making good progress in implementing the actions. We also note that the Medical Director is currently meeting with the RCP on a monthly basis to identify solutions and provide a framework going forward.

50 The QPSO Committee continues to receive quarterly patient experience reports and updates on patient experience. The latest report, provided in June 2021, outlined the Health Board's efforts to gain patient feedback during the pandemic using various methods in the absence of an electronic system. The Health Board is working closely with the Community Health Council in progressing a range of alternative methods for gaining patient feedback such as virtual FaceTime appointments. The report indicated that results are analysed and considered by

divisions who prepare action plans to address any weaknesses identified through patient experience feedback.

51 In **paragraph 27** we comment on the improvements made to the Health Board's Patient Quality, Safety, and Outcomes Report. The report aligns to Healthcare Standards and includes performance information on a range of quality metrics, including healthcare associated infections, COVID-19, pressure damage, and inpatient falls. Whilst the report is predominantly secondary care focussed, the report does include performance information on wider areas of the Health Board's business such as Child and Adult Mental Health Services (CAMHS) and Primary Care Mental Health. The Health Board is also strengthening its reporting on the Welsh Health Specialised Services Committee (WHSSC); however, opportunities exist to strengthen reporting on the services the Health Board directly commissions.

52 Last year we found opportunities for the Health Board to better identify which COVID-19 issues should be routinely reported to the Board or its Committees for assurance. This year, we found that COVID-19 updates were a standing item on Board and Committee agendas up to March 2021. The four harms associated with COVID-19[5] were routinely reported via a Safety Dashboard report to the new Patient Quality, Safety and Outcomes Committee and the predecessor committee until June 2021. Since then, all issues are escalated through the Quality and Safety Outcomes Report. Whilst COVID-19 issues are included in various reports and papers for the Board, the removal of COVID-19 updates as a standing item on the Board agenda has limited opportunities to provide assurance. However, we note that Committee Chairs are able to escalate and raise specific concerns and issues at Board meetings as required.

53 In previous years' structured assessment reports, we issued recommendations relating to Putting Things Right (**2018, recommendation 1**) and Clinical Audit (**2017, recommendation 4**). We will assess progress against those recommendations as part of the quality governance review which will be published in 2022.

Tracking progress against audit recommendations

54 We found that **the Health Board has taken steps to further develop its arrangements for tracking internal and external audit recommendations, but opportunities to strengthen these arrangements remain.**

55 The Executive Team regularly reviews progress against internal and external audit recommendations. The AFR Committee receives information from the Executive Team on the status of each high priority recommendation as well as requests to extend implementation deadlines or to close high priority recommendations and

[5] The four harms are – (i) harm from COVID-19 itself; (ii) harm from overwhelmed NHS and social care system; (iii) harm from reduction in non-COVID-19 activity; and (iv) harm from wider societal actions / lockdown.

remove them from the tracker upon completion. The Committee continues to scrutinise and challenge the Executive Team's assessment, particularly where deadlines are overdue, or actions are taking too long to complete.

56 Whilst the AFR Committee receives summary information on the status of all outstanding recommendations, these are monitored by divisions with issues escalated to the Executive Team as necessary, such as when recommendations are not on course for completion, or when there is a significant change. The Health Board, therefore, may want to consider sharing the full tracker with the AFR Committee to enhance transparency and enable detailed analysis and scrutiny.

Managing financial resources

57 Our work considered the Health Board's financial performance, financial controls and arrangements for monitoring and reporting financial performance.

58 We found that **the Health Board has achieved its financial objectives and has generally effective financial controls and monitoring and reporting arrangements in place. However, it will need to manage its underlying deficit to ensure its financial sustainability going forward.**

Achieving key financial objectives

59 We found that **the Health Board has successfully met its financial duties over the past three years and has achieved its revised savings targets despite the pandemic. It also has a prudent approach to respond to future challenges, although savings deferred during the pandemic may be a significant challenge to implement later.**

Financial performance 2020-21

60 The Health Board met its financial duty to break even over the three-year period 2018-21, with a cumulative surplus of £0.512 million for revenue expenditure. In 2020-21, the Health Board recorded a surplus of £0.245 million and spent £1.551 billion in revenue expenditure providing and commissioning services. It received £1.495 billion from the Welsh Government and £105.020 million in miscellaneous income from local authorities, dental fees, or other NHS bodies.

61 The Health Board also met its duty to break-even in relation to capital expenditure with a surplus of £0.082 million over the same three-year period. For 2020-21, the surplus on capital expenditure was £0.013 million. The Health Board spent £110.958 million on capital expenditure in 2020-21, including funding to accelerate the opening of the Grange University Hospital, the Hospital Sterilisation and Decontamination Unit, and other construction work.

62 The Health Board also met the duty to have its three-year integrated medium-term plan (ITMP) for 2019-22 approved by the Minister for Health and Social Services.

However, IMTPs were suspended in 2020 due to the pandemic and replaced with quarterly plans during 2020-21 and an annual plan for 2021-22.

63 The Health Board's 2020-21 budget was approved by the Board in March 2020. As the budget was prepared prior to the pandemic, the assumptions and targets were set on a 'business as usual' basis. Total income was budgeted to be £1.311 billion, and the total delegated expenditure was budgeted to be £1.305 billion. To achieve financial balance in 2020-21, the Health Board identified the need to use additional funding allocations of £37 million and deliver savings totalling £33.4 million.

64 The impact of the COVID-19 pandemic prompted the Health Board to revise its savings target to £9.229 million. By March 2021, it had delivered £9.468 million savings (2.6% above its target) consisting of £8.281 million recurring and £1.187 million non-recurring savings. Whilst savings in some areas were above target, such as non-pay expenditure (£1.315 million above target), pay related expenditure was significantly below target. Only £1.516 million of pay-related savings were achieved compared to a target of £3.732 million.

65 During 2020-21, the Health Board spent £142.428 million (net) responding to the pandemic. This additional funding was provided by the Welsh Government to support the response on areas such as test, trace and protect, the vaccination programme, field hospitals and personal protective equipment (PPE).

66 As a result of delayed or cancelled procedures, the Health Board did not spend £39.370 million of intended expenditure, and this offset additional expenditure arising from the pandemic.

Financial planning 2021-22

67 The financial plan for 2021-22 was presented to the Board in March 2021. Reflecting the exceptional nature of the pandemic and the uncertainties in response and recovery, the Health Board has agreed to utilise a quarterly budget planning process to manage and mitigate the challenges.

68 The plan anticipates income of £1.383 billion and proposes delegated budgets of £1.346 billion in expenditure. Given the unpredictable nature of the pandemic, the Health Board's officers have informed us that there is uncertainty around the financial plan and there is constant dialogue with the Welsh Government on any changes in forecasted expenditure.

69 The financial plan accounts for the continuing impact of the pandemic. It does not assume any additional allocation funding from the Welsh Government in response to COVID-19 or service recovery. Recovery plan funding was subject to discussions with Welsh Government and initial recovery cost estimates were circa £19 million 2021-22 as reported in the Health Boards annual plan.

70 In November 2021, the Board was notified that the Health Board is predicted to break-even for the year based on performance within the first six months of the financial year. The financial report concludes that there is sufficient funding in place to provide the services planned in-year and the Health Board has received

confirmation from Welsh Government that it will receive previous, unconfirmed funding of £65m relating to COVID-19.

71 The financial plan initially identified a recurrent savings target of £33 million in order to achieve a break-even position. This savings target is significantly greater than the amount of savings achieved in 2019-20 or 2020-21. To help achieve this ambitious target, the Health Board has established a savings delivery programme which was presented to the AFR Committee in April 2021. However, like in 2020-21, the continuing impact of the COVID-19 pandemic resulted in the Health Board revising its savings target to £16.596 million of which £13.586 million relates to recurring and £3.010 million to non-recurring savings levels. Subsequently, the underlying financial deficit brought forward from 2020-21 of £20.830 million remains. The Health Board is anticipating that its underlying financial position will not improve during 2021-22 due to in-year cost pressures and the continuing financial pressure it is facing. This represents a significant risk as the savings will need to be achieved in future years. At, September 2021, the Health Board has achieved £5.757 million of its savings which is slightly above its planned delivery. However recurrent schemes have slipped and have been replaced by non-recurrent schemes.

72 Finance reports provided to the AFR Committee, and the Board include a section on savings delivery. This provides an overview of Health Board savings progress to date and performance of its high level 'green' savings schemes. Whilst this information is sufficient to oversee the impact of financial savings, it is not sufficient to enable Board members to scrutinise or recommend action of individual savings schemes.

Financial controls

73 We found that **the Health Board has generally effective financial controls and counter-fraud arrangements.**

74 As noted in our 2020 Structured Assessment, the Board made some temporary adjustments to the Scheme of Delegation. These temporary arrangements ceased in March 2021.

75 During 2020-21, the Internal Audit Service examined financial controls and governance in other areas of the Health Board. In June 2020, Internal Audit provided reasonable assurance over the financial controls relating to the Grange University Hospital, concluding that costs were adequately substantiated and accorded with the contract in place. In June 2020, Internal Audit provided reasonable assurance over financial planning and budgetary control, and in May 2021, the service provided substantial assurance on the financial governance and controls in the consolidation process relating to Test, Trace and Protect. During November 2021 the Internal Audit Service completed a follow-up review on financial assurance at the Grange University Hospital and provided substantial assurance.

76 Our review of counter-fraud arrangements in August 2020 found that the Health Board demonstrates a commitment to counter-fraud, has suitable arrangements to support the prevention and detection of fraud, and is able to respond appropriately where fraud occurs. The report highlighted one area of improvement around local counter-fraud specialist capacity. Information recently received from the Head of Counter Fraud Services Wales indicates that the Health Board's Counter Fraud Team is currently well resourced with experienced investigators and is one of the high-performing teams in Wales NHS services.

Monitoring and reporting

77 We found that **the Health Board provides sufficient, clear information to enable effective financial monitoring by the Board. However, there is scope to further develop the knowledge of Independent Members on financial matters to support effective scrutiny and challenge.**

78 Financial performance is reported to the Board and the AFR Committee. Both receive a report detailing financial performance against the most recent completed month against targets. The report breaks down performance in each area, such as income, pay expenditure, and non-pay expenditure. It also includes a breakdown of COVID-19 additional expenditure. The report also provides an update on savings delivery and financial risks and opportunities. However, opportunities to provide more detail in respect of progress against savings schemes remain (see **Exhibit 5 2017 R1**). The information is publicly accessible via the papers for Board and AFR Committee meetings.

79 The Health Board continues to submit monthly monitoring returns to Welsh Government detailing its financial performance compared to forecasted performance. The Board and AFR Committee receive copies of the monthly returns to scrutinise.

80 In **paragraph 37** we comment on the Health Board's Independent Member (Finance) vacancy. To provide coverage for finance, the Health Board temporarily appointed a special advisor who supported the AFR Committee and Board on financial matters until July 2021. Since July however, this has left a knowledge and capacity gap amongst the current Independent Member cadre. We understand the interviews to fill this vacancy took place in December 2021.

Exhibit 5: progress made on previous year recommendations

Recommendation	Description of progress
Savings Schemes Monitoring and Reporting 2017 R1 The Health Board should provide more detail to Executives and Independent Members in respect of progress against savings schemes. This should help them to provide sufficient scrutiny and challenge to schemes which are off target.	**Incomplete** Finance reports provide an overview of Health Board savings progress to date and performance of its high level 'green' savings schemes. Whilst this information is sufficient to oversee the impact of financial savings, it is not sufficient to enable Board members to scrutinise or recommend action of individual savings schemes.

Planning Arrangements

81 Our work considered the Health Board's approach to preparing an Annual Plan for 2021-22 as well as the arrangements it has in place for monitoring and reporting on plan delivery.

82 We found that **the Health Board has reasonable planning arrangements which align to wider corporate and regional strategy. The Annual Plan while providing clarity around the Health Board's strategic objectives, lacks the target milestones needed to enable effective monitoring. The Health Board intends to introduce a monitoring and outcomes framework; however, this work has been delayed due to the pandemic. As a result, the Health Board has been unable to provide assurance on overall delivery against the priorities outlined in the Annual Plan.**

Arrangements for developing plans

83 The Health Board has adopted a new approach to planning, which focusses on a life course approach with the aim of reducing inequalities across communities through improving population health. Whereas quarterly plans primarily focussed on the Health Board's COVID-19 response and winter planning, the Annual Plan incorporates learning from the pandemic and outlines a strategic approach to providing healthcare in the region.

84 The Annual Plan is aligned to Building a Healthier Gwent[6] and the Health Board's Clinical Futures Strategy[7]. The Health Board's long-term ambition is to contribute to

[6] Building a Healthier Gwent

[7] https://abuhb.nhs.wales/clinical-futures/caring-for-you-and-your-future/

reducing the 18-year gap in healthy life expectancy by 2030. The plan acknowledges the early opening of the Grange University Hospital and the work around embedding a new model of care across the hospital system during the pandemic. However, it recognises the need to develop and accelerate plans to provide care closer to home.

85 In developing the Annual Plan, the Health Board used its quarterly plans and previous IMTPs as a baseline to understand progress made against its immediate and longer-term priorities. Priorities not achieved during 2020-21 were incorporated in the Annual Plan where possible.

86 The Health Board's change in approach has led it to agree five new clear, understandable, and flexible strategic objectives underpinned by a set of outcomes and measures to achieve them. Whilst the content and clarity of the plan appears to be sufficient, it lacks target dates / milestones to enable the Health Board to monitor and track progress against the various measures and ensure intended priorities and outcomes are achieved.

87 Our discussions with staff suggest the Health Board's use of data for planning purposes is maturing. It has engaged Lightfoot Solutions who are using its 'signals from noise'[8] data tool to support and build resilience in the Health Board's planning approach and provide robust evidence to support decision making.

88 The Health Board's Planning Team also adopted a 'light touch' approach to engagement, developing a framework for discussion with operational areas to identify service priorities, deliverables, and challenges. The Health Board's Executive Team tested planning assumptions as part of its Health Systems Leadership Group meetings. The Health Board also engaged with its partners as part of the planning process recognising partnership working as a key enabler for delivering services across the region. But there is also acknowledgement that arrangements have varying levels of maturity and integration although opportunities exist for partnerships to adapt to changing needs.

Planning for recovery

89 The Health Board's approach to recovery and longer-term planning needs to be seen in the context of the unprecedented service pressures it is currently dealing with. The latest performance report, presented to Board in November 2021, highlighted the continuing impact of the pandemic across the Health Board's services:

- Attendance at the Health Board's emergency departments have been increasing since the start of February 2021, with the number of walk-in patients exceeding predictions, particularly at the Grange University Hospital.

[8] https://www.lightfootsolutions.com/approach/signalsfromnoise/

- Pressures facing the Welsh Ambulance Service in terms of staffing and handover delays have resulted in a reduction in ambulance conveyances and contributed to the increase in the number of walk-in patients.
- Performance against the 4-hour and 12-hour emergency department waiting times targets is deteriorating, particularly at the Grange University Hospital. This is mainly due to acuity of patients, the pace they flow through the hospital system, and the high number of patients who could be seen in other health settings.
- There is currently a high level of bed occupancy across the Health Board's Enhanced Local General Hospitals and community hospital network due to patients awaiting further intervention from both health and social care services. This directly impacts patient flow and capacity available within the Health Board's emergency departments and assessment units to support new presentations.
- The community health and social care system is experiencing significant pressure to meet demand for domiciliary care provision and rehabilitation placements alongside the continuing impact of the pandemic within nursing and residential homes resulting in closure to admissions.
- Sickness absence at the Health Board is currently at 7% compared to a pre-Covid-19 average of 5.5%. The Health Board is planning for an additional 3% for the winter period and is planning to open an additional 180 beds during this period, however its analysis indicates that workforce availability will not meet the expected demand. The Health Board is considering a range of actions to optimise its workforce and ensure these are targeted to priority areas.

90 The Health Board recognises the need to reset its urgent and emergency care system. This is a key element of its Clinical Futures programme and one of its Annual Plan priorities. It proposes a new system to simplify access to its urgent care services, with three workstreams to develop and embed the new model, encompassing:

- Further development of the Health Board's Flow Centre, to offer a more comprehensive model;
- Launch of the Clinical Review Hub (Contact First) model building on phase 1 of 'Contact First' launched in December 2020; and
- Further development of the Urgent Primary Care Centres at the Royal Gwent and Nevill Hall Hospital sites.

91 It is also working to address the increasing demand within the urgent and emergency care system by establishing an Urgent and Emergency Care Transformation Board and an associated work programme focussing on improvements across the whole system to secure long-term improvement in patient experience and outcomes. However, the continuing service pressures the Health Board is experiencing across its services particularly at the Grange University

Hospital presents significant risks in terms of pace of recovery and the achievement of its strategic priorities.

92 The Health Board is also developing separate recovery plans to address immediate issues arising from the pandemic. This was the focus of a Board Development Session during August 2021. The session's aim was to update Board members on the consequences of the pandemic, provide an up-to-date position on waiting lists, risk prioritisation and an overview of its restart and recovery plans across primary, secondary care, and externally commissioned services. However, whilst the Health Board is clearly planning for its recovery from the pandemic, we found limited evidence of the availability of these plans in the public domain.

Submission of plans

93 The draft 2021-22 Annual Plan and accompanying Minimum Data Set ('MDS') were discussed and approved by the Board in March 2021. They were submitted to Welsh Government within the required timeframe. The Health Board involved Independent Members in the development of the plan prior to approval and submission.

94 The Health Board submitted the final version of its Annual Plan to Welsh Government by the end of June 2021. The plan was retrospectively approved by the Board in July 2021. No changes were made to the plan between the draft and final versions, but the Health Board did take the opportunity to update the MDS based on activity in quarter 1 2021-22 and refreshed COVID-19 modelling.

Arrangements for monitoring delivery of plans

95 In our 2020 Structured Assessment, we reported that there was an opportunity for the Health Board to provide a clearer indication of its intended actions, milestones, and outcomes in its operational plans to support the Board to monitor progress and delivery.

96 This year, the Health Board has started to develop a monitoring and outcomes framework. The initial proposal was presented to the SPPW Committee in April 2021. Planned developments include introducing an annual plan reporting dashboard using the 'signals from noise' data tool, and a clear reporting framework to allow the Board and SPPW Committee to monitor, scrutinise, and challenge performance of the Health Board's strategic priorities on a quarterly basis.

97 The Health Board has not yet finalised its monitoring and reporting framework, with the work taking longer than anticipated due to the pandemic. As a result, the Health Board has been unable to provide assurance to the Board on overall delivery against the priorities outlined in its Annual Plan. We understand that the monitoring and outcomes framework is due to be considered by the Board at one of its upcoming development sessions **(Recommendation R5)**. However, we note that the Annual Plan has been used to inform Board and Committee business, with assurance on individual strategic objectives provided at different points of the year.

Exhibit 6: progress made on previous year recommendations

Recommendation	Description of progress
Reporting on delivery of the IMTP and Clinical Futures 2019 R3 Board updates on Clinical Futures do not include information on whether planned actions / mitigation are effective, and it is unclear whether risks no longer reported have been eliminated. The Health Board should include information on the effectiveness of risk mitigation in its board updates.	**Incomplete** The Health Board's last dedicated Clinical Futures Update was presented at its Board meeting in March 2020. Our review of this progress report found limited information relating to the effectiveness of actions / mitigations to risks and it was unclear whether any of the risks no longer reported were closed. There have been no dedicated update reports since due to the pressures of the pandemic. However, the early opening of the Grange University Hospital and Clinical Futures have been referenced in different Board and Committee reports and other papers. As the Health Board moves into the recovery phase of the pandemic, it should consider how progress on the Clinical Futures programme is reported to Board going forward.
Reporting on delivery of the IMTP and Clinical Futures 2019 R4 The recent report to the Finance and Performance (F&P) Committee on progress against the IMTP SCPs did not include progress against the relevant high-impact priorities aligned to them. The Health Board should ensure that committee reports on SCP progress clearly link relevant high-impact priorities with the achievements set out.	**In Progress** The Health Board is developing a monitoring and outcomes framework that will enable the Board to monitor, scrutinise and challenge performance against its strategic priorities. However, the work is still not finalised and is taking longer than anticipated.

Recommendation	Description of progress
Information Technology and Information Management 2017 R5 The Health Board should ensure resources allocated to information technology and information management provide sufficient capacity to meet the Health Board's plans.	**In Progress** There has continued to be increased investment in informatics both in terms of capital and revenue to help progress the digital strategy and infrastructure priorities. However, the non-recurrent nature of some of the local and national funding impacts on the ability to recruit to some posts and establish sustainable workforce to take the agenda forward at pace. The Health Board works closely with Welsh Government digital team to ensure all opportunities for investment are maximised aligned to national priorities. Strengthening a benefits led approach to investment and programmes is also a key priority to support further investment to take forward the strategy.
Engagement 2017 R7 The Health Board should review, refresh and update the Engagement Strategy – 'Hearing and acting upon the voice of our staff and citizens'.	**In Progress** With the merger of the communications and engagement functions, the Health Board, will review and refresh both the Engagement and the Communications Strategies for the Health Board in 2022.

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

Management response

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Document reference: 2811A2022

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Website Content and Information** The Health Board's website contains some outdated information relating to its governance arrangements and incomplete performance data which is not supported by appropriate explanatory information. The Health Board, therefore, should	Enhanced public transparency of Health Board business. .	No	Yes	The Health Board accepts this recommendation. The website is in the process of being reviewed and updated to reflect suggestions made including, ensuring all fundamental Health Board information (related to Board, Committees, and governance arrangements) is accurate and up to date for the public and stakeholders.	March 2023	Associate Director of Communications and Engagement

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	take immediate action to ensure: • Content is well-organised, easy to navigate, clear and concise, and • Key information / data is up-to-date and in a format that the public and stakeholders can interpret and understand.				Further developmental work will be required to ensure Divisional engagement around local pages on the website are kept up to date with useful and meaningful information. However, it should be acknowledged that the resource required in order to conduct such a substantial review is not inconsequential.		
R2	**Reviewing the new Governance Structure** Some Board members have expressed concerns about the volume of work	Assurance on the effectiveness of the Health Board's revised	Yes	Yes	The Health Board accepts this recommendation. A complete and robust Committee and Board effectiveness exercise will be undertaken by April 2022.	April 2022	Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	now undertaken by some of the committees and the robustness of the arrangements for ensuring flows of assurance. The Health Board, therefore, should complete its review of the new governance structure by its intended deadline of April 2022 to be assured that it is operating as intended.	governance arrangements.			The results of which will inform an assessment of strengths and opportunities and will provide a baseline for Board and Committee development programmes in the future.		

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R3	**Corporate Governance Support Team resilience and capacity** Recent staff turnover within the Corporate Governance Support Team has impacted on the quality of service it is able to provide to the Board and its Committees. The Health Board, therefore, should review the effectiveness of its Corporate Governance Support Team as soon as possible to ensure that it has sufficient resilience and capacity to support all governance functions. Arrangements should also	Sufficient resilience and capacity within the Corporate Governance Support Team to support all governance functions.	Yes	Yes	The Health Board accepts this recommendation. The Health Board will undertake a review and endeavour to ensure adequate and appropriate corporate governance capacity to fulfil the statutory functions of the Board and the Committees, enabling it to discharge its functions. It should be noted that external training in specific corporate governance, information governance and accredited risk management has been undertaken over the last two years, despite the pressures of the pandemic. This demonstrates the Health Board's commitment to	April 2022 September 2022	Board Secretary

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	be put in place to ensure staff are able to access suitable training / learning opportunities to develop their knowledge and skills within their respective roles.				develop and enhance skills within its governance team. However, it is also recognised that further mentorship and training programmes could be developed in order to 'future proof' the department and provide a robust corporate governance function.		
R4	**Stability of the Board** The Health Board has experienced significant changes in its Executive Team and cadre of Independent Members resulting in several interim Executive Director	Stable Executive and Independent Member leadership.	Yes	Yes	The Health Board accepts this recommendation. Independent Members Interviews have now been undertaken for Independent Members for Finance and Digital and the recruitment process for this continues to progress.	April 2022	Chair

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	appointments and is currently recruiting to two independent member vacancies. However, maintaining these temporary arrangements indefinitely alongside the turnover of Independent Members present risks at a time of significant operational pressures. The Health Board, therefore, should seek to make permanent appointments to these key Executive Director roles at the earliest possible opportunity. In addition, there remains a need for the Health Board to strengthen its induction				Continued liaison with the Public Appointments Team to progress the substantive recruitment of the Vice Chair and an Independent Member for Community is anticipated to progress from February 2022. Executive Team: Chief Executive Officer (CEO) – interim arrangement to be continued during 2022. Director of Primary Care, Community & Mental Health – recruitment in process. Director of Finance & Procurement – interim appointment to be extended in line with Interim CEO arrangement.	 In place February 2022 In place	 Chair Interim CEO Interim CEO

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	and training for new Independent Members in line with our recommendation in 2019.				Deputy CEO – interim appointment to be continued in line with Interim CEO arrangement. Interim Director of Operations – current interim appointment until April 2022. Recruitment process to commence shortly.	In place April 2022	Interim CEO Interim CEO
R5	**Monitoring delivery of Strategic Priorities** The Health Board has not finalised its monitoring framework due to the pandemic, subsequently there continues to be limited oversight and scrutiny at Board-level on	Improved ability to monitor progress against the Annual Plan and future Integrated Medium-Term Plans.	Yes	Yes	The Health Board accepts this recommendation. The delivery framework of the 3 year IMTP process did include a quarterly monitoring report structure which has not been completed this year against the annual plan due to the challenges of the Health Board's response to	June 2022	Director of Planning, Digital and ICT

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	overall delivery against priorities outlined in the 2021/22 Annual Plan. The Health Board, therefore, should complete the development of its monitoring framework as soon as possible to allow the Board to review and if necessary, challenge delivery of its strategic priorities and progress against the Annual Plan and future Integrated Medium-Term Plans.				the pandemic and other priorities. The shared objective of developing a comprehensive outcomes based framework for the organisation is a developmental one and progress has been limited in this area due to the challenges associated with the pandemic, a change in leadership of the performance function (due to the Exec team changes referenced in the report) and due to Welsh Government developing an All Wales outcomes framework that would enable the Health Board to align a local framework to. The Health Board will therefore		

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
					develop the first iteration of an outcomes framework for 2022/23 to support the 3 year IMTP and align to the Welsh Government framework. The new outcomes framework is intended to enhance and enrich the information provided to the Board but will not be the only basis for scrutiny and assurance at a Board level.		

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 23rd March 2022 Agenda Item: 4.2

Aneurin Bevan University Health Board

Clinical Futures and Grange University Hospital: Reflections on the first twelve months

Executive Summary

The report outlines the key developments in our system of care over the past 12 months since the Grange University Hospital opened and reflections on key areas of progress and the priorities for further work.

The 7 key benefits criteria from the Full Business Case (FBC) are outlined and analysed in detail along with the benefits associated with the new model in supporting the pandemic response.

Detail is provided on the key areas of patient experience, outcome, performance, workforce and finance.

The outline of how the revised Clinical Futures Programme will develop the response to challenges in our system is also included.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	X
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	

Executive Sponsor:	Nicola Prygodzicz, Executive Director Planning, Digital & ICT		
Report Author:	Neil Miles, Clinical Futures Programme Director		
Report Received consideration and supported by :			
Executive Team	✓	**Committee of the Board [Committee Name]**	**Board Briefing Session**
Date of the Report: March 2022			
Supplementary Papers Attached: N/A			

Purpose of the Report

The purpose of this report is to provide an overview of the system, patient and staff benefits experienced from the opening of the Grange University Hospital (GUH) and the new hospital network alongside some of the key challenges since it's opening in November 2021 and the planned actions through the Clinical Futures Programme and IMTP 2022/23

Review

The Health Board's Clinical Futures Strategy has remained resilient and relevant for over a decade, and the opening of the new Grange University Hospital as part of a new network of hospitals was a fundamental milestone in the delivery of the broader strategy, and a key focus of the Health Board agenda since its final approval in 2016.

This report provides an overview of how the new system is operating one year on from the opening of The Grange University Hospital and the implementation of the new hospital network.

Highlighting the benefits and challenges, the report also takes into account the significant pressures facing healthcare services as a result of the pandemic, which has impacted on how services have been able to implement the new service models. The report also sets out the future priority areas of work as the opportunities arise, as we continue to manage our way out of the pandemic.

Assessment and Conclusion

The long awaited Grange University Hospital which opened on the 17th November 2021, four months ahead of schedule and within budget, was critical to the Health Boards response to meeting the population needs for the winter of 2020/21 in the context of the ongoing challenges of the Covid-19 pandemic.

The opening of the GUH also heralded new roles for our Enhanced Local General Hospitals (eLGHs) and the system of health care that connects them to each other, the community and the new Specialist and Critical Care services at the GUH.

One year on, the GUH and overall system has continued to treat increasing numbers of patients, far greater than previous services models in some areas across the Health Board as well as continuing to adapt to the changing nature of the pandemic.

In line with other Health Care systems, workforce availability in parts of the system remains a key constraint but conversely the experience of the new hospital is positive in terms of attracting and retaining key staff.

Due to the design of the new hospital, Infection control and Hospital Acquired Infection has been a key improvement attribute as a result of the new site compared with other sites, greatly assisted by the provision of single roomed accommodation.

Patient centred care and staff well-being are at the core of our focus and feedback from staff and patient stories all inform the ongoing planning and relentless efforts of the teams to improve on the challenges still facing the urgent care system and in particular the pressures presenting at the Grange University Hospital.

Clinical outcomes for patients across our system show signs of improvement and resilience when compared with Welsh peers for key metrics. Likewise, the performance of our system and key parts of it remains in the upper quartile for the majority of measures.

However, performance and patient experience in urgent care still falls short of the Health Board and public expectations. To improve this the Same Day Emergency Care model and the development of the 'Integrated Front Door' which will expand the waiting area at the Emergency Department respond to the changing nature of urgent care demand and the increase in presentations.

The ability to deliver planned improved efficiencies, full system transformation and financial sustainability are all challenging in the context of the covid environment but will require a significant focus as things potentially move towards a "new normal".

The focus on the workforce is a top priority given the fragility and morale of staff who have worked throughout the most relentless two years of their career.

The IMTP priority programme for 2022/23 will include the key priority areas identified throughout this report to ensure we continue to stabilise the system and drive further improvements across the system in line with the ambitions of the Clinical Futures strategy.

Recommendation
The Board is asked to DISCUSS and NOTE the contents of this report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework. The opening of GUH was a major mitigation of the Health Boards capacity and capability to manage the Covid-19 response.
Financial Assessment, including Value for Money	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of New Terms	New terms are explained within the body of the document.
Public Interest	Report to be published.

Clinical Futures Programme

The Grange University Hospital and New Hospital Network Model – Year One Evaluation

1. Introduction and Context

The Health Board's Clinical Futures Strategy has remained resilient and relevant for over a decade, and the opening of the new Grange University Hospital as part of a new network of hospitals was a fundamental milestone in the delivery of the broader strategy, and a key focus of the Health Board agenda since its final approval in 2016. Intended to open in March 2021 after significant planning, the hospital was required to be opened four months ahead of schedule in November 2020 as part of the Health Boards response to the worldwide Covid-19 pandemic and the second wave that hit in the winter of 2020/21.

This report provides an overview of how the new system is operating one year on from the opening of the Grange University Hospital and the implementation of the new hospital network. Highlighting the benefits and challenges, the report also takes into account the significant pressures facing healthcare services as a result of the pandemic, which has impacted on how services have been able to implement the new service models. The report also sets out the future priority areas of work as the opportunities arise, and as we continue to manage our way out of the pandemic.

2. The Case for Change Pre and Post Pandemic

The Grange University Hospital and a new hospital network system has been in the planning for many years. A total of 47 service models were refreshed and tested to ensure they were aligned to the clinical strategy, based on the latest evidence, with updated workforce and financial plans and clear benefits and risks set out. The overarching case for change was based on the following key system benefits:

- Service and workforce sustainability
- Service improvement and enhanced quality of care
- Modern functional estate and
- Wider system opportunities.

A more detailed overview of the Full Business Case key investment objectives and expected benefits is included in Appendix 1 and fall under the following broad headings:

1. Deliver access targets for both planned and unscheduled patient care, in line with national targets for 2015 and beyond
2. To achieve and exceed, where possible, minimum quality standards for health care service (As outlined in NSDF, NICE and Standards for Healthcare) to improve outcomes for patients
3. Improve the local provision of services and minimize travel times for access to health services, and in particular, hospital and specialist services
4. To deliver a fit for purpose environment for patients and staff, which is NEAT and AEDET compliant
5. Support a workforce model that is sustainable, and complies with the European Time Directive and Deanery requirements
6. To improve and expand provision of community based alternatives to hospital services
7. To achieve and exceed, where possible, upper quartile performance on key performance indicators across all levels.

Whilst significant progress had been made, there was still a years' worth of more detailed planning, operational commissioning, staff consultation, and OD work to be completed when the Covid-19 pandemic hit. The whole organization effort to respond to the public health threat was unprecedented, and the Health Board and its staff faced challenges like no other before. Whilst other Health Boards and Trusts in England sought temporary field hospitals as contingency capacity in the first wave, the Health Board with the contractors successfully accelerated the hospital build to enable the commissioning of all ward areas of the GUH by the end of April 2020, to support its surge capacity plans. Whilst these were fortunately not required due to the impact of government restrictions, the status of the hospital build put the Health Board in an excellent position to consider the benefits of accelerating the project further to fully open the hospital ahead of schedule and ahead of winter 2020/21 where a daunting second wave of Covid-19 was predicted. Following comprehensive clinical discussion and engagement, and consideration of the risks and benefits of an early opening, the decision was made in June 2020 to open in November 2020, four months ahead of schedule to achieve the following benefits:

- Enhanced service sustainability particularly for as Women and Children's services which were facing significant risks
- A new large critical care unit that provided the workforce benefits of centralisation and improved capacity plans ahead of winter and any further Covid-19 surges
- Having an extra site with 75% single rooms would supplement the Health Board winter response and infection control benefits.
- Significant additional oxygen capacity to ventilate patients in either a full critical care environment or using CPAP.
- Maximizing the transformation capability within the organisation.

- The opportunity to centralise several services to better utilise resource, creating economies of scale including the Emergency Department, Critical Care, Theatres and Women and Children's services

Clinical, operational and corporate teams came together with a significant effort to enable the delivery to the new timeline despite the ongoing challenges facing the Health Board throughout the pandemic. Whilst detailed operational readiness assessments were a key component of the go live assessment, many of the planned activities had to be curtailed where possible on a balance of risk to enable the early opening. Importantly, as the GUH signified a major milestone in our whole system change, the decision by the Health Board to accelerate delivery of Clinical Futures was a systemwide one. This model was now required to be delivered within a new context. The entire health system had to be reconfigured in many areas to facilitate the new rules and requirements of Covid-19 and had to be flexible to the ever changing demands of the virus and manage risk and safety across the sites.

3. Implementation of Service Models and Impact of Covid

The operational commissioning of the Specialist and Critical Care centre at the GUH was an essential part of the Gwent Health Care system response to the COVID-19 pandemic over the winter of 2020/21.

During the summer of 2020 readiness assessments were carried out to consider how a safe, early move to the GUH could occur. Detailed assessments, and the subsequent decision to pursue early opening, were very much focused on enabling a system Covid response.

This meant that at the time of opening, some services were able to deliver near to their full 'Clinical Futures models' (such as Maternity, Pharmacy, Pathology) from November 2020, whilst others modified their approaches to move existing services, workforce and processes into the new facilities and then continue to develop their full service models once in situ.

Opening a new hospital, in a Covid environment was challenging. The Grange University Hospital brings many benefits in terms of its modern infrastructure and single room environment, however like any existing facility the planned use of space and departments had to be repurposed to ensure the separation of Covid and non-Covid areas.

This resulted in limitations to access of areas of the hospital, and also added delays to patient processing in the Emergency Department due to necessary pre-screening and swabbing processes required.

Following the first 6 months of opening in May 2021 the 47 Clinical Futures service models were reviewed to establish how they had adapted to the

new site and system of care. 13 of the 47 were needing to remain under review where, for various reasons, the model was not in place as originally intended.

Most of these challenges (as of May 2021) were in relation to workforce gaps impacting on the model delivery – either where the new model required an increased workforce, and posts were not fully recruited to, or there was an ongoing challenge to support the existing approach. Recruitment throughout the year has continued to fill many of these gaps, with service areas moving off the watch list (e.g. T&O, Radiology).

There are other areas where service models now require review in the context of Covid and recovery and will be developed through the current IMTP process and period e.g. inter site patient transfer and hospital at night / out of hours workforce models which are being developed through the Urgent Care Transformation Programme.

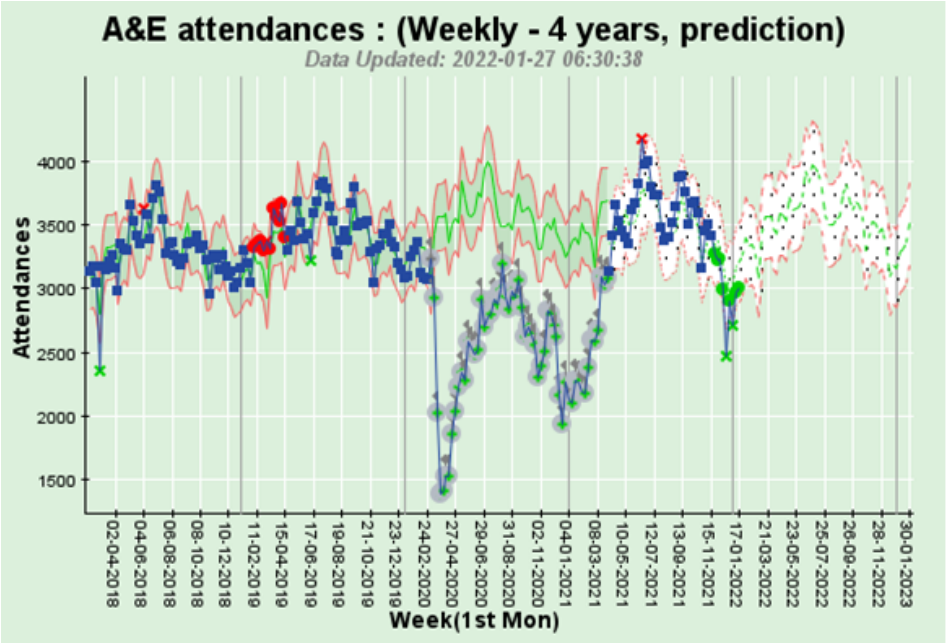
4. System Demand and Context for 2021

The Full Business case for the GUH was based on a set of demand assumptions using 2015 as a baseline. Annual demand since 2015 had been above predicted levels with significant pressures across the health and social care system. New modelling had been undertaken as part of the refreshed planning post FBC approval. The impact of the pandemic further compromised the modelling assumptions which have seen unpredictable patterns of demand as we have moved through the different phases of the pandemic.

The first wave saw significant reductions initially in urgent care demand across the NHS with an incremental increase throughout 2020 as the situation settled. Post the second wave urgent care demand rose sharply in the first half of 2021 as the lockdown restrictions eased and the longer term impact of restrictions presented new pressures for the NHS. Patterns of demand also changed for the numbers of Covid positive, suspected and recovering patents that had to be and still need to be accommodated in the complex covid pathways that are required for Infection Prevention and Control.

The following table and headlines summarise how demand has impacted on the system over the last 12 months and is relevant context for consideration as to how the new system is working compared to the original plans set out in the further sections of the report.

	Pre GUH Opening (attendances per week)			Post GUH Opening (attendances per week)		
Site	**RGH**	**NHH**	**Total combined**	**GUH** (Nov 20-June 21)	**GUH** (from April 21 onwards)	**Total combined**
ED	1500 – 1800	800- 1100	**2300 – 2900**	1200 - 1600	1600 - 2000	**3200 - 4200**
MIU	Inc above	Inc above	Inc above	1600 - 2000		



Key Headlines include:

- Attendance levels across the system and particularly at GUH sharply increased in the first six months of 2021 rising to above pre pandemic levels with June 2021 seeing the highest ED / MIU attendances on record for the Health Board. Attendance levels have recently stabilised albeit new challenges are presenting with the Omicron variant of concern.
- Increased demand of self presenting patients particularly at GUH beyond those planned creating significant pressure on the Emergency Department. Self presenter demand for the GUH via ED was predicted to average 167 attendances per day (pre-covid) the actual has ranged from 88-281 with periods regularly seeing 220 self presenters a day.
- Higher than predicted MIU activity at the eLGHs.
- Increased paediatric attendances and GP referrals above pre pandemic levels. Paediatrics have also rolled out Healthier Together, a tailored website for the public and professionals to understand pathways and appropriate access. With time, as these changes bed in, positive trends are now beginning to show.

- Higher levels of inappropriate attendances to GUH initially, some of which was due to public understanding of the changes to the model, system demand, and reduced access to GP's,111 and WAST. The number of patients redirected from GUH ED to other services is currently half of the peak seen in June 2021, reducing from 200 to 100 redirections per week. This indicates that public messaging and pre-hospital services (e.g. WAST, 111, Flow Centre) are improving and not directing so many patients to GUH ED. It also suggests that the new system model is starting to be accepted and utilised by the local population as designed
- Increased demand post lockdown for a number of key specialties such as Cardiology and Emergency Surgery
- All 3 eLGHs have seen a step change increase in MAU activity since April 2021, with a corresponding decrease in GUH MAU activity. This again indicates the system is moving closer in line as to what was originally designed as a decentralised medical assessment and admissions service away from the main ED. However this is presenting some medical and training challenges at the elGHs that is covered further in the report.
- Beds occupied by patients over 21 days across the Health Board have been steadily increasing since March 2021 and currently sits at 650 and AVLOS is at its highest level since June 2016.

As seen across the UK, these highest ever rates of attendance, coupled with the ongoing Covid impact and mitigating measures, created a systemwide strain that required active management to maintain safe services on each site.

5. One Year on - High Level System Reflections

One year on since the operation of the new system, the Health Board has reflected on numerous occasions about the impact the new hospital and system has had on its service delivery. At a high level the benefits of an early opening have undoubtedly been achieved in terms of:

- Service sustainability for Women and Children services
- A more resilient and flexible Critical Care service
- Improved infection control management
- More resilient Specialist Acute services
- Additional physical space across the system to manage the increased demand that presented in 2021 (the Health Board did not commission a field hospital unlike many other Health Boards in Wales).
- Additional ED and Resus capacity to meet increasing demand and acuity
- Improved recruitment in many areas particularly around specialist medical staff and registered nursing at GUH.

- Ability to maintain elective activity at times of high emergency demand due to the separation of elective and emergency care and the POCU model at RGH.
- Increased diagnostic capacity to support increasing demand and significant backlogs

However, there is no doubt the system has also been under significant pressure trying to meet the Covid pressures and post lockdown impacts. Unprecedented demands for urgent care, adapting to the new model, and a cultural change for many staff, has been challenging. The continuation of Covid's impact such as testing, Covid pathways, social distancing and PPE has had a significant impact.

The impact on staff has also been significant, both in terms of those adapting to a new environment and new ways of working at GUH in addition to some significant pressures at the eLGHs and community hospitals in terms of the fragility of the workforce, particularly around medical staff and trainees and registered nurse vacancies at a time when additional wards have been opened to support a Covid safe environment in line with IPAC guidance.

Linked to this is the inappropriate presentations to the MAU/MIUs at eLGHs where transport delays have sometimes resulted in inappropriate levels of risk for certain staff groups to manage and a risk to patient care. Patient transfers across the system, often out of area, are also a key area of further work primarily due to the system pressures and the different Covid pathways in operation at each site.

The following sections focus in more detail on the impact of the new system both in terms of benefits and challenges from various perspectives, and sets out where the pandemic has, and continues to impact, on the original model and its delivery.

6. Progress against 7 Key Investment Objectives in a Covid-19 Context

This section outlines a more detailed assessment of the 12 month period since the opening of the GUH for the 7 Key Investment Objectives outlined in the Full Business Case (FBC). Concluding findings for each benefit are provided.

6.1 Deliver access targets for both planned and unscheduled patient care, in line with national targets for 2015 and beyond

Urgent Care

When the FBC for the GUH and systemwide change was produced, there were key areas the Health Board sought to improve against in unscheduled care. These were captured in the Benefits Realisation plan.

The GUH opening and service model change to the urgent care service structure across Gwent coincided with broader demand changes across all health care systems and services due to the pandemic, lockdown effect(s), and changes in planned care. This had a huge impact on our data and performance, and it is challenging to extrapolate where Covid impacts stop and system wide changes start. Some conclusions can be drawn from the data and comparative performance from other Health Boards.

The access measures for 4 hour and 12 hour waits of ED patients are telling. Whilst improvements and challenges in the health environment were being influenced by demand and our response pre pandemic, the impact of Covid cannot be underplayed in the immediate response or the change in access behaviours.

Measure	2015 - FBC Published	Pre COVID, pre GUH	Post GUH during COVID	Current status
Percentage of patients spending **no longer than 4hrs in ED** Target 95%	90.3% average monthly figure for 2014/2015 Source ISD portal	72% ABUHB snapshot for Nov 2019 (National rank 6) Source: HealthStats	58.70% GUH ONLY. Period covers Nov 2020 to Aug 2021 Source: Qlik Sense Urgent Care App	76.2.1% ABHUB for Jan 2022 (National rank 1) 57.8% GUH ONLY Jan 2022 Source: HealthStats
Number of patients spending **12hrs or more in ED** Target 0	212 no of patients spending ≥ 12 hours in age - average for the 12 months April 2014 - March 2015 Source ISD portal	821 or 5.8% patients ABUHB snapshot for NOV 2019 (National rank 3) Source: HealthStats	1,005 monthly average 10,055 GUH ONLY. Period covers Nov 2020 to Aug 2021 Source: Qlik Sense Urgent Care App	1239 or 9.5% patients ABUHB for Jan 2022 (National rank 1) 12635 (GUH ONLY) Jan 2022 Source: HealthStats Wales

The way in which the public accesses urgent care has changed, driven by the messaging through the pandemic to stay away from hospitals, or planned activity pauses, with more complex cases presenting. These changes in urgent care demand and methods do not fit the workforce model that was planned for through the Clinical Futures programme. The specialist acute emergency only model is not aligned to the current workforce model in place (e.g. walk-in patients and 111 redirects).

In response to this, the Same Day Emergency Care Service (SDEC) proposal is a part of the evolution of the clinical model for urgent care at the GUH site which will seek to, in part, address these issues. The SDEC service will support patients who attend ED and require assessment and diagnosis but do not require admission.

Further work is also required on the promotion and consistency of the eLGH offer to ensure that urgent care is appropriately accessed outside the GUH.

Demand across the system is seemingly now (December 2021) stabilising to more normal levels following the increase seen in the middle of 2021, resulting from the easing of social restrictions. This is also echoed in eLGH Medical Admission and Minor Injury demand, which is also now in a more stable state with peaks and reductions linked to lockdown impact and release, also felt through these services.

Planned Care

The impact of the pandemic on elective waiting lists is significant with over 113,000 patients on the outpatient waiting lists as at the end of December 2021 compared to 74,000 pre pandemic.

The table below summarises the position to date.

	Mar-20	Dec-21	Feb-22
New Outpatient Waiting List	74,673	113,866	113,904
Inpatient Waiting List	7,289	9,478	10,165
Daycase Waiting List (incl Endoscopies)	18,325	23,594	23,151
Radiology Waiting List	15,051	10,180	11,803

This represents almost 20% of the Health Board population on a waiting list which is consistent with the All Wales position.

Measure	2015 - FBC Published	Pre COVID, pre GUH	Post GUH during COVID	Current status
Referral to Treatment Time target: % of patients waiting **less than 26 weeks** for	87.90% average (of %s) monthly figure for 2014/2015	86.8% Figures based on ABUHB (in totality, not just GUH) as at the end of March 2020	59.0% Figures based on ABUHB (in totality, not just GUH) as at the	58.4% Figures based on ABUHB (in totality, not just GUH) as at the

treatment - all specialties Target 95%	Source performance team	Source: RTT submission (matches figure reported on HealthStats website)	end of August 2021 Source: RTT submission (matches figure reported on HealthStats website)	end of December 2021 Source: HealthStats website
Referral to Treatment Time target: Number of **36 week breaches** - all specialties Target 0	2675 average monthly figure for 2014/2015 Source performance team	1623 Figures based on ABUHB (in totality, not just GUH) as at the end of March 2020 Source: RTT submission (matches figure reported on HealthStats website)	39065 Figures based on ABUHB (in totality, not just GUH) as at the end of August 2021 Source: RTT submission (matches figure reported on HealthStats website)	34,257 Figures based on ABUHB (in totality, not just GUH) as at the end of December 2021 Source: HealthStats website
% of patients waiting **less than 8 weeks for a specified diagnosti**c Target improvement	3993 average monthly figure for 2014/2015 - source stats Wales Source D&T waiting time data	88.8% Figures based on ABUHB (in totality, not just GUH) as at the end of March 2020 Source: HealthStats	61.7% Figures based on ABUHB (in totality, not just GUH) as at the end of August 2021 Source: HealthStats	54.93% Figures based on ABUHB (in totality, not just GUH) as at the end of December2021 Source: HealthStats website

Whilst this presents unprecedented challenges in terms of recovery and will require new ways of working the new Health Board system and additional physical capacity available provides some opportunities for planned care Whilst this presents unprecedented challenges of recovery and will require new ways of working the new Health Board system and additional physical capacity available provides many opportunities in this area.

The Health Board and the planned care system has been creative in its approach with flexibility based on patient demand.

The POCU (Post Operative Care Unit) at RGH is bedding in to enable more higher risk planned surgery to occur at the eLGH, with patients safely treated on site. The Transfer Practitioner model (currently running for 12 hours per day) has been signed off for expansion to cover 24 hours 7 days a week. This means that the systemwide response to a patient requiring unexpected escalated or emergency care post procedure, has been

bolstered, and gives confidence to clinical staff that these patients can be managed effectively in an eLGH system, rather than relying on GUH capacity for treatment.

Many planned systems are coming back on line and prioritising reducing waiting lists, or finally rolling out as described in the Clinical Futures model -such as Paediatric surgery who are now running dedicated lists on a Monday at RGH, in addition to GUH, and have the potentially to expand to a further session on Tuesday. Patients have been prioritised and systematically allocated as required.

Improvements in recent activity are beginning to show in the data, and those patients who have breached 36 weeks are being addressed, with these total numbers dropping by almost 4500 between August 2021 and December 2021, a 12% improvement in the context of all other Welsh Health Boards maintaining their position.

Median waiting time for referral to treatment, by local health board, September 2011 onwards

Month and year	Betsi ULHB	Powys	Hywel Dda ULHB	SB University ULHB	CTM ULHB	Aneurin Bevan	C&V	Wales
Oct-21	22.4	6.6	21.7	24.5	26.8	20.2	21.2	**22.4**
Aug-21	22.1	7	20.5	24.3	25.9	19.4	20.3	**21.5**
Mar-20	11.4	6.4	10.4	11.8	12.0	10.3	11.7	**11.1**

Summary

Issues	Actions
URGENT CARE • significantly higher numbers of attendances to the urgent care system than predicted • high numbers of self-presenters than predicted • 4 hour performance deteriorated through initial period, has now stabilized and recovered to pre pandemic levels. • MAU and Urgent Primary Care services have also seen increased attendances at the	**URGENT CARE** • Urgent Care Transformation Programme (UCTP) will provide leadership for improvement and optimization of pre-hospital, GUH Emergency services and eLGH 'front door' services • Continue to communicate with the public to ensure appropriate access to Urgent Care across the system via the 'Work with Us' campaign • Development of SDEC at GUH and all eLGH sites to enhance

eLGH sites over what was planned.	the system of rapid assessment and treatment of patients • eLGH Network Programme to support the development of the hospital system including the GUH and links between all sites and services.
PLANNED CARE • Overall waiting list sizes have grown significantly. • Referral demand has also decreased through the pandemic i.e. fewer patients than would normally be expected were presenting to General Practice and being referred to the waiting list. • Emergency and Planned care separation between GUH and eLGH a significant advantage in maintaining a level of elective activity through the pandemic	**PLANNED CARE** • Outpatient Transformation Programme to continue to support significant change and adoption of new approaches at greater pace • Develop new services to supporting patients whilst waiting and helping them keep well and as active as possible to aid their recovery from any treatment. • eLGH Network Programme and Planned Care Programme to review and optimize eLGH contribution to planned care recovery.

6.2 To achieve and exceed, where possible, minimum quality standards for health care service (As outlined in NSDF, NICE and Standards for Healthcare) to improve outcomes for patients

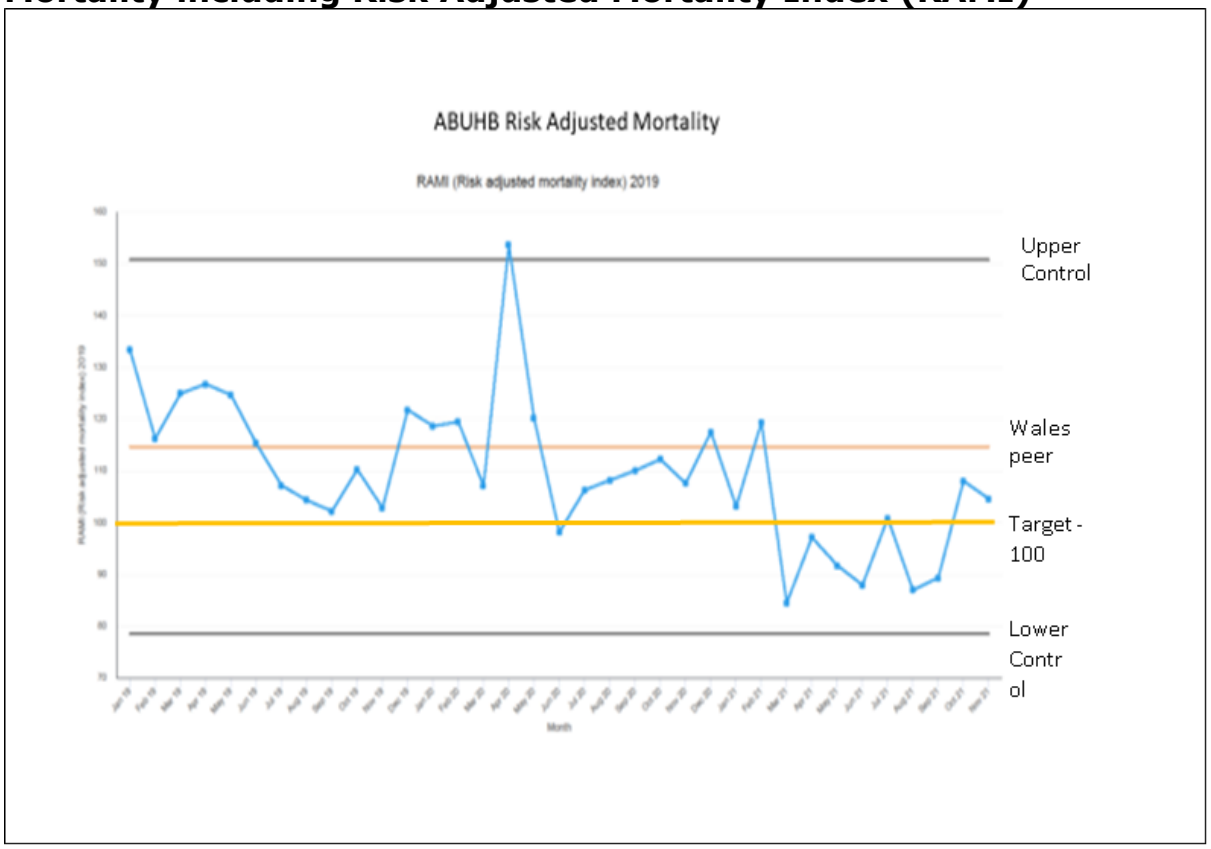
(a) Patient Outcomes

The Health Board undertakes a number of audits regarding clinical outcomes and standards of care that are peer or national body reviewed and published on an annual basis. These indicators of clinical quality and outcomes are condition specific but, in aggregate, can provide a high level insight into achievements of the clinical model in the reconfigured health system.

This section outlines a number of the key indicators and outcomes of care e.g. Risk Adjusted Mortality (RAMI), Readmission rates, inpatient falls and condition specific outcomes such as Orthopaedic Trauma (National Hip Fracture Database), Stroke Services, Cardiac (Myocardial Infarction) and emergency surgery (NELA Audit).

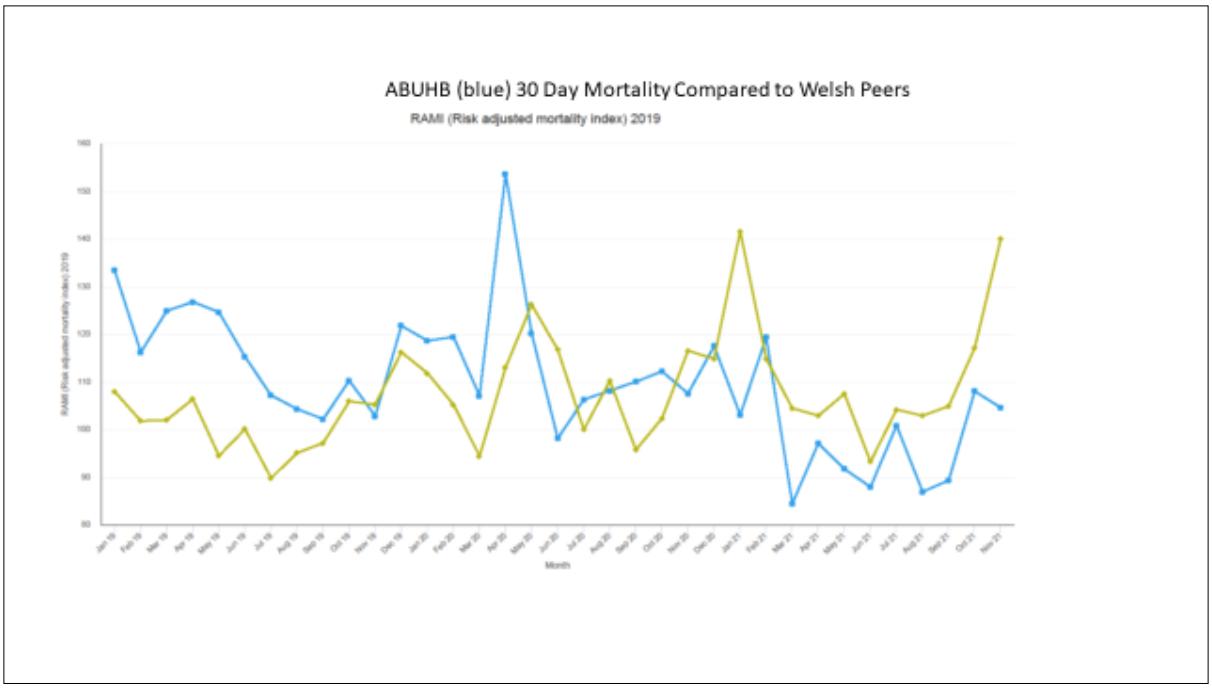
It should be noted that the measures are Health Board wide where appropriate (including all sites). It is important to consider outcomes of care as a whole for the Health Board given that care for patients with the most complex needs may be shared across more than one hospital site during their treatment and recovery.

Mortality including Risk Adjusted Mortality Index (RAMI)



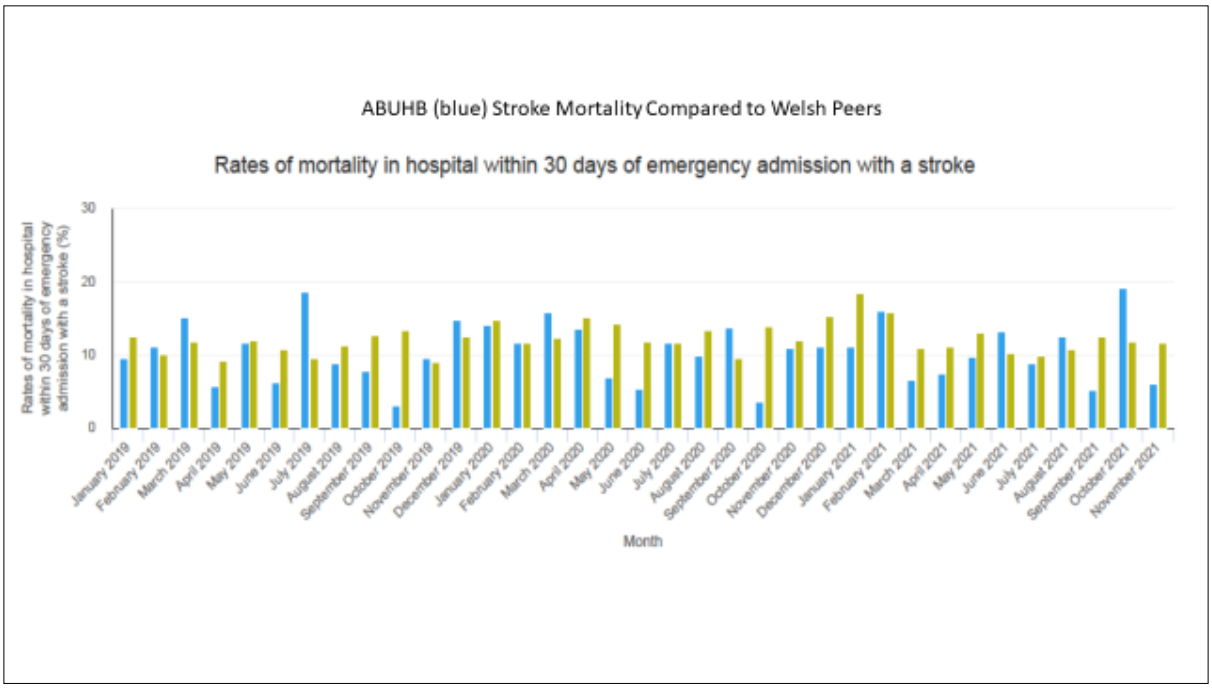
RAMI across the Health board has fallen since January 2019 apart from a spike in March 2020 during wave one of COVID-19. Most encouragingly the median RAMI has been trending below 100 since March. The value "100" represents the median value for risk adjusted mortality for all providers in the UK whose data contributes to the measure. A value of less than 100 means that the health boards mortality outcomes for care overall are better than its peers.

The following chart compares the Health Board figure to the Wales average (green line). This suggests that despite the levels of challenge on our health care system as a result of Covid and the disruption caused by opening our new health system early, to meet the challenge our 30-day mortality has improved in comparison with our peers and has been maintained during subsequent waves of Covid.

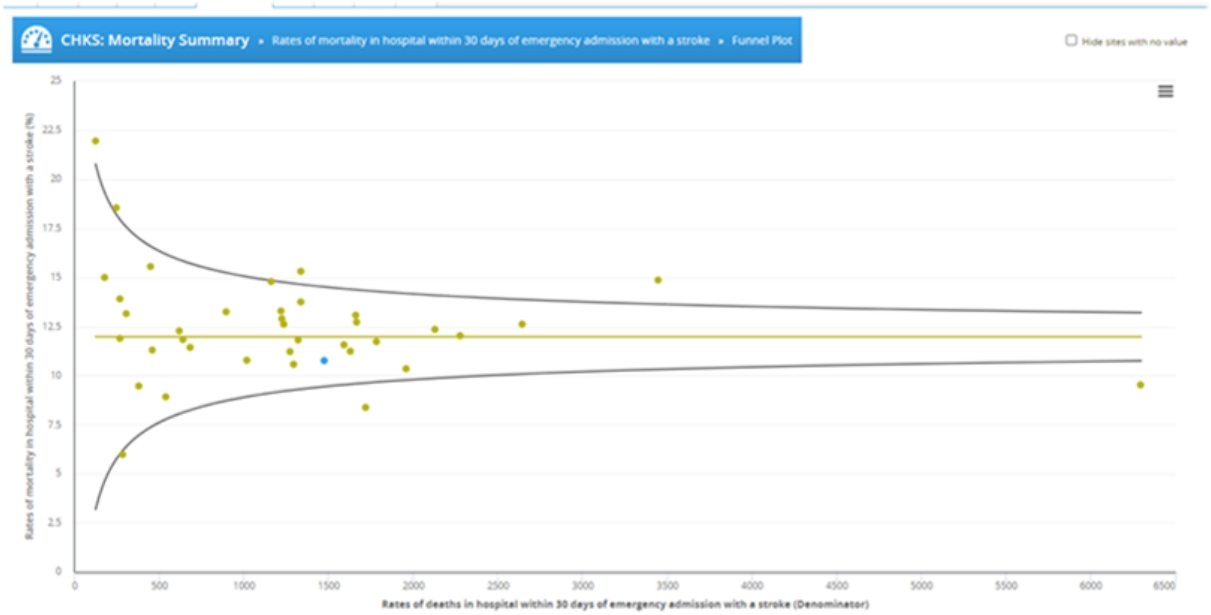


Outcomes for other conditions that are audited nationally are also favourable when compared to the national position.

The chart below outlines the position for stroke. There is a significant variation in mortality over time (due to small numbers). The background trend suggests favourable outcomes for the Health Board compared with peers.



This is confirmed by the mortality rate within the control limits on the funnel plot below where outcomes for the Health Board lie below the mean nationally in the UK.

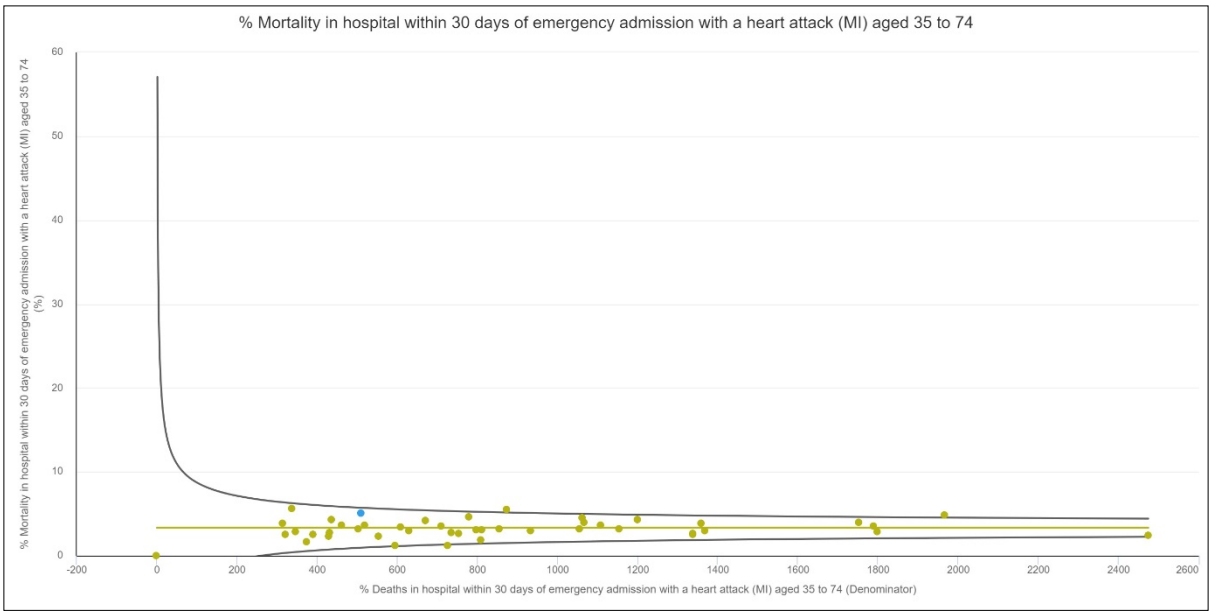


Within the Health Board all stroke deaths are reviewed by the clinical team as part of on-going mortality review. These reviews identify areas where care can be improved and seek to understand whether deaths are related to significant comorbidities or haemorrhagic conditions where mortality is higher than in ischaemic stroke (where more treatment options are available).

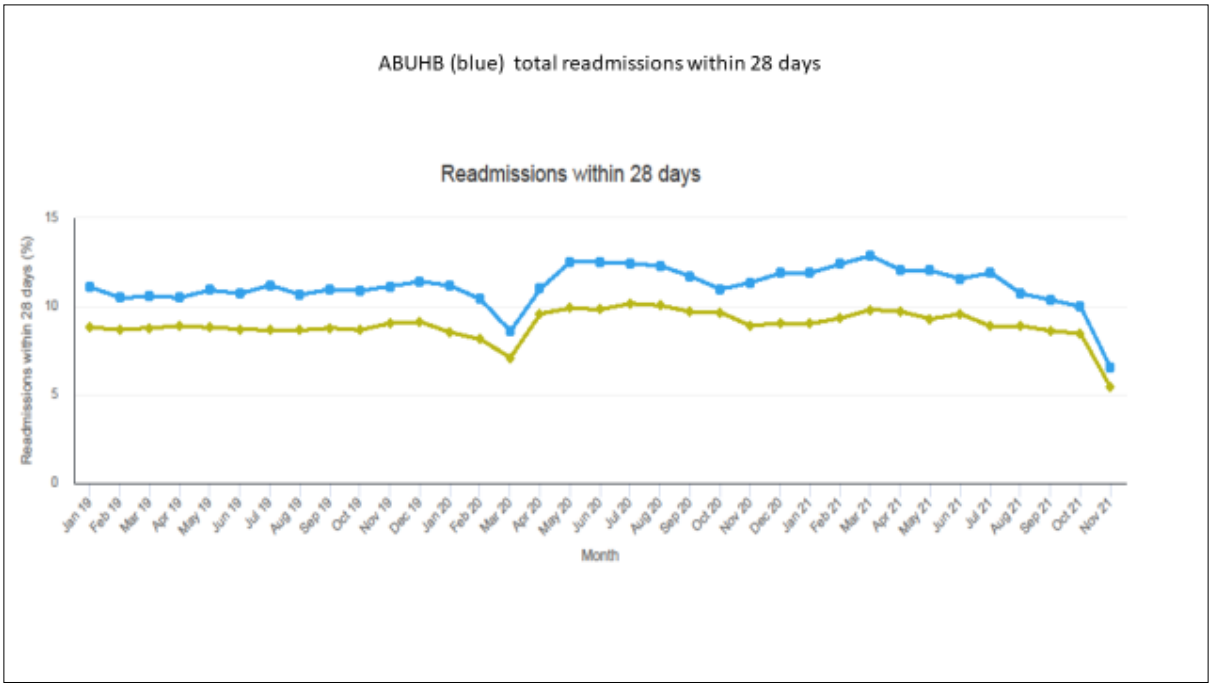
Similar information is gathered for mortality rates in patients presenting with myocardial infarction (MI). This shows a rate above the median value for the Health Board, but still within the control limits.

When interpreting results, consideration must be given to the fact that data includes figures from the two main Cardiac Centres in Wales (Cardiff and Swansea) who provide tertiary STEMI services for their own and neighbouring health boards. Patients who present with STEMI out of hours are transferred to the 24/7 catheter labs in Cardiff following initial assessment by WAST or in a local ED. This cohort therefore represents a group of patients who are amenable to treatment and who therefore would be expected to have a lower mortality than patients retained in the non-tertiary centres, who are not suitable for tertiary treatment, who are therefore likely to have a higher mortality rate.

The actual number of Health Board MI deaths (age 35-74) per month remains very small between 1 and 4 deaths each month since November 2021. The small number accounts for the volatility of the data.

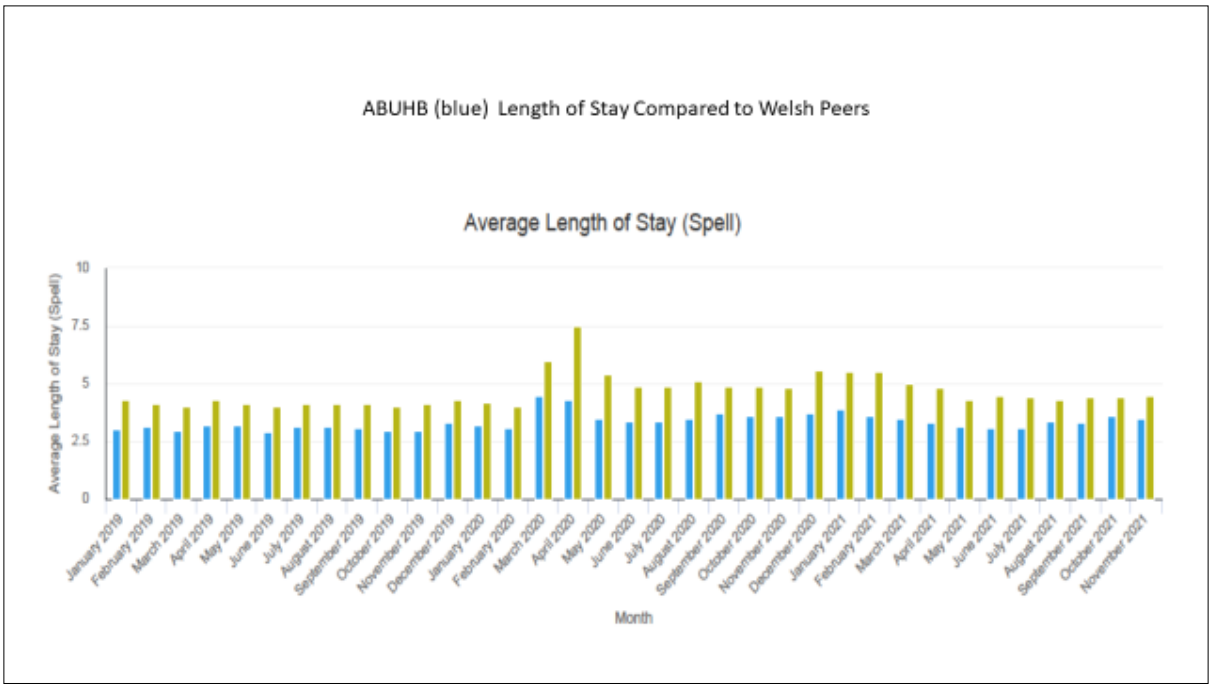


Readmission rates and Length of Stay



Readmissions to ABUHB hospitals is consistently higher than the 'all-Wales' comparative figure. The low figure for both in November 2021 should be discarded as this illustrated a 'coding lag'.

Conversely, average length of stay in the Health Board hospitals is generally lower than the Wales peer group. These 2 values often reflect each other, where shorter lengths of stay are reflected in higher readmission rates. The gap in readmission rates between the Health Board and Welsh peers seems to be narrowing, after a brief increase following opening of GUH. It is to be hoped that this improving trend will continue.

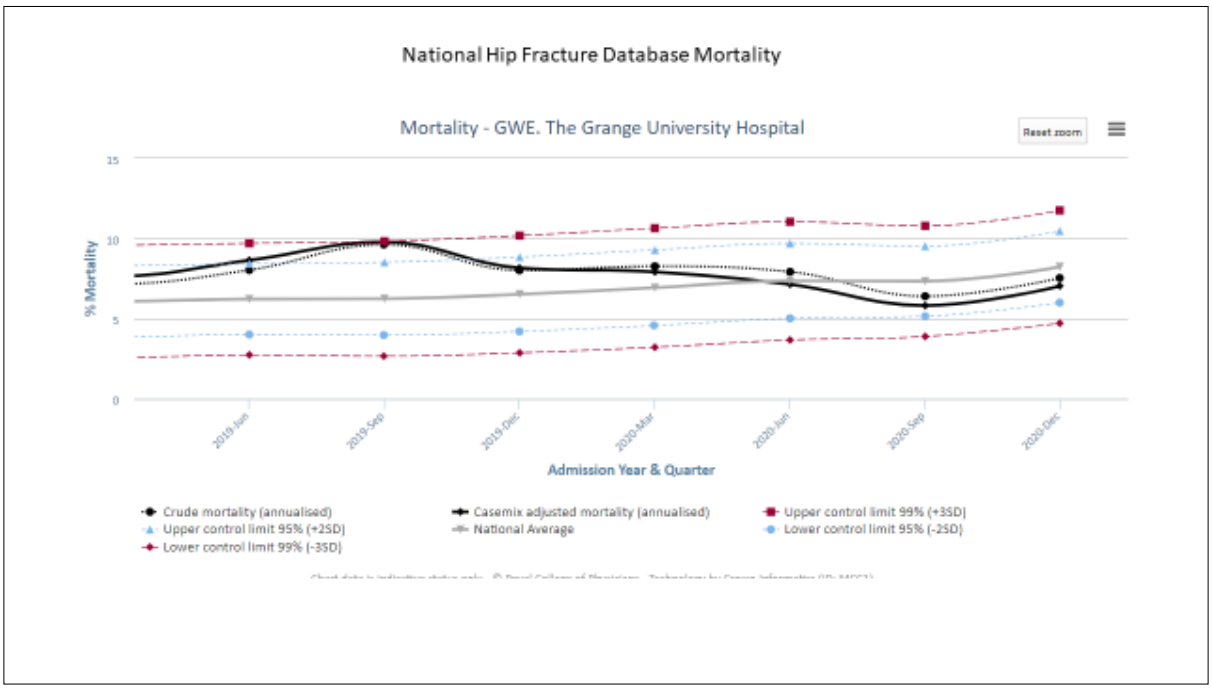


Further work is ongoing to embed and refine the hospital flow processes across the Health Board. This remains a focus of development for the Clinical Futures Programme and Divisional teams.

Patient outcome – Hip Fracture (NHFD) and Stroke (SSNaP)

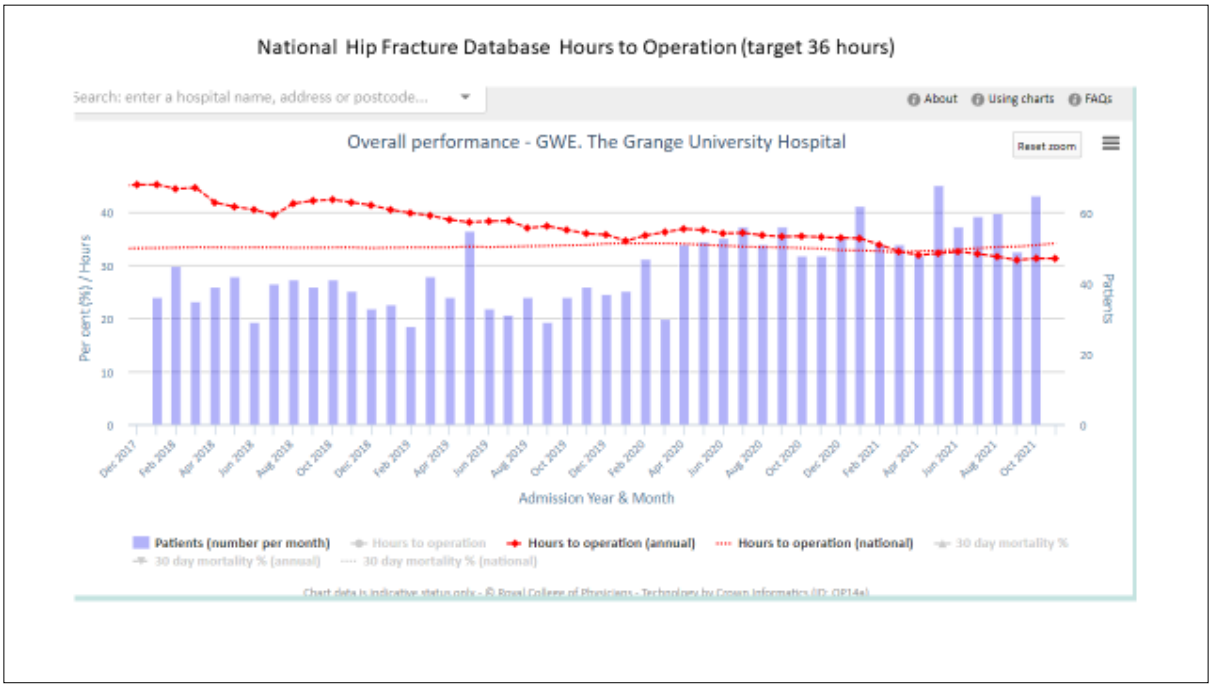
The NHFD is a peer reviewed, publicly available database of outcomes for patients who experience hip fractures.

The NHFD has noted an improvement in hip fracture mortality for patients in the Health Board, against the national trend of deterioration.



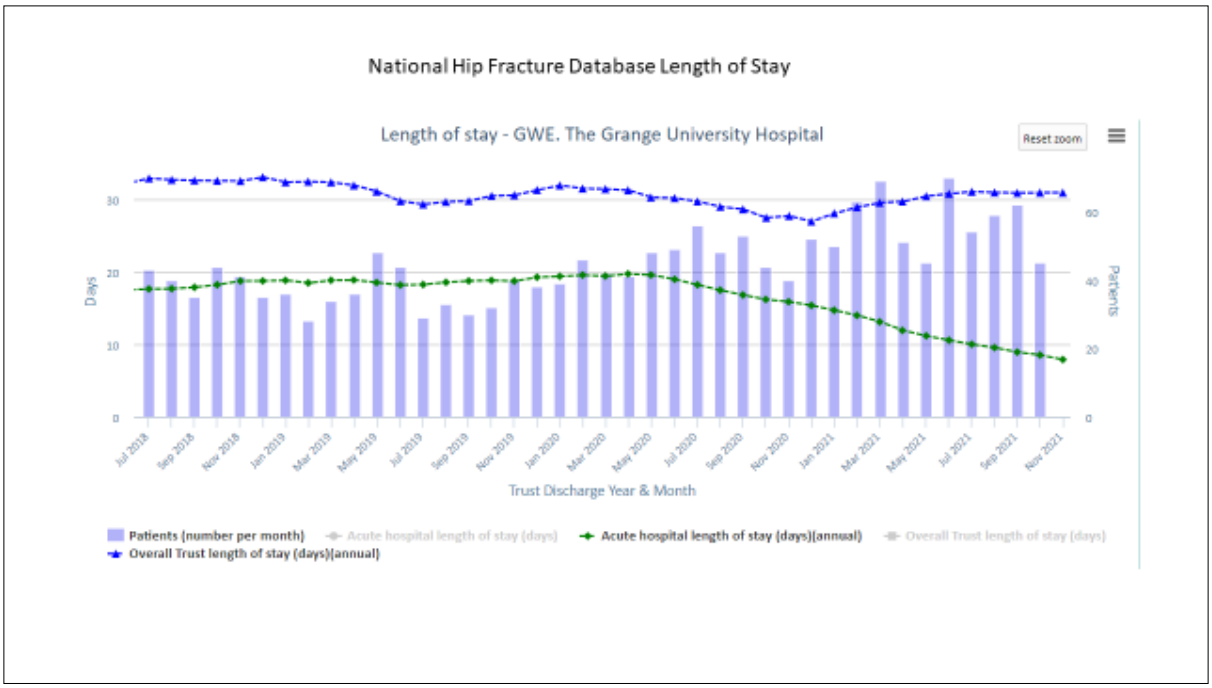
This chart illustrates that mortality in the Health Board has been improving in recent years. Information is released on a calendar year so 2021 is not yet available (GUH opened November 2020).

In addition, the database records a number of process indices for patients undergoing surgery following a hip fracture. Some of the key indicators are as follows:

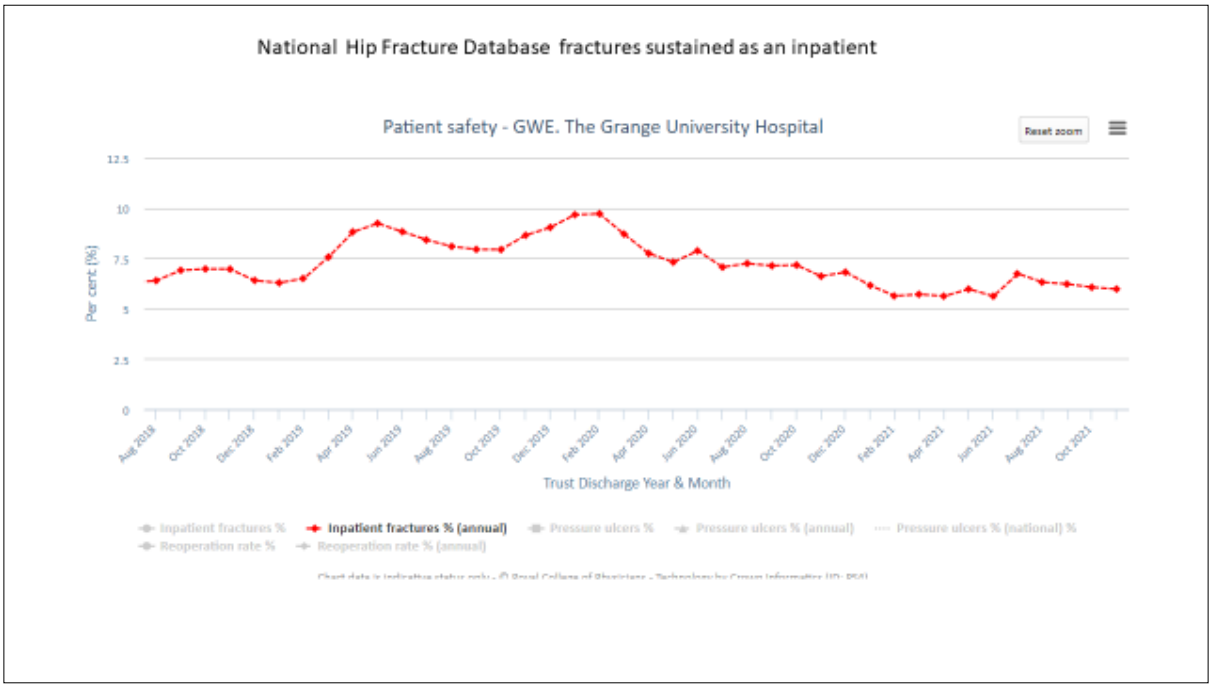


Hours to operation have improved over the past 12 months and are now lower the national average. Early surgery is a key factor in reducing mortality. The improvement in this metric observed since GUH opened will hopefully be reflected in a continuing trend of reducing mortality for the Health Board.

However, hospital stay following surgery has remained in the same range. So, whilst the service is responding quickly to patients requiring surgery in the GUH their overall hospital stay across the Health Board remains too long. This is an area of focus for clinical and operational teams.

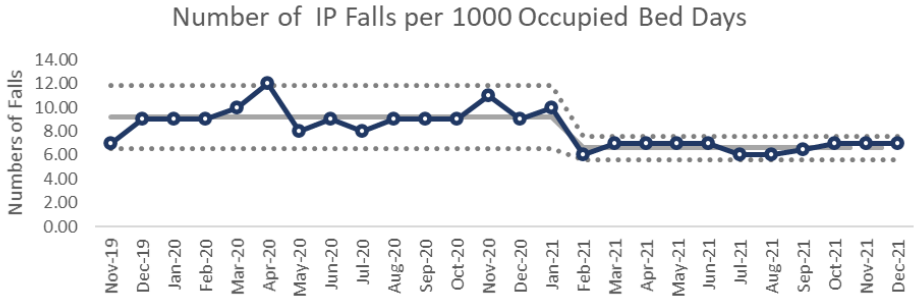


The NHFD also monitors hip fractures sustained whilst an inpatient in hospital across the Health Board. The below shows a decreasing trend from a peak in early 2020.

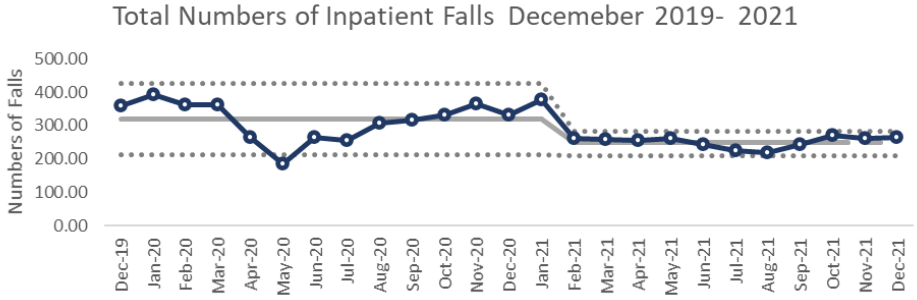


The process for monitoring inpatient falls continues on a weekly basis. Monthly control charts identify shifts and trends associated with the numbers of reported injurious fall incidents. All serious falls are discussed weekly at the Executive Team.

The graph below demonstrates the rate of inpatient falls per 1000 occupied bed days (OBD's) for the period December 2019-21. For the period since the opening of the GUH, in November 2020, there has been a sustained reduction in the overall number of IP falls.



With specific reference to falls incidents reported in GUH, the timescale provides a limited data set. It is, however, currently reflective of a trajectory which remains closely aligned to the average value. The figures are aligned to the redistribution of reported falls incidents allied to the changing functionality of the ELGH's in association with the GUH and as such has not promoted significant increases in the numbers of falls reported overall.



The complete data set, going forwards, will be monitored by the 'Hospital Falls and Bone Health Group' reporting to the Falls and Bone Health Committee, through its recently established governance structure.

The NHS Wales Delivery Unit (DU) provided a report on the Health Board stroke performance versus other Health Boards in Wales and the all Wales average. Summary performance is as below:

Quality Improvement Measures Summary — November 2021

72 Hour Pathway Quality Improvement Measures		Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
		The Grange	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Withybush	Glangwili	Prince Philip	Morriston	
Urgent Intervention	Percentage of stroke patients given thrombolysis (all stroke types)	16.1%	10.7%	4.5%	21.9%	6.0%	2.3%	9.1%	25.0%	16.7%	8.3%	0.0%	26.8%	12.4%
	Thrombolysed patients DTN <= 45 mins	30.0%	0.0%	0.0%	57.1%	0.0%	100.0%	100.0%	50.0%	100.0%	100.0%		9.1%	34.9%
	Percentage of patients scanned within 1 hour of clock start	43.5%	46.4%	36.4%	50.0%	46.0%	59.1%	54.5%	62.5%	58.3%	83.3%	85.7%	43.9%	51.0%
	Percentage of patients directly admitted to a stroke unit within 4 hours of clock start	8.2%	33.3%	22.7%	11.1%	6.8%	7.5%	0.0%	62.5%	66.7%	45.5%	46.2%	12.2%	17.4%
	Percentage of applicable patients who were given a swallow screen within 4 hours of clock start	56.7%	78.3%	68.4%	41.7%	42.0%	55.8%	70.6%	57.1%	83.3%	100.0%	100.0%	43.9%	58.5%
Urgent Assessment	Percentage of patients assessed by stroke specialist consultant physician within 24 hours of clock start	87.1%	64.3%	86.4%	71.9%	56.0%	72.7%	72.7%	87.5%	100.0%	100.0%	92.9%	95.1%	78.7%
	Assessed by one of OT, PT, SALT within 24 hours	43.5%	96.4%	90.9%	81.3%	82.0%	75.0%	90.9%	62.5%	100.0%	75.0%	100.0%	82.9%	77.2%
	Percentage of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start	94.4%	100.0%	100.0%	81.8%	94.4%	75.0%	83.3%	66.7%		71.4%	100.0%	71.4%	88.2%

The Health Board is above or close to the Wales average for 7 of the 8 indicators for the first 72 hour pathway measures.

The Health Board is, however, below all measures for Discharge Standards and Quality Improvement measures.

Quality Improvement Measures Summary — November 2021

Discharge Standards Quality Improvement Measures		Aneurin Bevan	Betsi Cadwaladr			Cardiff & Vale	Cwm Taf Morgannwg		Hywel Dda				Swansea Bay	All Wales
		The Grange	Bangor	Glan Clwyd	Wrexham Maelor	UHW	Prince Charles	Princess of Wales	Bronglais	Withybush	Glangwili	Prince Philip	Morriston	
Inpatient Rehab	*Compliance with patients receiving the required minutes for OT (3-month rolling)*	42.0%	42.9%	49.7%	37.0%	55.8%	88.9%	59.0%	50.7%	56.0%	67.8%	49.8%	59.5%	55.9%
	Compliance with patients receiving the required minutes for physiotherapy (3-month rolling)	39.7%	60.8%	51.9%	34.4%	66.2%	67.8%	43.7%	53.9%	98.6%	66.5%	57.1%	69.0%	59.5%
	Compliance with patients receiving the required minutes for SALT (3-month rolling)	15.5%	30.1%	43.1%	31.3%	31.1%	55.5%	26.2%	27.1%	58.8%	54.2%	25.4%	51.3%	34.7%
Discharge Standards	Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (exc. palliative care pts)	50.0%	80.0%	100.0%	91.7%	100.0%	91.7%	90.9%	100.0%	100.0%	100.0%	100.0%	50.0%	92.5%
	Percentage of patients discharged with ESD/Community Therapy Multidisciplinary Team	11.5%	4.2%	0.0%	2.1%	62.5%	50.0%	1.4%	5.0%	70.2%	0.0%	0.0%	47.9%	28.1%
	Percentage of patients treated by a stroke skilled Early Supported Discharge team	11.5%	2.1%	0.0%	0.0%	62.5%	42.7%	1.4%	0.0%	68.1%	0.0%	0.0%	43.8%	26.0%
	Percentage of patients discharged with a multidisciplinary community rehabilitation team	3.1%	4.2%	0.0%	2.1%	0.0%	9.8%	1.4%	5.0%	2.1%	0.0%	0.0%	4.2%	3.1%

(b) **Patient Experience**

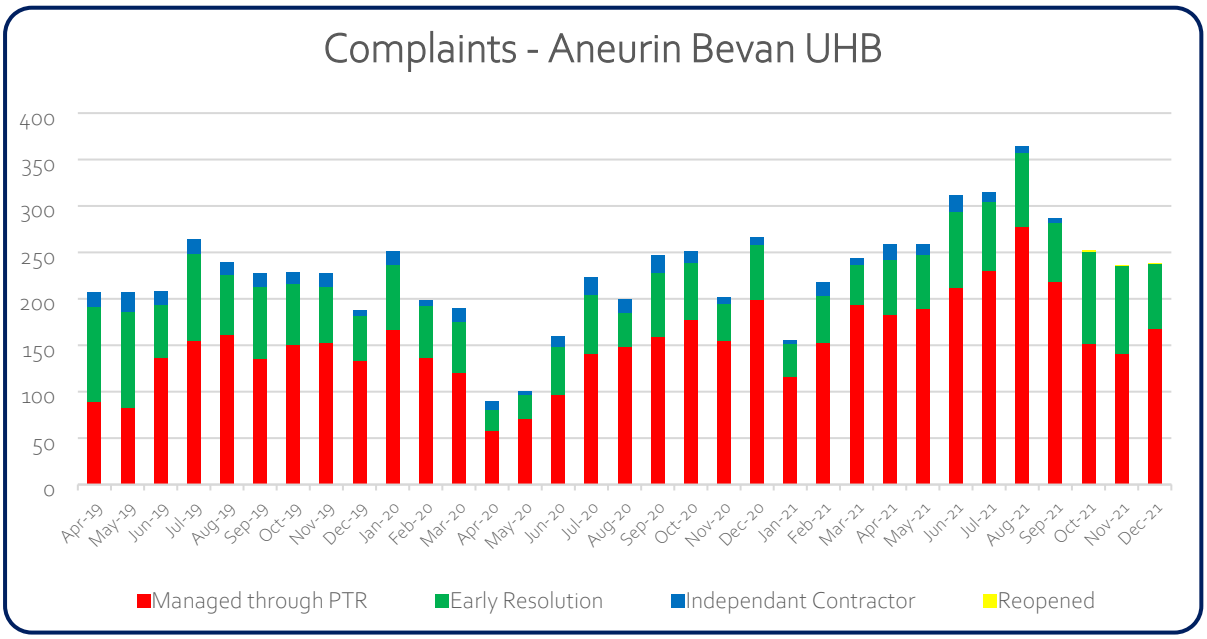
In addition to clinical outcomes described above, patient experience and listening and learning from feedback is also a key element of evaluating services and outcomes and a measure of the impact of the new system. The two main methods of evaluating patient experience in this report are formal complaints data and listening and learning from structured feedback through patient surveys and visits.

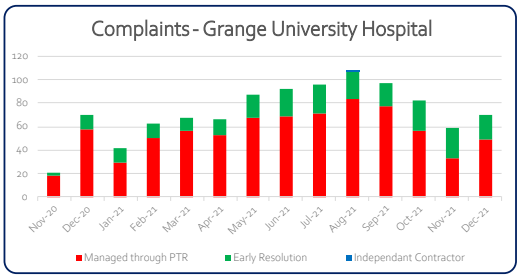
Whilst these are extremely helpful methods, the issues raised will be symptomatic of the challenges of the pandemic as well as a new system of healthcare being implemented. It will be difficult to separate these for some issues albeit some will be more relevant to the local situation versus others, that will be consistent with UK wide issues.

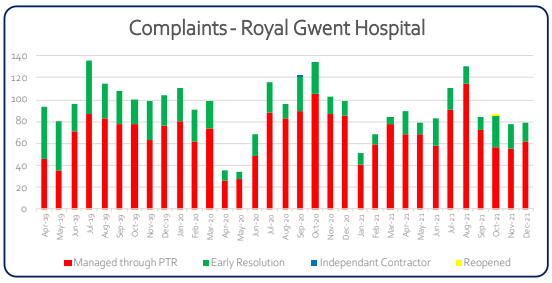
- **Formal and Informal Complaints**

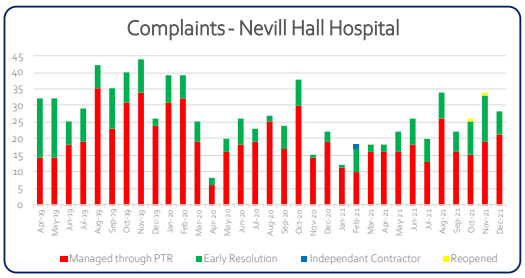
The number of complaints received by the Health Board is summarised in the following graphs since April 2019 through to December 2021.

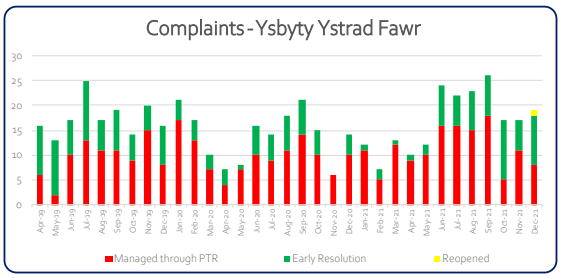
Graph 1 ABUHB Total Complaints





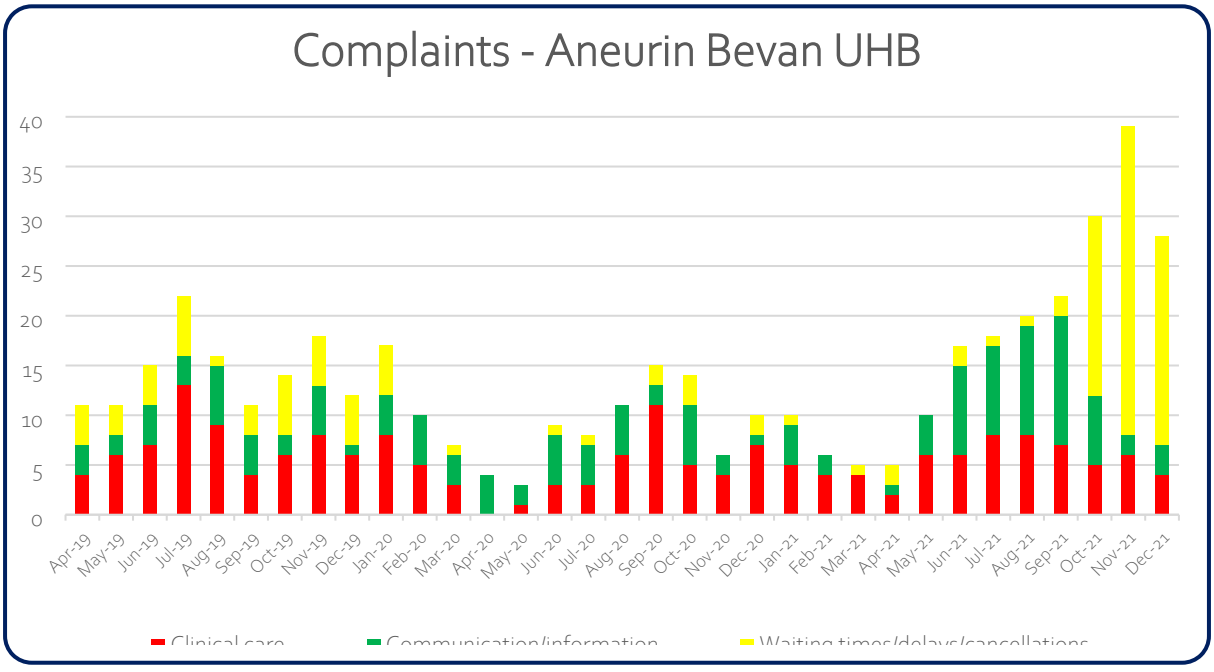


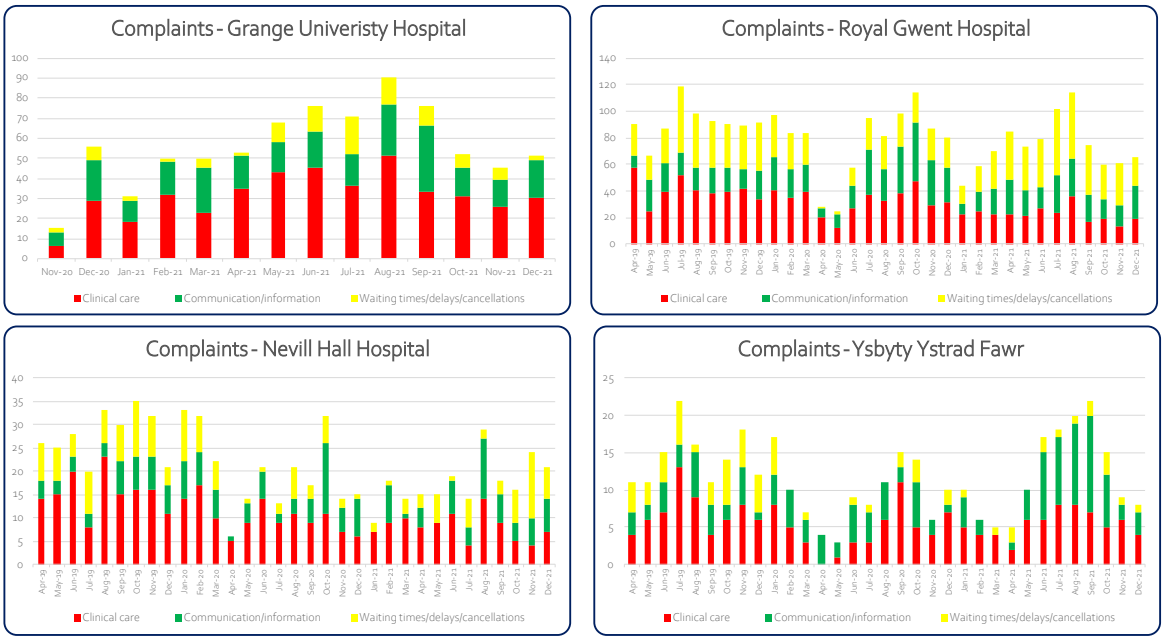




As identified from the above graphs the total number of complaints has been fairly static but with a peak around the summer of 2021. The supporting graphs also provide the number of complaints across the GUH and eLGHs.

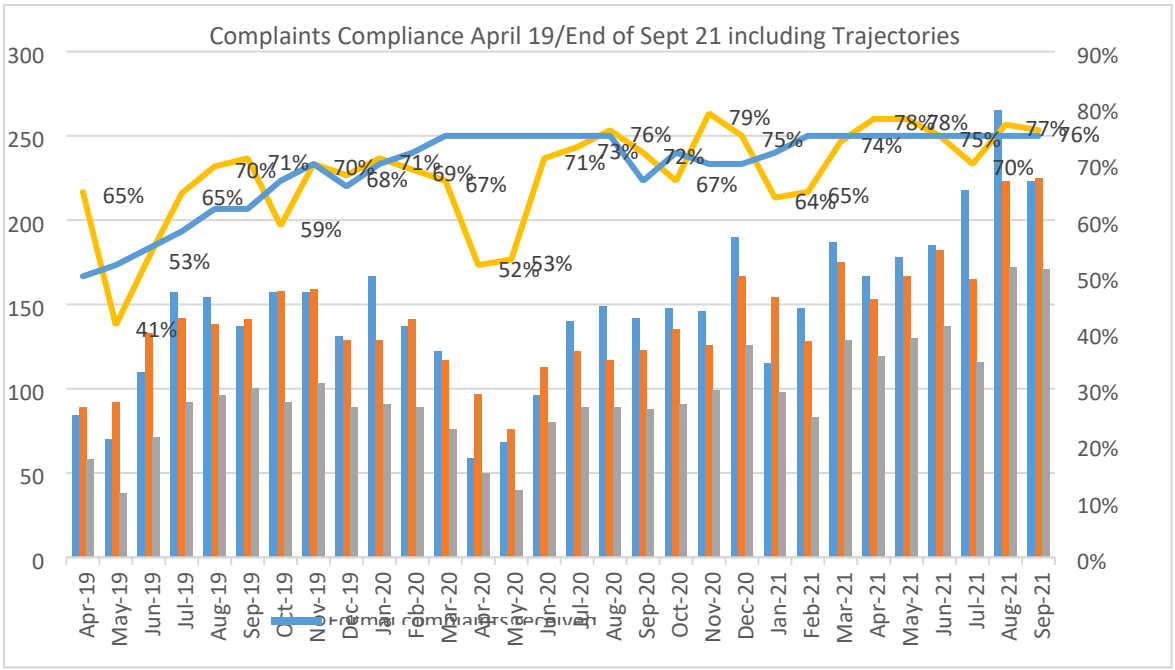
A large proportion of complaints are categorised as: clinical care, poor communication and long waiting times, all of which has been further impacted by the staffing challenges throughout Covid. An increasing number of complaints are more recently relating to long waiting times and delayed treatment.





Communication is also a common and growing feature in the complaints received, which is covered further in the report.

Overall compliance with the Putting Thigs Right (PTR) Regulations has continued to be above target and continues to be on an improving trajectory. The Putting Things Right Regulations (April 2011), require the Health Board to respond to complaints within 30 days, amongst other statutory requirements, to ensure the patient voice is heard and acted upon in a timely manner.



- **Patient Experience: Listening and Learning from feedback**

Peoples experience during Covid-19 has been impacted by the pandemic, both in hospital and across the community. An essential component of safe and compassionate person-centred care is listening to and responding to people's experience. Since the start of the pandemic and since the opening of the new hospital, a number of patient experience surveys have been undertaken to better understand patient experience across ABUHB. These have been undertaken through direct visits (where visiting restrictions allowed), through virtual 'buddying' with the Community Health Council (where patients were connected to a CHC Member through i-Pads) and postal surveys. There were a number of surveys specifically targeted at GUH patient experience but many other focusing on the wider system. 782 people provided feedback through these methods.

Date	Area	Method	Respondents
Sept-Oct 2020	LGH's	Virtual Buddying	96
Dec 2020	County Hospital	Survey	23
Jan 2021	Accident and Emergency Department GUH	Physical Visit	321
Jan 2021	Care at Home- Complex Care	Virtual Buddying	15
Jan 2021	Community Huntington's Disease	Postal Survey	12
January 2021	District Nursing	Postal Survey	158
March 2021	GUH Wards	Virtual Buddying	32
May/June 2021	ED Attendance Snapshot over 3 days GUH	Physical Attendance	56
June 2021	Mental Health and Learning Disabilities in Patients	Virtual Buddying	42
Oct 2021	Head and Neck Cancer- GUH	Postal Survey	27

Each of these surveys provided overwhelmingly positive feedback relating to staff attitude and compassionate care, with many respondents identifying staff going 'over and above' during very challenging times.

The main themes identified through patient feedback are:

- **Communication and information**, specifically relatives' ability to contact wards

As well as employing more ward clerks, Patient Liaison Officers for all hospital sites, with a specific role in supporting communication between wards and relatives, were introduced and have been extended to June 2022. All wards have been issued with i-pads to support relative to patient communication via digital connection.

- **Loneliness and isolation** - compounded by restricted visiting and absence of ward-based volunteering

Following the All-Wales Covid risk assessments, volunteers have been reintroduced to wards. Visiting with a purpose has also been implemented. Provision of TVs has been significantly increased across the Health Board particularly for those in single room environments.

- **A lack of meaningful activity**, increasing boredom and, for those with cognitive impairment, often an escalation in behaviours that challenge.

All wards now have access to online and physical meaningful activity resources. RITA units have been issued to all areas. An enhanced observation framework that embeds meaningful activity has been developed and is in use across all wards. TV's have been installed across the GUH.

- **Mobile /digital connection**- in the GUH initially, and on some mental health and general wards

Mobile telephony connectivity has been improved as has the mobile phone signal, with all major network providers upgraded to offer coverage across the GUH site (delayed due to early opening). A number of digital companion volunteers have been trained and are supporting patients with digital connectivity.

Additional to direct patient feedback, issues identified through concerns and complaints highlighted the negative impacts on patients who experienced numerous inter-hospital ward transfers and specific concerns in regard to person-centred dementia care. A transfer protocol has been developed to reduce ward moves. The In-Patient Dementia Group have refined the priorities within its action plan to focus on the fundamentals of care for those people living with dementia in general wards. This has influenced the introduction of ward-based Dementia Companion volunteers.

There are ongoing discussions to support the implementation of a digital platform to gather patient experience across the Health Board. A business

case is being prepared to inform the consideration of the Once for Wales Citizen Feedback Platform, provided by CIVICA as the preferred system.

A summary of responding and listening to patient feedback is attached as Appendix 3.

Summary

Issues	Actions
• Patient Outcomes broadly positive,high performing (vs Wales) and improving in a number of areas i.e. mortality, NHFD, • NHFD overall positive but high rates of fractures in community required further work to reduce harm and risk • Stroke services an area of further improvement on key access and outcome measures • Waiting times remain a key concern for patients both for planned and unplanned care. The pandemic impact on waiting lists is a key concerns for those waiting and the challenges in accessing urgent care for COVID and non COVID reasons also is a key cause of concern for residents. • Communication with relatives in hospital has been a significant area of concern through the pandemic and the GUH specifically. COVID restrictions on visiting and telephony challenges were not easily addressed in the initial phases of the hospitals operation.	• Continued work of falls and stroke improvement groups working across hospital and community services with partners to reduce incidence and improve outcomes and onward care • The establishment of a formal Planned Care recovery oversight Programme as part of the revised Clinical Futures portfolio will focus on Planned Care recovery and support for patients whilst awaiting surgery including optimising their health pre surgery • The continued work of the Urgent Care Board focussed on the urgent care system and waiting times for ambulances and ED. Improved performance is in place over the past 3 months since the 12 months of the GUH but more work is to be done to improve the patient experience from long waits. • Appendix 3 outlines the detailed work and changes and support that have and continue to be made to improve families access to communication with relatives who are receiving inpatient care in our services

6.3. Improve the local provision of services and minimize travel times for access to health services, and in particular, hospital and specialist services

One of the key focuses for the Clinical Futures Programme following commissioning of GUH has been to support the transition of enhanced Local General Hospital's (eLGH) sites to enable delivery of the agreed services and maximise care closer to home where possible.

Despite the challenges of the pandemic there has been growth in the breadth of services available at our eLGH sites, offering a wider range of urgent and planned services closer to home.

Importantly the development of our eLGH sites has enabled service recovery, when pandemic pressures has allowed, with the ability to offer green elective capacity in the Royal Gwent Hospital and effective streaming of care through Nevill Hall and the YYF.

Better Access to Urgent Care Close to home

The urgent care offer on our eLGH sites is a core component of our Clinical Futures Model. For patients who do not need to attend A&E, having accessible 24/7 access to a range of urgent care service to keep them well in their communities is vitally important. This is why the organisation has significantly developed the urgent care offering on our sites over the last 12 months.

Urgent Primary Care Centres (UPCC) on a 24/7 basis have been established in Nevill Hall and the Royal Gwent Hospitals. This means a wide multidisciplinary team consisting of a GP, Nurse Practitioner, Mental Health Practitioner and Physiotherapist are available to the public via a contact system. Patients are booked into an appointment to be seen at the UPCC through the "Phone First" system and clinical hub meeting, the ambitions of care closer to home and right place first time. Phase one of the service went live in December 2020 with phase 2 in May 2021.

- Total patients managed via Contact First 6,516.
- 77.6% of patients routed via the Contact First Hub are managed in alternative pathways to ED.
- 30.4% of these patients are managed via the Urgent Primary Care Centres.
- 40.2% of patients are managed via MIU.
- 6.4% of patients directly admitted to secondary care.
- 0.72% of patients are managed by another professional such as Optician or Community Dentist.

In addition, the Urgent Primary Care Centres have been able to support 111 pulling through from calls to the 111 service. The Urgent Primary Care Centres have managed 30.4% of the patients that have accessed the Think 111 First service, this evidences some of the whole system impact that the Urgent Primary Care pathfinder linked with Think 111 first can have on the wider system. Without the model in place these patients may have had extended wait times within ED or MIU's, in addition this releases capacity within ED to manage the patients that need emergency care most.

Another core component of the front door offer of our eLGHs is Minor Injuries and Medical Assessment Units. The Medical Assessment Units support a selected take of patients directly from General Practice. All 3 eLGHs have seen a step change increase in MAU activity since April 2021, with a corresponding decrease in GUH MAU activity. This indicates the system is moving to performance more as originally designed as a decentralised medical assessment and admissions service away from the main ED. Of Patients admitted to Medical Assessment Units 60% for RGH, 52% for NHH and 53% for YYF do not progress into any other wards in the hospital

In an average month of 12000 attendances roughly 7000 are attending GUH and 5000 to the eLGHs. This represents around 45% of those who previously would have attended NHH and RGH and are now almost always seen within 4 hours.

The MAUs at the eLGHs were planned to close the GP take at 10pm at which point all GP admissions would be directed to GUH. Due to some of the delays by WAST associated with system wide pressures many "green" categorised patients would be conveyed after 10pm resulting in increased presentation to GUH and then requiring transfer to an eLGH in the morning. The MAU opening times were changed to 24/7 to mitigate the risks of increased GUH attendance and long ambulance waits however this is now repenting challenges around medical staff capacity and skills linked to junior doctor training requirements. This is a key focus of work to ensure a 4 site model can be sustained.

eLGH System Role

Each of the eLGH sites plays a core role in our system and we have seen these further develop over the last year. The Royal Gwent Hospital has played a crucial role in maintaining elective surgery, with the development of an onsite Post Operative Care Unit (POCU) enabling a greater level of surgery to be performed on the site. Similarly Nevill Hall Hospital is developing as a centre of excellence for day surgery with increasing numbers of procedures being delivered at the site.

During the pandemic waves we have had to adapt the sites to meet the population need. YYF due to its single room design has operated as our main Covid 19 site, enabling effective infection prevention control and streamlining of pathways.

In line with the Clinical Futures model the eLGH sites are increasingly playing a role in the delivery of ambulatory models of care. For example the new women's ambulatory care unit in NHH is unique in Wales and has continued to evolve despite Covid and it now delivers a range of procedures in the unit that would have normally happened in theatre. Through upskilling of staff and introduction of new pathways and protocols since March last year, it treated 192 patients, many of which would normally have been seen in theatre. Over the next 6 months it will treat a minimum of a further 96 patients in 24 clinics and it continues to be scaled up introducing new procedures.

In addition, plans are developing for the eLGH sites to deliver Health Board wide specialist services in purpose built facilities. There is significant Welsh Government capital investment committed to delivering a Unified Breast Care Centre at YYF and the development of a Satellite Radiotherapy Centre at NHH. In addition, plans are progressing to establish a Regional Eye Care Unit at NHH.

Critical Care capacity

The early opening of the GUH in November 2020, and the merging of both intensive care units from NHH and RGH, facilitated an increase in critical care capacity, from 22 beds to 24. Managing critical care on a single site has most certainly improved the flexibility in managing level 2/3 patients. This has been particularly beneficial in managing the demand associated with the COVID-19 pandemic.

Inter-Hospital Patient Transfers

It is pleasing to note, no patients have been transferred out of ABUHB critical care unit for capacity reasons since opening the Grange University Hospital in November 2020. There are times when we are required to send tertiary care cases to UHW, if beds are available. This tends to be patients requiring cardiology input, renal for dialysis and long-term ventilation.

The Health Board have provided mutual support accepting and repatriating patients from other health boards, due to their lack of capacity, which has eased pressure in other critical care units across Wales, UHW.

The Health Board have received extremely positive feedback from the critical care network in regards the mutual aid support offered to other

organisations – to date ABUHB have accepted the highest number of critical care patients across Wales.

Travel Times and Public Transport

Whilst there is a strong focus on the role of eLGHs and services provided locally the centralisation of services at GUH does require many patients to travel further to access care.

The Health Board liaised with Local authorities and private transport providers to influence the public transport provision and to improve the transport links from local communities to the GUH. Whilst there is a regular service from Newport bus station and Cwmbran train station, the areas of Blaenau Gwent and Caerphilly have poor public transport links to GUH which has been further impacted during the pandemic. The Health Board has been successful in working with partners to increase the provision of community transport in these areas to support patients and families in accessing services. This may become more of an issue when patient visiting returns to normal. An evaluation and potential expansion of the community transport model may be required. Additional car parking was also secured before the opening of the new hospital. This is being closely monitored especially in the context of additional parking being required during the pandemic due to limited car sharing and public transport options.

There has been feedback from the Blaenau Gwent and Caerphilly population around access to neighbouring hospitals in CTM and C&V (both with whom there are well established contracting arrangements) due to their closer proximity than the GUH. At an appropriate time we will review travel times and public feedback on current and potential patient flows across the system taking into account the benefits of continuity of care as well as location.

Summary

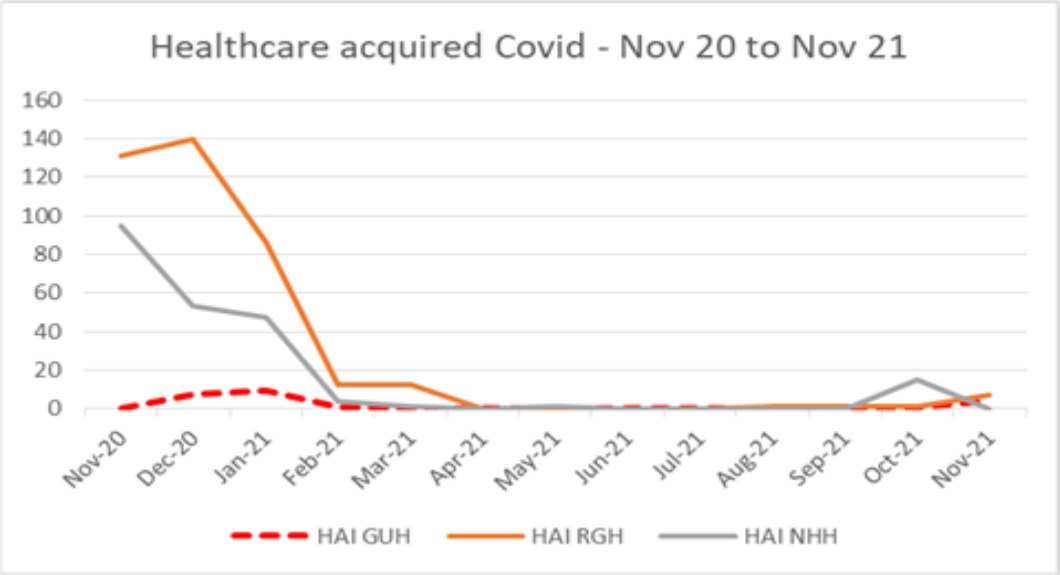
Issues	Actions
• Flow Centre as a new service, developing communications plan and reviewing access and sustainability of workforce model. • Concerns from patients and residents from Caerphilly borough over access to GUH via road and public transport • Transfer of patients between hospitals and has been a	• Stabilisation and optimisation of Flow Centre and Think 111 through Urgent Care Improvement Board • Reinstitution of communications and engagement plan to advice residents on the most appropriate access points to urgent care to be carried out. • Reinforcement of access to alternative Health Board sites

concern, both in terms of frequency and timeliness of transfer and the communication with relatives of patients moving through the system.	which are closer to patients has been actioned. • Travel times and experiences of patients and relatives will be re reviewed as services return and COVID restrictions ease. Community transport projects being developed and evaluated • Establishment of eLGH Network programme to review transfer protocols and requirements of patient movement through the system.

6.4. To deliver a fit for purpose environment for patients and staff, which is NEAT and AEDET compliant

The design of the GUH was carefully considered to provide the highest standards of air and space segregation, with a significantly higher proportion of single roomed accommodation than any other hospital in Wales. This section considers the Infection and Prevention and Control (IPAC) information over the 12 month period since the hospital has been in operation.

Hospital Acquired COVID

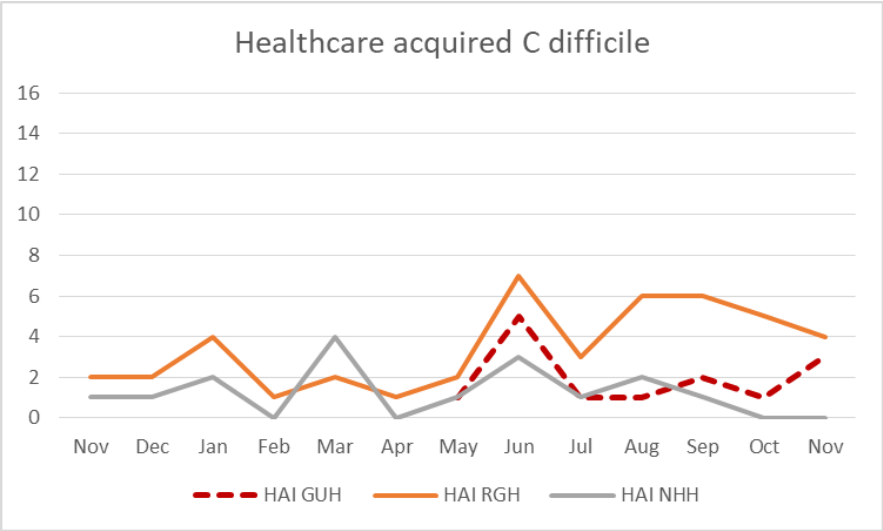


The number of healthcare acquired Covid-19 cases at GUH is significantly lower than other acute sites within ABUHB. There has been one outbreak to note where several patients within the same pod tested positive and the learning associated with this outbreak was a patient who was identified

positive on admission was cared for in the bay area. All other cases on GUH have been sporadic.

The Infection Prevention and Control Team review each case and examine the possible root cause of the incident and learning is shared at the local bronze meetings and the Reducing Nosocomial Transmission Group (RNTG). Contributing factors to the low numbers is due to the majority of patients being cared for in single rooms, good ventilation, admission screening and testing, strict visitor policy and adherence to Covid measures.

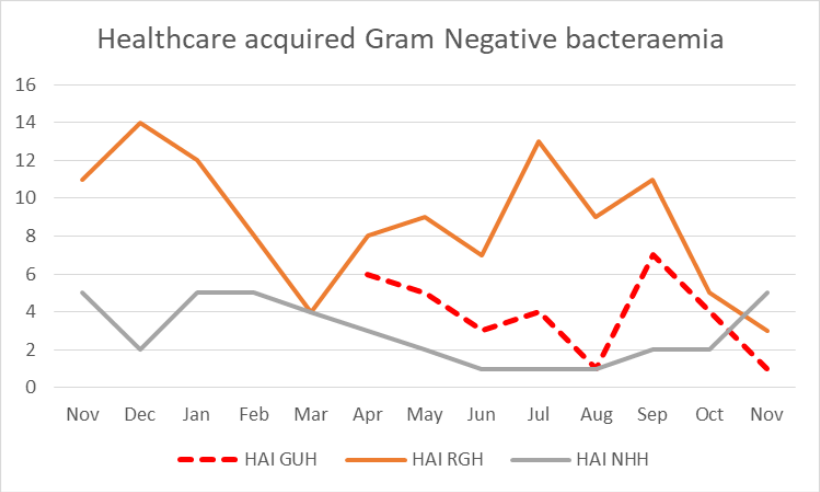
C difficile



Graphs displays cases of C difficile in acute hospitals for period Nov-2019 to Nov-2020 compared to the year of GUH opening.

There has been one outbreak of C difficile on ward A4 in June 2021. Other cases have been individual and sporadic. Maintaining a focus on prudent antimicrobial stewardship, patient assessment and fundamental infection prevention measures was the findings of the outbreak review meeting. Although anecdotal, the extent of the spread was significantly lower than could have been envisaged in more traditional ward layouts without single rooms.

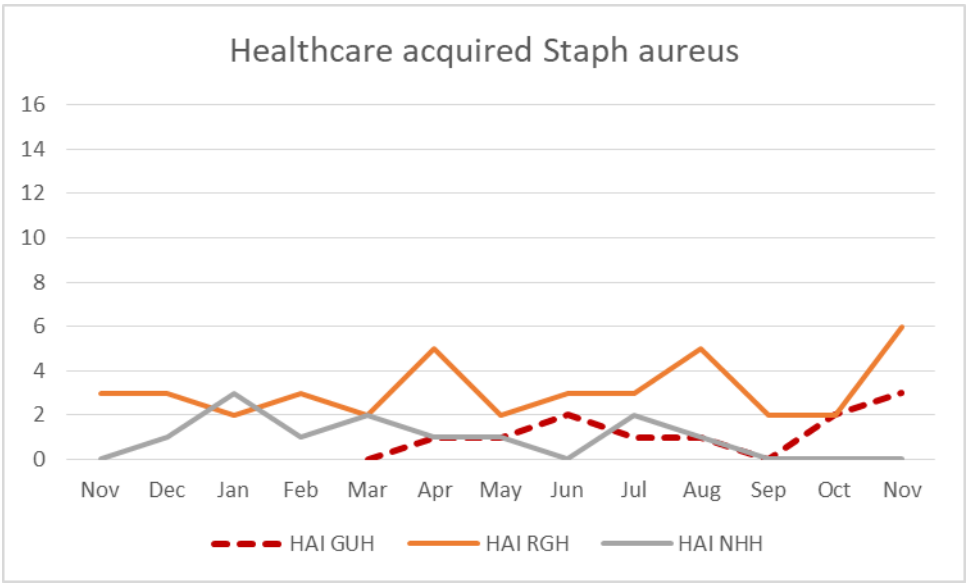
Gram Negative bacteraeamia



All sporadic cases of gram-negative bacteraemia have been linked to the patients' medical condition i.e chest infection or biliary sepsis. Of those identified as urinary tract infection there has been two patients associated with a urinary catheter. A focus on the urinary catheter bundle and Aseptic Non Touch Technique (ANTT) has been supported.

Staph Aureus

There have been no reports of MRSA bacteraemia at GUH. All sporadic cases of MSSA are often linked to the patient's medical condition, however there has been two line infections. The IPAC team have reviewed ANTT practice and documentation of care bundles in these areas.



Within GUH there has been a rolling programme of education highlighting the importance of the concordance with key IPAC measures and recognising that single rooms do not eliminate all risks.

Benefits of Single room

Single rooms have a benefit to patients not only reducing the risk of onward hospital transmission of infection but also for patients' dignity and privacy. Single rooms in the Grange University Hospital (of which there are 24 of the 32 beds on each standard ward) have ensuite and bays have shared ensuite facilities. This significantly reduces the risk of infections such as C difficile and gram negative bacteraemias, where patients carry the bacteria within their normal gut flora. The good estates are another contributing factor to risk reduction for patients, as the environment is easy to clean and maintain. Within the GUH there is ventilation that meets national standards, again reducing the risk of onwards airborne/respiratory infection. The number of single rooms allows patients to be isolated quickly which further prevents onward hospital transmission.

Summary

Issues	**Actions**
• Low levels of HCAI disease (Covid) on GUH site not replicated on other sites. Impact of different environmental standards on eLGH sites from GUH	• Maintain good practice methods and approaches in addition to the benefit single room accommodation at GUH brings • Consider refurbishment programme of eLGH sites in line with revised service models to improve IPAC

6.5. Support a workforce model that is sustainable, and complies with the European Time Directive and Deanery requirements

Workforce Sustainability

In opening GUH early and commencing roll out of the system wide model, the benefits of centralisation of some services provided the intended workforce resilience and sustainability. These include:

- Sustainability and improved safety achieved for Paediatrics and Obstetrics. Both services were under significant pressures running a two site model pre-pandemic which escalated following the first wave with a real risk of collapse in the winter 2020/21 without centralisation.
- Improved workforce resilience for Critical Care and ability to meet Covid demand within its own footprint.
- Improved workforce resilience through centralisation or additional investment in staff for Emergency Department, Respiratory,

Gastroenterology, Cardiology and within Emergency Surgery for many specialist consultant posts.
- Improved nurse recruitment at GUH with low numbers of registered nurse vacancies.
- Ability to offer new roles in new services e.g. POCU.

Recruitment

The new system model has provided the Health Board with an attractive new offer to recruit staff with the GUH becoming a beacon site in Wales. This is highlighted below:

- A positive influence on our ability to recruit clinical and non-clinical staff with 241 additional posts recruited to the new system (91% of all posts required).
- Reduced RN vacancies from 336wte (April 20) to 150wte (Sept 21) with newly qualified and overseas nurses reducing the vacancies across wider areas and sites.
- Additional HCSWs recruited
- A "People First" approach to change management processes, offering preferences and choice to existing staff, where possible, to support retention. This was critically important as the majority of staff at GUH were redeployed from other sites.

However, whilst we have had some success in the recruitment market, the pandemic has presented many workforce challenges. This includes restricted staff movement across Covid pathways, high levels of staff absence, shielding and more latterly fatigue. Due to staff absence and the requirement to open additional capacity to comply with infection prevention control guidelines there has been a heavy reliance on variable pay through bank and agency contracts. An additional circa 1000 bank workers and further agency workers have been engaged to support the service models and demand throughout pandemic. Colleagues have shown remarkable commitment and dedication to ensure continuation of service delivery and many times have gone above and beyond to ensure patient safety.

Workforce Challenges

Health Education Improvement Wales (HEIW) have been visiting Health Board sites where post-graduate medical training is delivered, Nevill Hall Hospital (NHH), The Royal Gwent Hospital (RGH), Ysbyty Ystrad Fawr (YYF) and The Grange University Hospital (GUH). These visits took place within 12 months of the GUH being operational, the overall changes to the health care system, and the changes for those trainee's working within those sites.

The Royal College of Physicians (RCP) undertook a virtual visit to the GUH, in June 2021, and published a report of their findings. In December 2021, the RCP provided a 6-month follow-up report to the Health Board.

The initial reports undertaken in the spring, 6 months into operation of the new system, raised a number of concerns regarding training, overall staffing numbers and working arrangements.

There are encouraging aspects to both follow up reports; including that most trainees would "recommend the post to a friend". This reflects a clear improvement on responses provided by trainees in the spring. Several issues regarding service resilience and training have been raised and these will be to be addressed.

Following receipt of the official HEIW report, along with the follow up RCP report, work has been undertaken to review the documents in detail and formulate actions that address the concerns raised.

A detailed action plan and work programme was developed to address these issues raised in the reports. Reassuringly some of the most significant issues are already being addressed via the different working groups, including:

- Inter hospital transfer processes
- Rota management and vacancies
- MIU safety
- Patient transfers working group
- People first initiative
- Safer staffing work stream.

The latter identified the need to accelerate additional workforce investment in the junior doctor workforce into non training grades. It also highlighted the need for Physicians Associate roles to complement existing medical staff and reinforce rota structures and teams across all sites.

The reports highlight the challenges of adding an additional hospital to the health care system in Gwent during a pandemic, but reassuringly much of what was identified as needing response echoed those recognised by the Health Board and was in the process of being addressed. The report has helped to tailor the planned subsequent work to appropriately respond to concerns.

Work is currently focussing on ensuring that robust Hospital at Night/Out of Hours workforce models are developed for all sites, but particularly the eLGH sites. The SDEC model now being progressed by the Health Board also are key to the system offering and workforce deployment. This alongside significant successful recruitment as detailed above is intended to alleviate and address much of the report findings.

Staff Wellbeing Survey

Since the start of the pandemic the Health Board has prioritised increasing the capacity and widening the reach of its wellbeing offer to staff. To inform the relevance of this offer we have surveyed our staff regularly to allow an opportunity to express their wellbeing concerns. This has allowed us to shape and modify our wellbeing interventions to provide the most appropriate support.

Issues related to increased workload, lack of suitable staffing and increased patient demand as well as concerns relating to the care of COVID patients and associated system reconfigurations all feature in responses.

This is all reflective of a broader picture across NHS Wales and the Health and Care sector as a whole and highlights the challenges we have in sustaining and supporting our workforce through the pandemic period and beyond.

In relation to the GUH, 288 of the 1956 respondents to the November 2021 survey stated it as their main place of work. More detailed analysis (anonymous) of their responses to the 21 questions has revealed several themes, summarised as follows:

- Concerns about rest/non clinical environment and space
- Development of the 'GUH culture', how is this being supported?
- Office accommodation and ability to 'break out' in teams
- Staff catering; availability, quality/healthy choices, space to eat
- Development of a safety first culture
- Challenges in staffing all shifts *(pandemic)*
- Transport (public) to site
- Positive teaching and learning environment for developing new teams
- Questions over Clinical Futures model and deliverability *(pandemic)*

The overall Health Board response was 25.55% of staff felt they were "fatigued and unclear how they can sustain their role", this was 30% when just considering the GUH staff response.

The Health Board is keen to ensure that, particularly after the unprecedented and pressured 2 years of the pandemic, our staff are looked after, in a conducive and caring environment.

Actions are in hand to address some of these issues where possible. We have worked with staff to address issues in relation to office accommodation, break out and rest space as well as key staff facilities. Work to provide a wellbeing space for staff has been prioritised and work to adapt space at Grange House is already underway. This is also driving a Health Board wide focus on staff wellbeing areas and facilities.

We have actively launched a dedicated staff engagement programme to connect with staff. The #PeopleFirst programme will continue to be rolled out across the Health Board, each with a member of the Executive team present to participate and lead the sessions in its initial stages.

Staffing and teaching concerns identified by our staff and echoed in the HEIW and RCP reports should be addressed in part by the successful recruitment to key roles across the organisation.

The GUH Arts Strategy has now been delivered - with commissioned bespoke arts interventions to support the health and wellbeing of our patients, visitors and staff. This investment has successfully supported creative engagement and therapeutic environments specifically for the Grange.

As the direct impact of Covid hopefully reduces, with hospital Covid pathways streamlined, it is hoped the impact on rest and non-clinical areas is lessened, as well as the ability to offer a broader catering provision.

The above actions and continuing to invest in our staff wellbeing and working environment after a challenging time, will help to boost morale and improve wellbeing levels across the Health Board.

Summary

Issues	**Actions**
• Recruitment positive in GUH but remains challenged in a number of other workforce areas and locations linked to national skills shortages • HEIW and RCP concerns around junior medical trainee experiences at the GUH and other HB sites in terms of levels of cover, support and supervision have been received. • Staff Survey highlighted a number of concerns with both GUH and Health Board wide working arrangements. Key issues included, culture, rest and opportunities for space for non clinical work. Refreshment	• eLGH Network group to review workforce requirements and collective site wide impacts of individual service changes on recruitment position • Medical Workforce action plan in place developed with junior doctor input and senior clinical leaders • eLGH Network and Urgent Care Transformation to consider medical workforce models on GUH and eLGH sites and opportunities for enhancement and addition of other professional groups to integrated out of hours models of care.

and break facilities on GUH site also an area of concern.	• People First programme to review Staff Survey and establishment of revised programme to improve staff experience

6.6. To improve and expand provision of community based alternatives to hospital services

Flow Centre

The Flow Centre was originally set up during the first wave of the Covid pandemic and has evolved since then to deliver its intended purpose of supporting the wider AB system. The Flow Centre is crucial to the current successful implementation of AB patient pathways by pre-hospital streaming urgent same day attendances to the right place for their exact clinical needs and delivering the comprehensive inter-site transfer system.

Pre-Hospital Streaming service was initially brought in to support the initial Covid response, ensuring patients were being streamed to the correct healthcare facility for their requirements, either from General Practitioners within the community or from a WAST referral.

For the opening of the GUH and system wide change, the Flow Centre expanded to offer a full 24/7 Pre-Hospital Streaming and Inter-site transport coordination service which is clinically led, aligned to the WAST-delivered inter-site service and utilise digital technology to facilitate system-wide operational planning.

Since starting in November 2020, the Flow Centre has processed between 70 and 160 pre-hospital streaming calls per day, and receives between 15 and 65 calls regarding inter-site transfers a day. This is a lower volume of calls than anticipated partly as the step down process has changed to a predominantly email-based booking system, and as the volume of step up transfers required has not been as high as predicted.

Although the call volume is lower, the time required for each transfer to be clinically assessed, logged, booked and tracked to completion is longer than anticipated. In addition, the Flow Centre team participate in 5 times daily site meetings and are in regular contact with hospital sites.

Whilst in early days, the Flow Centre is seen as a success of the systemwide change and has generated interest from across Wales as a future model. Continuous work has been undertaken to evolve and clarify processes and approaches. As the Flow Centre refines, the service is being utilised more

by colleagues across the health care system to avoid unnecessary pressures on secondary care.

Urgent Primary Care Centres

The model was aligned to the Clinical Futures aims of care closer to home, and right place first time. Patients are booked into an appointment to be seen at the UPCC through the "Contact First" system and clinical hub. It was imperative that there was a clear pathway from the Clinical Review Hub to an Urgent Primary Care Centre, ensuring that patients could be reviewed face to face if required by a member of the multidisciplinary team.

Phase 1 Royal Gwent Urgent Primary Care Centre

The Urgent Primary Care Service launched phase 1 of the pathfinder on the 16th November 2020 within RGH. Aligned to the model the service launched with a GP, Nurse Practitioner and non-clinical Receptionist within the Urgent Care Centre. This structure has been supported by a Senior Programme Manager, Clinical Director, Senior Nurse, Business Support Manager and shift lead, supported by the wider Urgent Primary Care service.

The service was launched a day earlier than the proposed launch on the 17 November 2020. This allowed the team to become established and start to make early links with the Minor Injuries Unit (MIU) team at RGH prior to the opening of The Grange University Hospital (GUH) on the 17 November 2020.

This early implementation has proved invaluable to building relationships, especially due to the initial location of the Urgent Primary Care Centre within Main Outpatients RGH. It was hoped that the two services could become part of the front door model from the outset but due to the series of moves to GUH this was not possible. With the collaborative working between Urgent Primary Care and MIU, it is believed that there is no negative impact from this, and the Urgent Primary Care Centre re-located to within the front door footprint within RGH on the 16 December 2020.
The relocation to the front door footprint has enhanced already embedded working relationships between departments and allowed a smoother transition through the pathway for patients, with less distance to travel for patients if requiring a face to face appointment. This enhances the safety and patient experience of the patients presenting.

Phase 2 Nevill Hall Urgent Primary Care Centre

The Urgent Primary Care Centre within NHH launched on the 14 December 2020. The UPCC located within the Outpatients department, in close proximity to the MIU unit and part of the front door footprint. On assessing phase 1 of the model for the department to be within close proximity of the MIU department was key for patient journey and experience, in addition to close working staff relationships.

NHH UPCC launched with a GP and Receptionist initially, recruitment was initially ongoing for Nurse Practitioners and subsequently 2.6 WTE Nurse Practitioners have been appointed into the pathfinder model. With the appointment of additional Nurse Practitioners this has enabled the expansion of the Multidisciplinary team in order to support additional pathways as the pathfinder progresses.

Links to Think 111 First/Contact First

In addition to the Urgent Primary Care Centres the management of the Think 111 First pilot, within AB transferred to Urgent Primary Care and launched on the 15 December 2020.

Think 111 First manages the flow of patients from 111 with existing ED and MIU outcomes and navigates patients to the most appropriate route of care for their needs.

Additional workstreams developed:

- Trial support for test of concept in-hours practice escalation – daily triage of patients within Managed Practice
- Support for ad-hoc in hours GP Practice escalation
- Medical cover for the Step Closer to Home Unit
- C3 WAST stack review support to commence mid February Monday – Friday 8am – 8pm

Direct Admission Pathway (DAP)

The DAP was introduced in early August 2021 and was designed to support GP/WAST/District Nurses to refer an individual to Community Rehabilitation Team (CRT) with a view to the individual being admitted directly to a community bed as required. As the programme has evolved we have developed a Ring Fence protocol that now supports the community hospital team to 'hold' 6 beds that then allows individuals to be admitted closer to home. A bed is situated in each of the community hospitals and works well however when acute sites are in extremis the beds are utilised for formal admissions.

Since the programme began we have admitted 59 people via this route and have had 23 other referrals that have not been accepted – usually because a bed isn't available. The average length of stay is about 8 days, the ALoS for a person in a community bed was 27 days with 26 days in an acute bed ahead of transfer. We are meeting with key stakeholders to review progress in February 2022 as this will be six months since the programme commenced and our aim is to develop into a robust process by which we could admit via this route at weekends and also embed the Direct Transfer Pathway. The DTP is designed for those people who have needed to go to an acute site and who would benefit from a very short stay in a community

hospital rather than being admitted to an acute bed. These transfers would be only permissible from the front door

Community Rehabilitation Pilots

Flow Centre – CRT pilot
It was recognised that GP's were referring residents to the Flow Centre when they could be managed successfully by CRT. A pilot was commenced in Caerphilly which saw 33 people being transferred to CRT over 8 weeks, and all bar two were able to stay safely at home. The pilot has expanded to Blaenau Gwent on the 24th January 2022, and work will be ongoing to develop this approach across the remaining three boroughs.

Monmouthshire CRT
Traditionally Monmouthshire did not have a medical model as part of the CRT. The pilot was funded via R&R monies from October 21, and whilst the model is only available part of the week, the team have seen approximately 10-15 people a month who would have otherwise gone to an acute site.

Summary

Issues	**Actions**
• Significant service developments in out of hospital care have not yet been consistent across the Health Board area. • The innovative approaches developed need to mature and replicate across all areas of the Board	• Transformational Programme through the Clinical Futures programme will provide focus on community services through Accelerated Cluster Development and combined COTE and Frailty Programmes. These key programmes will provide the leadership for significant pathway transformation.

6.7. To achieve and exceed, where possible, upper quartile performance on key performance indicators across all levels.

In terms of broader system performance and delivery against the model the table below shows the bed plan for the Health Board pre and post GUH opening.

Hospital	Pre -GUH	Original CF Plan
GUH		470
RGH	695	383
NHH	401	208
YYF	171	164
STW	100	50
YAB	96	93
County	48	48
Other Comm	62	62
Total Non MH	**1573**	**1478**

The model was run to calculate whether the predicted models would result in a patient occupancy that was likely to fit within the planned bed base at each site. The cumulative occupancy of elective and non-elective patients at the GUH was likely to fit within the bed base of 470 beds but the RGH was likely to be a challenge to remain within its proposed footprint.

How it is working now - Total system occupancy is around 1430 (excluding Mental Health beds). GUH occupancy has hovered around or just under 400 patients at a time The RGH has proved the most challenging site for capacity

With the Families and Therapies specialities removed the GUH utilisation is regularly running at **90 - 96%.** Both RGH and NHH regularly have additional medical beds opened above the agreed level with high occupancy due to the increased demand, increased acuity and LOS due to wider system constraints around discharge. The bed pressures are complicated further due to the Covid pathways.

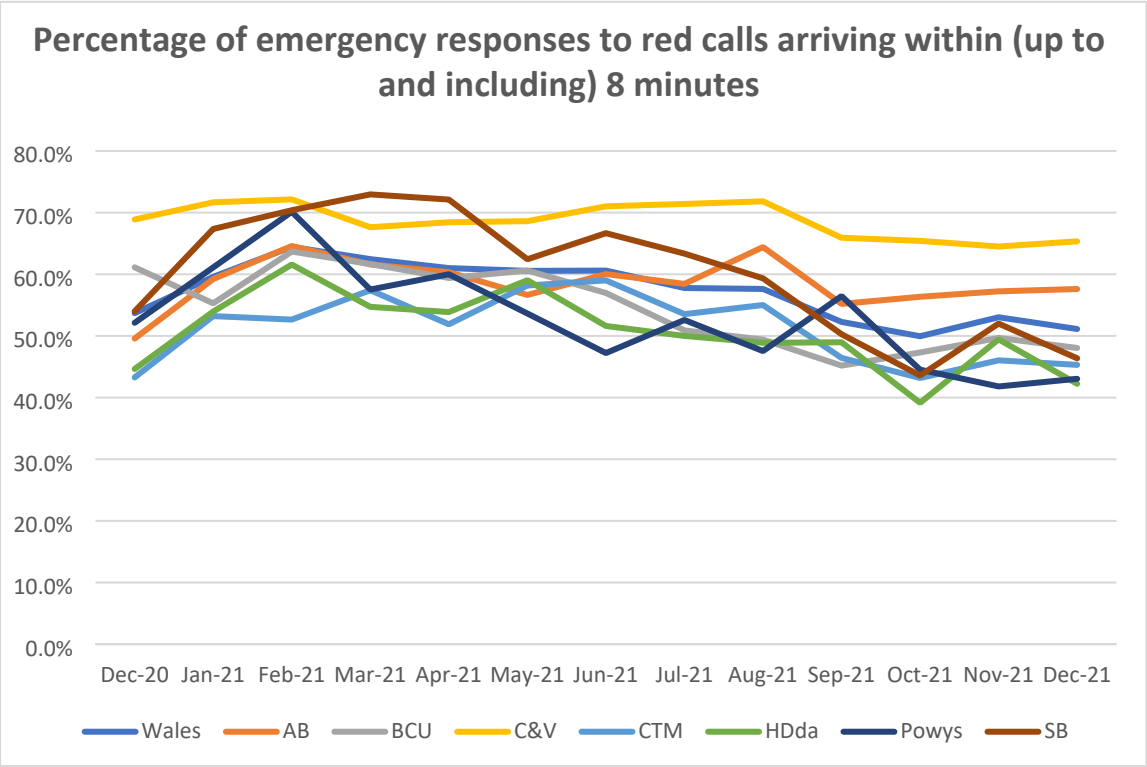
In terms of patient LOS at GUH, 76% of all patients are discharged or transferred from GUH within 3 days which was in line with the modelling assumptions.

53% of patients who are admitted to GUH MAU do not progress into any other wards in the hospital and go home direct from MAU. This rate is 60% for RGH, 52% for NHH and 53% for YYF.

Bed planning for 2022/23 is a key element of the IMTP and is important to ensure there is sufficient capacity to meet current and projected demand. It remains a key focus to improve and transform working across the broader system with partners and reinforcing the graduated model of care and care closer to home.

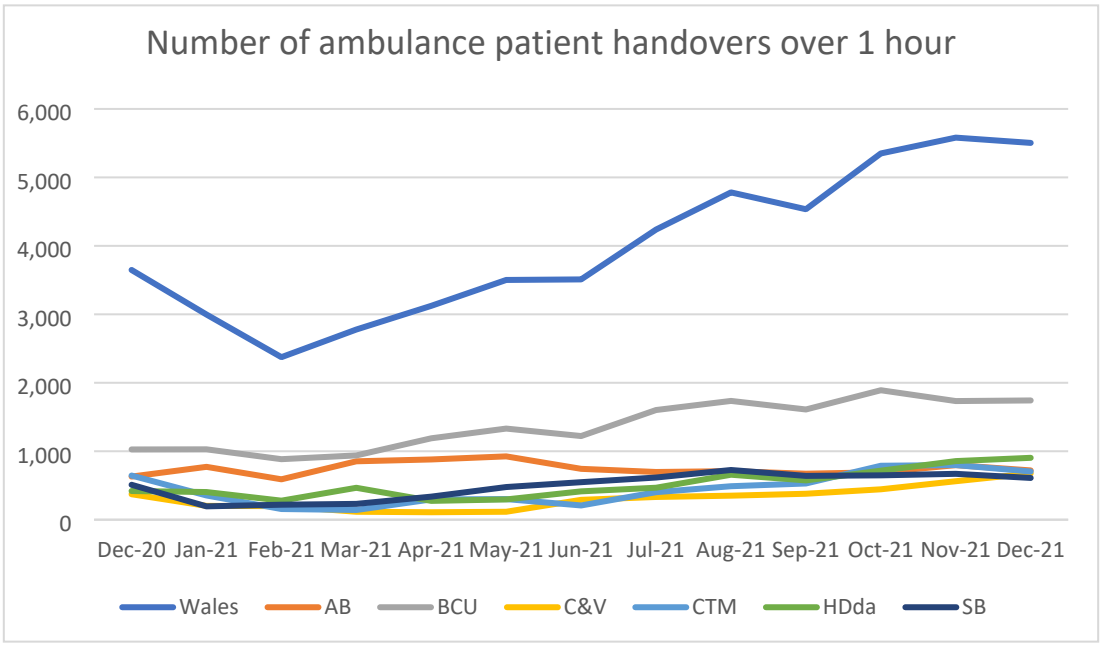
Utilising data from NHS Wales Planning, Delivery and Performance analysis of key performance indicators of the AB system versus the all Wales

position for the same period is possible. The following considers the period December 2020 to December 2021.



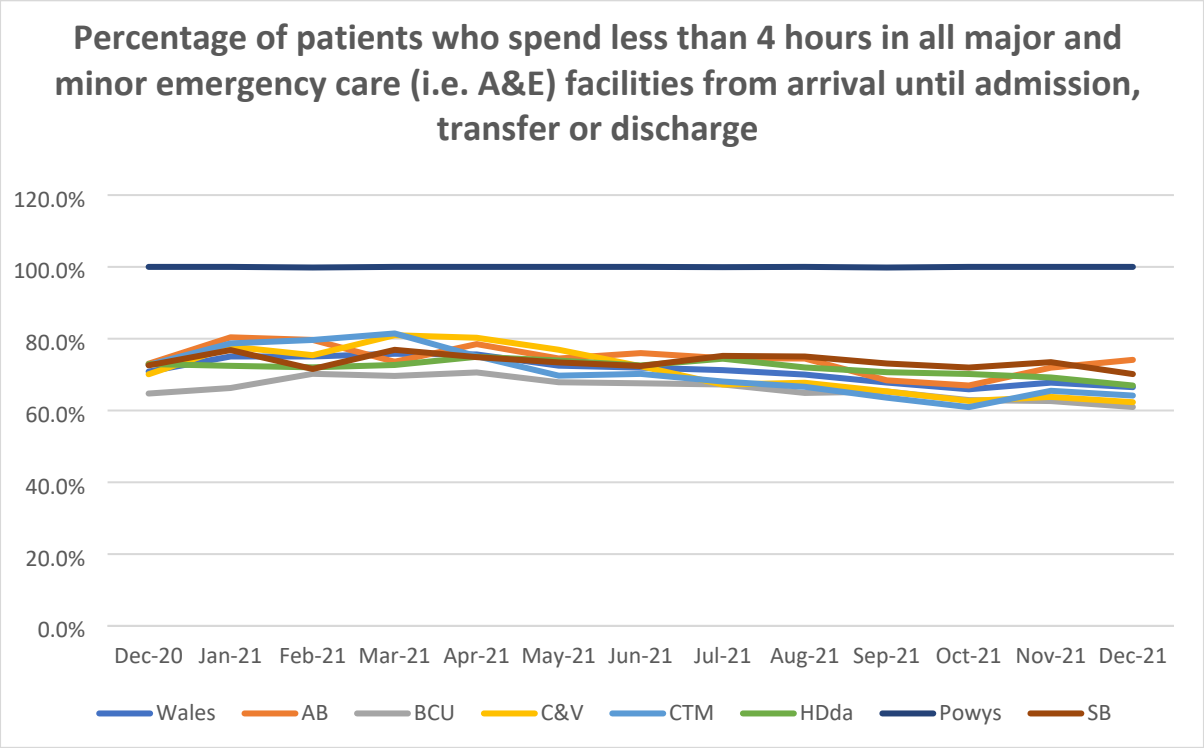
Against a target of 65% the Health Board have been around 60% through the period. Whilst the Cardiff and Vale position has been consistently the best performer all other Health Boards have deteriorated in the latter half of 2021 with the Health Board holding its position into winter.

In December 2021 the AB rank for the 8 minute performance is number 2 of 7.



Ambulance handovers over an hour have deteriorated over the period significantly on an all Wales basis. The Health Board position had deteriorated but has stabilised towards year end at around 700 per month.

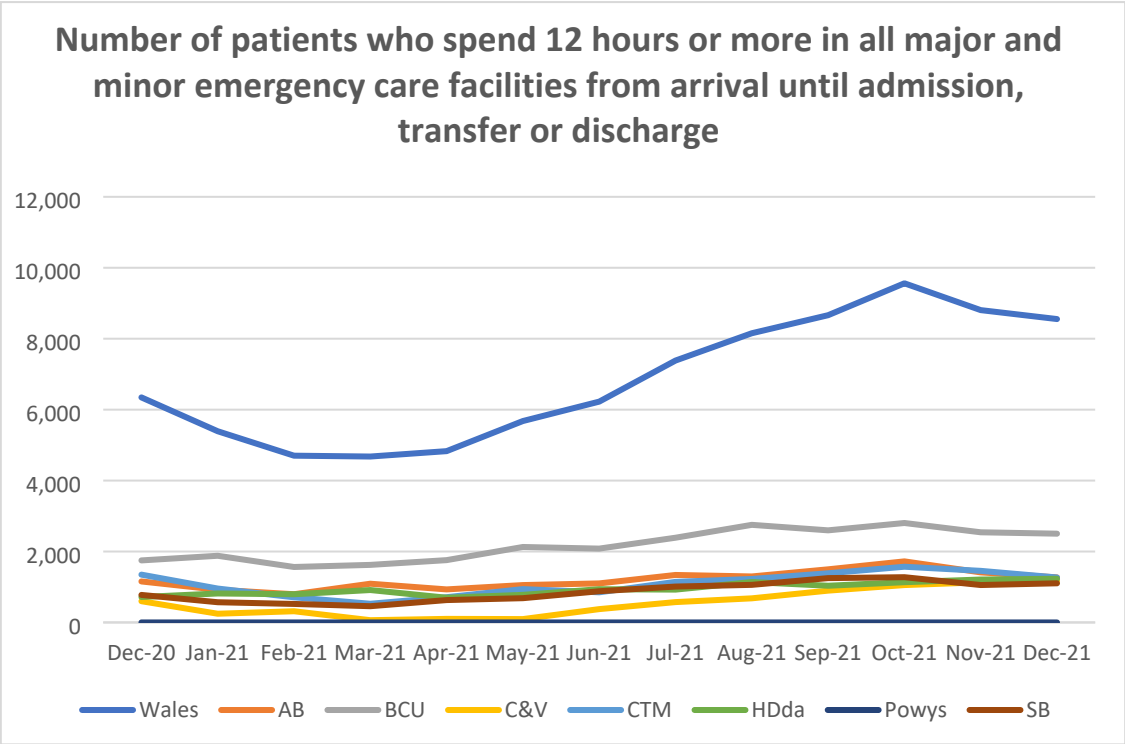
In December 2021 the Health Board rank for the over 1 hour handover is number 4 of 7 in absolute numbers but adjusted based on ambulance demand or per head of population would put the Health Board in the top 2.



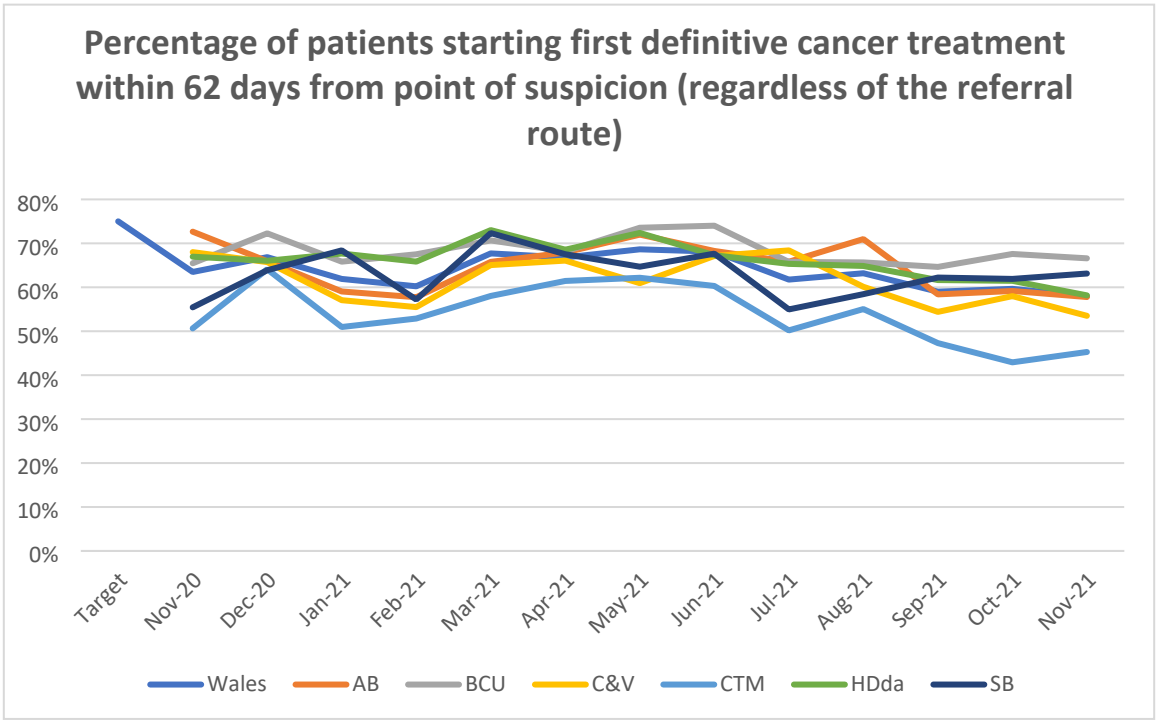
4 hour performance on an all Wales basis ranged from 66.5 to 75.8%. In the Health Board for the period the range was 67.0-84.7%.

NB the 100% line performance is Powys which does not have a major ED department within its Health Board area.

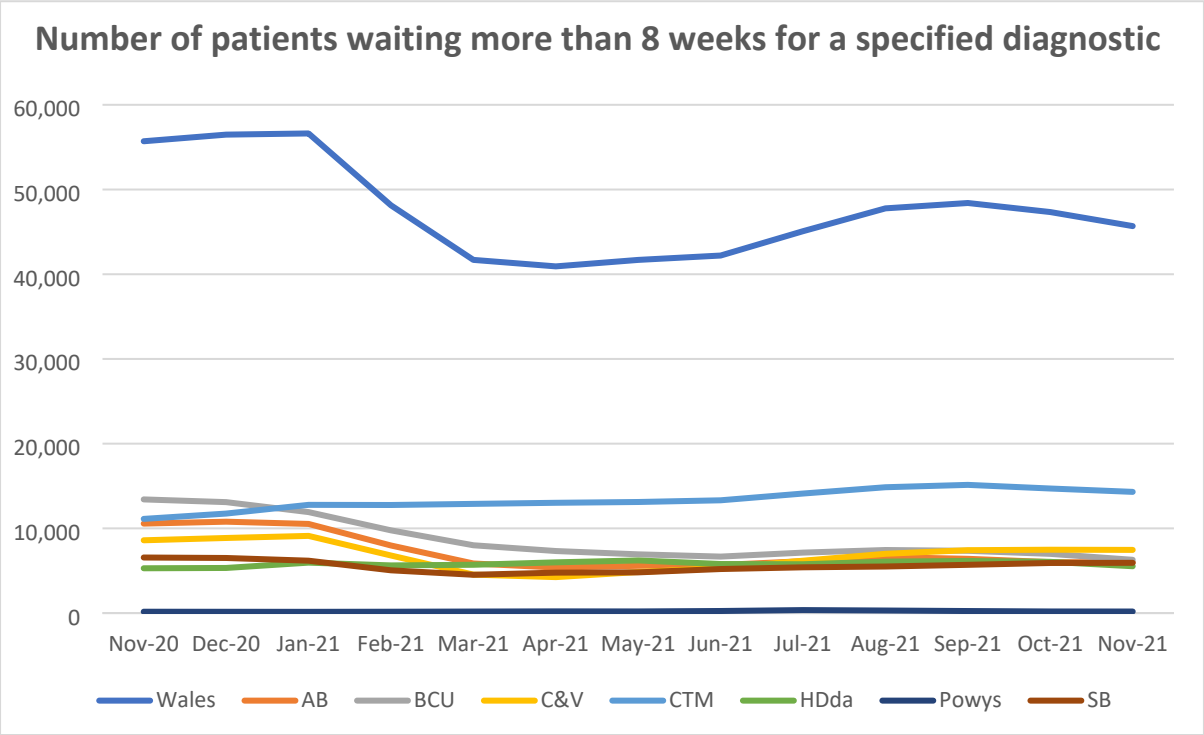
In December 2021 the Health Board rank for 4 hour performance is number 2 of 7 or highest in Wales excluding Powys. The Health Board performance is improving as other Health Boards are seeing a deteriorating position.



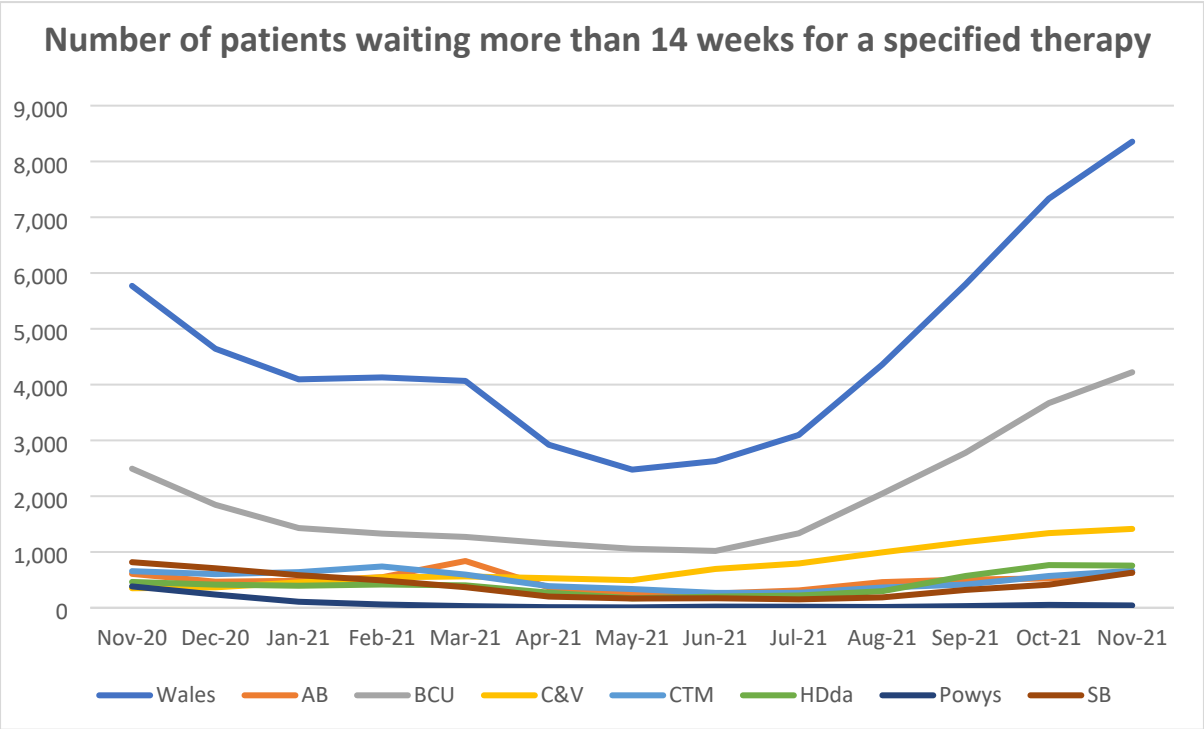
A further measure of the urgent care system is the patients who spend over 12 hours in emergency departments. As you can see this position has deteriorated significantly over the 12 month period in Wales overall. The Health Board is on an improving trajectory over the last few months and when adjusted for population share is in the top two for December 2021. This is still a significant concern and a focus of the Urgent Care Transformation Programme and developments in Same Day Emergency Care across ABUHB.



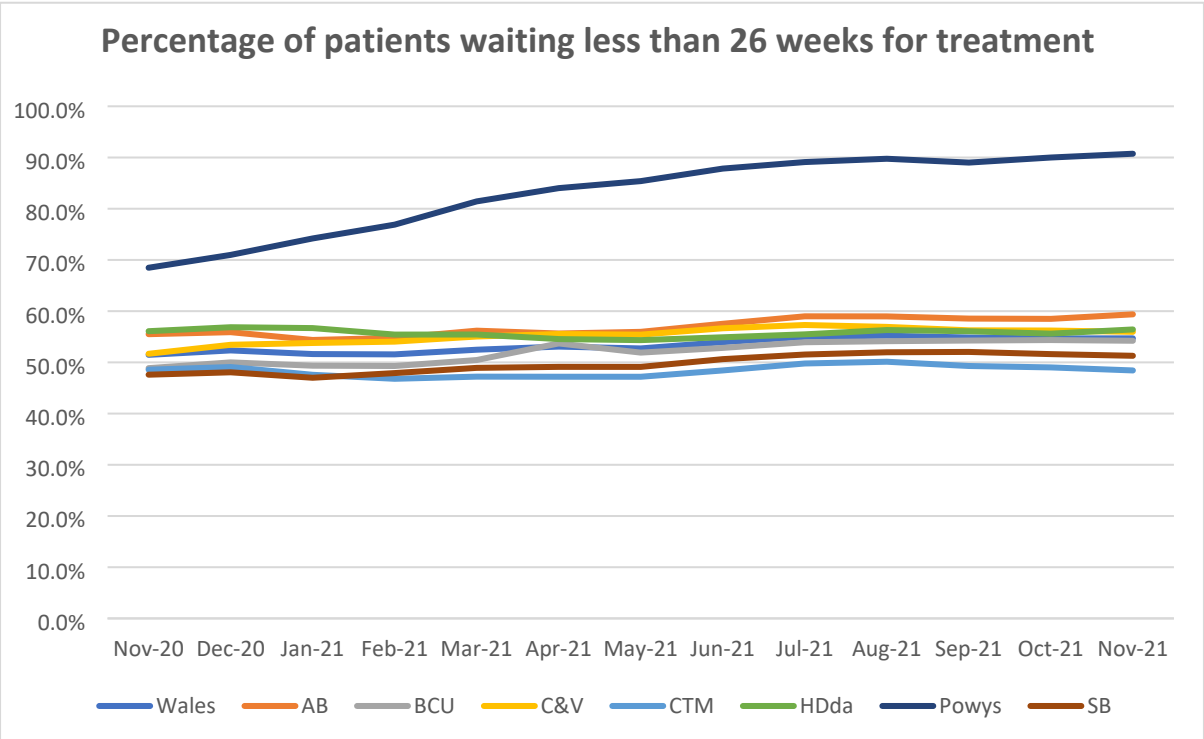
The above chart outlines performance against the 62 day cancer target. The all Wales position has deteriorated over the period with a range against the 75% target of 57.8-68.8%. For the Health Board that range is 57.8-72.0%. The rank in December 2021 was 4th, but that was the lowest performance for the period. The Health Board has ranked first with 71% (Aug 20) and 3rd with 72% (May 21). The Health Board also has the second lowest backlog numbers per head of population.



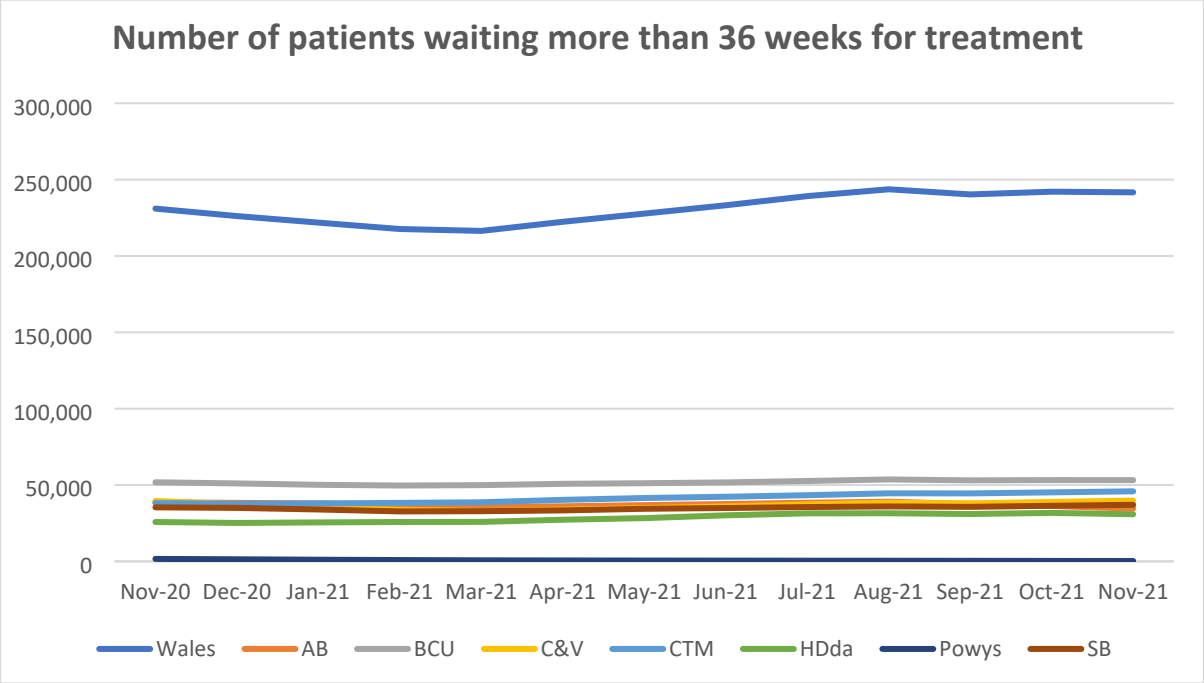
There has been an increase in waits above 8 weeks across the 12 month period for diagnostics, however all Health Board have improved from the peaks of last winter. However, performance is relatively static and increasing slightly including the Health Board. In December 2021 the Health Board ranked 1st out of the 6 main HBs when adjusted for population share with 5979 patients waiting longer than 8 weeks.



Waits above 14 weeks for Therapy have deteriorated significantly in the latter 6 months of the period. This is predominantly due to a deterioration in the position in BCU. However, most Health Boards have seen increased waits to some degree in this period. The Health Board ranked 2 in December 2021 for this measure.



The all Wales range for patients under 26 weeks has been between 50-55%. The Health Board has been between 55-59%. AB is ranked second in December 21, again with Powys coming in first for their provider waits.



There remains a significant number of patients waiting above 36 weeks for treatment in Wales. Over the period the number has risen from 231022 to 241667. The Health Board was ranked 2nd when adjusted for head of population behind Powys.

The trend however in AB over the period was of a decreasing number, down from 38,696 to 34,582. AB was the only Health Board apart from Powys to show an improvement in this figure over the 12 month period.

For the 3 main planned care measures, 8 week diagnostic, 26 week and 36 week waits AB generally ranks 1st when excluding Powys given they do not provide acute services. The new system model and additional diagnostic capacity enabled through the new hospital are key factors contributing to this position albeit there is significant work to be done to address the thousands of patients waiting for elective care.

Summary

Issues	**Actions**
• Upper Quartile levels of performance achieved for a number of metrics when compared to Wales HB peers but this does not mean the	• Stabilisation of bed numbers across the system through IMTP 2022/23 process will be delivered.

services are performing at or close to target levels. • Bed numbers in the system through the pandemic rose above expected levels. This put pressure on planned care delivery and workforce to staff them as well as financial performance	• Performance in emergency and urgent care continues to improve through Urgent Care Transformation programme leadership but further work required to meet top performance levels. • Optimisation of Planned Care recovery through green/protected eLGH spaces to be driven by newly established Planned Care Transformation Board.

7. Financial Overview

The GUH is a key enabler for the full delivery of the Clinical Futures Strategy, investments in service models are associated with operating services across the new ABUHB system of care including the GUH.

Several Audit reports have confirmed the effective control processes around capital and revenue financial planning for the GUH.

The achievement of the economic benefits as described in the FBC have not yet been fully delivered, largely due to Covid-19 pandemic implications on service delivery. The expectation is that full benefit achievement will be delivered in the future.

Capital - GUH Update February 2022

The original approved budget for the original Grange University Hospital scheme was £360.536m. Further funding of £9.3m was received during 2020/21 to enable the hospital to open early to respond to the pandemic.

During 2021/22, the Health Board has been awarded a further £3.5m of Covid Recovery monies to fund the works to create the Same Day Emergency Care Unit planned to be complete in 2022/23. Works to create a temporary solution to the ED main wait issues are also being funded from the Covid Recovery allocation (£556k). As a result of original scheme savings, WG approval has been secured to reallocate budget towards the funding of further Well-being and Admin Facilities on the wider LGH site (£1.5m) and the purchase of informatics licences in relation to the Lightfoot system (£1.5m).

The latest cost reports indicate a forecast saving on the scheme of £8.2m. Of this saving, £5.1m relates to the Health Board's gain share achieved on the construction contract which will be retained by Welsh Government. The

Health Board is seeking approval from Welsh Government to retain the remainder of the savings generated through further VAT recovery and inflation savings. These savings would allow the Health Board to fund the extension to the temporary car park (£600k), the anticipated overspend on the SDEC scheme (£500k) and the CAEU Wait scheme (£750k). Proposals for a permanent solution to the ED Main Wait issues are being developed. As current costs for this proposal are in the region of £3-3.5m a further funding bid to Welsh Government will be required to progress.

Revenue - Financial Update February 2022

The SCCC Full Business Case stated that the recurrent cost post introduction of the GUH and wider Clinical Futures model would be an annual cost in the region of £1m in addition to £10m annual investment requirements identified in the Clinical Futures Programme Business Case to meet demand growth and sustainability etc. As the detailed GUH/CF service models and directorate plans were developed over time, additional requirements were identified, the implications of operating 4 emergency care sites and the continued increases in patient demand. Estimated costs converting to actual commitments including inflationary implications and changes to comply with statutory regulations and requirements, eg. Nurse staffing act.

The analysis presented to the Clinical Futures Delivery Board in March 2021 and previously to the ABUHB Board indicated a recurrent cost of c.£27m. This is broadly broken down in the categories as described below:

Medical Staffing £5m, Nurse Staffing £3m, Diagnostics & Therapies £3m, Facilities £3m, Estates £5m, WAST inter-site transport £4, Flow Function £2m, HSDU £1m, Non-Pay.

A key element of the financial plan involves the significant system change and efficiency benefits of the wider clinical futures strategy with reductions in bed numbers and workforce. As described in the previous sections the Covid-19 pandemic resulted in specific system pressures resulting in the delay to leverage the benefits and efficiencies planned.

In addition, other system costs have been incurred across a wide range of areas, some of these are temporary and relate to the immediate system pressures, operating in a covid compliant environment and requirements to comply with best practice guidelines. Examples include:

- Additional nursing (ED, Covid pathways, MIU, enhanced care) - £3.5m.
- Estates and Facilities (Energy, security, enhanced cleaning) - £2.5m.
- Safer staffing and additional medical costs - £3m.

- Support to enable greater flow (Flow Centre, Discharge Lounge) - £1m.

It is noted in a previous section, a number of workforce challenges remain and these vacancies off-set some of the costs incurred. HSDU costs have not been incurred in full and inter-site transport costs have been slightly reduced due to vacancies within WAST.

Once the Covid-19 pandemic pressures on the system have eased, the investments made should place ABUHB in a favourable position to transform in line with the Clinical Futures Strategy aims, improving outcomes for patients and delivering efficiencies across the ABUHB system of care.

8. Clinical Futures Programme - Key Priorities for 2022/23 and beyond

Following the commissioning of the GUH, the Clinical Futures Programme was reshaped to deliver the 10 key programme priorities from the 2021/22 Annual Plan. The key programmes were:

1	Urgent Care Transformation	6	Integrated Pathway Programmes
	- Pre hospital - Emergency Care Improvement - Graduated Care		- MSK - Respiratory - Ophthalmology
2	Living Well, Living Longer	7	End of Life
3	Cancer	8	Mental Health and LD
4	COTE	9	Iceberg
5	Outpatients Transformation	10	Agile

In addition, support from the Clinical Futures Team has been given to various operational improvement projects and programme supporting medical staffing, non-pay procurement, TTP and Mass Vaccinations and contract development and monitoring.

During late 2021 a Programme Team was established through recruitment to replace vacant posts that remained after the GUH opened. The team was focused on delivery of the above Annual Plan Programme and continuing the implementation of the GUH across the whole care system in Gwent, considering whole system change as well as system optimisation.

As the organisation develops the 2022-2025 IMTP for submission to Welsh Government, discussions with Divisions and departments have considered the resetting of the Clinical Futures Programme against the changing

picture of system optimisation, recovery from Covid-19 and the need to transform our service delivery.

These, key priorities which, based on our understanding of our system, will deliver the biggest impact and improve the sustainability of our system. They will also pick up the many issues raised in this report as referenced under each of the key sections. These are:

1. Public Health Protection and Population Health Improvement
2. Accelerated Cluster Development
3. Redesigning Services for Older People
4. Mental Health Transformation

As we transition from a pandemic to an endemic state we are emerging as a very different system to the one we had planned as part of our Clinical Futures Strategy. Learning from the experience of the last 18 months we have recognised that there are opportunities that will enable us to create a more resilient and sustainable system. Consequently, a number of our priorities transcend but are integral to our life-course approach, and form part of the Clinical Futures Programme for 2022/25, these are:

5. Planned Care Recovery (Outpatient Transformation & Pathway Optimisation)
6. Transforming Cancer Services
7. Urgent Care Transformation
8. Enhanced Local General Hospital Network
9. Net Zero - Decarbonisation

A number of existing programmes will remain under broader new programme titles. The realignment gives significant focus to the development of enhanced and sustainable services for Older People in community and hospital settings and the transition between.

In line with the evolution of the Programme role the branding of the programme is being updated to reinforce the whole system focus being undertaken. The title, logo and rainbow remain but with developed graphics packages to emphasis the community first approach to our work.

9. Summary and Conclusions

In summary, evaluation of the detailed benefits of opening the Grange University Hospital and implementing the new hospital network in the context of its original investment objectives is complex in the context of implementing the new system in the middle of a worldwide pandemic.

The benefits of opening the new hospital early as part of the 2020/21 winter response and second Covid wave are clear, particularly around addrerssing significant workforce sustainability issues, critical care services, additional capacity, infection control, recruitment in some areas and greater resilience across the system.

Further system benefits have become more evident in the last six months as the new system stabilises and the Health Board is sustaining its challenging position in the context of many other Health Boards deteriorating across the key metrics of urgent and planned care. Many of the clinical outcomes data is showing an improvement trajectory with some areas of further work.

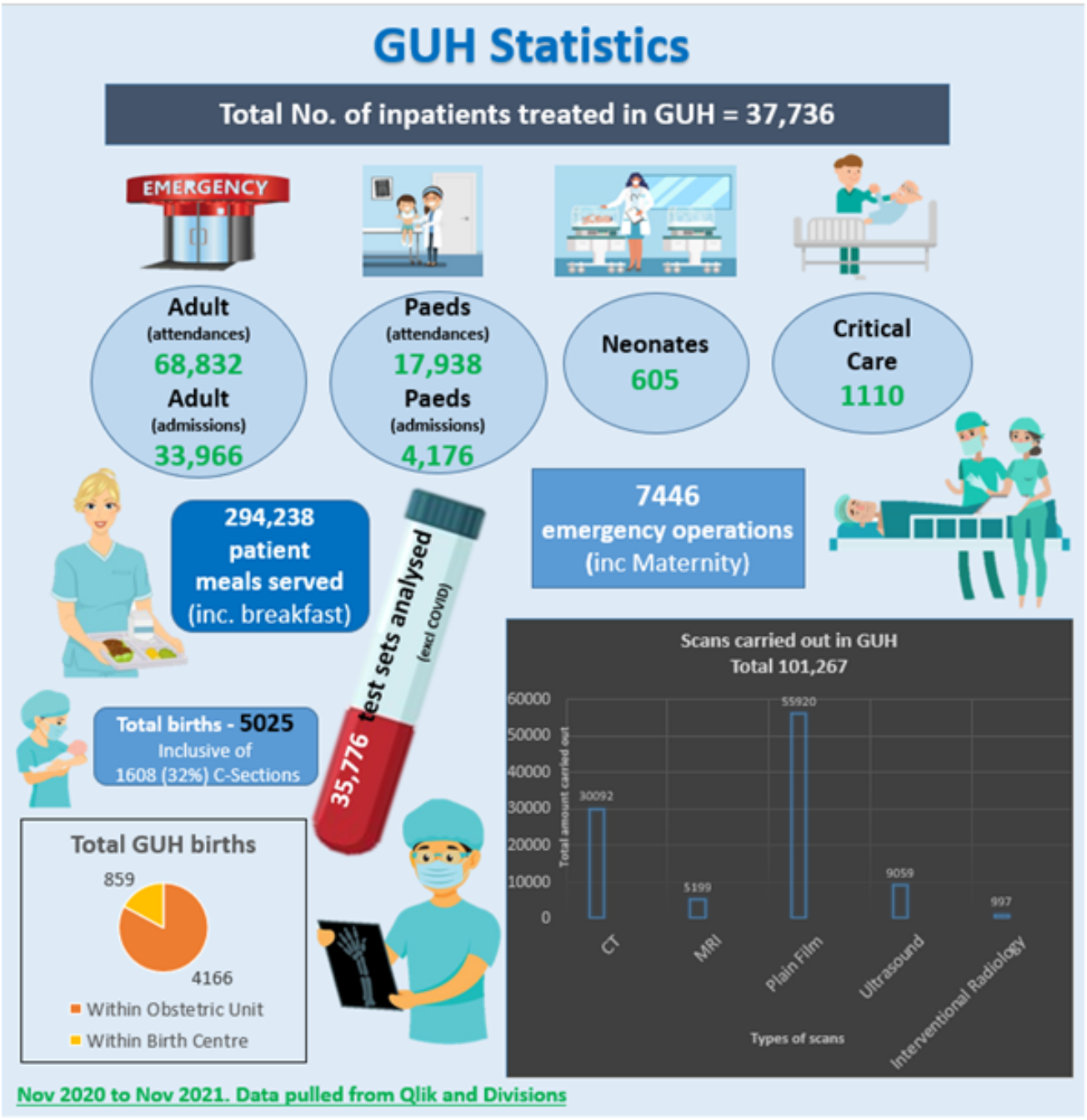
There continue to be key areas of concern around workforce challenges at the eLGHs, patient transfers across the system in the context of capacity, IPAC pathways and communication with families given visiting restrictions and workforce challenges.

The ability to deliver planned improved efficiencies, full system transformation and financial sustainability are all challenging in the context of the Covid environment, but will require a significant focus as things potentially move towards a "new normal".

The focus on the workforce is a top priority given the fragility and morale of staff who have worked throughout the most relentless two years of their careers.

The IMTP priority programme for 2022/23 will include the key priority areas identified throughout the report to ensure we continue to stabilise the system and drive further improvements in line with the ambitions of the Clinical Futures Strategy.

Appendix 1 – GUH Statistics, first 12 months activity



Appendix 2 – Detailed Full Business Case Investment benefits

Investment Objectives	Benefits
Deliver access targets for both planned and unscheduled patient care in line with national targets for 2015 and beyond.	Better outcomes for patients through having more timely access to services.
	More timely access to services with reduced waiting times.
	Better staff morale by being able to deliver services in a timely way.
	Less disruption to planned services through having the appropriate capacity in place to deal with the targets.
	Ability to deal with fluctuations in activity by having the appropriate capacity in place.
	Improved productivity in delivery of services.
	Sustainability of health services.
To achieve and exceed where possible minimum quality standards for health care service as outlined in National Service Delivery Frameworks, NICE and Standards for Healthcare for Wales to improve outcomes for patients	Better outcomes for patients by providing recognised standards.
	Opportunity for skills development.
	Enhances recruitment and retention by being able to offer good quality care.
	Improved integration of services across all levels through implementation of clinical pathways.
	Opportunity to further develop services / specialisation.
	Safer services for patients.
	Better staff morale.
	Less duplication of services and effort.
	Reduced number of complaints and litigation claims.
	More sustainable services for Gwent.
	Improved staff morale by being able to deliver quality services.
	Increased opportunities for further clinical specialisation.
Improve the local provision of services and minimise travel times for access to health services and in particular, hospital and specialist services.	Reduce non-attendances of appointments.
	More care available closer to home.
	Reduce length of stay.
	More convenient for patients.
	Reduce avoidable admissions.
	Improve integration between services at local level.
	More continuity of care for patients.
	Reduce travel times and transport requirements.
	Reduce delayed transfers of care and delays in the patient pathway.
	Develop services that are responsive to local need.
	Reduce flows of patients out of Wales.
	Help to reduce inequalities in health.
	Support local regeneration initiatives.
To deliver a fit for purpose environment for patients and staff which is NEAT and AEDET complaint	Improve outcomes for patients by providing care in therapeutic environments.
	Reduce length of stay by facilitating recovery.
	Reduce infection rate by providing facilities that are easier to clean.
	Increase staff productivity by arranging facilities in logical patterns.
	Improved safety by developing buildings that are easier to maintain and arranged logically.
	Improvements in privacy and dignity through modern design.
	Improve staff recruitment and retention by providing attractive working environments.
	Reduce disruption to services through developing facilities which are easier to maintain and based on more reliable technology.
	Reduce stress for visitors and carers by providing appropriate therapeutic environments.
	Promote sustainable development through the design and construction of new buildings.
	Promote sustainable development in terms of the ongoing operation of new buildings.
	Improved training and development environments for clinical staff and achievement of royal college guidelines.
Support a workforce model that is sustainable and complies with the European Working Time Directive and Deanery requirements	Robust and reliable services based on robust and reliable staffing patterns.
	Meet requirements of Deanery for junior doctor training.
	Safe services based on safe working hours for staff.
	Improve outcomes for patients by ensuring that the right care is delivered by the right person.
	Improve training opportunities for staff.
	Improve recruitment and retention.
To improve and expand provision of community based alternatives to hospital services	Increased local access to services.
	Reduced number of hospital admissions.
	Less time spent in hospital.
	Shorter lengths of stay.
To achieve and exceed where possible upper quartile performance on key performance indicators across all levels	Reduced variation in performance within health community.
	Increased productivity through increased patient throughput from reduced LOS.
	Shorter lengths of stay.
	More timely access to services through reduced waiting times.
	More patients treated as day case procedures instead of inpatient.
	Reduced number of queues and bottlenecks in system.
	Reduced number of cancelled operations due to patients being unfit.
	More effective pre-admission processes.
	Better use of resources.

Appendix 3 – Patient Experience Report 21 February 2022

Summary / Situation:

During COVID-19 and with the additional pressures of opening the Grange University Hospital, priority has needed to be focussed on managing the direct clinical needs of patients accessing services alongside redeploying clinical and non-clinical staff to manage the significant challenges of the pandemic. Patient experience and listening and learning from feedback is a key element of evaluating services and outcomes and a measure of the impact of the new system.

Direct patient feedback has highlighted that many patients on wards have been negatively impacted by visiting restrictions, resulting in increased loneliness and are experiencing boredom due to the lack of meaningful activities as a result of the restrictions. Relatives are becoming increasingly frustrated with their inability to contact wards, via telephone, and unable to speak to their loved ones. Additionally, third-party feedback from the Community Health Council is emphasising broader issues about access to primary care, ward-based care, and the implementation of Test, Trace, and Protect (TTP).

Currently we do not have an electronic system in place to obtain real-time patient feedback. A 'Once for Wales' Service User Feedback tender was undertaken in 2020 and contracts are now available to all Health Boards in Wales. The Health Board is currently in the process of procuring a system.

The purpose of this Patient Experience Report is to present the Board with a narrative summary of patient experience related activity.

Background and Context:

Improving patient experience is the responsibility of all staff, regardless of their position, staff group, profession, or location of work. It is everybody's responsibility to improve experience for patients, carers and colleagues regardless of the setting.

Recent patient surveys have identified that the pandemic and restricted visiting by patient families and volunteers has had a negative impact on patient experience. Due to a lack of meaningful activity, patients have expressed feelings of loneliness and boredom.

Interim Telephony Support

During the pandemic, the Health Board has received a number of calls and complaints from relatives who have been unable to contact wards. This has led to an increased anxiety for relatives who are unable to visit loved ones. During discussions with Switch Board leads, it was discovered they indicated a significant increase in calls from relatives, especially during times when families would have been visiting.

The Health Board identified the need to provide additional support to the wards, especially with clinical staffing deficits, and actively recruited ward clerks and ward assistants. To manage the escalating concerns from families, the Health Board agreed two immediate measures to support relative communication:

1) Patient Liaison Officers (PLO's) were employed working 8am-8pm, 7 days a week at the 3 acute sites, linking in with the other hospitals. Act as a link between the relative and all the wards. Relatives are encouraged to phone the wards first and if no response to ring a dedicated telephone line. This service went live on the 13th of January 2021.

2) To support with increased calls during late afternoon/evenings, 30 additional hours at band 3 were secured to supplement the current Switchboard team.

The duration of this service has been extended until June 2022.

Patient and Family Liaison Pilot (Patient Connectors)

The second wave of COVID-19 put additional pressure on clinical teams. Restricted visiting has resulted in an increase of calls from worried relatives and often, there are delays in clinical staff being able to either answer the phone or spend time talking to relatives. As the Chaplaincy Team were unable to undertake the totality of their roles on the wards due to COVID-19, they supported Patient and Family Liaison enabling patients and family to connect via i-Pads and mobile phones. The Health Board are now in the process of recruiting 'Patient Connector' volunteers to undertake this role, supporting connections during and after the pandemic.

An example of impact...

The Person-Centred Care Team received an email from an external colleague to ask if it were possible to connect a patient who was last days of life with his daughter. The daughter was unable to visit as she had multiple health issues and was herself recovering from COVID. His daughter just wanted to be able to speak to him via FaceTime, say a prayer with him and say she loved him. A chaplain went to the ward within an hour of receiving this message. He was able to connect both patient and daughter via Facetime. The gentleman passed away the next day.

Volunteering

During the pandemic, all volunteer activity was ceased. This was to protect patients, staff and keep volunteers safe. The withdrawal of volunteers impacted on access to meaningful activity with many patients expressing boredom and loneliness.

Although during lockdown, many of the Health Boards existing volunteers fell into the 'at risk' category, volunteers have now started to return to the wards,

supported through the All-Wales Covid Workforce Risk Assessments. Volunteers are now active on all hospital sites, within the ED department and over 100 are supporting telephone befriending.

End of Life Companions

The End of Life (EoL) Companion volunteer service commenced at the very start of the pandemic, March 2020. Companions were recruited and trained so they were ready to assist any patient nearing the end of their life who was at risk of dying alone. End of Life Companions have supported patients both as befrienders and also provided support to patients who are nearing the last days of their lives. The Person-Centred Care Team continued to recruit and remotely train End of Life Companions during the pandemic. 50 Companions have now been recruited and based on risk assessments, 18 are currently active. These Companions visit patients who are at risk of dying alone and, while 'visiting with a purpose' currently refers visiting for those at the end of life, Companions will also provide respite visits for families who are unable to be present when a loved one is dying.

An example of impact…

The Person-Centred Care Team had a request for the EoL Companions to support a family in providing some additional company for their relative. The family members were exhausted. They had been sitting with their relative 24-hours a day and they needed some rest. However, they did not want their relative to be alone. The EoL Clinical Skills Trainer met with the family to explain the Companion role. She then arranged for 3 Companions to visit the following day so that the family could have some much-needed rest. The Clinical Skills Trainer also met with the ward staff so that they were aware of the support that had been put in place. The Companions are aware that they may be contacted at short notice and were very pleased that they could support both the patient and the relatives. It was during one of the Companion visits that the patient peacefully died and importantly they were not alone which was a comfort to both the patient and their relatives.

Snapshot Attendance at GUH Emergency Department

A snapshot of ED attendances at GUH over three days during a two week period was undertaken in June 2021. 55 patients were surveyed. Almost **80%** attended on the advice of a health professional, **42%** by their GP, **33%** by 111, **24%** via MIU (including Royal Gwent Hospital) and other services such as Maternity, 1 patient attended via Police and Ambulance. Of the 12 remaining, 1 patient attended due to an accident at work and the remaining attended through their own decision. From an observational point of view the majority of patient's understood the options available however were grateful to be in attendance at ED with the assurance that they would be seen by a doctor. The Executive Team was informed of the findings of this snapshot audit.

Patient Experience at the Accident and Emergency Department

In the absence of the 'Happy or Not' consoles, a discussion took place with the Person-Centred Care Team about the possibility of undertaking the National Patient Reported Experience Measures (PREM) to gain real time patient feedback. The PREM was not deemed appropriate for an ED Department, due to its ethos

embedded in secondary care. It was therefore agreed to pilot a bespoke and confidential patient experience survey to provide the ED department and MAU with real time patient experience at the point of care. The survey questions focused on 7 key themes:

- Politeness of staff
- Thoughtful and caring
- Reassuring and kind
- Informative
- Respectful of privacy
- Communication
- Cleanliness of the environment

The survey ran from 11th January to 31st March 2021. A total of 321 surveys were completed during the pilot.

Positive Feedback:

- "Just run so smoothly with transition from ambulance to ward, and felt reassured that people were listening to me"
- "Great care, great area, fantastic staff"
- "Very professional, and very thoughtful and respectful"

What needs to improve:

- "Not being told what to expect. Not given information."
- "Just the wait for results, and no TV to help with boredom"
- "My daughter couldn't get through to the hospital. That's terrible."
- "I feel as though I could have been more informed of what is going on "sometimes.
- "Been waiting for a bed on the ward for 18 hours. Slow progress."

The findings of the PREM have been shared with the ED Senior Management Team and an action plan developed.

Virtual Buddying with the Community Health Council

Peoples experience during Covid-19 has been impacted by the pandemic, both in hospital and across the community. An essential component of safe and compassionate person-centred care is listening to and responding to people's experience. Since the start of the pandemic and since the opening of the new hospital, a number of patient experience surveys have been undertaken to better understand patient experience across the ABUHB. These have been undertaken through direct visits (where visiting restrictions allowed), through virtual 'buddying' with the Community Health Council (where patients were connected to a CHC Member through i-Pads) and postal surveys. There were a number of surveys specifically targeted at GUH patient experience but many other focusing on the wider system. 10 bespoke sessions have been undertaken and 782 people provided feedback through these methods. The main themes from patient feedback relate to:

- Communication and Information
- Loneliness and Isolation
- Lack of Meaningful Activity

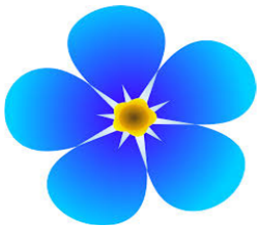
Each of these surveys provided overwhelmingly positive responses regarding staff attitude and compassionate care, with many respondents identifying staff going 'over and above' during very challenging times. Areas for action have been actioned by the relevant Divisions.

Electronic Patient Survey Systems

The National PREM was piloted in 2019. To date there is still no electronic system in place that allows the Health Board to routinely gather real time electronic patient feedback. In 2020, a Once for Wales Service User Feedback System tender exercise was undertaken and the contract awarded to a company called CIVICA. The system is Cloud accessible and allows for real time feedback, enabling 'ward to board' reporting. A demonstration of the system and exploration of the hierarchy requirements has taken place. Contracts for this service were made available to all Health Boards from December 2020 and ABUHB is developing a business case for consideration of implementation.

Improving Dementia Care - Proof of Concept

There is clear evidence that meaningful activity helps alleviate behavioural and psychological symptoms of dementia by enhancing overall quality of life through engagement, enhanced social interaction, and opportunities for self–expression and self-determination (Han, et al. 2016). A Proof of Concept (PoC) and Service Evaluation commenced at Ysbyty Aneurin Bevan (YAB) on the 1st July 2021. Through locally agreed outcome measures, the PoC and Service Evaluation aimed to verify the vision that meaningful activity, dementia training for staff and the creation of Dementia Companion Volunteers would collectively improve overall quality of care, patient safety, patient experience and support transferability.



The PoC and Service Evaluation identified the benefits that meaningful activity, staff training and the introduction of Dementia Companions has in supporting patients who require an enhanced level of care. Throughout the PoC, closer MDT working relationships has seen the reinstating of the FIG group, allocation of a Nutrition Support Worker, development of a Referral Data Tool, inclusion of quality improvement measures in wider strategic plans such as the Nutrition and Hydration Group, In Patient Dementia Hospital Group, improved communication with relatives and co-ordinated visiting etc. demonstrating a committed and shared vision to improve person-centred dementia care.

This model is transferable to other ward areas. Investment has ensured that staff training and learning, promotion of ward-based Dementia Champions, recruitment, training and support of Dementia Companion volunteers, and meaningful activity resource have been driven forward.

Meaningful Activities

Meaningful activity is fundamental to the health and wellbeing of the individual accessing care and support. It can help to improve physical fitness, improve mood and help to combat depression and anxiety, as well as combat loneliness, improve the quality of sleep and even reduce falls.

Feedback from patients has indicated that a lack of meaningful activities on the wards has negatively impacted upon them. Although ward-based volunteers have primarily undertaken meaningful activities with patients, in most cases, all staff members have a role to play in ensuring that patients are meaningfully occupied during their admission. The general lack of cognitive stimulation is noteworthy, and for some patients this has exacerbated their challenging behaviours.

A number of 'easy to do' activities have been developed including large print crosswords for group/individual use, picture card activities to encourage discussions (either as group or one to one) and a communication prompt to enable staff to engage patients in reminiscence. A dedicated resource link on the intranet is being pursued, making this resource accessible to all staff. Additional to this, 47 RITA Units have been commissioned with distribution to the wards with an additional 10 purchased for GUH in the absence of any entertainment presently.

To be noted, a bid has been submitted for consideration by the Charitable Funds Committee to secure funding from NHS Charities Together to employ a specialist OT to support the development of a Meaningful Activity Strategy that would promote social stimulation across our wards, care homes and community.

Dementia Learning and Development

Following the evaluation of the PoC at YAB, a series of training was delivered with the support of Senior Nurses at GUH. A dedicated GUH Dementia improvement group aligned to the ABUHB Dementia in hospital group has been established.

6 dates through November and December were arranged around ward rosters and attended by 50 staff (Registrant/ non registrants delivered at GUH education centre/ Grange house Board Room). Training was then on hold due to COVID priorities and winter pressures. On the appointment of a Person-Centred Care practice educator (seconded until March 2022), we have developed a training flyer sharing 4 more dates from February to mid-March for all staff. We have advertised 2 dates for Dementia Champion all day training.

Dementia Volunteer Companion – half day sessions on Introduction into Dementia and Meaningful Activities sessions have been undertaken. Coleg Gwent student are also undertaking Health and Social Care courses are now offered 2 half day sessions on Introduction into Dementia and Meaningful Activities.

Assessment:

A number of innovative ways to gather patent feedback has been implemented during the pandemic. Patient feedback has enabled the Health Board to prioritise areas for action to improve patient experience including virtual visiting, development of new volunteering roles and a suite of meaningful activities.

1) **Interim Telephony Support**: this service went live on the 13th January 2021 and will continue until the end of June 2022.

2) **Patient and Family Liaison**: Volunteer 'Patient connectors' will be recruited in April 2022, using digital means to connect patients and families.

3) **Volunteering**: The PCCT are continuing with the recruitment and risk assessment of volunteers. A number of new role profiles have/are being developed in response to patient feedback

4) **Electronic Patient Feedback**: A Business Case is being finalised for consideration of implementing the All Wales Civica system.

5) **Meaningful Activity**: Investment has secured a rich resource of meaningful activities, many of which will specifically support patients with sensory loss and dementia.

6) **CHC Buddying Pilot**: This activity has provided a real opportunity to gain patient feedback during the pandemic and will continue. The pilot has been extended to the community enabling patients with complex needs who are cared for at home to provide feedback.

7) **CHC Feedback**: th**e Board of CHC's report 'Feeling Forgotten'** has been considered by the Executive Team**.** Local feedback has been shared with divisional teams for action.

Aneurin Bevan University Health Board

Annual Equality Report 2020/21

Executive Summary

The purpose of this report is to demonstrate the work that was undertaken from 01 April 2020 - 31 March 2021 within the Health Board to meet Health Board objectives that were identified and agreed within the Strategic Equality Objectives. The report also includes the Equality Monitoring data based on a snapshot as of 31 March 2021.

The Health Board has a legal obligation under the Equality Act 2010 to publish this report by the deadline of 31 March 2022.

The Board are asked to review and approve the Annual Equality report, for it to be published by the deadline of 31 March 2022.

The Board is asked to: (please tick as appropriate)	
Approve the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Sarah Simmonds; Director of Workforce & OD

Report Author: Ceri Harris; Equality, Diversity, and Inclusion Specialist

Report Received consideration and supported by:

Executive Team – 10 March 2022	✓	**Committee of the Board [Committee Name]**	

Date of the Report: 07 March 2022

Supplementary Papers Attached: Appendix 1 - Annual Equality Report

Purpose of the Report

The purpose of this paper is to give an overview of key work in relation to delivery of our Strategic Equality Objectives for the period 2020/21. Within this, we have also included the Equality Monitoring data for the same period, focusing on the snapshot data as of 31 March 2021.

In April 2020, the Health Board published its third Strategic Equality Objectives report, a four-year vison of the actions it will take to meet the requirements of the Public Sector Equality Duty (Equality Act 2010) in the exercise of its functions to demonstrate due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited under the Act.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Background and Context

Each year the Health Board is required to publish its Annual Equality Report, demonstrating progress against the Health Board's Strategic Equality Objectives and an Equality Monitoring Report. The report includes data on its workforce's equality information, to ensure that there is no widening of diversity gaps, and that the workforce is representative of the communities that it provides its services too.

The report in ***Appendix 1*** provides the baseline equality data and narrative of equality activities over the past year, to ensure the Health Board meets its legal requirements.

Assessment and Conclusion

The Annual Report covers the period 2020/21, which includes the beginning of the pandemic, when many services were paused or re-purposed, while assessments and pandemic plans were put in place.

The report demonstrates that despite a very difficult year, with multiple challenges, the Health Board has continued to progress equality and inclusion in its services. From wellbeing support for staff to developing and maintaining inclusive services for patients and the community.

Recommendation

The Board are asked to review and approve the Annual Equality report, for it to be published by the deadline of 31 March 2022.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	The Health Board has a legal obligation under the Equality Act 2010 to publish this report by the 31 March 2022.
Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	N/A
Equality and Diversity Impact Assessment (including child impact assessment)	The Annual Report has undergone an EQIA, no negative impact was identified.

Health and Care Standards	The progress that has been identified in the Annual Equality report reflects on each of the Health Care Standards • Staying Healthy • Health Promotion, Protection & Improvement Safe Care • Managing Risk and Promoting Health and Safety • Preventing Pressure and Tissue Damage • Falls Prevention • Infection Prevention and Control and Decontamination • Nutrition and Hydration • Medicines Management • Safeguarding Children and Safeguarding Adults at Risk • Blood Management • Medical Devices, Equipment and Diagnostic Systems • Effective Care • Safe and Clinically Effective Care • Communicating Effectively • Quality Improvement, Research, and Innovation • Information Governance & Communications Tech • Record Keeping • Dignified Care • Patient Information • Timely Care • Timely Access • Individual Care • Planning Care to Promote Independence • Peoples Rights • Listening and Learning from Feedback
Link to Integrated Medium Term Plan/Corporate Objectives	Many of the actions identified in the Annual Equality Report are also included within the IMTP and service action plans as equality is threaded through the Vision, Values and Aims of the Health Board.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The Annual report identified different areas of work, form pilot projects to strategic changes within the organisation which will impact service delivery in the long term.
	Integration – Thought-out the Annual report it refers to collaboration and partnership working.
	Involvement – Thought-out the Annual report it refers to collaboration and partnership working, especially with diverse communities.
	Collaboration – Thought-out the Annual report it refers to collaboration and partnership working.
	Prevention – The key aim of the strategic Equality Objectives is to prevent discrimination and ensure dignity and respect for our staff, patients, their families, and the wider community.
Glossary of New Terms	
Public Interest	Public Interest

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Annual Equality Report 2020/2021

This document is available in Welsh and on request in a range of accessible formats.

Dyfodol Clinigol Clinical Futures

All publications are also available to download on our website https://abuhb.nhs.wales/

Table of Contents

Introduction and Background

This is the Aneurin Bevan University Health Board Annual Equality Report. It gives an overview of key work in relation to delivery of our Strategic Equality Objectives for the period 2020/2021 and should be read in conjunction with other relevant Health Board publications. These include our Strategic Equality Plan, Annual Report, Annual Quality Statement, Population Needs Assessment, Integrated Medium Term Plan and Annual Report of the Public Health Director. These reports can be found by following the below link: https://abuhb.nhs.wales/about-us/key-documents/

Aneurin Bevan University Health Board is responsible for the delivery of health care services to 639,000 people living in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen, and South Powys. We are also responsible in partnership for improving the health and wellbeing of local people.

The University Health Board employs 14,539 members of staff to deliver our services.

In March 2020 following a formal consultation and ongoing engagement activities with the community we serve and our staff we published a new Strategic Equality Plan and Objectives for the period 2020-2024.

The Equality Act 2010 protects people from discrimination because of their protected characteristics, which are: age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, non-belief including philosophical belief, and sexual orientation. These categories are known in the Act as 'protected characteristics'. The Act places a duty on listed public sector organisations to have Due Regard to the need to:

- Eliminate unlawful discrimination, harassment, and victimisation.
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not.
- Foster good relations between those who share a relevant

protected characteristic and those who do not.

In order for public bodies to better perform and demonstrate compliance with the Public Sector Equality Duty, the Welsh Government legislated to bring in specific equality duties as set out in the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 (also referred to as the Welsh Specific Equality Duties). The Regulations aim to ensure that the Health Board and others carrying out 'public functions' consider how we can positively contribute to a fairer society in our day-to-day activities.

The Well-being of Future Generations (Wales) Act 2015 and Social Services and Well-being (Wales) Act 2014 also provide opportunities to advance equality in a more integrated way. Despite the 2010 Equality Act coming into force on 08 April 2010, Part 1 of the Duty regarding socio- economic inequality lay dormant on the statute book, as neither the UK Government nor the devolved legislatures elected to commence it.

Welsh Ministers have since elected to commence the Socio-economic Duty on 31 March 2021. The statutory requirement places a legal responsibility on relevant bodies when taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. We continue to work to maximise the opportunities presented to align the equality duties within this framework. There is a range of activity taking place across Aneurin Bevan University Health Board, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations.

Our equality objectives relate to the 9 'protected characteristics' covered by the Equality Act (2010). These are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

Our Values and Purpose

Our Values

Listen.....
to patient, carer and visitor concerns

Prioritise & Promote.....
actions that improve service and patient safety

Reduce Harm.....
always report incidents or near misses that could cause harm to others

Be Proactive.....
looking for ways to improve patient experience

Be Curious....
Always asking "how can we do better?"

Be Ambitious
know what is "best in class" know when we are "top of class"

Problem Solve....
use initiative to solve problems

Challenge.....
unhelpful behaviours

Go the Extra Mile...
For patients, make connections and learn from others.

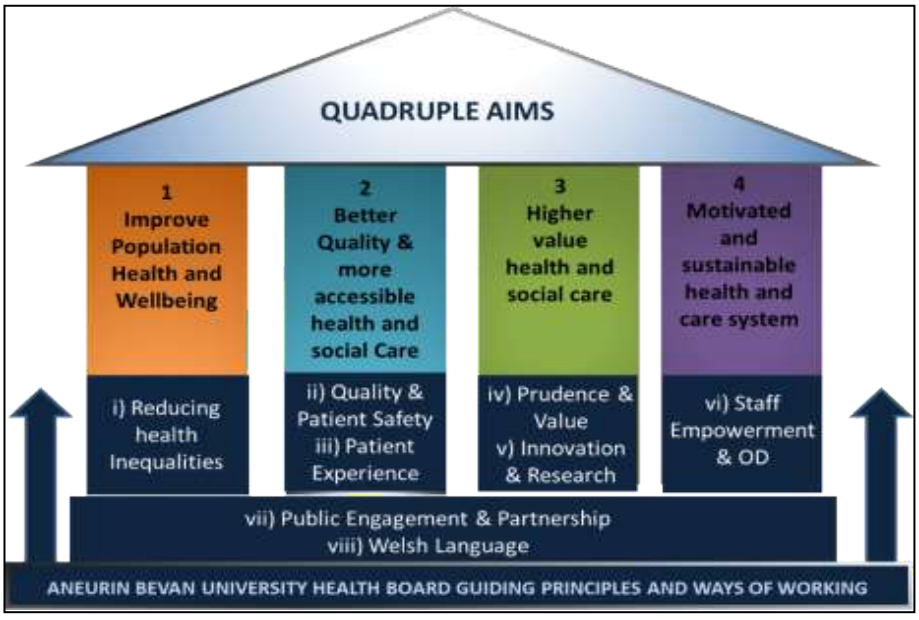
Take Pride....
in our own work and that of our team

Celebrate....
success and share good practice

Be Professional...
be a positive role model, be smart.

Lead By Example

Our Aims



Looking back over the last year

Progress has been made in the delivery of our equality objectives and the range of information we are increasingly able to draw on. We recognise that due to the entrenched nature of some inequalities stronger progress must continue to be made. We have ensured that these areas have been carried forward via our Strategic Equality Objectives for 2020 – 2024, integrated in to our IMTP and response to our Population Needs Assessment.

As this reporting period starts, we entered a national lockdown, and no one could have predicted that the spread of the Coronavirus (COVID-19) throughout the UK would become an unprecedented national emergency and how much the services we provide were to be significantly disrupted. Our Health Board area soon became the first and one of the worst-hit location in the whole of Wales and the UK. The pandemic has further highlighted existing inequalities and has widened others. Older people, ethnic minority people and some disabled people, particularly those in care homes, have been disproportionately impacted by the pandemic. We will keep our Strategic Equality Plan 2020-2024 under review to ensure that as more evidence continues to emerge our action plan will reflect what needs to be done to address inequalities.

This Annual Report describes our work towards implementing our equality objectives during 2020/2021. It highlights our achievements and identifies areas where further work is still required to make progress.

Key achievements in 2020-2021 aligned to our Strategic Equality Objectives

Equality Objective 1: Work in partnership to reduce all hate crime.

We have continued to raise awareness and understanding among staff of how to report hate crime and support colleagues who are victims of abuse/hate crime. Work continues with multi agency partners to raise awareness and respond positively to victims of hate crime.

This has included sharing information, resources and upcoming events and training opportunities.

Work has progressed in raising awareness of 'modern slavery' and the implementation of our action plan in relation to the Welsh Government Code on 'Ethical Employment in Supply Chains'.

Equality Objective 2: Work in partnership to reduce the incidence of domestic abuse, 'honour' based violence and elder abuse

Working in partnership we have continued to work with the South East Wales Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) Partnership Board. This provides the governance vehicle for the regional partnership for related services. We are key partners in the delivery of the **Gwent Regional Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2018-2023.**

To implement the National Training Framework for- 'Violence Against Women. Domestic Abuse and Sexual Violence Act (2015) we are members of the Regional Training Group and have accredited trainers.

In 2020/2021 the Pandemic had an impact on training resulting in reduced compliance of 67%. We continue to promote our policy for staff who are victims of domestic abuse, working with Divisions and Trade Union colleagues to promote the policy and training requirements. We were particularly mindful of staff who may be victims of abuse when working from home and ensured that provision for them to safely remain in the workplace were undertaken. We have participated in the White Ribbon campaign, including information in our communication to all staff. Opportunities have been developed for staff to undertake Group 2 and 3 training online ask-and-act-role-frontline-practitioner.pdf (gov.wales). This has enabled us to build an infrastructure of Domestic Abuse Champions to support and

signpost staff and patients affected by Domestic Abuse and Violence.

The Intranet pages of the Corporate Safeguarding team have been revamped and a new newsletter and Twitter account promoted publicising important information and training http://howis.wales.nhs.uk/sitesplus/866/page/60486

In the mass vaccination centres the Corporate Safeguarding team set up domestic violence awareness information areas promoting the 'Live Fear Free# helpline.

Equality Objective 3: Work in partnership with carers to continue awareness raising, provide information, and improve practical support for carers.

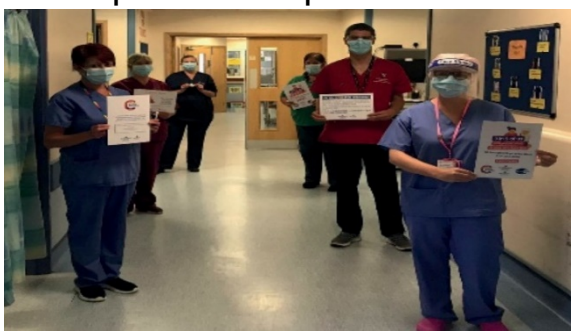
The Social Services and Wellbeing (Wales) Act 2014 (SSWBA) has significantly strengthened the legislative requirements for health boards and local government to integrate services in support of carers and the progress made to date with partner organisations provides an important foundation.

In April 2018, Welsh Government confirmed the annual allocation of £1 million across Wales to support carers under the SS&WBA. The total allocation for the Aneurin Bevan University Health Board area was £191,000 of which £16,609 was ring-fenced for young carers.

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

The Gwent Regional Partnership Board (RPB) was established (under Part 9 of the SSWBA) and has a duty to oversee implementation of the Act including the population needs assessment and subsequent area plans. Good progress has been made during the past year to implement the requirements of the SSWBA.

The Health Board would traditionally have information stands at hospital sites, however because of the pandemic and lack of access to sites this year, carers week links and carers stories were shared on IT platforms and with partnership networks. Nevill Hall hospital highlighted Carers Trust South East Wales (CTSEW) services and carer friendly accreditation at the main hospital reception area and the Royal Gwent hospital A&E and C4 East ward supported and promoted carers week with staff.



As part of our work with the Carers Strategic Partnership, we continued to provide information and support to carers during the pandemic and national carers week, as well as administering the carer's small grant scheme.

Equality Objective 4: Improve the wellbeing and engagement of our staff.

Improving the health and wellbeing of our staff continues to be an identified priority within the Integrated Medium Term Plan (IMTP). The Health Board has maintained its Corporate Health Standard awards at both Gold and Platinum level.

During the reporting period, the Health Board utilised 450 Clinical Futures Champions from across all areas of the Health Board and all roles to support two-way conversation and wellbeing to help ensure the successful delivery of our Clinical Futures model and the early opening of the Grange University Hospital in November 2021 as pictured below.

During the reporting period we continued to offer a very successful wellbeing module as part of a suite of staff development transformation modules and our award-winning staff development programme called 'Leading People' that focusses on self-care and compassionate leadership.

Our comprehensive Employee Wellbeing Service has been further expanded and plans continue to progress in relation to the establishment of a 'Wellbeing Centre of Excellence'. The Employee Well-being Centre of Excellence supports the priority placed on employee engagement and wellbeing within 'A Healthier Wales', the Royal College of Physicians 'Doing things differently: Supporting junior doctors in Wales' 2019, Health Education and Improvement Wales - Health and Social Care Workforce Strategy - HEIW (nhs.wales) and the Health Boards IMTP. It also supports a wide range of national strategic drivers identified within the All-Wales Staff Survey, NHS Wales Workforce Strategy, Well-being and Future Generations Wales (2015). During the pandemic the Employee Wellbeing Service was configured to form a 'hub and spoke' model to ensure staff were supported at this most challenging time. Many wellbeing initiatives were established including the establishment of a COVID-19 Peer Support Network – see link https://aneurinbevanwellbeing.co.uk/wp-content/uploads/2020/11/peer-support-network.pdf

The Health Board's lead psychologist for employee well-being is leading the framework for employee well-being through COVID-19. A framework of support has been put into place including:

- Staff well-being plan developed
- Access to well-being support on-line
- Well-being resource on intranet for staff https://aneurinbevanwellbeing.co.uk/
- Network of psychologists to support at local level
- Intensive care and emergency department spoke teams established
- Weekly briefing from Head of Employee Well-being to all staff
- Road to well-being programme being delivered virtually

- Evidence based Well-being Strategy and first in Wales psychological therapy trauma pathway and low intensity psychoeducational support pathway
- Mental Health support scheme for doctors extended to every frontline healthcare worker in Wales

Objective 5: 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.

Our Annual Quality Statement, IMTP and Annual Report of the Director of Public Health gave a comprehensive overview of the range of work that has been undertaken to reduce inequalities.

All patient and public areas continue to work towards improving the experience for those with sensory loss. This continues to be supported by the Health and Care Standards Audit.

The Health Board has a Patient Information Unit that promotes accessibility guidance for staff producing information for patients and the public. The Patient Information Unit continues to update its intranet pages and publicise this widely to increase staff awareness of the service and information on offer. This includes guidance for staff on producing accessible information.

Aneurin Bevan University Health Board were involved in the pilot for clear face masks, to support patients who needed to lip-read, and information was shared for staff to use speech to text services on their phones to support communication with patients who needed further support.

Lower uptake of COVID-19 testing within ethnic minority communities has seen a range of positive action initiatives undertaken to ensure equality of access. This included creating a 'drop in' facility at the mass testing centre, tailored communications, and the use of community influencers to

spread the word. This is a model we have continued to use since the COVID-19 vaccination became available.

During the first few months of the pandemic, the disproportionate impact of COVID-19 had on some groups of staff, such as ethnic minority staff, pregnant staff, older staff, and those with underlying conditions were emerging. There was a considerable amount of work with Staff Side and the Local Negotiating Committee to promote vaccinations to British, Asian and Minority Ethnics. As a result, we introduced an evidence-based risk assessment tool to safeguard staff in the workplace which became the basis for the All-Wales tool that was further developed as new evidence emerged. This tool undoubtedly reduced risk and protected lives.

Objective 6: Improve the access, experience, and outcomes of those who require Mental Health and Learning Disability services.

The Health Board's vision for mental health is underpinned by:

- Together for Mental Health Strategy.
- Together for Children and Young People Service Improvement Plans; the Mental Health Measure (Wales) 2010.

As well as local integrated strategies developed in partnership with local authorities, and other statutory legislation and policy drivers.

Based on these strategies and plans, our approach focusses on the following key principles:

- An emphasis on creating a culture and environment that is safe, therapeutic, respectful, and empowering. This includes a foundation of Inspirational leadership and a well-trained, competent workforce in sufficient numbers.
- A vision of services integrated evidence-based and high quality; services which offer accessible information that will allow services users to experience hope and optimism about their future and their recovery and will empower them to

develop their care in partnership with those that deliver care or offer support.

- An emphasis on working towards recovery and promoting independence where possible, by providing the information and support required to sustain and improve mental health and to self-manage mental health problems.
- Ensuring that people are treated and supported in environments and services that tackle stigma and discrimination.
- Developing services in partnership with the people that use them, including the design and evaluation of such services.
- Ensuring that the physical environment offers single sex facilities, usually in single rooms; gender safe communal areas; family areas; privacy and safety; and dignity for children and young people.

The Health Board's 2018-21 IMTP identified 5 major transformation programmes as its priorities. Two of these programmes:

- The redesign of the Older Adult Mental Health model and the Learning Disabilities Residential Services Review are sufficiently on track to conclude in the near future and are therefore being removed from the priorities list in this refresh.
- The Learning Disabilities residential review has resulted in some residential properties being declared surplus to requirements for people with learning disabilities. The Assessment & Treatment Unit at Llanfrechfa Grange has recently been refurbished to provide a fit for purpose and more homely facility until such time as the proposed Low Secure/Psychiatric Intensive Care Unit/High Dependency Unit development is commissioned. These programmes are replaced by two new integration programmes on young peoples' transition services (for the 15-25 age group) and developing service models that integrate physical and mental health care. A summary of their key achievements, opportunities and risks are outlined below along with a synopsis of the refreshed priorities for 2019-22.

Mental Health and Learning Disabilities Key Achievements 2020/21 and next steps

The Health Board's 2020/21 IMTP identified 5 major transformation priorities. A summary of their key achievements is outlined below along with a synopsis of the next steps for these priorities in the next planning phase 2020/23

Crisis Resolution 	A 12-month pilot of a new model for inpatient and Crisis Resolution Home Treatment Teams (CRFTT) started in October 2019 with a view to identifying a preferred option and implementation by summer 2020. Staff consultation was completed with agreement to new working hours that will support the future model of care and new staff were allocated to deliver the new CRFTT model in December 2019. A single site (St. Cadocs Hospital) has been identified for out-of-hours crisis assessment to improve access to a sustainable service 24/7. A business case is being developed following stakeholder evaluation of options for inpatient service re-design and once approved, staff engagement and consultation will take place early in 2020-21.
Sanctuary Service 	Development and testing of a Sanctuary Service is being led by third sector partners 'Growing Space' who have with health, social care, police and third sector to define the model needed for Gwent. This service is aimed at people in a self-defined or early stage of mental health crisis, providing a day facility that offers a safe place where people can go to talk with others who have a similar experience and where there are also self-help resources available to help people manage the causes of their distress and worry. Stage 1 'expression of interest' bid to fund a sanctuary service has been submitted for the Big Lottery 'People and Places' fund and following approval is now proceeding to Stage 2.
Learning Disabilities	The Learning Disabilities Services Review was completed, the impact of the recommendations on people affected by the change are being

Service Review 	evaluated. One of the immediate outcomes is the proposed new service model based on three 'agile' teams (highly skilled and well supported workforce) across Gwent to respond flexibly and effectively to crisis and engage early in transition. A business case is being developed to take forward the model which focuses on specialist health assessment, interventions, and expert advice with improved experiences for service users including those with complex needs and challenging behaviours.
Support House 	Ministerial and business case approvals were completed for the Support House (Crisis House). Funding of £1.4m was secured from the Intermediate Care Capital Fund and the programme has moved into invitation to tender and tender evaluation stages. The aim remains to be fully operational with delivery through third sector by 2021.
Shared Lives 	An operational model for the Shared Lives (formerly Host Families) was developed, baseline data gathered, and implementation tested in Newport local authority. This service model focuses on providing better support to prevent crises from escalating and suitable alternatives to inpatient admission for people already experiencing a mental health crisis. Evaluation of the initial pilot placements have taken place with positive, high impact outcomes for service users. The number of carer households increased to 7 families. The project team are designing carer support and training to facilitate full roll out of the programme in 2020/2021.

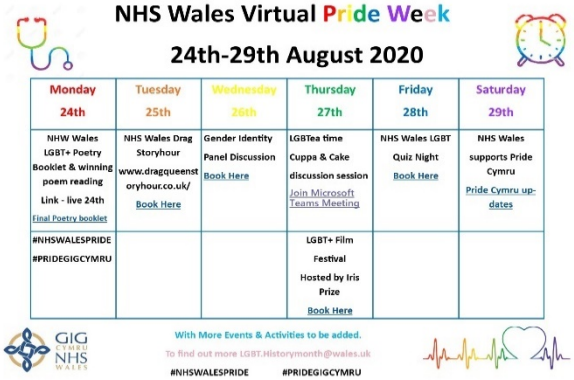
Objective 7: Improve the experience of lesbian, gay, bisexual and transgender (LGBT) service users and staff.

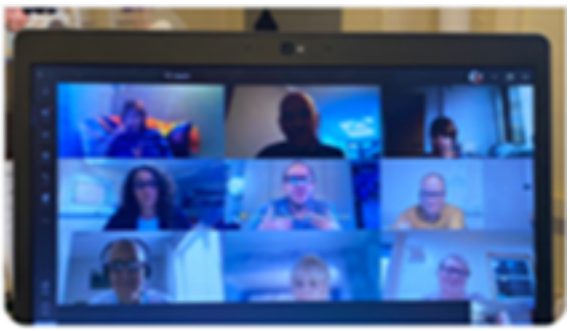
The Health Board has a long-established staff Lesbian, Gay, Bisexual and Transgender Advisory virtual Group. We continue to participate in engagement activities with the wider LGBT community.

Throughout the reporting period further work has been undertaken to increase awareness of the needs of transgender and non-binary people.

We continue to maintain membership of the Stonewall Diversity Champions programme.

As a result of the pandemic, Pride Cymru's annual event did not happen physically, so the Equality leads across Wales came together to share resources and hold the first NHS Wales Virtual Pride week event.





As part of our virtual LGBTea event, we were joined by Executive Director Peter Carr, the session was very positive, and staff even brought virtual biscuits to the event.

Equality Objective 8: Gender and Pay – Develop a fuller understanding of the reasons for any differences in pay and take the necessary action to address this.

Throughout the reporting period we have continued to encourage staff to complete their equality related data on their Electronic Staff Record (ESR) as an integral part of ESR training,

through specific promotional activities and regular communication messages on the ESR carousel. Despite the Health Board's move to online payslips for all staff, which has seen more staff logging into their online ESR account, significant gaps in our information remain. From an intersectional perspective, this continues to hamper a more detailed understanding in relation to gender and other protected characteristics such as ethnicity, disability, sexual orientation, and religion/belief.

It remains clear from the employment data that men continue to be underrepresented in the Health Board (as is the case across NHS Wales), however they are overrepresented in some job roles such as trade and estates related occupations and are disproportionately represented in the higher management banded posts.

The age and gender profile of the workforce together with anecdotal feedback from staff continues to identify that the menopause is a significant issue. During the reporting period ongoing work continues to implement the All-Wales Menopause Policy and the availability of awareness and support sessions for staff by the Health Boards menopause specialist nurse, who also runs a specific clinic for staff.

Proportionally more women than men work part time, our anecdotal information identifies childcare and other carer responsibilities as one of the main reasons for this. We have developed an agile working strategy to help staff with more flexible options for working.

Our roll out of Group 1 'Violence Against Women, Domestic Abuse and Sexual Violence' training continues to indicate a significant number of mainly historical disclosures that is also likely to be having a negative impact on women's progression within the workforce. We have continued to raise awareness and understanding of the effective implementation of our Health Board policy: "Supporting Staff Who Are Victims of Domestic Violence". This became increasingly important as the emerging evidence of increased domestic abuse became apparent during the lock down required as part of the management of the pandemic.

Other Key achievements 2020-21

- We have continued to advance equality through the delivery of a revised year 1 Strategic Equality Plan.
- Aneurin Bevan University Health Board were a key organisation to work with Welsh Government to develop the All-Wales Covid Risk Assessment, that is now available on ESR for all staff to complete and put support in place for High-Risk staff groups.
- We have taken action to understand the impacts of COVID-19 on people with protected characteristics and supported teams to consider the potential impact of equality within their decisions.
- We have delivered new programmes such as Test, Trace and Protect, Virtual Visiting and Attend Anywhere informed by Equality Q? Impact Assessments.
- We have taken action to strengthen equality and human rights scrutiny in governance and decision-making structures.
- We have prepared for implementation of the Socio-economic Duty.
- We established a Race Equality Advisory Group to concentrate awareness and support for our staff of colour. With the aim to develop a Race Equality Workforce Action Plan for the Health Board.
- Lower Monmouthshire Community Mental Health Team has signed up to the Diverse Cymru Race Mental Health Toolkit and accreditation programme.
- We opened Wales first vaccine clinic in a Jamia mosque.

- NHS Wales came together to hold NHS Wales Equality week, a series of events focusing on different aspects of Equality and inclusion, held virtually.
- Aneurin Bevan University Health Board invited staff to join a virtual Interfaith tour, to learn more about how they can

support the spiritual needs of our patients and families.

- During Sensory Loss Awareness Month in November, staff were invited to session on Visual Impairment, British Sign Language, and hearing loss. All sessions were held virtually.

Staff Case Study – David Chaffey BEM

David has been working as a switchboard operator for the Health Board since 2004. During that time, he has been a member of the Disability Advisory Group and is also a part of the Enable Staff network.

Since David was young, he has had problems with his vision, at the age of 7, he discovered that the nerves behind his eyes were disintegrating and after weeks of tests, he was told he would eventually go blind when he was diagnosed with Krabbe Disease. He was eventually registered blind at the age of 14. David had his first guide dog Gina when he was 18, which helped him build his confidence and made him more self-reliant. Later in life, David was diagnosed with dilated cardiomyopathy and had an implantable cardio defibrillator (ICD) fitted and in 2011 had a heart transplant.

Following his heart transplant, David has been able to take up horse riding again and has won competitions in Dressage. He also carried the Olympic torch in 2012 and received a BEM in 2014 for services to the NHS and voluntary work.

David has brought his own personal experiences of sight loss and disability into the workplace, getting involved in different projects including accessibility of the Health Board website, Access evaluations, visual awareness training, often in his own time. Having the combined perspective of the Health Board as an employee and patient he has often used his experiences to help improve services for others. During his time at ABUHB, he has faced barriers, around perceptions of his disability and access to personal development opportunities but has utilised

these experiences to work with departments to improve the experiences of others and create more inclusive services.

Conclusion

The unprecedented impact of the COVID-19 pandemic has shone a light on some of the entrenched inequalities that exist within wider society. It has become clear that some people within the communities we serve have been more negatively impacted than others. We have done our utmost to learn important lessons from the impact of the pandemic and have embraced new ways of working and innovative practices to support us to think and work differently to reduce inequalities.

The Equality and Human Rights Commission (EHRC) 2020 report 'How coronavirus has affected equality and human rights' summarises the emerging evidence. This has helped to provide clarity on the effects of the pandemic from an equality and human rights perspective and the risks to these in the longer term. We will take account of this and other evidence as it becomes available to update our Equality Action Plan.

Thank you

Thank you, as always, to the community we serve for their ongoing support and engagement and that of our partners and other stakeholders.

Thank you to our staff for their continued efforts to live the values of the Health Board every day and for their dedication, skill, and kindness during what continues to be unprecedented times.

Nathan Wyburn (artist - www.nathanwyburn.co.uk)

Contact us

If you would like to make any comments or discuss any aspects of the Annual Equality report, please contact:

Ceri Harris, Equality, Diversity, and Inclusion Specialist
Llanfrechfa Grange Hospital, Cwmbran, Torfaen,

E:Mail ABB.EDI@wales.nhs.uk Telephone 07976 321367.
Minicom 01633 238957.

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

EMPLOYMENT INFORMATION 2021

Introduction

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. Aneurin Bevan University Health Board (ABUHB) produce data yearly. The information provided relates to 31 March 2021 and includes:

Section 1: Gender
Section 2: Staff Group
Section 3: Age Band
Section 4: Disability
Section 5: Ethnicity
Section 6: Marital Status
Section 7: Religion/ Belief/ Non-Belief
Section 8: Sexual Orientation
Section 9: Working Pattern & Gender
Section 10: Contract Type
Section 11: Full Time Average Pay by Gender
Section 12: Average PT Hourly Rate by Gender & Staff Group
Section 13: AfC Pay Grade % Breakdown by Gender
Section 14: Medical & Dental % Breakdown by Role
Section 15: Leavers Data

Overview

1. Staff in Post (SIP)

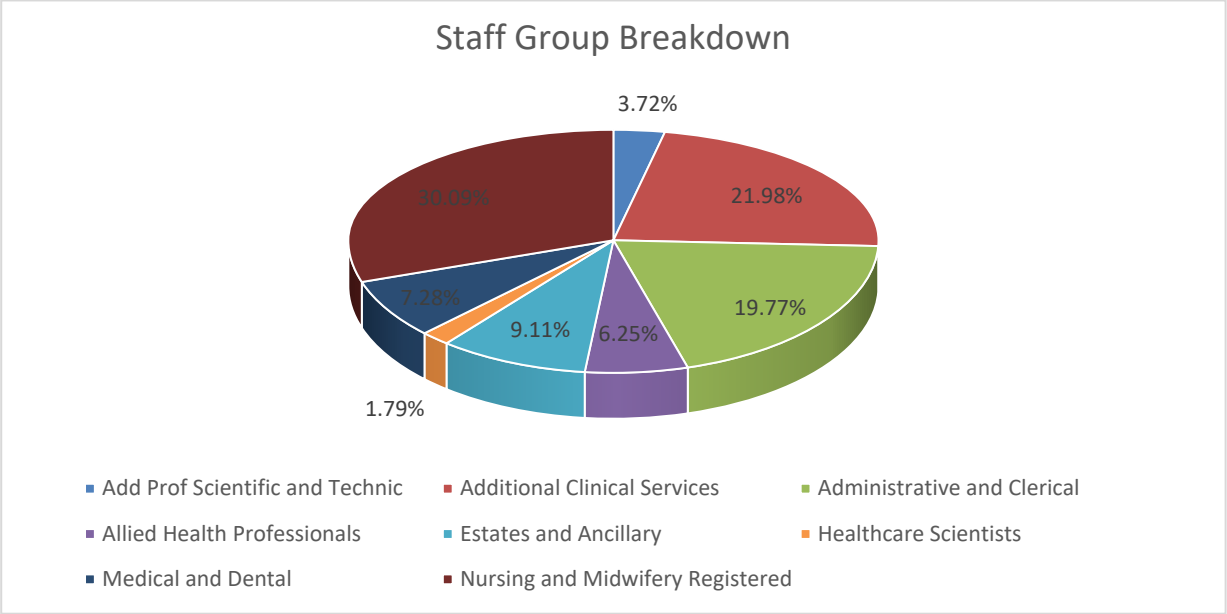
Our workforce is predominately female (over 80%), which is reflective of the majority of NHS Health Boards in Wales. Gender breakdown by headcount equates to Female – 11,808 and Male – 2,731, total headcount is 14,539.

2. Staff Group

The largest staff group is Nursing & Midwifery, which amounts over 30% of our workforce.

Total Staff in Post by Staff Group and Percentage Breakdown

Staff Group	Female	%	Male	%	Grand Total	%
Add Prof Scientific and Technic	400	2.75%	141	0.97%	541	3.72%
Additional Clinical Services	2792	19.20%	403	2.77%	3195	21.98%
Administrative and Clerical	2335	16.06%	540	3.71%	2875	19.77%
Allied Health Professionals	764	5.25%	145	1.00%	909	6.25%
Estates and Ancillary	846	5.82%	479	3.29%	1325	9.11%
Healthcare Scientists	179	1.23%	81	0.56%	260	1.79%
Medical and Dental	482	3.32%	576	3.96%	1058	7.28%
Nursing and Midwifery Registered	4009	27.57%	366	2.52%	4375	30.09%
Students	1	0.01%		0.00%	1	0.01%
Grand Total	**11808**	**81.22%**	**2731**	**18.78%**	**14539**	**100.00%**



3. Age Profile

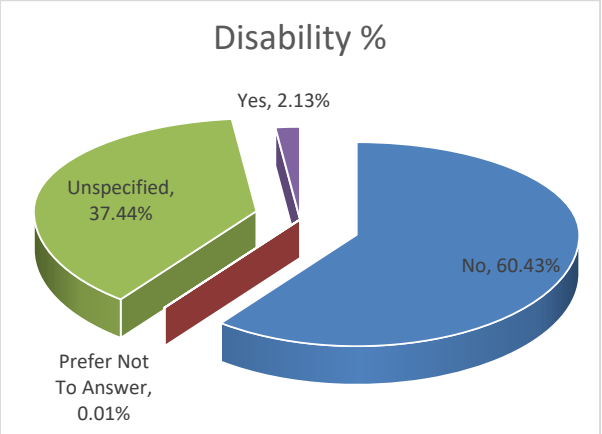
Nearly 30% (27.58%) of our workforce are aged between 51 and 60. Employees aged 71 and over has increased this year from 55 to 61 heads.

Age Band	Female	Male	Heads	%
20 and under	69	17	86	0.59%
21-25	660	154	814	5.60%
26-30	1232	313	1545	10.63%
31-35	1388	379	1767	12.15%
36-40	1365	341	1706	11.73%
41-45	1257	282	1539	10.59%
46-50	1452	334	1786	12.28%
51-55	1776	341	2117	14.56%
56-60	1585	309	1894	13.03%
61-65	805	189	994	6.84%
66-70	167	63	230	1.58%
71 and over	52	9	61	0.42%
Grand Total	**11808**	**2731**	**14539**	**100.00%**

4. Disability

37.44% of data is Unspecified, so full data not available. The collection of disability data has improved by 14.5% from March 2018. In 2018 only 49% of staff had completed this information compared to 62.56% in March 2021.

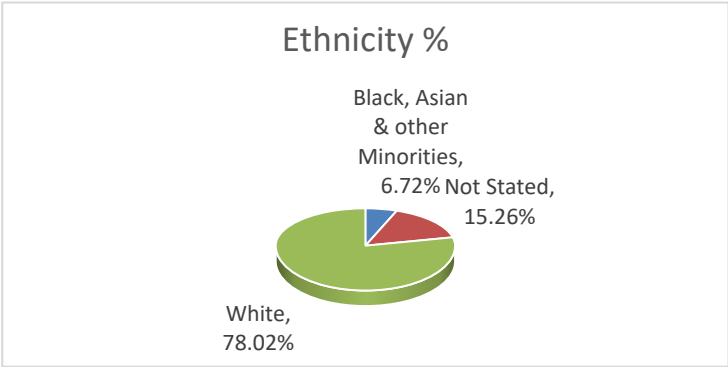
Disability	Heads	%
No	8,786	60.43%
Prefer Not to Answer	1	0.01%
Unspecified	5,443	37.44%
Yes	309	2.13%
Grand Total	**14,539**	**100.00%**



5. Ethnicity

Over 78% of employees identified as White. Within our workforce data base, we have 47 different Ethnic Origins identified which breakdown ethnicity further.

Ethnicity	Heads	%
BAME	977	6.72%
Not Stated	2,219	15.26%
White	11,343	78.02%
Grand Total	**14,539**	**100.00%**



6. Marital Status

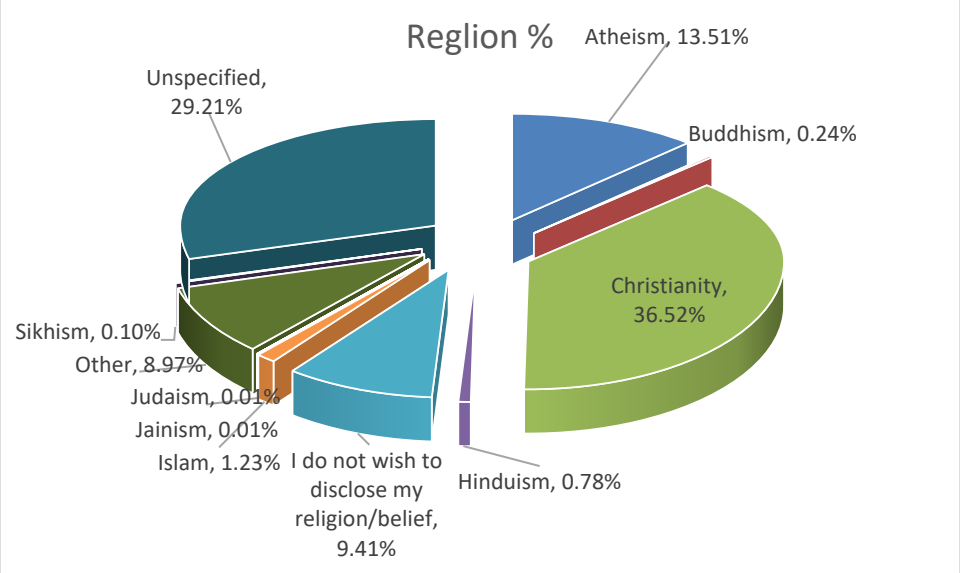
Only 11% of marital status data has not been provided and over 50% of employees identify as civil partnership/ married.

Marital Status	Heads	%
Civil Partnership	195	1.34%
Divorced	900	6.19%
Legally Separated	108	0.74%
Married	7,389	50.82%
Single	4,324	29.74%
Unknown	1,533	10.54%
Widowed	90	0.62%
Grand Total	**14,539**	**100.00%**

7. Religion/ Belief/ Non-Belief

9.41% of the workforce have expressed that they do not want to disclose their religion/ belief and another 29.21% are unspecified.

Religion, Belief, Non-Belief	Heads	%
Atheism	1,964	13.51%
Buddhism	35	0.24%
Christianity	5,310	36.52%
Hinduism	113	0.78%
I do not wish to disclose my religion/belief	1,368	9.41%
Islam	179	1.23%
Jainism	2	0.01%
Judaism	2	0.01%
Other	1,304	8.97%
Sikhism	15	0.10%
Unspecified	4,247	29.21%
Grand Total	**14,539**	**100.00%**



8. Sexual Orientation

Under 30% of the workforce have not disclosed their sexual orientation and 3.37% have identified they have declined to provide the information. Over 65% of the workforce have identified as heterosexual/ straight.

Sexual Orientation	Heads	%
Bisexual	90	0.62%
Gay or Lesbian	210	1.45%
Heterosexual or Straight	9,468	65.20%
Not stated (person asked but declined to provide a response)	489	3.37%
Other sexual orientation not listed	9	0.06%
Undecided	5	0.03%
Unspecified	4,268	29.39%
Grand Total	**14,539**	**100.00%**

9. Staff Group by Gender and Working Patterns

	Female					Male					
Staff Group	Full Time	%	Part Time	%	Female Total	Full Time	%	Part Time	%	Male Total	Grand Total
Add Prof Scientific and Technic	199	49.75%	201	50.25%	400	111	78.72%	30	21.28%	141	541
Additional Clinical Services	1098	39.33%	1694	60.67%	2792	303	75.19%	100	24.81%	403	3195
Administrative and Clerical	1208	51.73%	1127	48.27%	2335	457	84.63%	83	15.37%	540	2875
Allied Health Professionals	409	53.53%	355	46.47%	764	132	91.03%	13	8.97%	145	909
Estates and Ancillary	92	10.87%	754	89.13%	846	294	61.38%	185	38.62%	479	1325
Healthcare Scientists	111	62.01%	68	37.99%	179	70	86.42%	11	13.58%	81	260
Medical and Dental	334	69.29%	148	30.71%	482	503	87.33%	73	12.67%	576	1058
Nursing & Midwifery	2197	54.80%	1812	45.20%	4009	285	77.87%	81	22.13%	366	4375
Students	1	100.00%		0.00%	1		0.00%		0.00%		1
Grand Total	5649	47.84%	6159	52.16%	11808	2155	78.91%	576	21.09%	2731	14539

10. Contract Type

Under 10% of the workforce are on Fixed Term contracts.

Assignment Category	Female	Male	Grand Total
Fixed Term Temp	999	433	1,432
Permanent	10,809	2,298	13,107

11. Full Time Average Pay by Gender

Staff Group	Female	Male	Overall
Add Prof Scientific and Technic	£37,795.42	£41,256.85	£39,034.84
Additional Clinical Services	£20,554.93	£20,736.42	£20,594.08
Administrative and Clerical	£29,443.80	£36,738.39	£31,445.98
Allied Health Professionals	£35,419.67	£35,776.63	£35,506.77
Estates and Ancillary	£21,013.12	£22,547.85	£22,182.06
Healthcare Scientists	£36,991.17	£37,474.61	£37,178.14
Medical and Dental	£68,396.90	£74,511.09	£72,071.26
Nursing and Midwifery Registered	£34,034.77	£34,761.20	£34,118.21
Students	£44,503.00		£44,503.00
Grand Total	**£32,544.97**	**£41,314.85**	**£34,966.19**

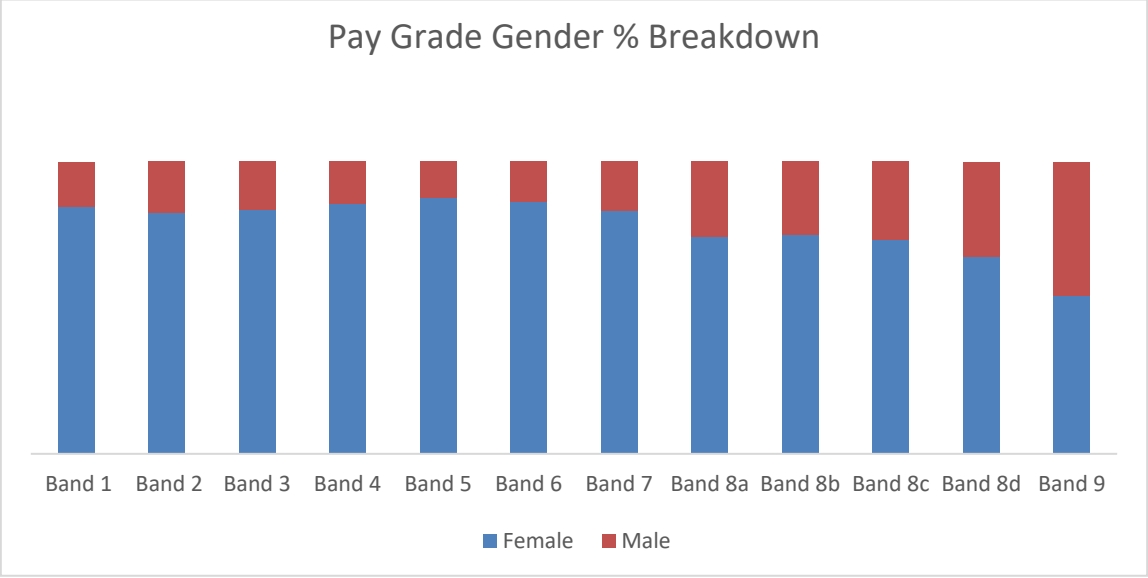
12. Average Part Time Hourly Rate by Gender and Staff Group

Part time contracted hours can vary between 1 and 37 hours so the average hourly rate has been calculated rather than average salary.

Staff Group	Female	Male
Add Prof Scientific and Technic	25.48	24.47
Additional Clinical Services	10.62	10.49
Administrative and Clerical	11.82	13.80
Allied Health Professionals	20.09	19.30
Estates and Ancillary	9.91	9.92
Healthcare Scientists	21.09	17.45
Medical and Dental	127.76	128.22
Nursing and Midwifery Registered	17.40	17.59

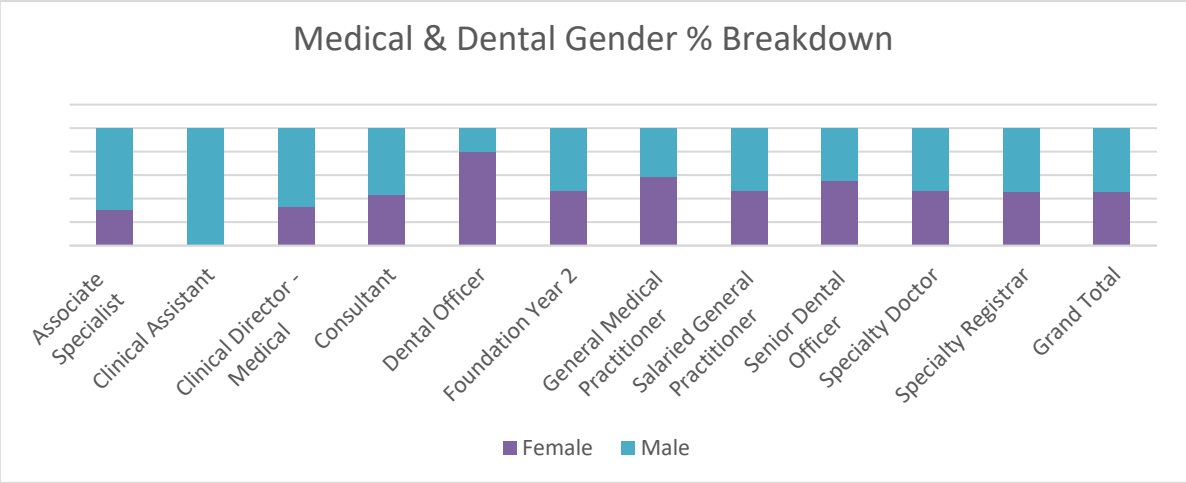
13. Agenda for Change Pay Grade % Breakdown by Gender

Agenda for Change Pay Band	Female	Male
Review Body Band 1	84.62%	15.38%
Review Body Band 2	82.47%	17.53%
Review Body Band 3	83.56%	16.44%
Review Body Band 4	85.52%	14.48%
Review Body Band 5	87.56%	12.44%
Review Body Band 6	86.06%	13.94%
Review Body Band 7	83.16%	16.84%
Review Body Band 8 - Range A	74.19%	25.81%
Review Body Band 8 - Range B	74.86%	25.14%
Review Body Band 8 - Range C	73.13%	26.87%
Review Body Band 8 - Range D	67.50%	32.50%
Review Body Band 9	54.17%	45.83%
Grand Total	**84.08%**	**15.92%**



14. Medical & Dental Gender % Breakdown by Role

Medical and Dental Role Breakdown	Female	Male
Associate Specialist	30.77%	69.23%
Clinical Assistant	0.00%	100.00%
Clinical Director - Medical	33.33%	66.67%
Consultant	43.66%	56.34%
Dental Officer	80.00%	20.00%
Foundation Year 2	46.94%	53.06%
General Medical Practitioner	58.82%	41.18%
Salaried General Practitioner	46.43%	53.57%
Senior Dental Officer	55.56%	44.44%
Specialty Doctor	46.49%	53.51%
Specialty Registrar	46.25%	53.75%
Grand Total	**45.56%**	**54.44%**



15. Leavers Data

Over half of all leavers (53.42%) are over 50 years of age.

Age Band	Female	Male	Grand Total	Leavers %
Under 20	7	2	9	0.78%
21-25	77	17	94	8.14%
26-30	94	20	114	9.87%
31-35	65	25	90	7.79%
36-40	93	14	107	9.26%
41-45	50	14	64	5.54%
46-50	42	18	60	5.19%
51-55	137	22	159	13.77%
56-60	180	31	211	18.27%
61-65	148	22	170	14.72%
66-70	51	10	61	5.28%
over 70 Years	14	2	16	1.39%

N.B. *Due to the constant movement of junior doctors, Medical and Dental data is not included in this data*

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Aneurin Bevan University Health Board
Wednesday 23rd March 2022
Agenda Item: 4.4

Aneurin Bevan University Health Board

GWENT REGIONAL PARTNERSHIP BOARD POPULATION NEEDS ASSESSMENT 2022-27 CONSULTATION

Executive Summary

The Social Services and Wellbeing (Wales) Act 2014 sets out a duty on local authorities and local Health Boards to produce one collective population assessment report per local government electoral cycle. The Act also stipulates that local authorities and local health boards are required formally to approve the PNA report and make it available on their websites. A copy of the population assessment report must be completed by April 2022 and be sent to Welsh Ministers at the time of publication.

The first regional Population Needs Assessment was overseen by the Gwent Regional Partnership Board (RPB) in April 2016. The PNA aligned to the Wellbeing Assessments completed by the 5 Public Service Boards as required under the Wellbeing of Future Generations Act. The 2022 PNA report has been developed in collaboration the regional PSB to provide a consistent regional assessment of need linked to the Gwent Wellbeing Assessment, previously presented to the ABUHB in January 2022.

Engagement with citizens is a key principle in the SSWB Act and the PNA has been developed and includes qualitative data from a range of citizen groups. In a similar way to the production of the previous PNA in 2016, data has also been collected from a range of sources, including from Data Cymru, national research and service providers in order to identify emerging challenges. The PNA highlights the joint priorities requiring partnership working across public services, the health board and voluntary sector.

Further details are available on the Gwent RPB's website: Population Needs Assessment - Gwentrpb

The next PNA is due to be published by 1st April 2022. The assessment will then be used to develop the Gwent Area Plan by April 2023.

The Board is asked to:	
Approve the Report	✓
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Dr Sarah Aitken, Executive Director of Public Health & Strategic Partnerships

Report Author: Gwent Regional Partnership Board

Supplementary Papers Attached:
The full Draft Gwent PNA is available via link: Population Needs Assessment - Gwentrpb

Recommendation

The Board is asked to approve formally the Population Needs Assessment report.

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

Gwent Regional Partnership Board Population Needs Assessment

Introduction

As set out in the Social Services and Wellbeing (Wales) Act 2014 local authorities and local Health Boards must produce one population assessment report per local government electoral cycle. The first regional Population Needs Assessment (PNA) was completed by the Gwent Regional Partnership Board (RPB) in April 2016 and aligned to Wellbeing Assessment completed by Public Service Boards as required under the Wellbeing of Future Generations Act. This PNA report will also align, integrate and cross reference the Gwent Wellbeing Assessment to avoid duplication and create a joint population wellbeing assessment for the region (this section can be read alongside the regional Wellbeing Assessment or as an individual document).

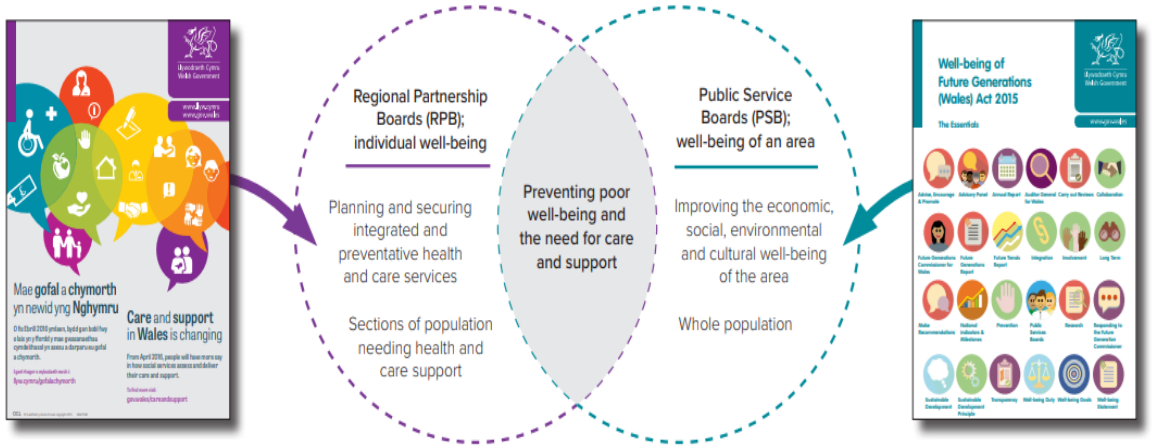


Fig 1: Relationship between RPBs and Public Service Boards.

As set out in Welsh Government's SSWB Act Part 2 Code of Practice, this population assessment comprises of (1) an assessment of need the (2) range and level of services required. It will also jointly assess:

- the extent to which there are people in the area of assessment who need care and support
- the extent to which there are carers in the area of assessment who need support
- the extent to which there are people whose needs for care and support (or, in the case of carers, support) are not being met.

Policy Areas included and within this Population Needs Assessment (PNA).

- National Health Service (Wales) Act 2006 and children and young people's plans as required by the Children Act 2004.
- Integrated Medium Term Plans produced by Local Health Boards as required by the NHS Finance (Wales) Act 2014,
- Part 2 of the Housing (Wales) Act 2014 including local homelessness strategies
- United Nation Convention on the Rights of Persons with Disabilities, United Nation Convention on the Rights of the Child, and the United Nation Principles for Older Persons

- Equality Act 2010 Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Beliefs, Sex and Sexual Orientation.
- National Outcomes Framework
- Welsh language strategic framework More than just words
- Socio -Economic Duty

Engagement - a culture not a process

The voice of citizens, third sector partners and service providers are key to developing this PNA and the guidance on effective citizen engagement, set out in *'National participation Standards, Participation Cymru's National Principles for Public Engagement in Wales'* and the Older People's Commissioner's Best Practice Guidance for '*Engagement and Consultation with Older People on Changes to Community Services in Wales'*, have been considered. Citizen voices have been included in each PNA section and coordinated through the regional Citizen Panel and Chair who sits on the RPB. This also includes populations from the secure estate in order to fulfil the requirements of section 11 of the Act.

There has been extensive engagement across the region using various methodologies such as Snap surveys, social media and established forums (Carers forum, Youth Council, Dementia Friendly cafes etc). An online survey was distributed across the region and the Public Service Board have analysed comments to identify themes; and there were over 1500 individual comments in relation to health and social care.

Social Care – "Affordable social care and good support for carers"

The need for increased social care provision was a regular theme that emerged through the survey, especially in regard to providing adequate social care for older people. Other comments include:

'More funding for those with learning difficulties will help provide more support and better quality respite for children and adults with learning difficulties'

A need for improved services for older people within the community and just want somebody to talk to

Elderly people are feeling isolated- More day centres need to be available as many services have closed during the pandemic

Local Authorities - "The Council is doing more to help residents than ever"

There is a mixed view on the local authorities across Gwent from residents. Many commented that their local council has provided more support than ever during the pandemic whereas other residents have expressed concern regarding a lack of involvement from their local council, finding difficulties in knowing what is available within their community as a result of this. When asked what we could do to help improve on this, one resident noted how we

could introduce well-being ambassadors to help improve cohesion between local communities and their council.

Health – "Fair and equal access to support when needed"

Health and wellbeing are important to residents across Gwent and many individuals commented on the importance of mental health services and improving access to them for both adults and children. Residents commented on the importance of exercise and the ability to maintain a healthy lifestyle, access to sports centres and green spaces were felt to be key to this.

'Need for a more efficient Mental Health and well-being service- Concerns around waiting times and responses from health and well-being advisors'

There were multiple positive comments on health services in the region however a number of residents noted the importance of having access to face to face appointments with their local GP. Difficulties in being able to access appointments for dentists and GPs were raised. Residents also highlighted the importance of given local communities the skills to be able to manage their own health and wellbeing so that there isn't as much need for services.

'Waiting list to access all services are high, housing, GPs, social services'

Schools – "There is a sense of community- good schools and facilities"

Throughout the feedback on what we can do to improve wellbeing in Gwent in the future, schools are highlighted as a tool that can be utilised by local communities for groups to meet and more community classes to be held. Schools are very much seen as a positive way to engage with our local residents too.

More Youth activities – Help improve mental well-being of teenagers

Focussed work with minority groups

We have engaged the views of those who would otherwise be hard to reach and marginalised including minority groups such as homeless people and travellers. We have used existing mechanisms to engage with vulnerable groups such as those set out below.

- *Military veterans*
- *Gypsy travellers*
- *Black And Minority Ethnic groups*
- *Asylum seekers and refugees*
- *Lesbian Gay Bisexual Transgender (LGBT) community*
- *People in secure estates and their families*
- *Children and young people in contact with the Youth Justice System*
- *Looked After Children and young carers*
- *Homeless people*

Veterans

A veteran is defined as: 'anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces.

In 2017 the Ministry of defence estimated 2.4 million UK Armed Forces Veterans in the UK, making up an estimated 5% of household residents aged 16 and over. There are approximately 140,000 veterans living in Wales and Veterans aged above working age (65+) are estimated at 82,000. The majority of Service Leavers transition from the Armed Forces well and integrate back to community life with the right support at the right time. Studies identify that most veterans in general view their time in the Services as a positive experience and do not suffer adverse health effects as a result of the time they have served. However, for a minority, adverse physical and mental health outcomes can be substantial and can be compounded by other factors – such as financial and welfare problems. Key health issues facing the veteran population relate to common mental health problems (but also include Post traumatic Stress Disorder (PTSD)) and substance misuse – including excess alcohol consumption and to a much lesser extent - use of illegal drugs. In addition, time in the Services has been identified to be associated with musculoskeletal disorders for some veterans.

Research suggests that most people 'do not suffer with mental health difficulties even after serving in highly challenging environments. However, some veterans face serious mental health issues. The most common problems experienced by veterans
(and by the general population) are:

- depression
- anxiety
- alcohol abuse (13%)

Probable PTSD affects about 4% of veterans. Each year, about 0.1% of all regular service leavers are discharged for mental health reasons. Each Health Board in Wales has appointed an experienced clinician as a Veteran Therapist (VT) with an interest or experience of military (mental) health problems. The VT will accept referrals from health care staff, GPs, veteran charities, and self-referrals from ex-service personnel. The service in ABUHB is based in Pontypool. The primary aim of Veterans' NHS Wales is to improve the mental health and well-being of veterans with a service-related mental health problem. The secondary aim is to achieve this through the development of sustainable, accessible, and effective services that meet the needs of veterans with mental health and well-being difficulties who live in Wales.

A Welsh Government report from 2014 'Improving Access to Substance Misuse Treatment for Veterans' identified that Substance Misuse Area Planning Boards lead on local collaborative planning, commissioning, and delivery for services to ensure that the needs of veterans are met. A 2011 report from Public Health Wales on 'Veterans' health care needs assessment of specialist rehabilitation services in Wales' identified a range of recommendations to support veterans with respect to their physical health and disability with regards to specialist rehabilitation service provision.

The Strategy for Our Veterans (MOD, 2018) has a 10-year scope to 2028. The strategy addresses the immediate needs of older Veterans as well as setting the right conditions for society to empower and support the newer generation.

The key themes that emerged as affecting Veterans lives were:

- Community, relationships and integrating into their community.
- Employment, education, and skills to continue to enhance their careers through their working lives.
- Finance and debt. Veterans have sufficient financial education, awareness, and skills to be financially self-supporting and resilient.
- Health and Wellbeing. All veterans enjoy a state of positive physical and mental health and wellbeing, enabling them to wider aspects of society.
- Making a home in civilian society. Veteran have a secure place to live either through buying, renting or social housing.
- Veterans and the law. They leave the Armed Forces with the resilience and awareness to remain law abiding civilians.

During the pandemic there were challenges of loneliness and isolation in Veterans with Welsh Government funding provided to address this issue.
There are a range of services across Gwent to support Veterans and The Armed Forces Covenant has been recognised in Law from December 2021, meaning that Housing, Education and Health services will have to pay 'due regard' when implementing policies.

Gypsy Travellers

- Blaenau Gwent 72 (0.10%)
- Caerphilly 31 (0.02%)
- Monmouthshire 6 (0.01%)
- Newport 84 (0.06%)
- Torfaen 155 (0.17%)
- Wales 2785 (0.09%)

The 2011 Census showed the following people identified as Gypsy/Traveller or Irish Traveller (this excludes Roma). However, it is likely that many households would not have completed the census – both because they were living on 'unauthorised sites' or encampments and as such did not appear on official records or because of a mistrust of the purpose of the census. Where people did receive forms, potential lower than average literacy levels may have meant that some households would not have completed them, and where they were completed some households would have chosen not to identify as Gypsies/Travellers or Irish Travellers. The largest Gypsy & Traveller (G&T) population is in Torfaen, however Nantyglo in Blaenau-Gwent also has a large population, many now living in 'bricks and mortar' in close proximity to a long established site. Newport also has a significant G&T population in unofficial sites around the periphery of the city centre and Newport is very often the unofficial unauthorised site for travellers in transit heading east/west from Ireland to England.

The Gypsy, Roma and Traveller people have the worst outcomes of any ethnic group across a huge range of areas including education, health, employment, criminal justice and hate crime (House of Commons 2019). It has been found that:

- Infant mortality rates are up to five times higher among this minority group when compared to the national rate.
- The immunisation rates among Travellers children are low compared with the rest of the population. Some suggest that GPs are reluctant to register Travellers as they are of no fixed abode, meaning they cannot be counted towards targets and therefore remuneration.
- There is a high accident rate among the Traveller and Gypsy population, which is directly related to the hazardous conditions on many Traveller sites – particularly as sites are often close to motorways or major roads, refuse tips, sewage work, railways or industrialized areas. Health and safety standards are often poor.
- Travellers have lower levels of breastfeeding.
- There is also a higher prevalence of many medical conditions when compared to the general population, including miscarriage rate, respiratory problems, arthritis, cardiovascular disease, depression and maternal death rates.
- Alcohol consumption is often used as a coping strategy, and drug use among Traveller young people is widely reported and feared by Traveller elders.
- Cultural beliefs include considering that health problems (particularly those perceived as shameful, such as poor mental health or substance misuse) should be dealt with by household members or kept within the extended family unit
- Travellers also face challenges in accessing services either due to the location of the sites (or due to transient nature of being in an area). Not having access to transport (particularly related to women who often cannot drive) to reach services is another reason for low use of services as well as low levels of health literacy of what services they are entitled to use or how to access them.

Generally the communities have low expectations in regard to their health and life expectancy. Studies have repeatedly shown that Travellers often live in extremely unhealthy conditions, while at the same time using health services much less often than the rest of the population.

Black And Minority Ethnic (BAME) groups

The 2011 Census shows the following percentages classed as BAME populations in each local authority compared to Wales

- Blaenau Gwent 1.5%
- Caerphilly 1.6%
- Monmouthshire 1.9%
- Newport 10.1%
- Torfaen 2.0%
- Wales 4.4%

Public Health Wales have found that ethnicity is an important issue because, as well as having specific needs relating to language and culture, persons from ethnic minority backgrounds are more likely to come from low income families, suffer poorer living conditions and gain

lower levels of educational qualifications. In addition, certain ethnic groups have higher rates of some health conditions. For example, South Asian and Caribbean-descended populations have a substantially higher risk of diabetes; Bangladeshi-descended populations are more likely to avoid alcohol but to smoke and sickle cell anaemia is an inherited blood disorder, which mainly affects people of African or Caribbean origin. Raising the Standard: Race Equality Action Plan for Adult Mental Health Services aims to promote race equality in the design and delivery of mental health services in order to reduce the health inequalities experienced by some ethnic groups. People don't always access support that is available as they are often unaware the support exists or it doesn't meet their needs. Langauage barriers can also cause difficulties for engagement and supporting people. Raising awareness of services and support within BAME communities is crucial to improve uptake of support. It has also been highlighted that although costly, the information needs to be accessible within areas of the community and also accessible in different formats and languages.

It is clear is that coronavirus has had an adverse and disproportionate impact on people from BME communities. A Government enquiry took place to identify why people from BME backgrounds appear to be disproportionately affected and further work is needed to ensure we can improve health outcomes.

Asylum Seekers, Refugees & Migrants

Until 2001, relatively low numbers of asylum seekers and refugees decided to settle in Wales compared to some parts of the UK. The numbers of asylum seekers and refugees increased when Wales became a dispersal area. The number of asylum applications in 2016 has seen an increase of 8% compared to the year before. Service provision to refugees and people seeking asylum by non-government organisations (NGOs) has decreased significantly in recent years. This has an adverse impact on people's health and Well-being. No recourse to public funds and safeguarding issues such as honour based violence and trafficking are key emerging themes for service providers. For service users the lack of, or limited access to information and tenancy support appear to be the key emerging themes. Various reports acknowledge that data collection systems for the number of migrants have weaknesses, which puts limitations on their reliability. There is no agreed definition for 'migrants' which further exacerbates reliable data collection.

The 2011 census found that the top ten countries of origin of people born outside the UK, in order of highest numbers first were: Pakistan, India, Bangladesh, Poland, Philippines, Germany, South Africa, Nigeria, Italy and Zimbabwe. Feedback from Education and Social Services indicate that people from Roma background have very specific needs in addition to those of the general new-migrant population. Good communication with migrants is essential. Determining the language and suitability of format (e.g. written, audio, face to face, telephone) and support available, such as advocacy and interpretation are critical elements to ensure effective communication. This will in turn benefit budgets and customer care as it contributes to determining the appropriate service. In addition, other issues highlighted for both migrants and asylum seekers include the need for more advocacy and floating support for migrants, lack of a strategic approach to information and service provision for new migrants and lack of coordination between services for migrants, asylum seekers and refugees.

Lesbian Gay Bisexual Transgender (LGBT +) community

The public health white paper 'Healthy Lives, Healthy People' identified poor mental health, sexually transmitted infections (STIs), problematic drug and alcohol use and smoking as the top public health issues facing the UK. All of these disproportionately affect LGBT populations:

- Illicit drug use amongst LGB people is at least 8 times higher than in the general population
- Around 25% of LGB people indicate a level of alcohol dependency
- Nearly half of LGBT individuals smoke, compared with a quarter of their heterosexual peers
- Lesbian, gay, and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm
- 41% of trans people reported attempting suicide compared to 1.6% of the general population

People in secure estates and their families

HMP Usk/Prescoed is situated in Monmouthshire and social care staff support inmates in line with the Act. The prisons have a combined population of 527. (MoJ, 2108) ABUHB also provide primary healthcare services to offenders in HMP Usk/Prescoed, in partnership with the National Offender Management Service (NOMS). In addition to the prison population it is likely that ex-offenders will require additional care and support to prevent needs arising, particularly those who misuse drugs and/or alcohol or have mental health problems. A recent 'Prison Health Needs Assessment in Wales' report was published by Public Health Wales and highlighted a number of key areas to address:

- Access to healthcare facilities
- Mental health and healthcare
- Substance Misuse including smoking
- Oral health
- Infections disease
- Support following release

During the pandemic we know that there were serious concerns to everyone living and working in prisons, resulting in restrictions put in place to limit the spread of the virus (HM Inspectorate of Prisons 2021) Prisoners have identified a decline in emotional, psychological and physical wellbeing at this time, due to chronic boredom and exhaustion of spending hours locked in their cells. They lacked enough day to day interaction and support from other prisoners, staff and family and friends.

Children and young people in contact with the Youth Justice System

Children and young people in contact with the youth justice system may have more health and well-being needs than other children of their age. They have often missed out on early attention to these needs. They frequently face a range of other, often entrenched, difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems. Many of the children and young people in contact with

the youth justice system in Gwent may also be known to children's social care and be among those children and young people who are not in education, employment, or training. For vulnerable children and young people, including those in contact with the youth justice system, well-being is about strengthening the protective factors in their life and improving their resilience to the risk factors and setbacks that feature so largely and are likely to have a continuing adverse impact on their long-term development. Well-being is also about children feeling secure about their personal identity and culture. Due attention to their health and well-being needs should help reduce health inequalities and reduce the risk of re-offending by young people. Across the region the Youth Offending Service (YOS) & partners are:

- Developing a health pathway in partnership with ABUHB for young people involved/in contact with the youth justice system.
- Testing the Youth Justice Board (YJB) Enhanced Case Management - a therapeutic approach towards addressing a child's offending behaviour
- Identifying, screening, and responding to Speech, Language & Communication Needs (SLCN) via the provision of a dedicated Gwent YOS Speech & Language Therapist.
- Commissioning a Substance Misuse Service for Children and Young People within Gwent.

(1) CHILDREN AND YOUNG PEOPLE

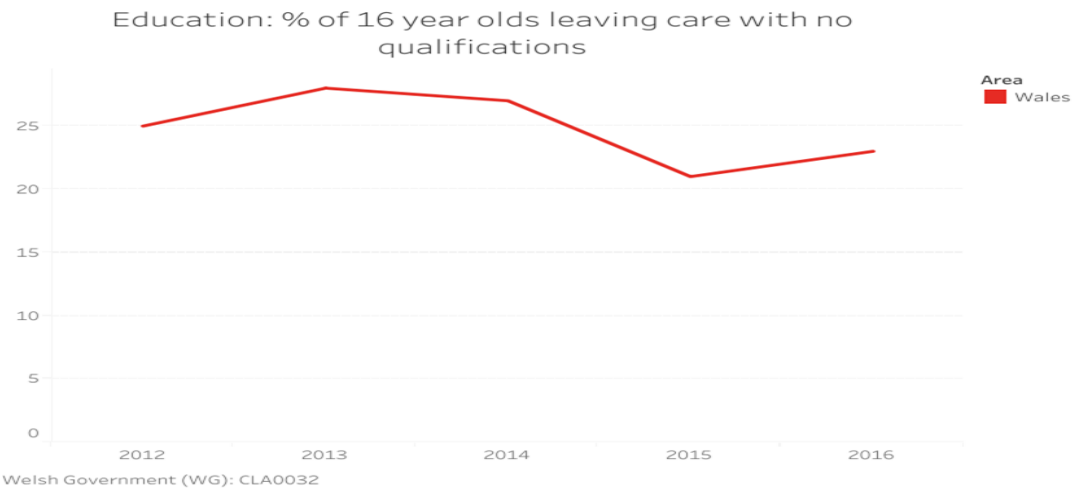
Key themes

- Children with Complex Needs, including seamless transition of care and support needs, for example between Childrens Continuing Care and Continuing NHS Healthcare.
- Safe accommodation for children with complex, high end emotional and behavioural needs. This is a new Welsh Government priority for 2021-22 and aims to both prevent individuals being unnecessarily escalated to, and facilitate de-escalation from, secure or inpatient care.
- Looked After Children and the increasing numbers going into care/adoption (Local Authorities have a specific duty under Section 75 of the Act to ensure they have sufficient accommodation to meet the needs of looked after children).

Policy Areas

- Amendments to Part 9 of the SSWB Act including revisions to the definition of Children and Young People (CYP) with complex needs to include children and young people: with disabilities and/or illness, care experienced, in need of care and support, at risk of becoming looked after, and those with emotional and behavioural needs.
- Children's Commissioner for Wales 'No Wrong Door' recommendations and annual reports.
- Together for Children and Younger People
- National Commissioning Board guidance for Integrated Commissioning of Services for Families, Children and Young People with Complex Needs.
- The NEST (Nurturing, Empowering, Safe, Trusted) Early Help and Enhanced Support National Framework
- United Nations Convention on the Rights of the Child

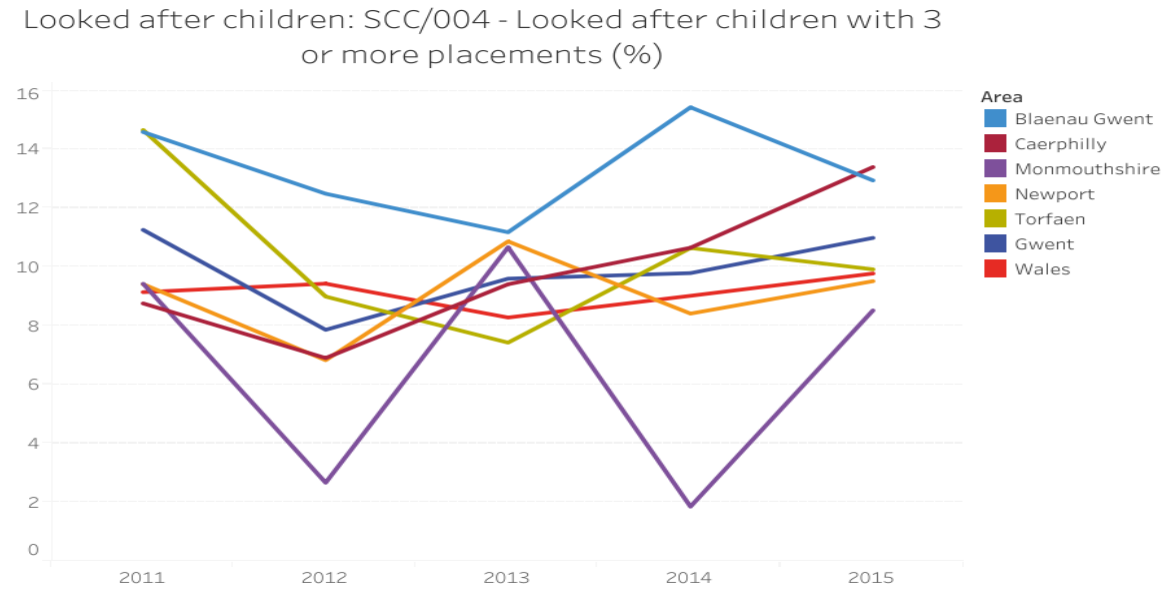
(1.1) Percentage of 16-year-olds leaving care with no qualifications



Care leavers will face a large number of personal and emotional challenges when family relationships breakdown and understandably education and aspirations will be affected. Attitudes to school, authority and adults will be indifferent and if a young person feels that

they have been 'given up on' it will be very easy said young person to give up on their selves. Schools will closely monitor the number of CLA and treat as vulnerable learners to ensure additional support and understanding are afforded to CLA. The availability of data is not consistent across the region, but the national data is stark with between 1 in 4 to 5 CLA leaving with no qualification which should not be accepted for any group of young people. The RPB includes statutory membership from education colleagues to ensure issues can be discussed and raised as well as planning actions across multi-agency partners and accessing preventative and transformation funding opportunities. Covid-19 has affected schooling for all young people and education achievements and accessing further education with additional emotional support and housing solutions will remain a priority.

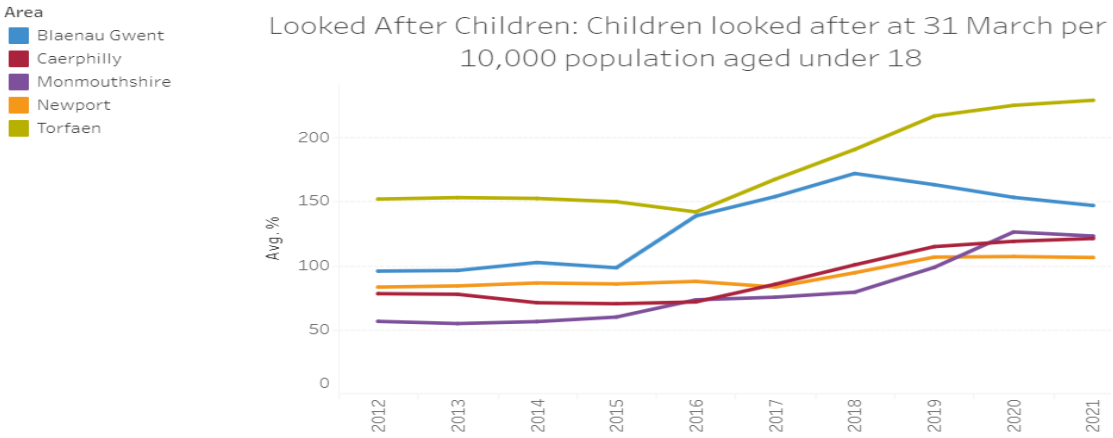
(1.2) Looked after Children with 3 or more placements



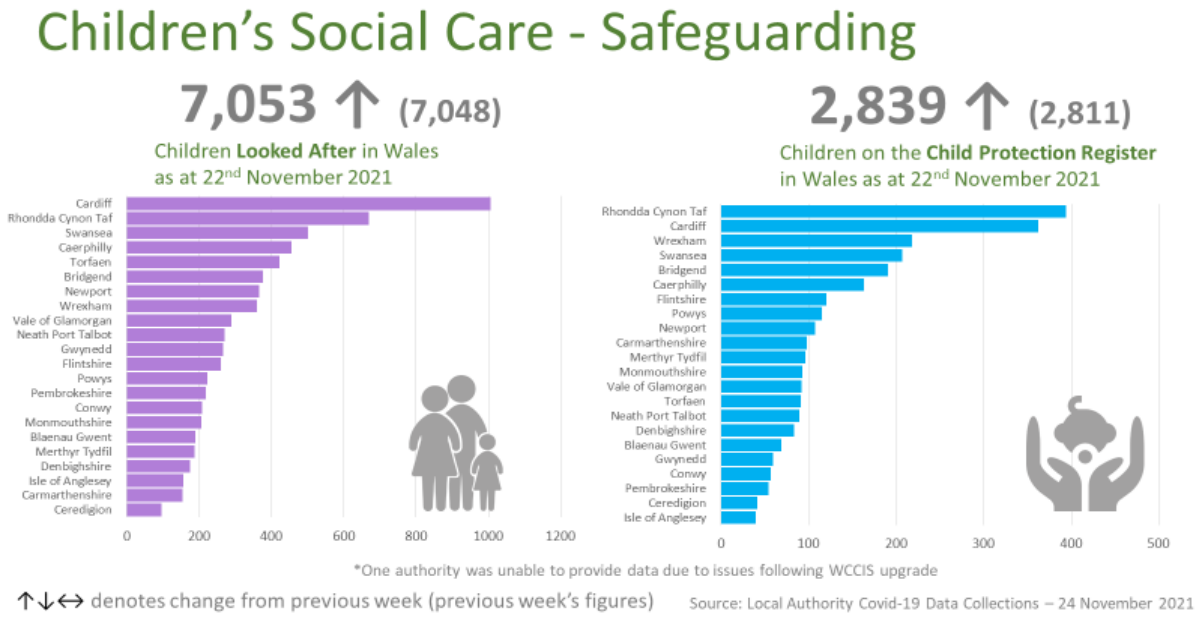
Welsh Government (WG): SCC004

Stability for CLA is key to supporting young people to develop positive relationships, trust, emotional wellbeing and access to education. A change of circumstances can often be unsettling and lead to lack of trust in support organisations as well disengagement, with comments from young people that 'people have given up on them'. A safe, stable home environment is a priority for any young person but especially CLA and even though the numbers seem relatively low, we know outcomes will be affected with increased number of placements. Partner and third sector organisations prioritise the need for remedial actions to avoid placement breakdown, with respite for carers and children a solution to help secure long-term placements. National Youth Advocacy Service (NYAS) offer an independent advocacy service for CLA to ensure the voice and views of young people are heard and greater support and working with third sector partners is key to partnership working through RPB. Covid-19 has affected the face-to-face opportunities for advocacy, but online sessions have been facilitated.

(1.3) Rate of Children Looked After per 10,000 population



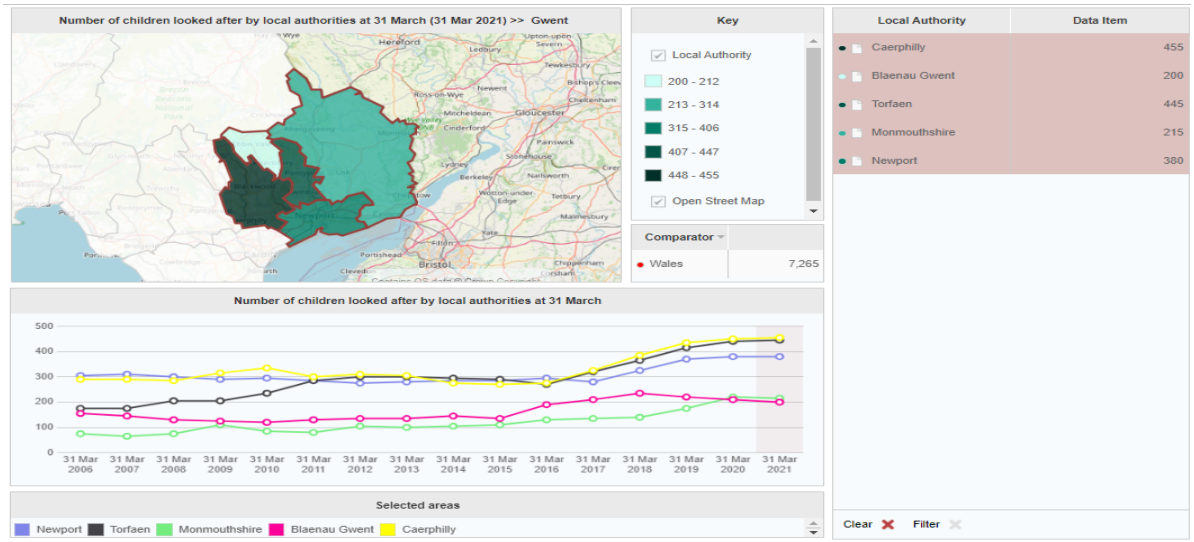
The number of Children Looked After (CLA) and percentage 10,000 still remains high across all local authority areas. We know that CLA face some of the most complex and challenging of circumstances amongst their peers and Welsh Government has prioritised support at a local and regional level through Integrated Care Funding guidance and legislation. Multi-agency partnership approaches under the RPB haven been established such as MYST project and SPACE Wellbeing Panels. However, there have been large costs for emergency and out of county placements incurred across the region which has led to the development of capital projects in Gwent such as Windmill Farm, trough ICF capital funding, where savings can be redistributed into preventative programmes. The impact of covid-19 pandemic will have exacerbated circumstances for CLA, and support and prevention will still remain a priority going forward especially the need to develop services and provision that mean young peoples' care and support needs can be met close to home



There are addition data graphs relating to young people in the Social Wellbeing section (Baby and children's health and development) of the Wellbeing Assessment including

1. % of low birthweight live single births
2. Teenage conceptions
3. Breastfeeding
4. Flying Start children reaching or exceeding developmental milestones
5. Healthy weight and obesity
6. Immunisations
7. Oral health
8. Adverse Childhood Experiences

In addition to the date included in the Wellbeing Assessment there are a number of national data portals outlining need across the region including Social Care Wales Data Portal Home - Social Care Wales Data Observatory (socialcaredata.wales) and below is the data relating to Children Looked After. This PNA will not duplicate the information but reference where necessary.



Emerging Themes, Future trends, and challenges

The most recent Welsh Government data (as of 31 March 2020) shows that there are 16,580 children who receive care and support from children's services across 22 local authorities. Of those children being supported, 7,180 are looked after. Of those children, 17% live with their families or with other family members through kinship care arrangements, 70% live with foster carers, 8% live in residential care, 3% of children are placed for adoption and 2% of older children live independently with support. Welsh Government have prioritized the need for safe accommodation for children with complex, high end emotional and behavioural needs. This is a new Welsh Government priority for 2021-22 and aims to both prevent individuals being unnecessarily escalated to, and facilitate de-escalation from, secure or inpatient care.

Emerging Priorities

1. **To improve outcomes for children and young people with complex needs through earlier intervention, community based support and placements closer to home.**

2. **To ensure good mental health and emotional well-being for children young people through effective partnership working especially mitigating long term impact of Covid-19 pandemic.**

(2) OLDER PEOPLE INCLUDING DEMENTIA

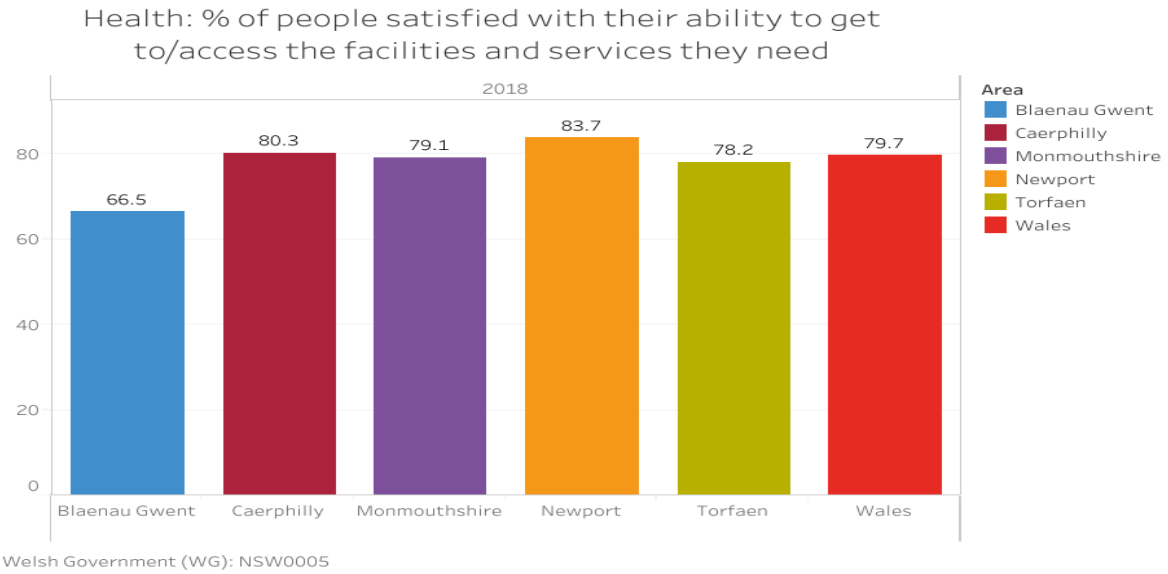
Key Themes

- Improve emotional wellbeing for older people to reduce loneliness and isolation with early intervention
- Improve life outcomes for people living with dementia and their carers.
- Protect the rights for older people as enshrined in the United Nation's Principles for Older Persons, and the SSWB 2014 Act.

Policy Areas

- United Nation's Principles for Older Persons, and the SSWB 2014 Act
- Dementia Action Plan 2018-2022
- Older People's Commissioner 'Making Wales the best place in the world to grow older: Strategy 2019-22
- Strategy for Older People in Wales: Living Longer, Ageing Well. (2013 -2023)

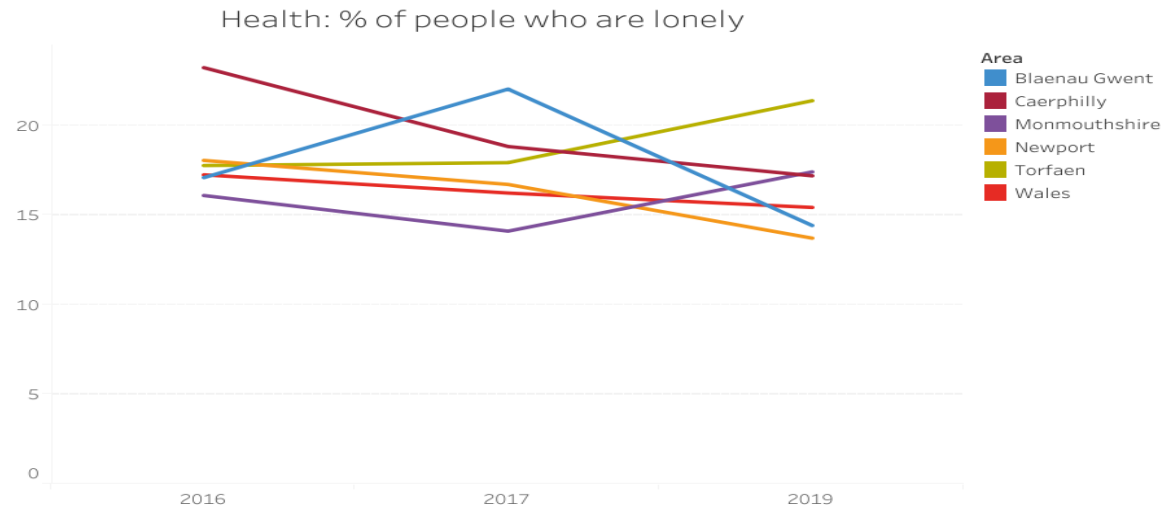
(2.1) Percentage of people satisfied with their ability to get to/access the facilities and services they need



A large percentage of people are generally satisfied with access to facilities across the region. This percentage is within the Wales average for Monmouthshire despite the rurality and access to bus services. This data is from 2018 and Blaenau Gwent figure is quite low in comparison to other local authorities, however since 2018 ABUHB have committed to building a new Health & Wellbeing Centre in Tredegar which was built on the former site of Tredegar General Hospital and Brynmawr Medical Practice has been built to improve access to services. There has been a big shift to digital technologies through the recent Covid-19 pandemic and recognition that a number of people would not have accessed services during lockdown and

therefore the RPB will still need to ensure an equitable access to services across the region, especially for older people who may not be confident with the use of technologies.

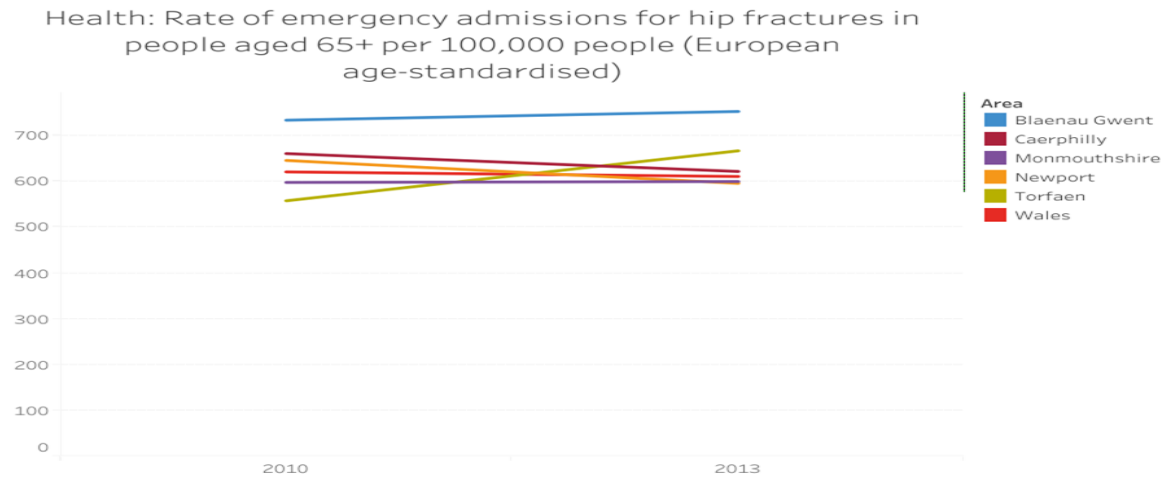
(2.2) Percentage of people who are lonely



Welsh Government (WG): NSW0011

We recognise that loneliness is an issue across all local authority areas and highlighted in the previous PNA; and this will have been exacerbated recently through the Covid-19 pandemic where a number of vulnerable people will have been shielding. The data varies across the region but is generally high and between 15-20% (1 in 5 people) which is a considerable number of people susceptible to poor emotional and mental health and deterioration in physical help. Loneliness may be perceived as an older person's issue – recognised by Older People's Commissioner for Wales – but given that the percentage is approximately 20% it is likely that younger people will be affected too, especially given virtual working arrangements. Solutions are generally low cost/no cost and important for RPB to promote networks, access to information and local groups, particularly through Dewis portal.

(2.3) Rate of emergency admissions for hip fractures in people aged 65 plus per 100,000 people



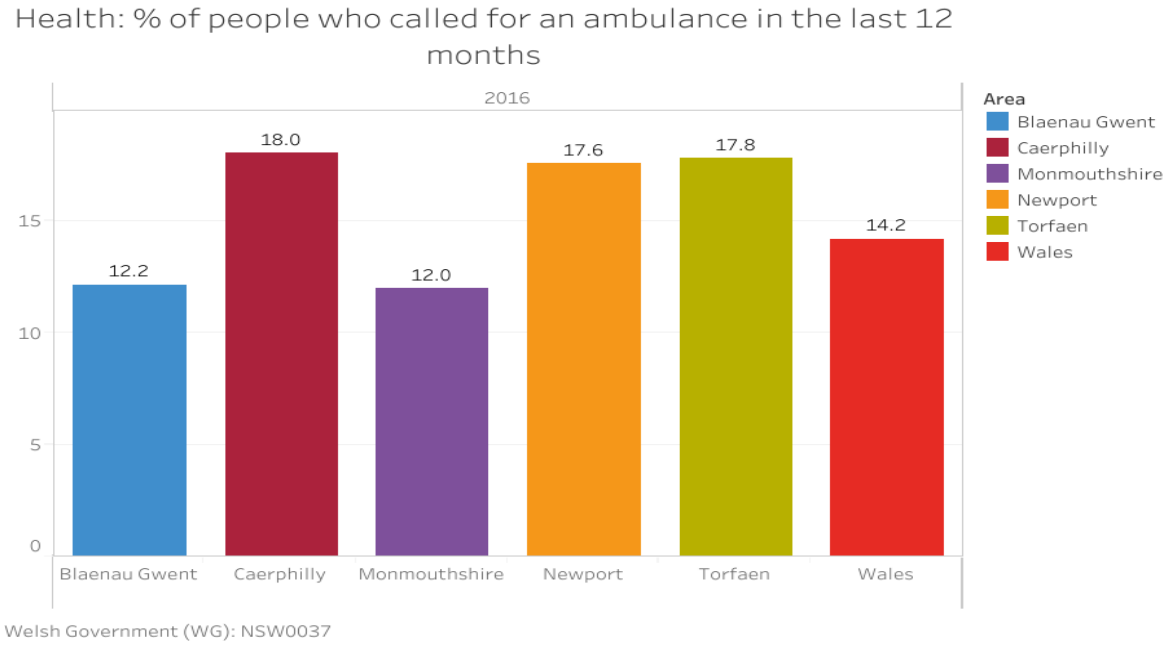
NHS Wales Informatics Service (NWIS): HMW0011

It is widely accepted that falls amongst older people are one of the biggest factors in hospital admissions and calls for ambulance assistance. Hip fractures data can be inferred and indicate level of falls amongst older people and subsequently hospital admissions.

1 in 3 people aged 65+ (over 3 million) fall in the UK every year and 1.2 million people are treated in Accident and Emergency Departments (A&E) after a fall, costing the NHS £1.6 billion each year (CSP, 2015; Tinetti, 1988). The Economic Model for Falls Prevention (CSP, 2016) suggests that mild falls (those that don't require any additional treatment on discharge from A&E) represent 47.2% of the total number of falls. Falls account for approximately 10% of 999 emergency calls received via the Welsh Ambulance Service NHS Trust (WAST) across Wales (WAST, 2016). There has been an emphasis on preventing falls and dedicated studies, roles and services within the ABUHB as well as wider public information and awareness. Gwent Frailty is a multi-disciplinary service within the Primary Care and Community Services Division in Aneurin Bevan University Health Board, centred on providing patients with care and/or treatment closer to home and promoting patient independence; and falls prevention is a core function of the service.

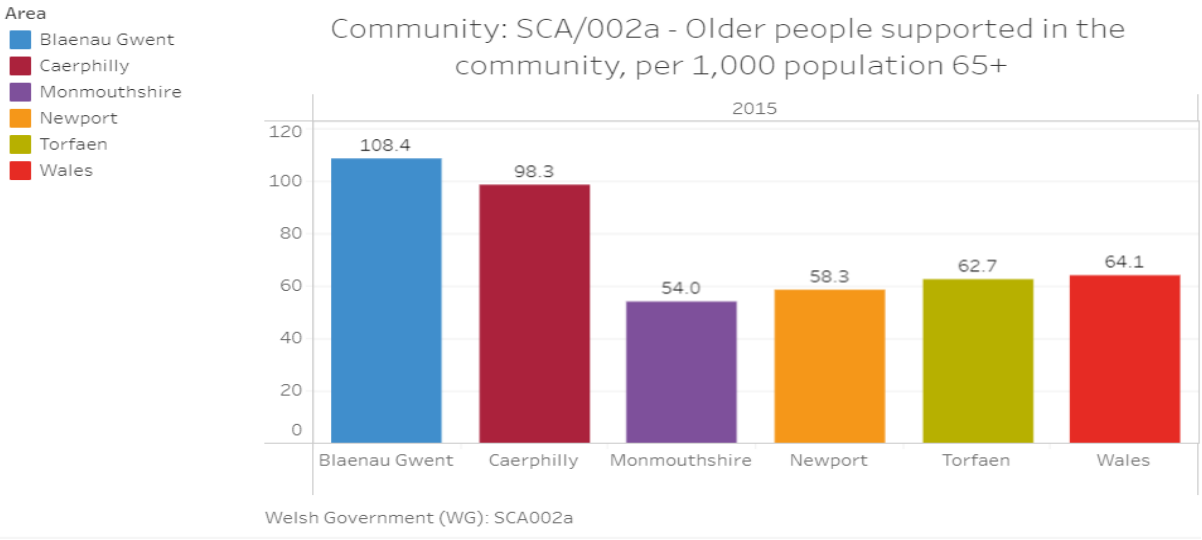
We have seen recently during the pandemic and during the winter periods the impact on WAST and hospitals, falls can have and along with progressed dementia, the predominant factor in 999 calls for ambulances. The data included is a conservative indication of falls given that not all older people will require surgery after an accident. However, the data when totalled is approximately 3000 people during 2013 and will not simply reflect hospital admissions but also the large number of rehabilitation services required and subsequent impact on independent living. Given the impact on health and social care, falls prevention will still remain a priority for RPB consideration.

(2.4) Percentage of people who called for an ambulance in the last 12 months



The data can highlight the acute needs of some local authority areas when compared to the rest of Wales. The 3 areas higher than Wales average are valley communities and could point to wider health detriments in those areas.

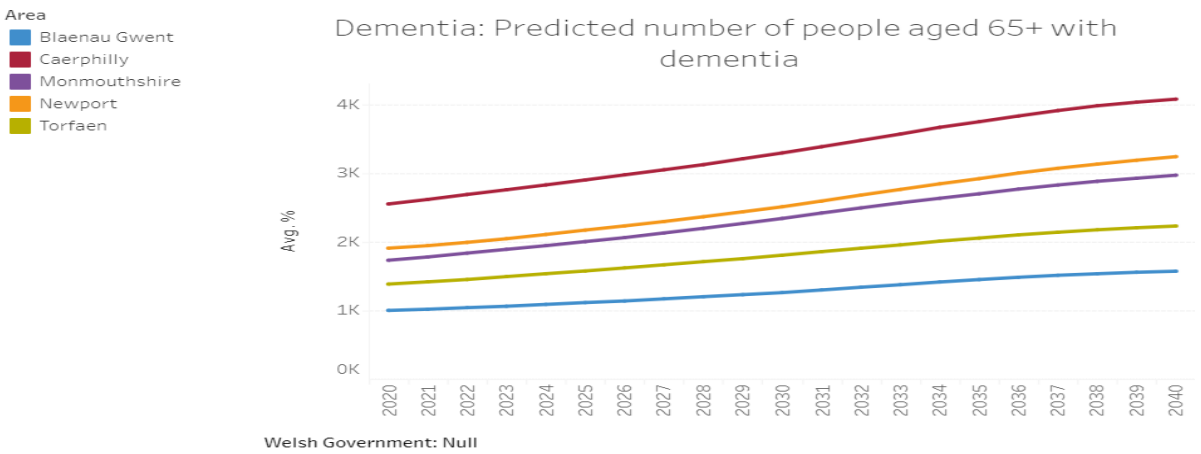
(2.5) Older people supported in the community, per 1,000 population 65+



Remaining at home is at the heart of many peoples view of being independent. People have told us they would like help and support to move around and maintain their own home, go out as they please and not have to depend too much on others. We also know that many older people with long term health conditions are caring for a family member, friend or neighbour and need to be supported to continue to do so. These unpaid carers contribute significantly to the Gwent economy and potential health and social care costs.

Older people need good, timely and accurate information to be able to understand what support is available to them and this can be important to maintaining independence. This also needs to be provided in a range of ways so people can access it. Small things can be quite significant – such as size and type of fonts in leaflets or background colours to aid readability. Information is now often provided digitally and so access to online information for older people is dependent on skills and resources. Greater consideration should be given to supporting older people to develop the necessary skills and confidence to access information online. Public access areas such as GP Surgeries, public transport and community libraries can act as access points for information but in some areas of Wales these are underutilised and overlooked. We have valuable community library resources across Gwent which provide information, advice, and guidance for both older people and those living with dementia.

(2.6) Predicted number of people with dementia 65 plus

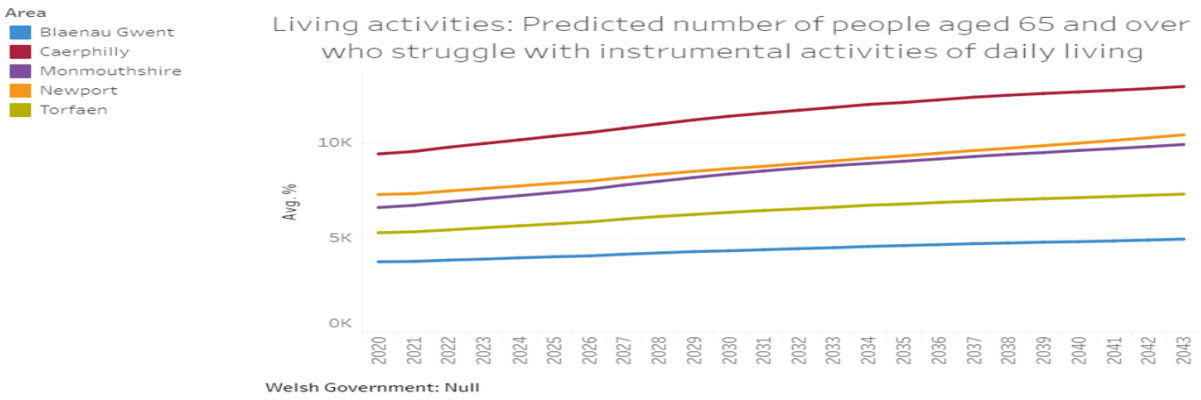


Approximately 42,000 people are living with dementia in Wales, and it is most common in older people, affecting 1 in 20 people over the age of 65 and 1 in 5 over the age of 80. It is predicted that 1 million people in the UK will have dementia by 2025 and this could increase to 2 million by 2050 (Alzheimer's Research UK). Above figures are from *'Dementia UK: A report into the prevalence and cost of dementia*' prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007. The prevalence rates have been applied to population projections of the 65 or older population to give estimated numbers of people predicted to have dementia, to 2035.

Across all local authority areas in the Gwent region, an increase in the number of people living with dementia is predicted. The increases range from 62.1% in Blaenau Gwent to 97.1% in Monmouthshire over the period 2013 to 2035. The RPB are working to support more timely diagnosis and are developing a consistent clearly understood diagnosis, care and support pathway which incorporates standards of care and outcome measures. Living with dementia can have a big emotional, social, and psychological impact on a person, their families, and carers. This can affect the relationships a person has with their environment and the support that they receive. It is important to people living with dementia that people develop awareness and understanding of the condition so they can be supported to maintain quality of life. As an RPB we provide development and learning opportunities jointly with our key partners to the workforce and communities to raise awareness, understanding and highlight risk factors and preventative measures. We also work with partners and continue to develop and build on the strengths of our Dementia Friendly Communities, working in collaboration of Age Friendly Community groups.

We are aware of the impact of the pandemic on people living with dementia and professionals within health and social care have been working hard to support people through assistive technology, online support and telephone calls where face to face visits could not be provided. We have also been supporting people living with dementia their family and carers through the Get There Together National project, working with partners to create a series of films aimed to reduce concerns and reassure anyone who is anxious about getting beyond the front door as well as dealing with the stresses of Covid-19.

(2.7) Predicted number of people unable 1 task 65 plus



Healthy life expectancy is increasing over time, which is positive, however when the time comes where the oldest population develop care and support needs, those needs are more intensive and expensive as people live longer. People over the age of 65 are more likely to need extra support to remain independent in their own homes and across all local authorities in Gwent it is predicted there will be an increase in people unable to manage at least one domestic task on their own.

Predicted number of people aged 65 or over that will be unable to manage at least one domestic task on their own (household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities). Figures are taken from *Living in Britain; Results from the 2001 General Household Survey, Supplementary report: People aged 65 and over, table 37, ONS*. The predicted increases range is from 44.9% in Blaenau Gwent to 71.6% in Monmouthshire. As an RPB we have a range multi-disciplinary reablement and care services in place to provide long and short-term support to help people live independently in their own homes. We also have been using grant funding from the Integrated Care Fund to promote digital and mobile assistive technology solutions to support the prevention of falls.

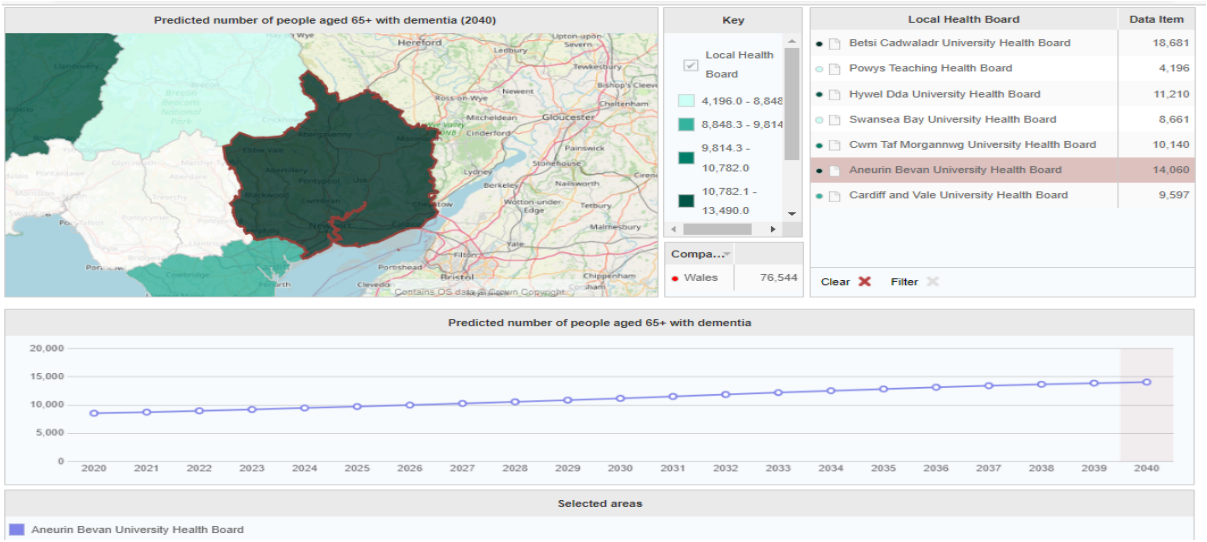
There are addition data graphs relating to adults in the Social Wellbeing section of the Wellbeing Assessment including

1. Life expectancy and health inequalities
2. Cancer registrations
3. Deaths due to cancer
4. Deaths due to cardiovascular disease
5. Delayed transfers of care

Healthy lifestyles including

6. Physical activity
7. Healthy diet
8. Alcohol
9. Smoking
10. Individuals who are overweight or obese
11. Overweight/obesity
12. Diabetes

In addition to the date included in the Wellbeing Assessment there are a number of national data portals outlining need across the region including Social Care Wales Data Portal Home - Social Care Wales Data Observatory (socialcaredata.wales) below is information relating to number of people predicted to be living with dementia. This PNA will not duplicate the information but reference where necessary.



Emerging Themes, Future trends, and challenges

Wales has an ageing population and many people stay healthy, independent, and well into old age, however as people age, they are more likely to live with complex co-morbidities, frailty, and disability. By 2030 it is projected that there will be over 1,008,000 older people in Wales (33% of the population) (ONS 2017/2018). Older people have lots of skills, knowledge, and experience to contribute to society and are a valuable resource to us in Gwent, with many volunteering and sharing their skills in communities. A whole system approach is needed between health and social care and other partners to help people remain independent and as healthy as possible so they can continue to live at home.

What people have told us

Remaining at home is at the heart of many peoples view of being independent. People have told us they would like help and support to move around and maintain their own home, go out as they please and not have to depend too much on others. We also know that many older people with long term health conditions are caring for a family member, friend or neighbour and need to be supported to continue to do so. These unpaid carers contribute significantly to the Gwent economy and potential health and social care costs.

"I want to remain in my own home for as long as I can. It's where all my memories are".

"I am scared of being in contact with people as don't want to get covid, but I am also isolated so feel really down. It's confusing!".

What are the gaps in understanding of well-being?

The number of older people with unmet care and support needs is increasing substantially due to challenges in the health and care system. Effective solutions are needed to address these needs including addressing delayed discharges in hospitals that can lead to worsening health outcomes and complications around care and support needs. It is clear that most people desire to cope with their illnesses and remain independent at home and care models need to reflect the needs of the person as part of their care and support.

The public health restrictions put in place to keep people safe during the pandemic, meant that older people saw big changes to their normal activities and routines. It also meant spending time apart from family, friends, volunteering roles, jobs and communities and creating loneliness and isolation. These changes have meant some people are nervous and anxious to return to normality and are unsure of what the future holds.

Connecting through digital platforms became a valuable resource to many people in Gwent so they could stay in touch with family and friends, access health services, shopping, advice, guidance, and entertainment. However digital exclusion still remains across Wales where some older people have a number of barriers to getting connected such as lack of confidence in using digital technology, financial barriers, costs of broadband services or lack of broadband due to rurality of area. Some people also said that healthcare appointment had been cancelled and they were now struggling as had to wait for health procedures and were unsure of how long they would have to wait. This will impact future waiting lists for procedures and appointments and currently the total Outpatient waitlist position is 111,239, reduced from 116,336 as at October 2021. The Inpatient waitlist is currently 17,703 and as of December 2021, the Referral to Treatment Time position is: 4818 open pathways are over 104 weeks, 22,984 over 52 weeks and 34,254 over 36 weeks.

The pandemic has also brought to light positives about life in Gwent, with communities coming together to support each other, people volunteering and responding to calls for help. There has been a wave of solidarity during this time and the commitment and dedication of our health and social care workforce during this time and continues to be incredible. Also:

- We have key assets in Gwent such as our network of unpaid carers and volunteers and a passionate multi-agency workforce. We also have a very good relationship with our independent/third sector partners and Dementia Supportive Communities.
- There are roughly four million unpaid carers (for all service user groups), of whom one quarter provide more than 50 hours a week of care, giving practical help, companionship, and general supervision. Nearly 90% of older people with dependency problems receive some informal care (some alongside formal care). There is likely to be a fall in the future supply of such carers, arising from changes in the population age structure, rising divorce rates, decline in family size, rising childlessness, growing employment among married women, changing household composition of older people, and changing preferences of older people. (SCIE)

- Volunteers also play a major part in providing social care. It has been estimated that their contribution represents the equivalent of 221,000 full-time employees, or roughly one in every five hours of formal caring. Many such volunteers are older people themselves.
- There are pressures on social care services arising from the needs and preferences of older people increasing.
- Recruitment and retention of employees is challenging for services for older people. High levels of stress and dissatisfaction are reported by staff, and although low pay is an issue, the introduction of the national minimum 4 wage should have eased recruitment. This has been exacerbated by the pandemic.

Emerging Priorities

1. **To improve emotional well-being for older people by reducing loneliness and social isolation with earlier intervention and community resilience.**

2. **To improve outcomes for people living with dementia and their carers**

3. **To support older people to live, or return following a period of hospitalisation, to their own homes and communities through early intervention and integrated care models.**

(3) HEALTH / PHYSICAL DISABILITUES & SENSORY IMPAIREMENT

A person with a 'health or physical disability including sensory impairment', may have difficulty carrying out everyday activities, as their movement and senses may be limited. Sensory impairment is reduced or loss of sight, hearing, or both. Those included are the blind, partially sighted, deaf, and hard of hearing. A disability may be present from birth or occur during a person's lifetime. Health disabilities can include chronic conditions such as obesity or an individual might have had a stroke and have long term effects with movement, speech, hearing, and sight. Equipment and adaptations can help a person to live more independently and confidently at home. Prevention, early identification and providing practical and emotional support and easier accessibility to services can have a real positive impact on life outcomes.

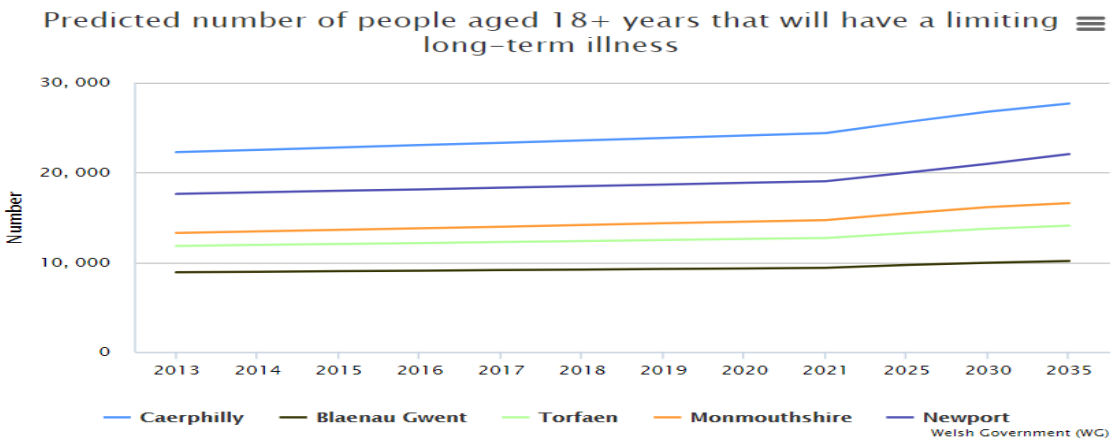
Key Themes

- Supporting disabled people through an all-age approach to live independently in appropriate accommodation
- Support access to community-based services, including transport.
- Help people reduce the risk of poor health and well-being through earlier intervention and community support.
- Ensure people are supported through access to accurate, timely information and assistance and 'rehabilitation' where required.
- Improve emotional well-being particularly through peer-to-peer support.

Policy Areas

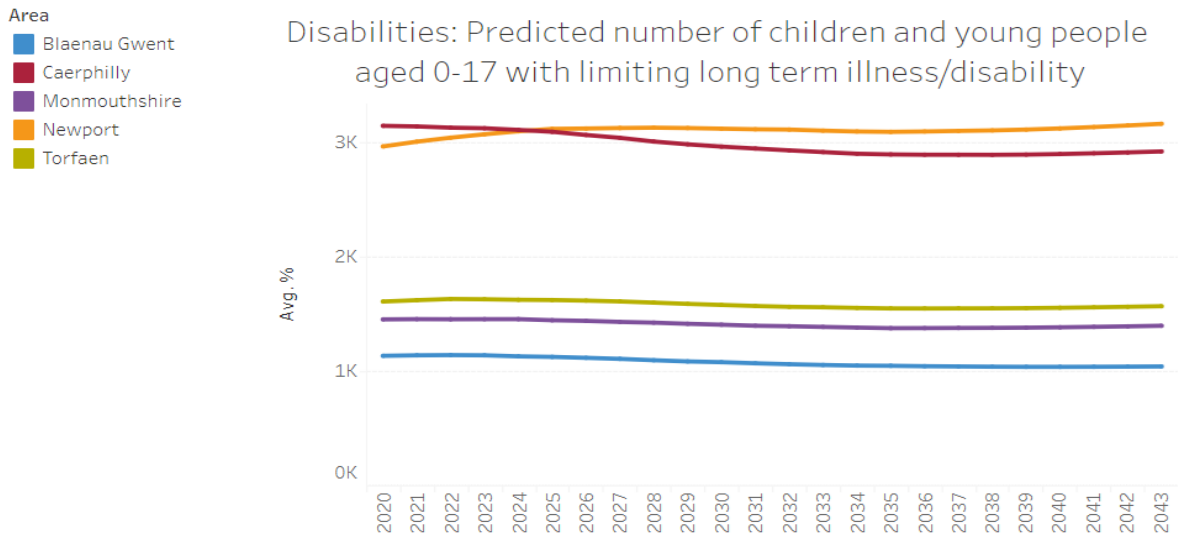
- Welsh Government's Disability Equality Forum Impact of Covid-19 on disabled people in Wales and 'Action on Disability' framework
- Wales Council of the Blind. Rehabilitation Officers for Visual Impairment, Addressing a workforce crisis in Wales
- All Wales Deaf Mental Health and Wellbeing Group. Deaf People Wales: Hidden Inequality.

(3.1) Predicted number of people aged 18 plus years with a limiting long-term illness



The impact of chronic conditions on peoples lives and services in Wales is of growing concern. Wales has the highest rates of long-term limiting illness in the UK, accounting for a large proportion of unnecessary emergency hospital admissions (NHS Wales). Figures are taken from the *Welsh Health Survey 2012, table 3.11 Adults who reported having illnesses, or being limited by a health problem/disability, by age and sex*. Adults who reported having a limiting long-term illness were asked to specify the illness which was the main cause of their limitation. All local authority areas across the Gwent region are predicted to see an increase in the number. The predicted increases range from 14.1% in Blaenau Gwent to 25.1% in Newport

(3.2) Predicted number of people aged 0 - 17 that will have a disability according to Disability Discrimination Act definitions 2035

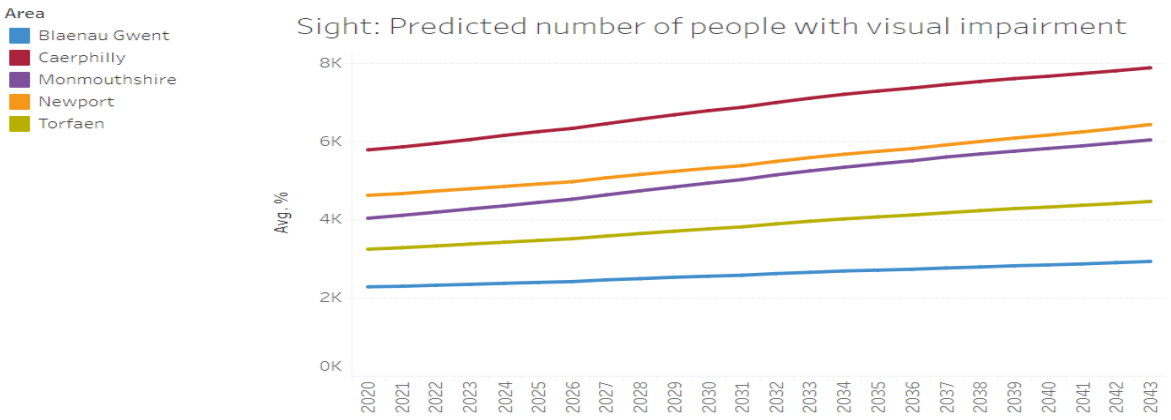


This figure is taken from the study *Prevalence of childhood disability and the characteristics and circumstances of disabled children in the UK, Blackburn et al, BMC Paediatrics 2010.* Children were defined as disabled if they met the Disability Discrimination Act criteria for a disabled person. Disability Discrimination Act definitions mean that the child has significant difficulties with any of the following areas: mobility, lifting/carrying, manual dexterity, continence, communication (speech, hearing, eyesight), memory/ability to concentrate or understand, recognise if in physical danger, physical coordination, or other problem or disability.

The number of young people living with a disability is predicted to be relatively stable over the next 10 years but will still remain significant in terms of multi-agency partnership support required to ensure outcomes. Transition arrangements between primary and secondary education is key to ensuring outcomes as well as effective planning between partners. Parents often highlight the number of different partners requesting information and the RPB has invested in an Integrated Service for Children with Additional Needs (ISCAN) to coordinate services for children and families in one place. ISCAN has been key to reducing multiple 'hand

offs' to partners and supported parents with caring of children with disabilities especially during Covid-19 pandemic.

(3.3) Number of sight impaired people 65 plus



The above data has been taken from the registers of people with physical or sensory disabilities, data includes all persons registered under Section 29 of the National Assistance Act 1948. However, registration is voluntary, and figures may therefore be an underestimate of the numbers of people with physical or sensory disabilities. Registration of severe sight impairment is, however, a pre-condition for the receipt of certain financial benefits and the number of people in this category may therefore be more reliable than those for partial sight impairment or other disabilities. These factors alongside the uncertainties about the regularity with which local authorities review and update their records, mean that the reliability of this information is difficult to determine and so it cannot be thought of as a definitive number of people with disabilities. People with sight impairment are registered by local authorities following certification of their sight impairment by a consultant ophthalmologist. The Certificate of Vision Impairment (Wales) formally certifies someone as partially sighted or as blind (now using the preferred terminology 'sight impaired' or 'severely sight impaired', respectively) so that the local authority can register him/her. Registration is voluntary and access to various, or to some, benefits and social services is not dependent on registration. If the person is not known to social services as someone with needs arising from their visual impairment, registration also acts as a referral for a social care assessment.

The majority of local authority areas in the Gwent region have experienced a decrease however this data will need to be explored further to ascertain if this is a registration issue and if people are aware of services.

Rehabilitation Officers for Visual Impairment (ROVI) provide early intervention support, helping people to remain independent and contribute to their community. There is a concern that in some areas some people are being signposted away from this support however we don't have the full data on this. The role has been identified across Wales as needing a clear pathway for referral to address unmet need and further promotion of the role which has been taken forward in Torfaen. The RPB work closely with third sector partners and will continue to support people with sight impairment through multi-agency partnership approaches and access to new technologies.

It is estimated that there are around 2000 children and young people aged 0-19 with a visual impairment in Wales. At least 20 per cent of these will have additional disabilities and/or additional learning needs; a further 30 per cent have very complex needs (Vision2020UK: Shared statistics and key messages about sight loss 2013). Wales Council for the Blind have highlighted that '*Partnership working is the only way to provide services that will ensure that Welsh CYPVI achieve their full potential and have the skills to be ready for adult life. This can only be achieved with early intervention by the right people at the right time.'* The report can be downloaded here http://www.wcb-ccd.org.uk/wales_vision_forum.php.

Emerging Themes, Future trends, and challenges

More than **600,000** people in Wales have hearing or sight loss (NHSWales2015) with the number increasing due to demographic trends and increases in chronic health conditions, amongst other causes. The effects of living with multiple health conditions can be profound, affecting quality of life, daily activities, poor physical and mental wellbeing and finding and maintaining employment, leading to financial hardship. This can then exacerbate inequalities, with loss of income and worklessness contributing to further declines in health. There is a danger that, without action, worsening socioeconomic inequalities will further concentrate this trend among the most disadvantaged.

Disability is extremely diverse and although some people might have extensive health care needs others might not, however all people with a disability need to access mainstream healthcare services. Almost everyone is likely to experience some form of disability during their lifetime, which could be temporary or permanent, having a dramatic impact on quality of life. There have been many improvements through the years, however the UK Disability Survey (2021) identified that public perception of disabled people is still a significant barrier to participation in areas, including employment and education and unhelpful perceptions and stigma.

People living with disabilities have been disproportionately impacted by the Covid 19 pandemic. They have had potentially higher risk of catching the virus due to underlying health conditions and had difficulty in engaging in preventative measures and experienced disruptions to health services they usually rely on. People with sensory loss have found it extremely challenging as their communication needs have not been met leaving them increasingly isolated. Although health and social care have worked hard across Gwent to reach out and support people during this time, we need more specific actions going forward, to recognise the impact there has been for people with health, physical and sensory disabilities.

There is an urgent need to improve the data we collect on disability, to further improve equality for disabled people and increase emotional wellbeing within health and social care.

What are the gaps in understanding of well-being?

Adults and children with disabilities have struggled both physically and mentally throughout the pandemic with the loss of services and support during this time. Some people previously found comfort in their daily routines which were removed with cancelled appointments and lockdown of education and activities.

Some people who are blind and visually impaired felt lonely prior to the pandemic but during this challenging time they have had to face more physical and psychological barriers. Social

distancing rules have been difficult, as this cannot be observed along with directional arrows, screens etc. In community settings and trying to follow the rules has caused anxiety, stress, and exhaustion. Rehabilitation in sight loss is key in preventative approaches to support new ways to accomplish essential tasks and to introduce a range of equipment and techniques to avoid injuries and falls and mitigate or defer the need for longer term care. There is a scarcity of ROVIs which needs to be anticipated and addressed in the Gwent area to support eye conditions, orientation and mobility, independent living and communication skills. During the pandemic the ROVI in Torfaen has provided training to social care colleagues on the ROVI role and referral pathways and the benefits they bring. This has resulted in more referrals.

Visual impairment is strongly associated with falls and hip fractures. The rate of falls in older people with visual impairment is 1.7 times higher than other older people of the same age, with hip fractures 1.3 - 1.9 times higher

The new normal is for people to wear facemasks to prevent transmission of disease. As a result of this deaf and hearing-impaired people feel excluded from the world. Deaf people who rely on sign language still need facial expressions for full communication, so this has been difficult.

What people have told us

Some people feel isolated and excluded and have been struggling with mental and physical health. Some people feel there is lack of multi-agency support and they don't always know who to contact. Some people also struggle with accessibility of certain buildings, pavements and using public transport.

"I have just applied for a guide dog and am on the 'awaiting training list' I can't wait to get my confidence back and be able to go out and have my independence back".

Some people have hidden disabilities which are not visible but are just as challenging. They have faced discrimination as their disability can't be seen. There needs to be more positive attitudes towards disabled people. It is important for us to have a more inclusive future that focuses on our strengths.

- People are living longer; however future trends indicate that on average a quarter of people after age 65 will live with some form of health disability. This needs to be considered when developing service models with a particular focus on effective prevention interventions. There are estimated to be about 9 million deaf and hard of hearing adults in the UK, that is about 18% of the total population. About 640,000 of these are profoundly or severely deaf. As people grow older the changes of becoming deaf increase: 7 out of 10 people over 70 will have developed a significant hearing loss. This could have a significant impact on health and social care services.
- Sensory impairment can be a significant life limiting condition and its incidence increases with age. This means the challenges associated with the condition are likely to grow over

coming decades. People with sensory impairment have a range of care and support needs. There is a scarcity of ROVI workers who can provide the necessary assessment and delivery of interventions including a lack of adequate supervision to support the workforce which also needs addressing.

- Early identification is vital, as is prevention, support to reduce loneliness, isolation and promote mental health and well-being. Offering effective care and support is likely to reduce other risks associated with age and frailty, such as falls. A focus is needed on further development of generic and specialist services and improving the access to other services for people with a sensory impairment. This will require a multi-agency approach.
- The prevalence of physical disability is much wider than those who need or want help from social care however this could change in the future if needs increase.
- Sight loss in the UK is estimated to double over the next 40 years, which will have a significant impact on the UK's health and social care system and damage the quality of life for millions of people. (RNIB 2009)
- Hearing loss is a common health issue in the armed forces. Many veterans will have had prolonged exposure to loud noise from small arms fire, artillery, engines, and other machinery during service, causing permanent hearing damage. The Veterans Gateway website provides information, advice and support for Veterans and their families on support and services currently available.

It is important that people with sight loss are signposted to support services within their communities and the sight loss sector in Wales recognises Perspectif as the tool to identify these services and it is available at http://www.wcb-ccd.org.uk/perspectif/index.php. Sight Cymru also provide a range of services across Gwent. Another critical service is Low Vision Service Wales – provided by Optometrists or Dispensing Optometrists accredited as Low Vision Practitioners in a Primary Care setting. People accessing the Service are able to receive low vision aids to support with day-to-day activities and are also offered advice and guidance. Practitioners will also be able to signpost service users to third sector providers for further support. There are currently 41 practices that provide the Low Vision Service to patients in Gwent.

Emerging Priorities

1. **To support disabled people through an all age approach to live independently in appropriate accommodation and access community based services, including transport.**
2. **Ensure people are supported through access to accurate information, assistance and 'rehabilitation' where required.**
3. **Improve transition across all age groups and support services**

(4) LEARNING DISABILITIES

There are approximately 54,000 people in Wales living with a learning disability (ONS, 2019). A learning disability affects the way a person learns new skills throughout their lifetime. This can affect communication, understanding new or complex information and coping independently. A learning disability can be mild, moderate, or severe. Some people with a mild learning disability might be able to communicate well and look after themselves independently but might need a bit longer to embrace new skills. Other people might not be able to communicate and have more complex needs, needing further support. It very much depends on the persons abilities and the level of care and support they receive.

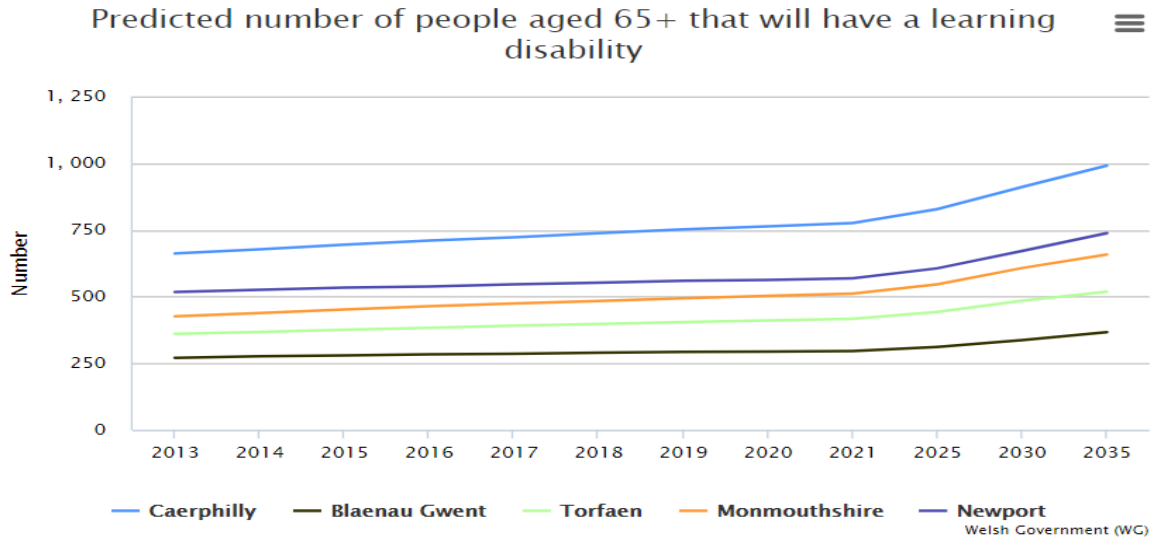
Key Themes

- Support people with learning disabilities to live independently with access to early intervention services in the community.
- Provide greater public awareness and understanding of people with learning disabilities needs.

Policy Areas

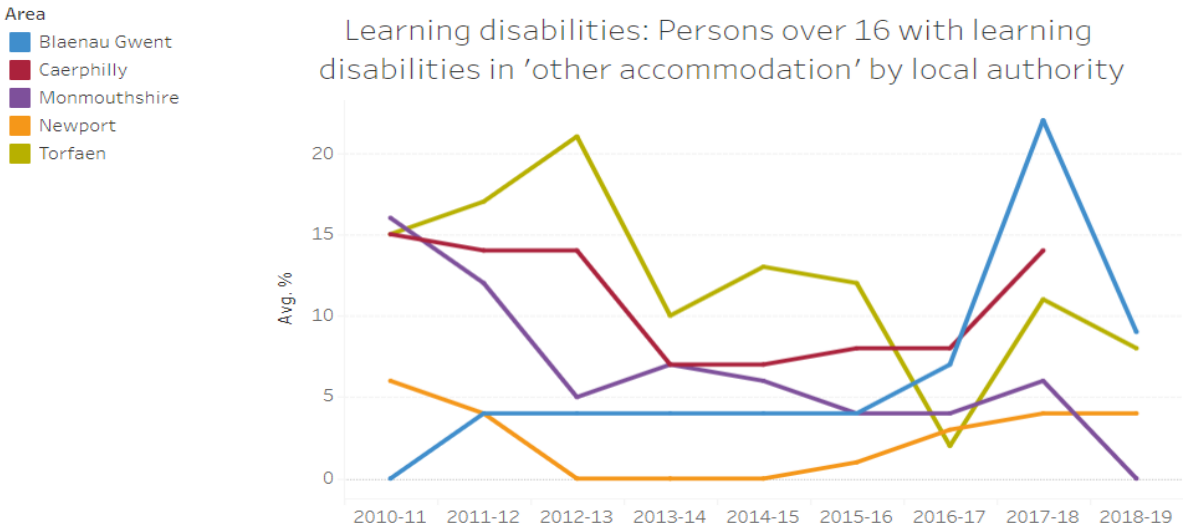
- Learning Disability Improving Lives Programme
- Children's Commissioner Report 'No Wrong Door' in relation to adult services for children with learning disabilities.

(4.1) Predicted number of people 65 plus with Learning Disabilities



The data is taken from the Register of persons with learning disabilities (SSDA901). The data may be an underestimate of the total number of people with learning disabilities as registration is voluntary. Local authorities submit numbers of those identified as having a learning disability currently known to the authority and included in a register for the purpose of planning or providing services. All local authority areas across the region are predicted to see an increase in the number. The predicted increases range from 35.4% in Blaenau Gwent to 54.5% in Monmouthshire.

(4.2) Number of placements for persons aged 16 years or older with learning disabilities



Emerging Themes, Future trends, and challenges

Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen
106	**205**	**80**	**153**	**129**

There are a total of 673 people with learning disabilities known to ABUHB with average life expectancy increasing over the last few decades. However, the impact of the pandemic has had a negative impact on people with a learning disability, where they have felt isolated at being separated from family and friends and daily routines disrupted. People have said that stress, anxiety, feeling isolated and changes to their normal routine has had a negative impact on mental health. Also, some people felt their health had deteriorated as they weren't as active and had put on weight due to not going out and about.

Communication and information was felt to be confusing surrounding Covid-19 which saw lots of organisations adapting the way they worked and providing more innovative ways to support people. Social media, websites and online platforms were used so people could connect and also telephone support calls as well as easy read resources so people could feel informed.

A reduction in community-based support due to restrictions has left some people feeling unsupported which has had a detrimental impact on mental health and physical wellbeing. There was also confusion over Government guidelines with people needing further advice and reassurance, which saw lots of people not wanting to visit a health professional even if this was needed. Organisations across Gwent adapted the way they worked and provided more innovative ways to support people. This was done through providing activities and services through social media, websites, and online platforms, so people could connect. Telephone check in calls were also provided by some organisations to help people stay connected, as well as easy read resources so people could keep informed.

Emerging Priorities

1. **To support people with learning disabilities to live independently with access to early intervention services in the community; and greater public awareness and understanding of people with learning disabilities needs.**

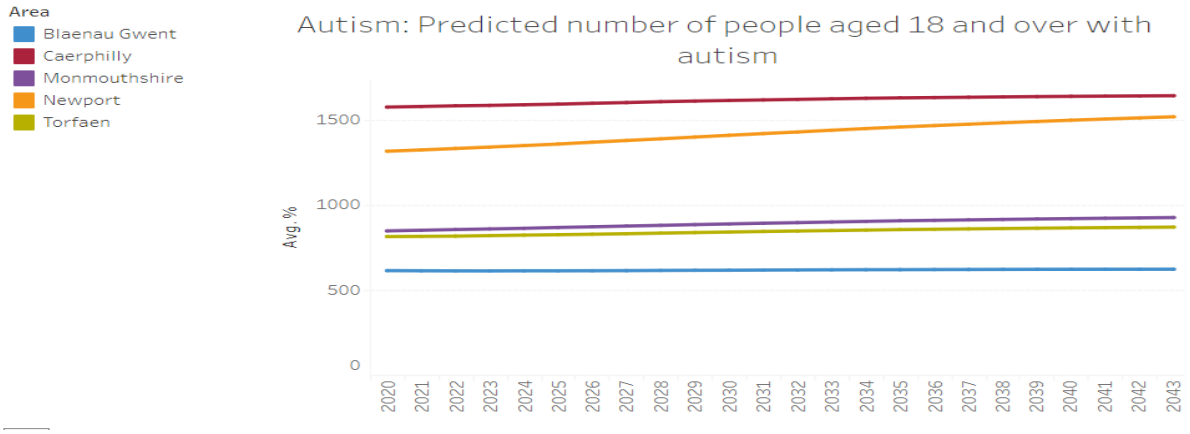
(5) AUTISM

Autism or Autism Spectrum Disorder (ASD) is a lifelong neurodevelopmental condition which affects how people communicate and interact with the world. One in 100 people are on the autistic spectrum and there are around 700,000 autistic adults and children in the UK (NAS). Each person living with autism has a distinct set of strengths and challenges and the way in which people learn with autism can range from highly skilled to severely challenged. Autism means that the way a person thinks about and experiences the world is different to most people. Autism is different for everyone and some autistic people need little or no support. Others may need help from a parent or carer on a daily basis. These figures are taken from the study Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: The Special Needs and Autism Project (SNAP), Baird et al, the Lancet, 2006.

Policy Areas

- Part 2 of the Code of Practice within the SSWB Act
- Autism Delivery Plan 2021-2022

(5.1) Predicted number of people aged 0-17 with Autistic Spectrum Disorder (ASD).



Across local authorities in the Gwent region, with the exception of Blaenau Gwent, all local authority areas are predicted to see an increase in the number. Across the remaining local authority areas in the Gwent region predicted increases range from 2.1% in Monmouthshire to 17.7% in Newport. Autistic people often have difficulty in accessing community activities, leisure facilities and other services. The RPB has supported the embedding of the Integrated Autism Service and raising awareness of autism in schools through a children's story book – 'Moli the Cow who Moo she was Different'.

Emerging Themes, Future trends, and challenges

What people have told us

People want help to plan their life the way they want with the right support and services to help. Person centred planning can help people to make their own choices and achieve life goals so people can reach their potential.

There is also a need for more meaningful activities that are fun but also help people to grow and learn. Although volunteering is considered important to learn new skills, more opportunities are needed for paid employment, training, and education. Organisations adapted through the pandemic with some activities being held on Zoom. This created barriers for some organisations to join, due to data protection laws. Many people appreciated the online support and to have options to connect on zoom but have now said they have 'zoom fatigue'.

Independent living is important and the opportunity to live in suitable housing, in a suitable location with the right individual support. One size does not fit all. Some people with autism said they felt that some professionals did not know enough about autism and had a very 'stereotypical view' and felt more training was needed for not just awareness but acceptance of difference.

> "My autism is unique to me. I want people to have not just a greater awareness of autism, but also an acceptance of it. My brain works differently to other people, but I have my own unique skills to offer so don't see my diagnosis, see me".

- People have felt isolated and feel nervous so could need emotional and practical support to return to normality.
- Children and young people with a disability need an improved transition support programme to improve outcomes.
- There have been difficulties with some people accessing suitable health provision so this need addressing for effective future support.
- Improved post diagnostic support is needed for adults as some feel since having their diagnosis they are left "to get on with it".
- People with autism have struggled through the pandemic with loneliness and want more meaningful activities that inspire and support learning.
- Increased Autism Awareness training for the workforce and communities and how each person is unique with their own strengths and abilities.

Emerging Priorities

1. **To provide more timely diagnosis of Autistic Spectrum Disorder and access to support services and information and advice.**

(6) MENTAL HEALTH

Mental health affects everyone as it includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It helps determine how we handle stress, relate to others, and make life choices. Mental health is important at every stage of life, from childhood and adolescence through to adulthood. A quarter of people will experience mental health issues or illness at some point during their lifetime, often facing discrimination and stigma and affecting the people around them.

- 1 in 10 children between the ages of 5 and 16 have a mental health problem and many more have behavioural issues. There is evidence this is increasing.
- Approximately 50% of people with enduring mental health problems will have symptoms by the time they are 14 and many at a much younger age, demonstrating that mental illness can affect people across the course of their lives.
- Between 1 in 10 and 1 in 15 new mothers experience post-natal depression.
- 1 in 16 people over 65, and 1 in 6 over the age of 80, will be affected by dementia. Current estimates are that approximately 43,000 people in Wales are experiencing dementia and this is predicted to increase by over 30% in the next 10 years.
- 9 in 10 prisoners have a diagnosable mental health and/or substance misuse problem
- 295 people took their own life in wales in 2020 (Samaritans)

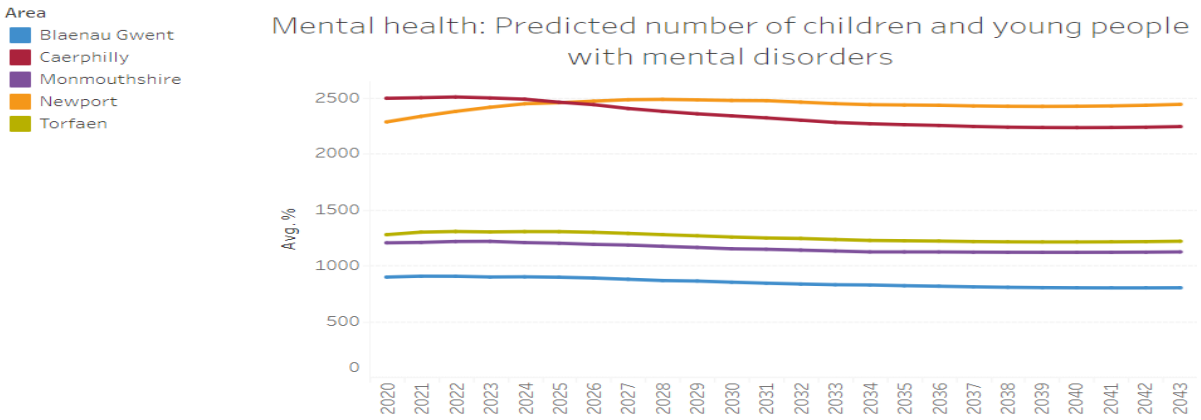
Key Themes

- Increased understanding and awareness of mental health amongst the public to reduce stigma.
- Improved interventions to help people to seek support earlier.
- To improve emotional well-being and mental health for adults and children through early intervention and community support.

Policy Areas

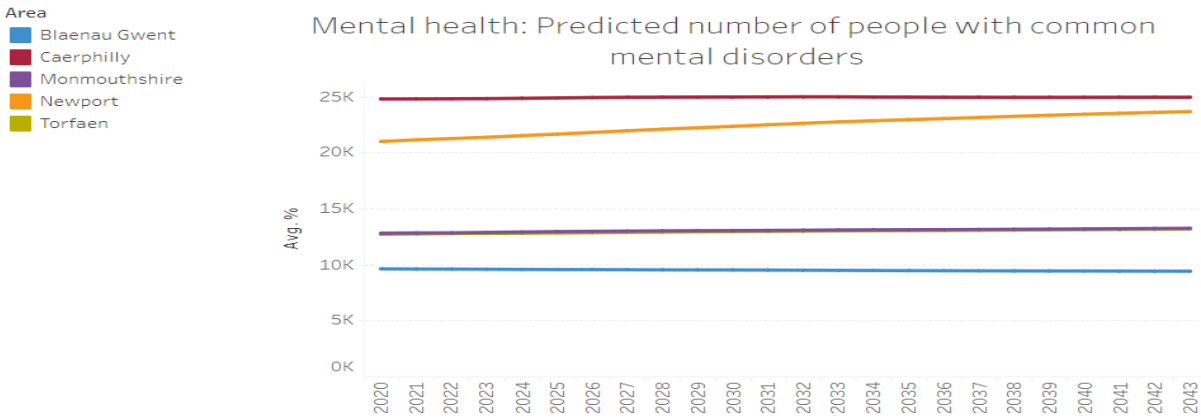
- Together for Mental Health Delivery Plan 2019-2022
- Together for Children and Young People Plan Together for Children and Young People, NHS Wales Health Collaborative
- Covid-19 in Wales: 'the mental health and wellbeing impact' by Cardiff University
- Talk to Me 2, Suicide and Self-Harm Prevention Strategy for Wales 2015-2020 talk-to-me-2-suicide-and-self-harm-prevention-strategy-for-wales-2015-2020
- National Mental Health Covid survey

(6.1) Predicted number of people aged 5-15 that will have a mental disorders



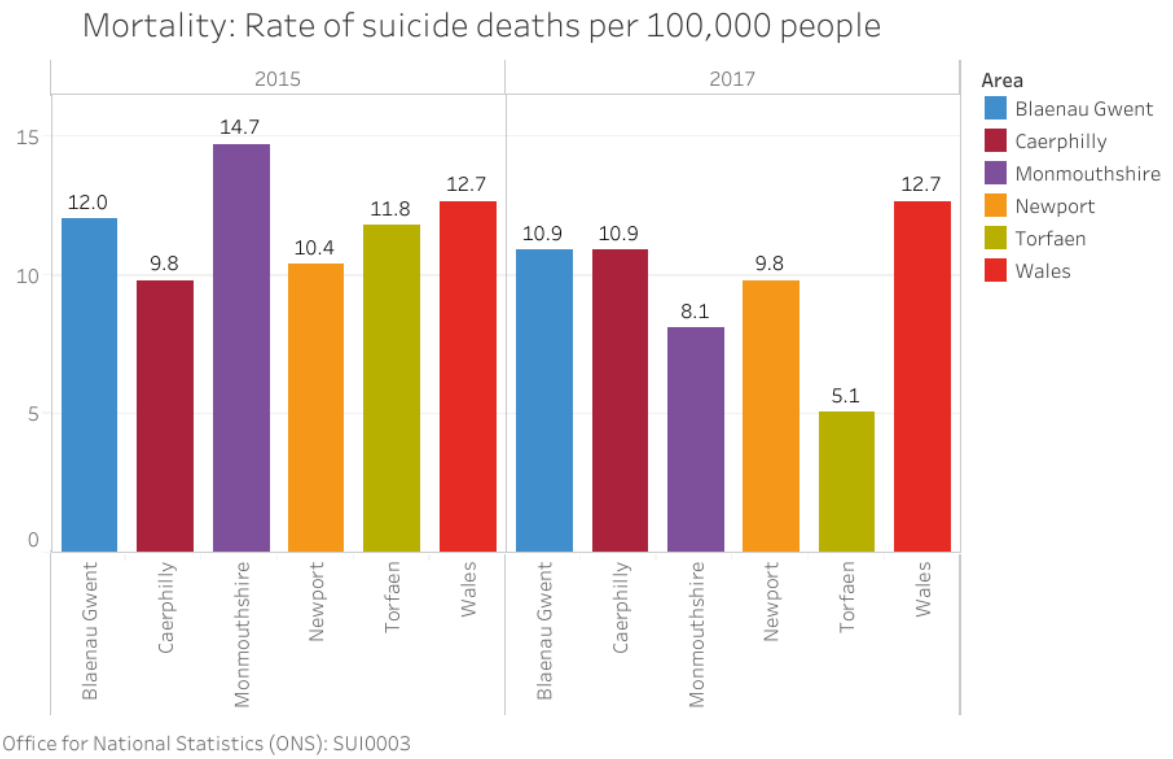
The percentage ranged from 66% in Blaenau Gwent to 78% in Monmouthshire. This compares with 72% of people aged 16 years or older free from a common mental disorder for Gwent and 74% for Wales.

(6.2) Number of people aged 16 plus free from a common mental disorder



Across the local authority areas in the Gwent region both Torfaen and Newport are predicted to see increases of 0.4% and 16.6% in the number of people aged 5 - 15 with a mental health problem. The other local authority areas are all predicted to see decreases over the same period

(6.3) Rate of suicide deaths per 100,000 people.



Office for National Statistics (ONS): SUI0003

Suicide is a major cause of death amongst the 15 to 44 age group. In Wales over the period 2010 – 2012 it accounted for almost one in five deaths in males aged 15 to 24 years and just over one in ten deaths amongst women of that age. Suicide (intentional self-harm and events of undetermined intent) accounted for 27% of external causes of death (transport accident, suicide, other accidental 9 injury, other external causes) in all ages (15 and over) between 2010 and 2012. This exceeded deaths from road traffic accidents which account for 9.1% (an average of 107 per year) in the same age group and time period.

Research was completed in 2020/2021 by a range of partners from ABUHB, Swansea and Cardiff University, *'The influence of the COVID-19 pandemic on mental wellbeing and psychological distress: A comparison across time'*. This research highlighted the impact the pandemic has likely had on psychological wellbeing and the mental health of many people. It was found that there was an increase in clinically significant levels of psychological distress in Wales, particularly in younger adults, women, and those from areas of greater deprivation. These findings can be used to prepare and plan for the wave of psychological distress that has been predicted to hit mental health support services due to the pandemic. 'There is a need to balance the efforts to stop the spread of the virus against the mental health problems being caused by the virus'.

In Gwent we have established the multi-agency Gwent Suicide and Self-Harm Prevention Steering group to develop our local plan to be responsive to the needs of the population. We hold biannual workshops to ensure we engage and take account of evidence and local data. Suicide and self-harm prevention are everyone's business and requires a collaborative

approach and we have a passionate proactive partnership to take this work forward. The Gwent Suicide and Self-Harm prevention plan reflects the national Talk to Me 2 strategy, setting our aims and objectives to prevent and reduce suicide and self-harm in Gwent and the workshops are used to discuss priorities for the year ahead.

There are addition data graphs relating to adults in the Social Wellbeing section of the Wellbeing Assessment including

1. Mental health
2. Loneliness
3. Suicide and self-harm

NHS Wales in conjunction with Cardiff and Swansea Universities developed a national survey to assess levels of mental health during the recent pandemic. This research examined the psychological wellbeing and mental distress of the population of Wales during the first and second national lockdown periods – June to July 2020 and Jan to March 2021 respectively.

- Survey 1 (June – July 2020): 12,989 completed the survey and of those, 2,470 (20%) indicated they lived in ABUHB region.
- Survey 2 (Jan – March 2021): 10,428 completed the survey and of those 3,486 (33%) indicated they lived in ABUHB region

(6.4) Research Findings: Variations across Wales – Percentage of respondents reporting moderate to severe psychological distress

Local Authority	Survey 1	Survey 2	Change from 2020 to 2021
Blaenau Gwent	**43%**	**49.1%**	**+ 6.1**
Caerphilly	**37.8%**	**48.2%**	**+ 10.4**
Monmouthshire	**23.4%**	**34.9%**	**+ 11.5**
Newport	**38.6%**	**44.8%**	**+ 6.2**
Torfaen	**32.0%**	**46.8%**	**+ 14.8**

More respondents were experiencing severe psychological distress in survey 2, compared to survey 1, and the RPB will need to keep the mental health and wellbeing of our population central to our medium/long whole system Covid-19 recovery policy and planning. The RPB will consider further actions at both a local and national level to mitigate the risk factors, and enhance the protective factors, associated with poor mental wellbeing and psychological distress; as well as exploring what further actions need to be taken to meet an increased need for mental health support across all tiers of service provision.

Emerging Themes, Future trends, and challenges

- Poor mental health and mental illness have a significant impact on individuals, society, and the economy overall. To respond to the mental health emergency, we need to work collaboratively to support more preventative and early interventions and encourage inclusivity.
- We need to promote the mental wellbeing of people in Gwent and ensure that the workforce is supported to be able to provide people with the support they need at the right time.
- Although progress has been made through previous strategies there is still work to do to improve life outcomes for people and address stigma.
- We need to improve information available to the public, to create more understanding of mental health and encourage people to talk to gain early support. It is also crucial we meet the needs of Welsh language, other languages, Easy Read and Braille; and other accessible formats so mental health information is accessible to all.
- There is a need for more meaningful activities to promote wellbeing and improve life outcomes.
- There is a need to tackle loneliness and isolation.
- In Gwent we need to look at ways of improving job opportunities for people with mental health issues to get people into work and out of poverty.
- The need to adopt the principles of consent, choice and inclusiveness, and respect for delivering care, within the least restrictive measure under the umbrella of ***mental capacity Act 2005 and the amended 2019 act***. This will mean commitment to implementing the newly amended MCA 2019 act when it finally becomes law

What are the gaps in understanding of wellbeing?

Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen
316	**758**	**324**	**567**	**378**

There are a total of 2,343 people supported with mental health services through ABUHB but there are also signs that the pandemic is driving a worrying rise in mental health in Wales. Two thirds of people in Wales have said the pandemic has had a negative impact on their wellbeing. People have gone through adverse experiences such as losing their jobs, falling into debt, worrying about their health, and been isolated from friends and families. For most people, the symptoms of Covid-19 pass within a few days or weeks, but for some people the effects can last for weeks or months. This condition is called long Covid and can impact mental health causing depression and anxiety as well as sleep issues, extreme tiredness and a range of other debilitating symptoms.

Research was completed in 2020/2021 by a range of partners from ABUHB, Swansea and Cardiff University, 'The influence of the COVID-19 pandemic on mental wellbeing and psychological distress: A comparison across time'. This research highlighted the impact the pandemic has likely had on psychological wellbeing and the mental health of many people. It was found that there was an increase in clinically significant levels of psychological distress in

Wales, particularly in younger adults, women, and those from areas of greater deprivation. These findings can be used to prepare and plan for the wave of psychological distress that has been predicted to hit mental health support services due to the pandemic. 'There is a need to balance the efforts to stop the spread of the virus against the mental health problems being caused by the virus'.

What people have told us

People have said they are struggling with poor mental health due to their early life experiences, financial issues, housing, long term illness, family worries, employment issues, bereavement or feeling burnt out from workloads and caring roles. Many people feel worse emotionally since the pandemic however it is worth noting that some people in Gwent also said they feel more relaxed in some ways; as life has slowed down for them and they don't have to go out of the house to access some services.

Some people felt they had to fight for support and had been pushed into financial difficulty as they had to give up work as unable to cope. Also, people from BAME communities said their mental health had been affected by racism, inequalities, and mental health stigma with added stress of the challenges of accessing services. There can also be language barriers and not knowing where to turn for help.

Waiting lists for mental health services can be lengthy due to the level of need and during this time an individual's emotional wellbeing can decline further. Some people also felt that there was not enough crisis support.

"I wish people viewed mental health differently I used to work but had to give up as I was not emotionally well enough and started having physical problems. That could happen to anyone at any time, People still judge and there is still a stigma to mental health".

Emerging Priorities

1. **Increased understanding and awareness of mental health amongst the public to reduce stigma and help people to seek support earlier.**

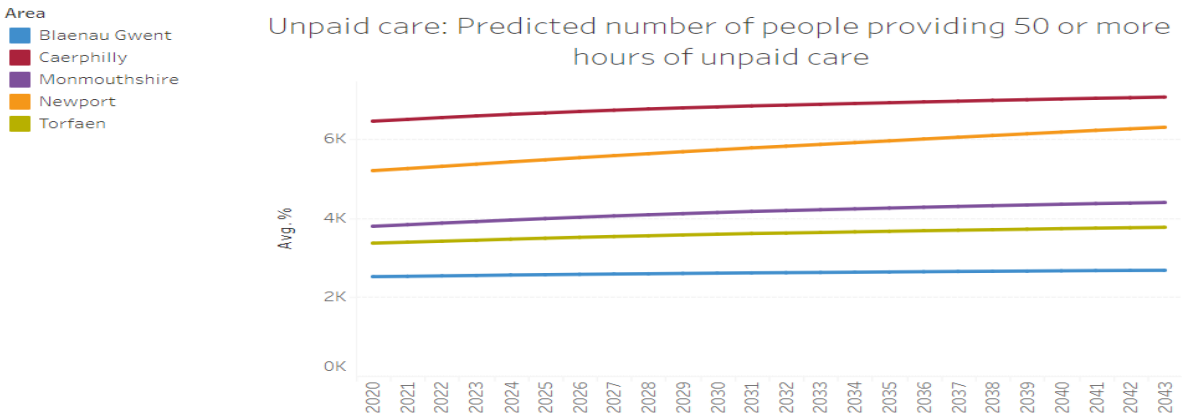
2. **To improve emotional well-being and mental health for adults and children through early intervention and community support.**

(7) CARERS WHO NEED SUPPORT

Policy Area

- Welsh Government's Strategy for Unpaid Carers

(7.1) Predicted number of people providing 50+ hours of unpaid care



Figures are taken from the Census 2011 reference CT0224 - Sex by age by provision of unpaid care by general health. This dataset provides estimates that classify usual residents of England and Wales by provision of unpaid care and by age and by general health. All local authority areas across the Gwent region are predicted to see an increase in the number. The predicted increases range from 35.6% in Blaenau Gwent to 58.9% in Monmouthshire over the period.

A survey by Carers UK of over 8,000 people currently caring unpaid for family or friends, the majority of whom provide well over 50 hours of care every week, reveals the huge personal and financial cost of caring for a loved one. Nearly one in four carers (23%) do not have enough money to cover their monthly expenses. Many carers are worrying about how they will cope this winter face rising energy prices and increases in the cost of living. As well as providing significant levels of care themselves, almost two thirds (63%) of carers are also using their own income or savings to cover the cost of care, equipment or products for the person they care for. On average carers spend an estimated £1,370 a year on services or equipment for the person they care for.

The situation has got worse during the pandemic with over one in three carers (36%) saying that their financial situation has worsened since the start of the COVID-19 pandemic and a quarter (25%) are spending more on equipment or products for the person they care for. As a result many are struggling financially and unable to save for their own retirement. Almost two-thirds of carers (65%) say they are worried about their ability to save and plan for the future. The financial strain is also damaging carers' mental health with over half (52%) reporting they feel anxious or stressed about their finances, and over one in three carers (35%) providing more than 35 hours of care a week said they have been or are in debt.

Carers are still having to take on more hours of care for the person they care for, with 55% of carers having reduced or no access to day services and a third of carers reporting reduced or no access to paid care workers.

(7.2) Number of young carers known to Social Services during the year 2016

Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen
17	45	38	51	49

A young carer is someone aged under 18 who takes responsibility for someone who is ill, disabled, elderly, experiencing mental distress or affected by substance misuse, or has substantial responsibility for caring for a sibling. A young carer may be from any family. They may be the person providing all of the care but may also help someone else to provide the care.

(7.3) Number of schools engaging in Young Cares in School Programme

	Number of Primary Schools	Engaging Primary schools	Number of Secondary Schools	Engaging secondary schools	Engaging PRS 1/5
Blaenau Gwent	23	3	4	3	
Caerphilly	78	8	12	7	
Monmouthshire	30	1	4	4	1
Newport	46	3	9	8	
Torfaen	26	6	6	5	
Total	203	21 (10%)	35	27 (77%)	1 (20%)

The RPBs commitment to supporting young/young adult carers in education remains high especially identifying hidden carers. We have seen a changing climate for young carers balancing their caring roles, alongside coping with firstly school closures and managing online learning and then reopening of schools further exacerbated by outbreak quarantines. It has become ever more important that systems are in place to understand, inform, identify, support and listen to young carers. We have been raising awareness with school staff and students about young carers and the challenges they may face and encouraging parents and young people to identify themselves to receive tailored support with their education. This has been done in a range of ways to take account of Covid restrictions which has made it difficult to offer face to face visits including: staff training is offered every 6-8 weeks virtually to schools in Gwent; assembly videos can be shared with students and staff of all ages; letters sent to families with information on how to access young carer services and carers assessments locally.

The Young Carers in schools programme delivered by CTSEW has seen an increase in demand. In Gwent, a total of 49 primary/ secondary schools are engaging with the programme. Originally this programme funded one Schools Development Worker with support from the Young Carers Manager. This year it has become necessary to review this, to take account of support and engagement needed with primary schools with an additional Young Carers in Schools Programme Officer to focus on primary schools in Gwent.

(7.4) Predicted number of people aged 16 - 24 that will provide 1 - 19 hours of unpaid care in 2035

Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen
266	904	236	740	464

Figures are taken from the Welsh Health Survey 2008: Health of Carers. The prevalence rates have been applied to population projections to give estimated numbers predicted to provide unpaid care, to 2035.

(7.5) Number of carers accessing regional Carers Hub

	Number of Carers Accessing Gwent Carers Hub	Number of Referrals Received	Number of Referrals from Professionals
April 2020 – March 2021	1105	530	187
April 2021	283	42	3
May	239	85	8
June	323	70	3
July	310	58	12
August	303	48	3
Sept	191	50	6
Total	1649	353	35

The Gwent Carers Hub is available to all carers in the Gwent region. During 2020/21, 1105 carers accessed the Gwent carers hub. We have already seen a significant increase this year; in the period April 2021- September 2021 up to 24th September 2021, 1649 carers accessed the service. The Carers Hub provide accesses to information as well as wellbeing activities, first aid training for carers, legal clinics, coffee morning, complimentary therapies and drop in services.

Emerging Themes, Future trends, and challenges

Carers UK report that:

- There are 370,230 carers in Wales according to the 2011 census
- The Office of National Statistics indicated that there are 487,000 carers in Wales in a 2019 survey
- Every year in Wales 123,000 people become carers
- Carers save the Wales economy £8.1 billion per year
- Nearly 3 million people in the UK juggle caring with holding down a job
- The main carers' benefit is worth just £64.60 for a minimum of 35 hours - £1.85 per hour
- 103,594 people in Wales provide over 50 hours of care per week

- People providing high levels of care are twice as likely to be permanently sick or disabled
- Over 1 million people in the UK care for more than one person
- 58% of carers across the UK are women; 42% are men
- By 2037 the number of carers in the UK will have increased to 9 million

On 1st October 2021, the **Older Persons Commissioner reported on her findings in their 'State of the nation' report.** This highlighted that unpaid care had increased significantly with 80% providing more care than before the pandemic, 72% had not had a break from their caring roles since the pandemic and reported loneliness of older people had increased from 49% to 75%.

In **2021/22 Welsh Government reaffirmed its commitment to carers with the announcement of £1 million nationally for Local Health Boards** to work collaboratively with partners to address four national priorities to improve support for carers by:

- identifying and valuing carers;
- providing information, advice and assistance
- supporting life alongside caring and
- supporting unpaid carers in education and the workplace.

In January 2022 the commitment was confirmed further but with a single focus of supporting hospital discharge.

Public Health Wales research ***'Unpaid carers in Wales: The creation of an e-cohort to understand long-term health conditions amongst unpaid carers in Wales'*** was the first study in Wales providing a comprehensive assessment of the prevalence of physical and mental long-term health conditions and multimorbidity as managed in primary care amongst unpaid carers, and compared to a matched comparison group of non-carers in Wales. The study highlights the health needs of unpaid carers are often overlooked due to the focus on the health of those being cared for. Understanding the health and wellbeing needs of unpaid carers themselves is of key importance, to ensure support is in place to maintain their own good health whilst they also care for others. The research also found:

- Routinely collected primary care data and National Survey for Wales data were used to identify 62,942 unpaid carers in Wales since 2011; this electronic-cohort **of unpaid carers were more likely to be female, of older age and live in deprived areas,** compared to the general population in Wales.
- Thirty-six out of thirty-seven physical and mental long-term health conditions recorded in primary care were more prevalent among unpaid carers than non-carers. The most **prevalent condition for both unpaid carers and non-carers was anxiety and/or depression, with standardised rates of 248 and 137 per 1,000 population respectively.**
- For some conditions, there was evidence to suggest onset at a younger age amongst unpaid carers such as anxiety and/or depression, irritable bowel syndrome and musculoskeletal disorders.
- **Unpaid carers were more likely to be living with multiple long-term health conditions (308 per 1,000 population amongst unpaid carers compared to 187 per 1,000 population**

amongst non-carers), and the difference in prevalence was greater at a younger age (e.g. for those aged 25-34yrs, 205 per 1,000 population amongst unpaid carers compared to 79 per 1,000 population amongst non-carers). In older age, the proportion of unpaid carers managing multiple long-term conditions exceeded 550 per 1,000 by the age of 65 years and above, whereas amongst non-carers this proportion was only exceeded at 75 years and above.

What Carers have told us?

During Cares week 2021, over 700 carers were involved in activities and information awareness including over 100 young carers. Carers week is an opportunity to raise greater awareness of the caring role and provide information to the public. One local authority used this an opportunity to all gather feedback on services.

There were 466 webpage views during Carers Week, an average of 1,684 people saw each daily Facebook carers posts between 3 and 13 June 2021 which resulted in 102 clicks for further information. The highest numbers of people who saw individual posts was on 8 June with a reach of 2,093 people. There was an average of 1,669 Twitter impressions across the week. The most popular post was on 3 June which detailed the lighting of the Civic Centre clock tower in blue to mark Carers Week 2021.

State of Caring 2021 in Wales: each year, Carers UK carries out a survey of carers to understand the current state of caring in the UK. This report contains a snapshot of what caring in Wales is like in 2021, capturing the impact that caring has on carers' lives and evidencing the policy recommendations that would improve this.

Finances: caring often brings with it additional costs, from equipment and care costs to increased expenditure on fuel and transportation. When asked to describe their current financial situation, 36% of carers in Wales said they were struggling to make ends meet. A further 23% are or have been in debt as a result of caring and 8% cannot afford utility bills such as electricity, gas, water or telephone bills. When asked about how their financial situation had changed since the start of the COVID-19 pandemic, 36% of carers said that their financial situation had got worse since the start of the pandemic. Caring can be expensive and 65% of carers are spending their own money on care, support services or products for the person they care for. The average monthly spend for carers in Wales is £109.75 and with high rates of inflation and a rising cost of living, this extra spend is likely to further disadvantage carers financially.

Support and Services: carers often need practical and emotional support to enable them to care safely for people with complex needs, and too often they struggle to get the support they need. When asked about barriers to accessing support, the largest issue for Welsh carers was that they did not know what services were available in their area with 40% of carers reporting this as a barrier. In addition, 30% of carers were concerned about the risk of catching COVID-19 and 32% say that the care and support services did not meet their needs. Considering the future of services, 51% of carers were uncertain about what practical support

they may be able to access in the next twelve months and 66% were worried that services will be reduced.

Health: Caring can have a detrimental impact on someone's physical and mental health. 26% of carers described their physical health as bad or very bad. 34% of carers rated their mental health as bad or very bad. Looking at wider indicators of wellbeing, 36% of carers reported that they are often or always lonely, otherwise known as being 'chronically lonely'. Carers also rated their overall satisfaction with life at an average of 4 out of 10 and their level of anxiety at 6 out of 10. Carer's assessments The Social Services and Well-being (Wales) Act 2014 gives Welsh carers the right to a carer's needs assessment. Despite carers' rights to assessments only 21% of Welsh carers reported having an assessment in the last 12 months. Of those, 28% waited more than six months for their assessment. Of those who hadn't requested a carer's assessment, 37% stated that this was because they didn't know what it was and 20% stated it was because they didn't think it would be beneficial. 10% of carers said their assessment had been postponed or they were still waiting.

Technology: When asked about their current use of digital technology, remote healthcare such as online GP appointments was the most popular technology listed with 37% of carers stating that this made their caring role easier. Looking to the future, 31% of Welsh carers would like to continue accessing support services digitally in the future and 44% stating they would like to continue accessing health and social care services digitally.

Work: Working carers represent a significant proportion of the working population and 196 respondents were in paid work. The pandemic is continuing to have an impact on working experiences, with 51% of working carers are working from home part or full time. The limited return of services continues to have an impact. 30% of working carers in Wales stated that if care services did not return, they would either need to reduce their working hours or give up work entirely.

Respite is continually highlighted as the highest support need for carers across Gwent.

Emerging Priorities

1. **Support carers to care through flexible respite, access to accurate information, peer to peer support, effective care planning and through an increased public understanding.**

2. **Improve well-being of young carers & young adult carers and mitigating against the long term impact of Covid-19 pandemic**

(8) HOUSING

Housing needs include specialist housing and accommodation needs of the core priority groups, including supported accommodation, such as extra care housing, supported living for adults with a disability, and small unit residential care for children with higher needs. Also included are additional investment in adaptations to support people in the priority groups to continue to live independently and safely in their own home.

Policy Areas

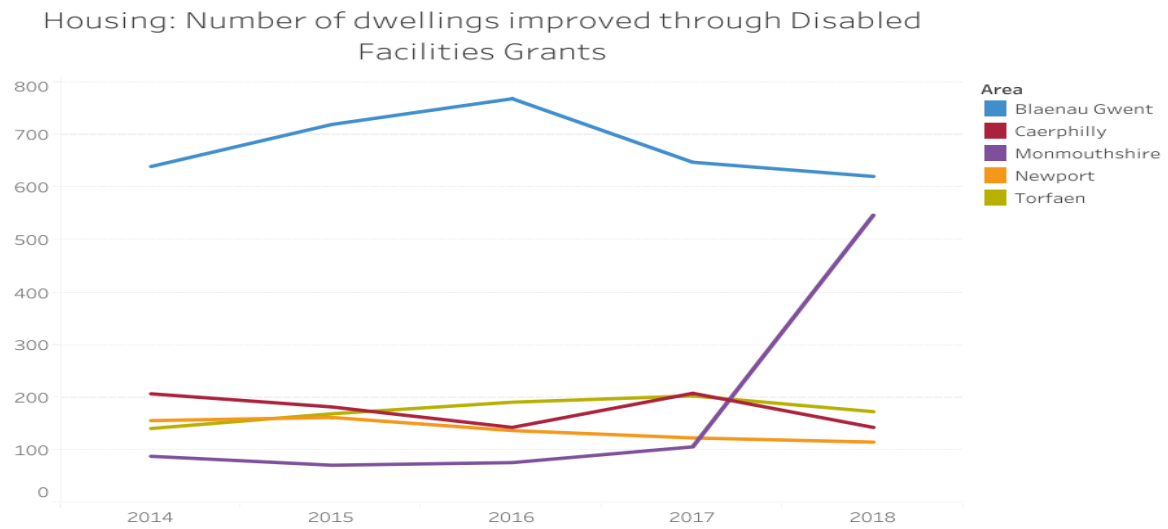
- The Housing (Wales) Act 2014
- Well-being of Future Generations (Wales) Act 2015
- Renting Homes (Wales) Act 2016
- Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Substance Misuse Delivery Plan 2019 – 2022
- Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales
- Equality Act 2010
- Code of Guidance for Local Authorities on the Allocation of Accommodation and Homelessness 2016
- Housing Support Grant Guidance March 2021
- Programme Plans and Objectives (PPO) being undertaken for the ICF Capital Funding programme.
- Local Housing Market Assessments (LHMAs)
- Welsh Government Strategy for Preventing and Ending Homelessness
- Ending Homelessness in Wales: A high level action plan 2021-2026

(8.1) Rate of all other accommodation for persons aged 16+ with a learning disability per 10,000 population

Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen
3.8	**6.6**	**9.4**	**7.6**	**5.1**

The data is taken from the Register of persons with learning disabilities (SSDA901). The data may be an underestimate of the total number of people with learning disabilities as registration is voluntary. Local authorities submit numbers of those identified as having a learning disability currently known to the authority and included in a register for the purpose of planning or providing services.

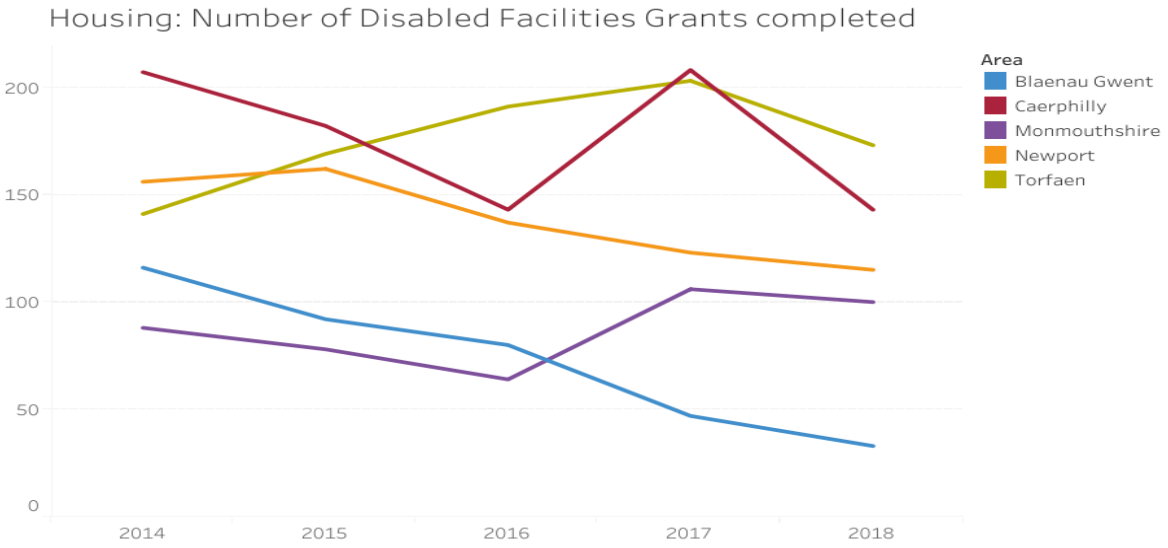
(8.2) Number of dwellings improved through Disabled Facilities Grant



Welsh Government (WG): DFG0001

The DFG is a mandatory council grant that helps to meet the costs of adapting a disabled person's home so that they can continue to live there as independently as possible. Tenants, owner occupiers and landlords who have a disabled tenant can apply for a DFG. The DFG is a means tested grant to disabled adults (means testing does not apply to parents of dependent disabled children or young people under 19). This means depending on your income, savings and outgoings, you might have to make a contribution towards the cost of the works. In Wales, the maximum DFG award is currently £36,000. There is growing concern amongst LAs given budget pressures and introduction of financial assessments, that a number of people are pulling out of the process and exacerbating original issues.

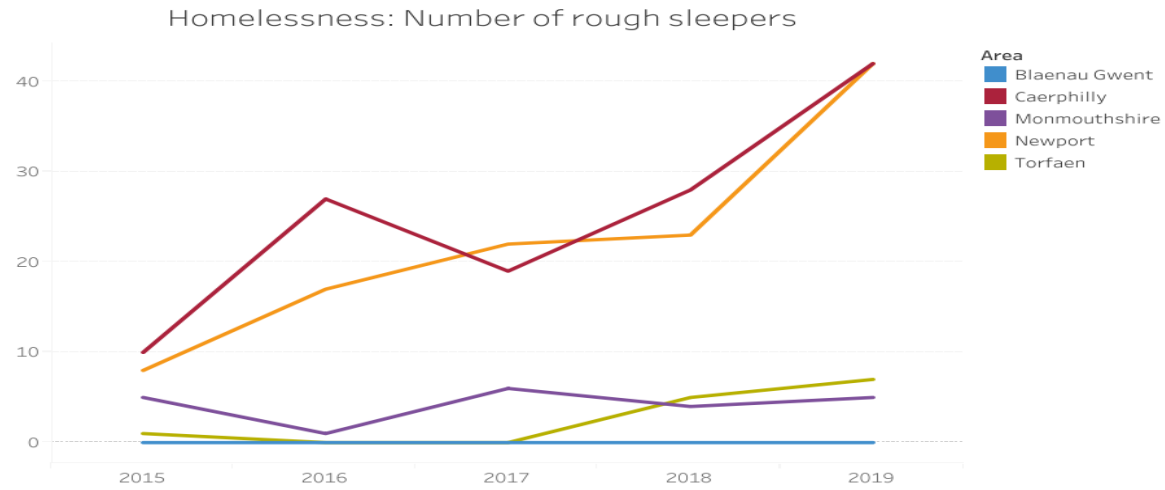
(8.3) Number of Disabled Facilities Grants completed



Welsh Government (WG): DFG0002

Examples of the sorts of adaptations the DFG covers include: Widening doors and installing ramps or stairlifts, Kitchen and bathroom adaptations for eg. walk in showers, Extensions (possibly for a downstairs bathroom and/or bedroom), Installing a suitable heating system that meets the disabled person's needs, Adapting the controls on the heating system or lighting so they are easier to use. Before a formal DFG application is considered, a social services department's occupational therapist (OT) will usually need to assess the disabled person's needs, including whether the works are "necessary and appropriate". The OT's recommendations are normally put to the Housing Department who administers the DFG. The council will then have to decide whether it is "reasonable and practicable" to do the works. Given the challenges and lack of recruitment into OT posts, there is a real concern that the number of DFG completed will decrease. The RPB are currently assessing the potential impact across the 5 LAs.

(8.4) Number of rough sleepers

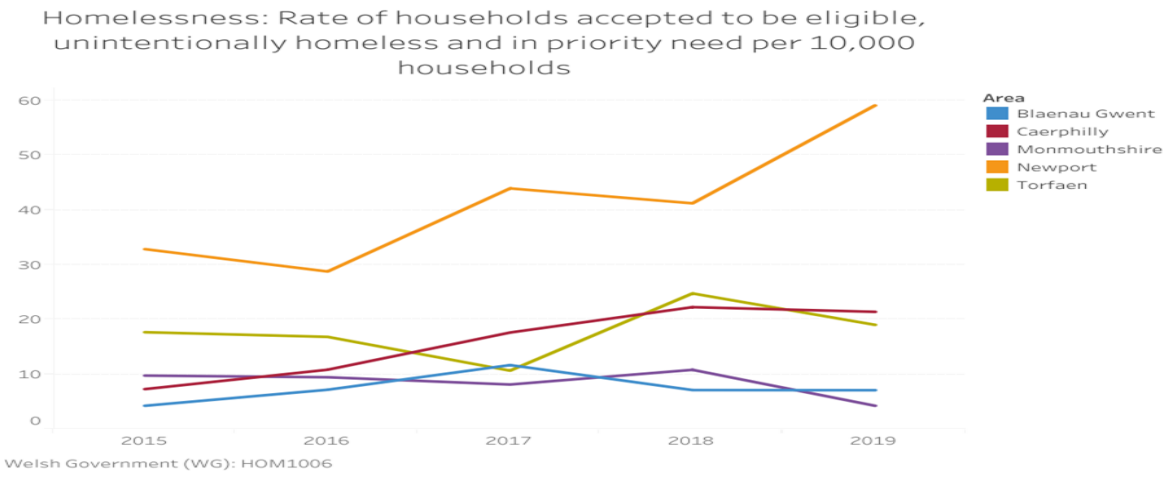


Homelessness is where a person lacks accommodation or where their tenure is not secure. Rough sleeping is the most visible and acute end of the homelessness spectrum, but homelessness includes anyone who has no accommodation, cannot gain access to their accommodation or where it is not reasonable for them to continue to occupy accommodation. This would include overcrowding, 'sofa surfing', victims of abuse and many more scenarios. A person is also homeless if their accommodation is a moveable structure and there is no place where it can be placed. Homelessness, or the risk of it, can have a devastating effect on individuals and families. It affects people's physical and mental health and well-being, and childrens' development and education, and risks individuals falling into a downward spiral toward the more acute forms of homelessness. The impacts can be particularly devastating if a stable, affordable, housing solution isn't achieved and people end up having to move frequently. The average age of death for people experiencing homelessness is 45 for men and 43 for women. People sleeping rough are 17 times more likely to have been the victims of violence. Homeless people are 9 times more likely to take their own life than the general population *Ref:* About Homelessness | Crisis UK

Implementation of Part 2 of the Housing (Wales) Act 2014 by local authorities across Wales has done much to prevent individuals and families from becoming homeless – over 23,673 households since 2015. However, whilst prevention rates remain high at 68% in 2018-19, there are still far too many whose homelessness is not prevented and who are falling through the net. The demand on local authority services under the 2014 Act duties is increasing. In 2018-19 over 10,000 households presented to local authorities as at risk and a further 11,500+ presented as homeless and owed a duty.

Rough sleeper numbers in Wales are estimated to be 128 in September 2021, with numbers increasing slightly over the summer period. The data available is more accurate and current than it has ever been and provides a clearer understanding of all forms of homelessness in Wales, which would otherwise be masked through sofa surfing, living in overcrowded homes or unconventional types of dwellings.

(8.5) Rate of households accepted to be eligible, unintentionally homeless and in priority need per 10,000 households.



At the start of the first lockdown in March 2020, an emergency homelessness response was put in place. This involved additional funding, together with both statutory and non-statutory guidance to ensure that no-one was left without accommodation, together with the support they need, to stay safe during the pandemic. The inclusive 'no-one left out' approach has been in place continuously since then and to date has resulted in local authorities and their partners supporting over 15,300 people into temporary accommodation since March 2020. Latest data shows there were 6,935 people in temporary accommodation at the end of September 2021, of which 1,742 were dependent children.

Whilst the pressure on homelessness services remains high, with around 1,000 people presenting a month, understanding the true scale of homelessness presents us with a unique opportunity to make the radical change required to address it. It increases the urgency and importance of preventative work to stop people ever experiencing the destabilising impact of homelessness. It increases the urgency and understanding of the housing capacity required, both in the social and private sector, to make the transformational shift required to end homelessness. Latest figures for 2021

Blaenau Gwent	Caerphilly	Monmouthshire	Newport	Torfaen	Wales
8	**24**	**4**	**58**	**33**	**28**

(8.6) Temporary Accommodation

The table below shows the number of homeless households in temporary accommodation in Gwent at 31st March 2021 and to allow for comparison the table following shows the number of households in temporary accommodation in Gwent as at 31st March 2020 and number of households in temporary accommodation in Gwent as at 31st March 2020 is also provided. *Ref:* Households in Temporary Accommodation (gov.wales)

Authority	No of households in temporary accommodation at 31 March 2021	Mid-year 2020 household estimates	Rate per 10,000 households	No of households in temporary accommodation at 31 March 2020
Blaenau Gwent	38	31,371	12.1	27
Caerphilly	224	77,242	29.0	123
Monmouthshire	131	40,712	32.2	21
Newport	346	66,543	52.0	153
Torfaen	88	40,813	21.6	60
Gwent	827	N/A	N/A	384
Wales	3,730	1,378,226	27.1	2,325

Newport reported the second highest number of households in temporary accommodation as at 31st March 2021 in Wales and saw the biggest increase during this collection period (April 2020 – March 2021). Following a Gwent regional snapshot collection that was collated during September 2021 through the Regional Housing Support Collaborative Group, we can see that the trajectory of people accommodated in temporary accommodation has since increased again to 936 households. Additionally, waiting list figures were also collected as part of this snapshot exercise and as of 10th Sept 2021 there were 452 households on the waiting list for temporary accommodation.

(8.7) Provision of accommodation for 16 and 17-year-old young people who may be homeless

Supporting children and young people to remain with their families is in the best interest of most children. This fundamental principle also applies to 16 or 17 year olds, unless it is not safe or appropriate to do so or where there are other responsible adults in their wider family and friends network that can care for the young person. Gwent Local Authorities explicitly recognise this principle, with services commissioned to work pro-actively with young people and their families to identify and resolve the issues which have led to the homelessness crisis. This could involve family support such as family mediation or family group conferences.

Where a young person approaches for housing assistance, their needs for accommodation are clearly assessed taking into consideration their welfare and ability to continue to live in their current accommodation or family home. If a young person is eligible for assistance the accommodation must be suitable. B&B accommodation is not normally considered to be a suitable option and therefore is only used by Gwent Local Authorities as an emergency short term provision.

The following information is collected by Welsh Government in order to establish the number of placements made by Local Authorities into Bed and Breakfast accommodation to meet the

immediate housing needs of all young people aged 16/17, and also 18-20 year olds (up to 21st birthday) who have previously been in care.

Total placements in bed and breakfasts during the quarter, by length of stay and whether the provision is through Homelessness or Social Services legislation - Period (2020-21 January –March)

	Total			
	Total of which are single person household: Aged 16 to 17		Total of which are single person household: Aged 16 to 17	Of which are care leavers only, aged 18 to 21, accommodated by the current Homelessness
	Of which are single person household: Aged 16 to 17, accommodated by the current Homelessness legislation	Of which are single person household: Aged 16 to 17, Accommodated by Children's Social Services		Of which are care leavers only, aged 18 to 21, accommodated by the current Homelessness legislation
Wales	75	42	120	69
Gwent	30	21	54	18

Emerging Themes, Future trends, and challenges

Each year local authority Housing Support Grant teams will distribute a Gwent Housing Support annual service user survey and the survey has become an important and established element of the needs mapping process. It is the responsibility of the local authorities in the region to ensure that engagement is undertaken with those who have used services. Those who have needed to use services funded through the Housing Support Grant come from a wide range of backgrounds and receive support on a range of different issues; the support they receive is person centred and aims to help people to secure and maintain sustainable housing and to develop the skills needed to help them thrive. Consultation with stakeholders happens with face to face meetings and forums taking place at a local level and regionally through an annual survey and quarterly regional provider forum meetings.

During 2020/21, a total of 262 responses were received to the questionnaire with engagement in the consultation exercise across all Gwent Local Authorities. There are approximately 7000 people receiving support across Gwent at any one time from services funded through the Housing Support Grant; finding ways to encourage people to engage in the survey continues to be an important consideration going forward. A number of key messages were highlighted through the survey and included

- access to technology as part of the support planning process
- closer links need to be made with digital inclusion projects delivered across the region
- access to digital inclusion services and projects to improve their skills and develop their learning in this area and this should be clearly identified in their support plan.

A stakeholder survey is also shared with the service user questionnaire and 31 partners provided feedback and includes

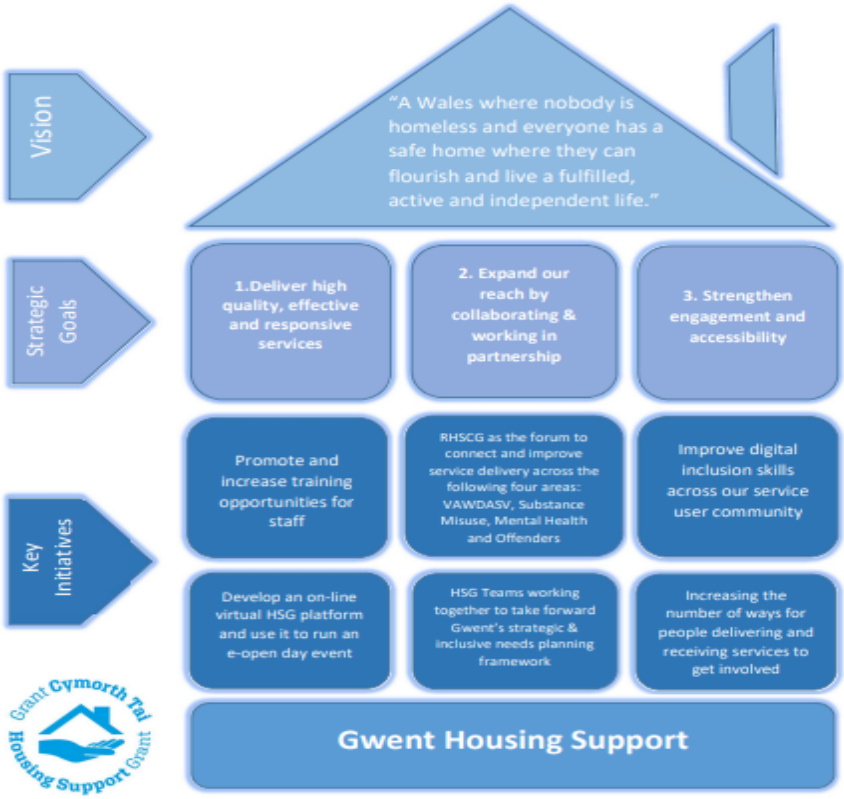
- Scope out exactly what is available
- Long term planning, partnership working and communication is key
- Develop assessments of need

- Lack of suitable affordable accommodation and not enough single units as there are not the properties available and we need to develop and bring online more accommodation
- Young people being placed in accommodation that does not meet their needs
- Great vision but stock needs to be there in order for it to be successful.

Following the Housing Support needs planning and consultation processes completed during 2021; the following regional strategic objectives have been developed and agreed with partners and the Regional Housing Support Collaborative Group:

- Deliver high quality, effective and responsive services
- Expand our reach by collaborating and working in partnership
- Strengthen engagement and accessibility

Key initiatives are being developed to deliver against these strategic goals and these will be reviewed on an annual basis *(– the attached pic captures the above responses – workforce development –training, promotion, collaboration and partnership working, digital inclusion and engagement).*



Homelessness

A change in circumstances or a significant life event such as a relationship breakdown or losing employment, has the potential to unexpectedly push any one of us towards the experience of homelessness; a devastating, dangerous, isolating and potentially life changing and

threatening experience. Some people are more at risk of homelessness and these include those who are leaving home for the first time or leaving care, being pregnant and having nowhere to stay, living on a low income, leaving prison, or from being an asylum seeker or refugee.

The Welsh Government definition of homelessness:

'Homelessness is where a person lacks accommodation or where their tenure is not secure. Rough sleeping is the most visible and acute end of the homelessness spectrum, but homelessness includes anyone who has no accommodation, cannot gain access to their accommodation or where it is not reasonable for them to continue to occupy accommodation. This would include overcrowding, 'sofa surfing', victims of abuse and many more scenarios. A person is also homeless if their accommodation is a moveable structure and there is no place where it can be placed.'

Homelessness, or the risk of it, can have a devastating effect on individuals and families. It affects people's physical and mental health and well-being, and children's development and education, and risks individuals falling into a downward spiral toward the more acute forms of homelessness. The impacts can be particularly devastating if a stable, affordable, housing solution isn't achieved, and people end up having to move frequently.

Impact and response during pandemic

The vision in Gwent is for everyone to have a home to live in and the right support if they need it to lead a fulfilling life. Since the onset of the Coronavirus (COVID-19) pandemic, an emergency homelessness response has been in place and the approach to homelessness has been transformed with the introduction of a 'no-one left out' approach, this involved additional funding, together with both statutory and non-statutory guidance to ensure that no-one was left without accommodation, together with the support they need, to stay safe during the pandemic. Many households were supported into emergency temporary accommodation and as at 31 March 2021, there were 3,729 households placed in temporary accommodation across Wales. This is an increase of 60% on 31 March 2020, and is the highest figure recorded since the introduction of the current legislation in April 2015.

This inclusive "no-one" left out approach has been in place continuously since then and resulted in over 15,000 people being supported into temporary accommodation across Wales between March 2020 and the end of September 2021. The scale of what may once have been considered hidden homelessness and inequality within Wales has become evident. Latest data shows there were 6,935 people in temporary accommodation across Wales at the end of September 2021, of which 1,742 were dependent children.

Whilst the pressure on homelessness services remains high, with around 1,000 people presenting a month, understanding the true scale of homelessness presents us with a unique opportunity to make the radical change required to address it. It increases the urgency and importance of preventative work to stop people ever experiencing the destabilising impact of homelessness. It increases the urgency and understanding of the housing capacity required,

both in the social and private sector, to make the transformational shift required to end homelessness.

The publishing of the "Ending Homelessness in Wales: A high level action plan 2021-2026 sets out that Welsh Government sees being homeless as simply intolerable and their vision to make homelessness

- ***"Rare"*** *- Ensuring homelessness is rare means preventing people from becoming homeless in the first place*
- ***"Brief"*** *– How a national focus on rapid rehousing will lead to a Wales where homelessness is brief*
- ***and "Unrepeated"*** *– Ensuring we have a system which places the right people in the right homes in the right communities with the right support, in order for people to succeed and thrive*

The above sets the direction of travel for the work of Welsh Government and its partners to end homelessness in the next five years and the responsibility for ending homelessness to extend beyond dedicated homelessness and housing teams and demanding an "all public services" response.

There were a number of principles set out in the Welsh Governments Strategy for Ending Homelessness 2019 that underpin the approach to homelessness prevention and going forward are expected to underpin the work of delivery partners and are to be reflected across public services.

- The earliest preventions are most effective and most cost effective and should always be the interventions of first choice.
- Tackling and preventing homelessness is a public services matter – rather than a 'housing matter'.
- All services should place the individual at the centre and work together in a trauma informed way.
- The duties in Part 2 of the Housing (Wales) Act 2014 should be the last line of defence – not the first - and all services should work to the spirit not simply the letter of the law.
- Policy, service delivery and practice should be informed and shaped in a co-productive manner and by those with lived experience.

Ref: Homelessness in Wales 2020-2021 Statistical First Release, Ending Homelessness in Wales; A High Level Action Plan 2021-2026

Emerging Priorities

1. **A multi agency partnership approach to ensure appropriate housing and accommodation for older people and vulnerable citizens**
2. **Homelessness requiring a collaborative response from public services**
3. **Non use of B&B accommodation for young people**

(9) Violence against women, domestic abuse and sexual violence (VAWDASV)

Domestic violence and abuse is a serious health and social care issue and has escalated through the pandemic, with access to services curtailed due to the covid 19 outbreak. It impacts on all services including adult and children's social service, health services, housing, criminal justice, education, police, and voluntary and community organisations; so, needs a collaborative approach. Anyone can be affected by domestic abuse and sexual violence including women, men, children, and young people. This can happen regarding of sex, age, ethnicity, gender, sexuality, disability, religion or belief, income, geography, or lifestyle. A significant number of people who experience VAWDASV will have one or more 'protected characteristic' under the Equality Act 2010 and will face additional vulnerabilities and have increased barriers to support.

Gwent has been working in partnership as the first region in Wales for strategic coordination of VAWDASV services, where we pioneer new ways of working. We have a range of early intervention and prevention services through Supporting People, Flying Start, Families First and also specialist sector services, recognising that survivors are the experts. There are a number of data sources available to the regional VAWDASV Board including

- Rate of sexual offences per 1,000 people
- Number of sexual offences
- Number of domestic violence offences
- Number of sexual and domestic violence offences
- Number of MARAC (domestic abuse) cases
- Number of recorded incidents of domestic abuse (DACC)

The RPB works alongside the VAWDASV Board and does not replicate the information monitored.

Emerging Themes, Future trends, and challenges

The pandemic has highlighted the dangers faced by victims and survivors. In Wales during the lockdown period calls to the Wales national helpline Live Fear Free, rose by 49% and call times trebled with those contacting the helpline often reporting more frequent abuse with shorter escalation periods. (Social Care Wales 2021) There has also been a surge in calls and website visits to specialist domestic violence services and emergency services have experiences an overstretched workforce tackling the pandemic.

As lockdown restrictions ease it is expected there will be a demand in services as individuals and

> **"I have spent most of the pandemic living with daily anxiety for fear something will kick off and have been trying to avoid conflict at all costs with my partner. It has been a scary depressing time for me, and I have felt like I can't breathe".**

families look for support. We need to build back better, investing in prevention and early intervention so people can access the right support at the right time. We also need to deliver a whole system approach to tackling abuse and ensuring the safety of both young people and adults through access to safe, effective, trauma informed support.

Emerging Priorities

1. **TBC by VAWDASV Board**

(10) GWENT WORKFORCE AND DEVELOPMENT

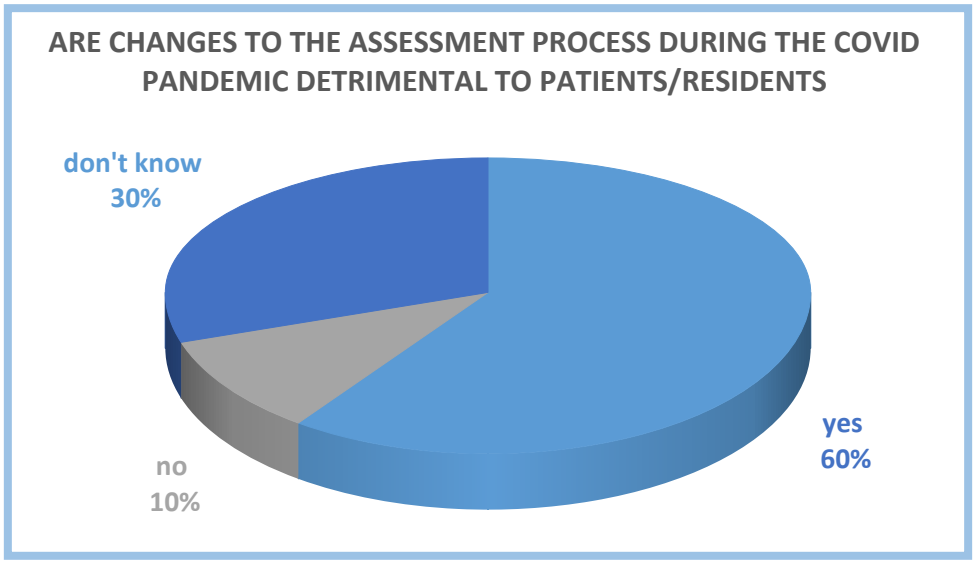
The RPB have established a regional Workforce and Development Board with a delivery plan which is monitored by the Board. Workforce Development managers and the regional Partnership Team meet regularly, prior to the board to ensure consistent developments across the workforce, joint training and continuous development of the regional training plan.

The health and social care workforce has come under an increased focus during the pandemic and with huge recognition amongst the public given the commitment of staff to support vulnerable citizens across the region. Recruitment and levels of pay have proven to be challenging issues across the UK, Wales and in the region. This will require national solutions and an area for RPB focus going forward given that workforce will be the foundations for all health and social care support going forward.

Local Workforce Development Managers and the regional Transformation team form part of a National Social Services and Well-being Act Workforce Development Group. The group ensures coordinated development across Welsh Government, Care Council for Wales and regional and Workforce Development teams and ensures there is a focus on raising the profile of the care sector as a career path and raising standards through commissioning.

(10.1) A survey of the experiences and views of Mental Health assessors and Deprivations of Liberties process during the COVID-19 pandemic.

The Deprivation of Liberty Safeguards (DoLs) provides a legal framework to protect vulnerable adults, who may become, or are currently being deprived of their liberty in a care home or hospital setting and who lack mental capacity to consent to their care arrangements. Measures introduced to manage the spread of COVID-19 by the UK and Welsh Government have impacted upon the assessment process for Deprivation of Liberty safeguards and Best Interest Assessors, Mental health Assessors and DoLs Signatories working in Gwent were asked to complete a survey in relation to their views and experiences during the COIVID pandemic.



It is clear from practitioners that the virtual and online form of assessment, although necessary at the time, has not been as seamless as other assessments. Barriers to completing DoLs assessments due to the COVID pandemic need further examination and an area of focus for Welsh Government as well as the RPB.

Aneurin Bevan University Health Board

Finance Report – January (Month 10) 2021/22

Executive Summary

This report sets out the financial performance of Aneurin Bevan University Health Board, for January 2022.

The 2021/22 financial performance is measured by comparing the expenditure with the budgets as delegated in the Budget Delegation papers agreed at the March, July, September 2021 and January 2022 Board meetings. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

Jan-22
Performance against key financial targets 2021/22
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	(42)	(145)	⇔	**0**
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £51,420	4,340 8.5%	31,443 61.3%	⇔	**0**
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	91.1%	94.9%	↓	**>95%**

Performance against requirements 20/21		**18/19**	**19/20**	**20/21**	**3 Year Aggregate**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	✓	**(235)**	**(32)**	**(245)**	**(512)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	**(41)**	**(28)**	**(13)**	**(82)**
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓				

Underlying Financial Position (Brought Forward ULP)	**18/19**	**19/20**	**20/21**	**21/22**
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	**£19.763m Deficit**	**£11.405m Deficit**	**£16.261m Deficit**	**£20.914m Deficit**

Note: The Health Board is in it's 3rd year of the approved IMTP, the HB has submitted a refreshed Annual Plan for 21/22 in place of a revised 3 year IMTP, as directed by WG.

Key points to note for month 10 and year to date position include:

- A year to date underspend of £0.1m against delegated budgets (in-month movement of £0.04m underspend),
- Income - includes anticipated and confirmed Covid-19 funding,

- Pay Spend – has increased by c.£1.2m, primarily due to 1% non-consolidated award payment coupled with an increase in medical and nursing agency costs, off-set by reduced elective activity.
- Non–Pay Spend (excluding capital adjustments) - has increased by £4.2m, due to increased funded WHSSC payments for Cystic Fibrosis drugs, as well as prescribing, ICF and 111 variable cost profiles,
- Savings – expected achievement remains on plan & at the same levels as previously reported for both the in year and recurrent position.

Significant issues for the Health Board's forecast financial plan include;

- Improving and achieving the level of savings and efficiency programmes on a recurrent basis to support long term financial sustainability, and
- Ensuring that service and workforce solutions, in response to the challenging demands being faced, are achieved in the most cost-effective way.

At Month 10, the forecast revenue and capital positions are break-even for the 2021/22 financial year.

The latest financial assessment of income levels, service and workforce costed plans is that the Health Board should be able to deliver these plans within anticipated available funding.

The underlying financial deficit (£20.9m) will need to be addressed to support financial sustainability and recurrent balance in future years.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	

Executive Sponsor: Rob Holcombe – Interim Director of Finance, Procurement & VBHC

Report Author: Suzanne Jones – Interim Assistant Director of Finance

Report Received consideration and supported by:

Executive Team		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	

Date of the Report: March 2022

Supplementary Papers Attached:

1. Glossary

Purpose of the Report

This report sets out the following:

- The financial performance at the end of January 2022 and forecast for 2021/22 – against the statutory revenue and capital resource limits,
- The revenue reserve position on the 31st of January 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy, and
- A financial assessment of the risks and opportunities which may impact on delivering the financial forecast for 2021/22.

Assessment & Conclusion

- **Revenue Performance**

  The month 10 position is reported as £0.1m underspend year to date (in-month movement of £0.04m underspend) with a forecast year-end out-turn break-even position. A summary of the financial performance is provided in the following table.

Summary Reported position - January 2022 (M10)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	277,501	(1,324)	(1,327)	3
Prescribing	106,494	811	1,030	(219)
Community CHC & FNC	66,855	(282)	(263)	(19)
Mental Health	113,465	81	151	(70)
Director of Primary Community and Mental Health	566	(70)	(64)	(6)
Total Primary Care, Community and Mental Health	**564,880**	**(784)**	**(473)**	**(311)**
Scheduled Care	238,308	584	544	41
Medicine	120,870	1,842	786	1,056
Urgent Care	40,703	2,395	1,674	721
Family & Therapies	119,407	(692)	(368)	(324)
Estates and Facilities	83,904	630	423	207
Director of Operations	6,036	1,175	980	194
Total Director of Operations	**609,228**	**5,934**	**4,039**	**1,895**
Total Operational Divisions	**1,174,109**	**5,150**	**3,566**	**1,584**
Corporate Divisions	127,684	(3,930)	(2,739)	(1,191)
Specialist Services	174,530	(3,049)	(2,707)	(342)
External Contracts	77,033	2,543	2,212	330
Capital Charges	30,971	(210)	(187)	(23)
Total Delegated Position	**1,584,327**	**504**	**146**	**358**
Total Reserves	4,485	(649)	(249)	(400)
Total Income	(1,588,812)	0	(0)	0
Total Reported Position	**0**	**(145)**	**(103)**	**(42)**

Financial impact of service and workforce pressures

- During January 2022, pay expenditure increased due to the 1% non-consolidated pay award for Bands 1-5. Variable pay costs increased as a result of Covid-19 sickness linked to the Omicron variant as well as coverage for enhanced care. Non-pay expenditure increased due to funded WHSSC costs linked to Cystic Fibrosis drugs, increased prescribing expenditure as well as additional ICF and 111 related costs.
- The number of Covid-19 positive patients in hospital increased significantly at the end of December and through January due to the Omicron variant of Covid-19. Whilst these numbers are lower than the levels being cared for during the 1st and 2nd waves of the pandemic, the number of patients being treated for and recovering from Covid-19 remains significant. ICU patient numbers relating to Covid-19 are at similar levels to previous months although this is decreasing. The temporary staffing costs in this area remain significant. All services still need to operate in a Covid-19 safe environment leading to a workforce and financial pressure.
- Demand for emergency and urgent care across all services – including primary care, mental health and acute/community hospitals – has increased significantly and in many cases is

above the levels seen pre-pandemic. Winter plans have been approved and implemented which are designed to help mitigate further operational pressures across the Health Board.

- Delays in patient discharges are adding to the flow challenges being experienced resulting in greater bed demand and workforce and financial pressures.
- The operational factors above result in significant financial costs however these are off-set by a reduction in elective activity in January linked to the Omicron variant. It should be noted that elective activity was maintained in a number of specialities using for example the St.Woolos hospital. In addition, many staff have been redeployed in order to ensure the progress of mass vaccination to the ABUHB population is continued at the start of January. As a result, there remains forecast slippage against a number of recovery and winter plan schemes.

Additional costs are being incurred due to the following:

- Additional workforce capacity to support the significant pressure on the Emergency Department and other urgent care services,
- Workforce costs for covering increased sickness absence and self-isolation periods,
- Maintaining 'green' patient pathways to minimise infection,
- Additional hospital bed capacity to ensure the safe and timely flow of patients,
- Increased acuity of patients presenting and demand for enhanced care,
- Delayed transfers of care related to challenges faced by social care to support discharges, and
- Commissioning step-down capacity to support patients in their discharge back home or to a longer-term care home placement.

To mitigate, key areas of focus for the Health Board are:

- System level working to expedite patients to the most appropriate care setting,
- Enhancing same day emergency care and flow,
- Securing additional capacity,
- Increasing Nurse staffing levels,
- Other actions to underpin the operational management and leadership to support clinical teams, and
- Prioritising utilisation of workforce.

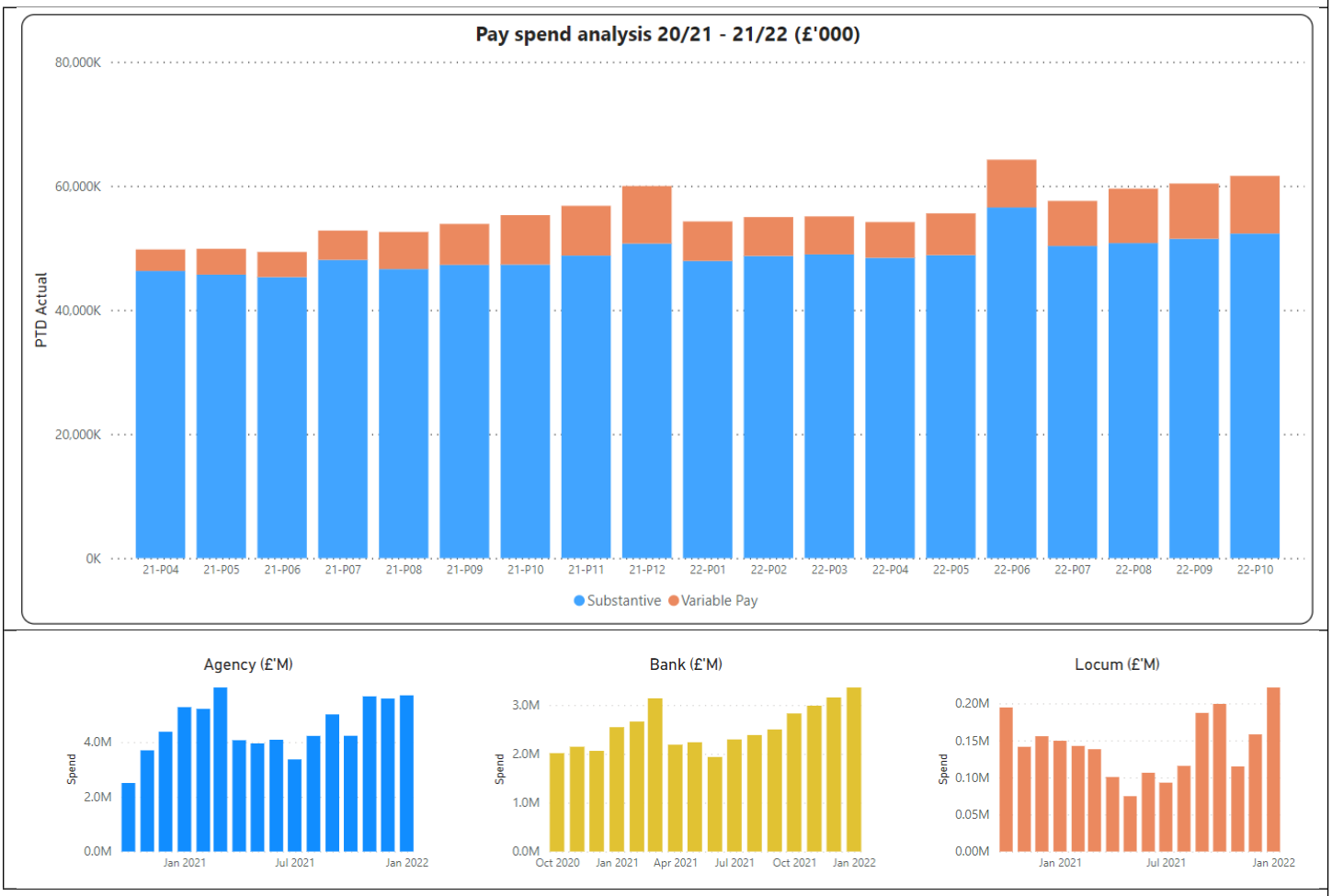
Workforce

Workforce costs (allowing for the wage award) have maintained a consistent average level of monthly spend of c.£58m for months 1-10 of 2021/22.

Substantive staffing costs have increased by £0.8m (1.6%) including the 1% non-consolidated payment for Bands 1-5 (£2.3m) offset by other pay cost reductions when compared to month 9. There were reductions in overtime compared to month 9 for mass vaccination. Bank costs have increased by £0.2m (6.5%). Agency costs have increased by £0.12m (2.1%) compared to month 9. This is linked to increased sickness and self-isolation linked to Covid-19 and increased enhanced care across the Health Board.

It is expected that the expenditure run-rates for agency staffing will remain and possibly increase for the remainder of the financial year given the requirement to deliver agreed recovery, winter and Covid-19 plans. The re-introduction of flexible rewards payments and the increase in specialist nursing rates of pay have also increased costs and subject to board agreement will likely continue throughout the rest of the financial year. There is still a continued and significant reliance on the use of agency and bank staff.

Workforce expenditure is shown below differentiating between substantive and variable pay[1]:



Substantive staff
Substantive pay was £52.32m in January – an increase of £0.85m compared to December. Substantive pay has increased by £0.61m for A&C, £0.31m for HCSW, £0.2m estates and ancillary. These increases were spread across most areas of the Health Board and are linked to the 1% non-consolidated pay award.

Variable pay
Variable pay (agency, bank and locum) was £9.29m in January – an increase of £0.38m compared to December.

The Executive Team have agreed the block booking of registered nurse (RN) agency and over recruitment of health care support workers (HCSW) to ensure safety of service provision.

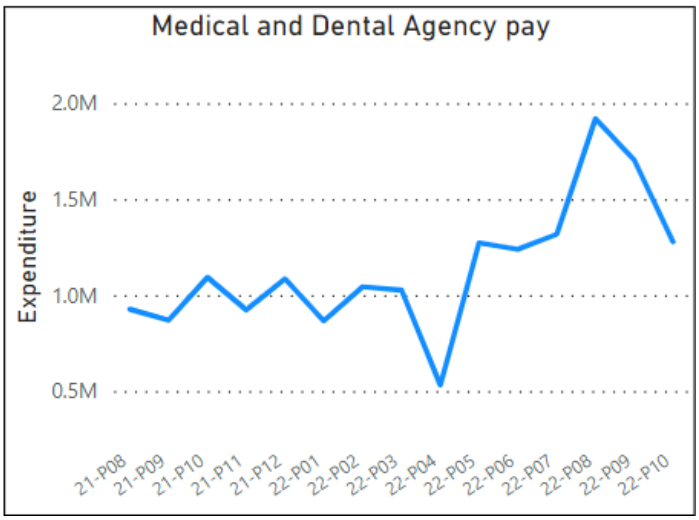
It should be noted that the number of unfilled registered nursing shifts remains at a high level throughout the Health Board. If all of these shifts were filled through variable pay the cost impact would be significant.

Bank staff
Total bank spend in January was £3.4m - an increase of £0.2m compared with December 2021, this is mainly due to the effect of Covid-19 sickness and self-isolation. Areas where bank usage continues to increase are ICU and GUH ED due to on-going Covid-19 additional support requirements.

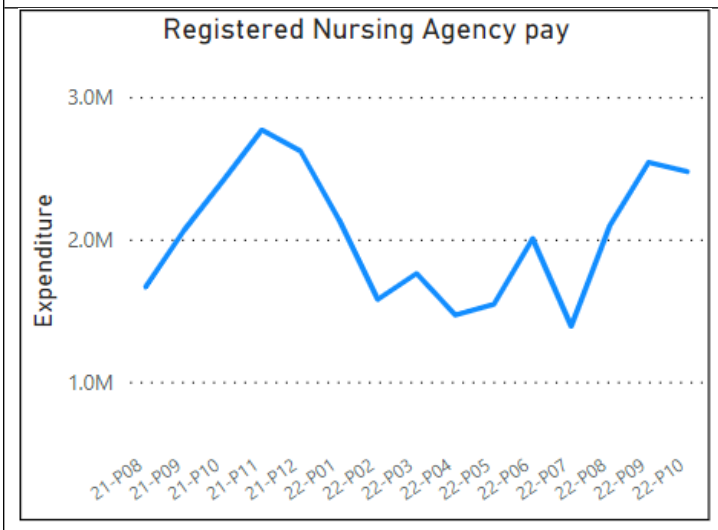
[1] *To enable useful comparisons and trends all references to 20/21 pay expenditure exclude the month 12 expenditure for: Covid-19 annual leave provision (£17m), Covid-19 bonus payments (£14.7m), and Additional employer pension contributions (6.3%/£25m).*

Agency

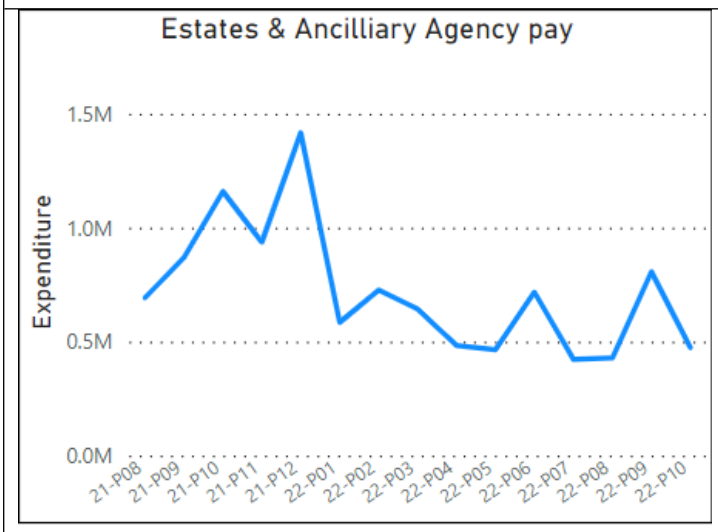
Total agency spend in January was £5.7m – an increase of £0.1m compared to December. Agency costs increased for HCSW linked to enhanced care and sickness. Medical agency costs have decreased partly linked to a review of previous months' shifts coupled with reduced elective activity and associated costs.



- Decrease in month £0.4m due to
  - Review of shifts worked in early 2021/22 which has reduced costs in RGH Medicine, COTE and Frailty specialities.
  - These were off-set by the continued pressures in COTE and YYF medical staffing backfilling a number of staff who are non-patient facing and numerous vacancies.
  - Ophthalmology and radiology reduction in costs linked to cover of vacancies.
  - Increased costs in Urgent Care and Mental Health.
- Medical agency spend is averaging c.£1.2m per month.



- In-month spend of £2.5m, at a similar level to December.
- Reasons for use of registered nurse agency include:
  - Enhanced Care on Medicine wards in NHH and YYF.
  - Additional service demand including opening additional hospital beds,
  - Enhanced care and increased acuity of patients across all sites,
  - Increased sickness,
  - vacancies, and
  - enhanced pay rates.
- Registered Nursing agency spend is averaging c.£1.9m per month.



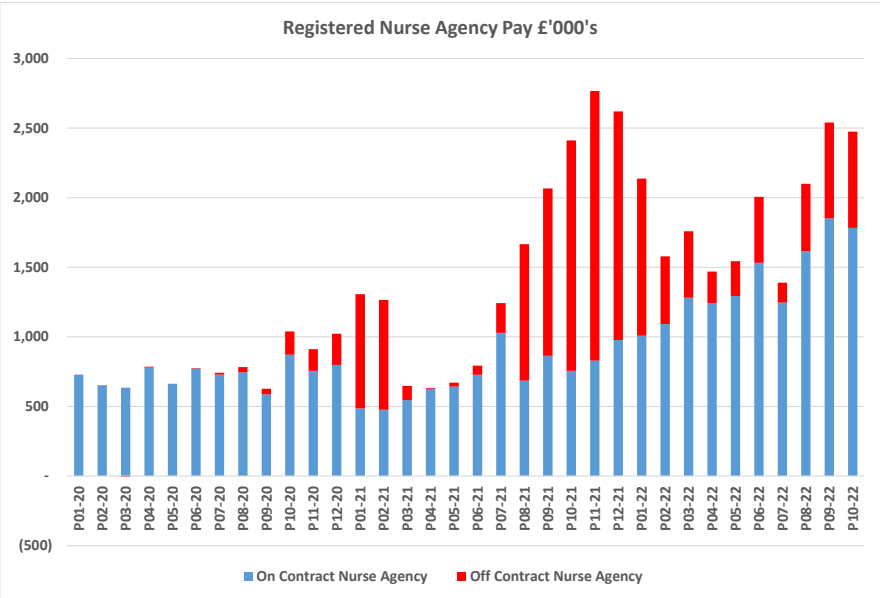
- In month spend of £0.5m on Estates & Ancillary, which is primarily within GUH and related to Covid.
- Reasons for use of agency include:
  - Meeting enhanced cleaning standards,
  - Enhanced care and increased acuity of patients,
  - Increased sickness,
  - Vacancies,
  - Recruitment difficulties, and
  - Supporting the Mass Vaccination Programme.
- Estates and Ancillary agency spend is averaging c.£0.6m per month.

Registered Nurse Agency

Registered nurse agency spend totalled £18.1m in 2020/21 and £10.2m in 2019/20.

If spend continues at the current rate, the Health Board will spend £22.8m on nurse agency in 2021/22, a 21% increase from 2020/21.

The use of "off-contract" agency – not via a supplier on an approved procurement framework – usually incurs higher rates of pay.



The Health Board spent £0.69m on 'off' contract RN agency in January which is at the same level as December. The main reasons for its usage are:

- Enhanced care,
- Additional capacity,
- Nursing vacancies,
- Patient safety,
- Covid-19 responses, and
- Increased sickness and cover for staff in isolation,

A Registered Nurse Agency Reduction Plan was approved by the Executive Team in May 2021, there is considerable pressure on this plan because of the on-going service and workforce pressures. There is an expectation this will be reinvigorated to deliver in 2022/23.

Medical locum staff

Total locum spend in January was £221k an increase compared with December 2021 of £63k. Of this increase £30k was in Pathology and £18k in Anaesthetics (off-set by reductions in specialities such as Cardiology) relating to on-going operational pressures and substantive vacancies.

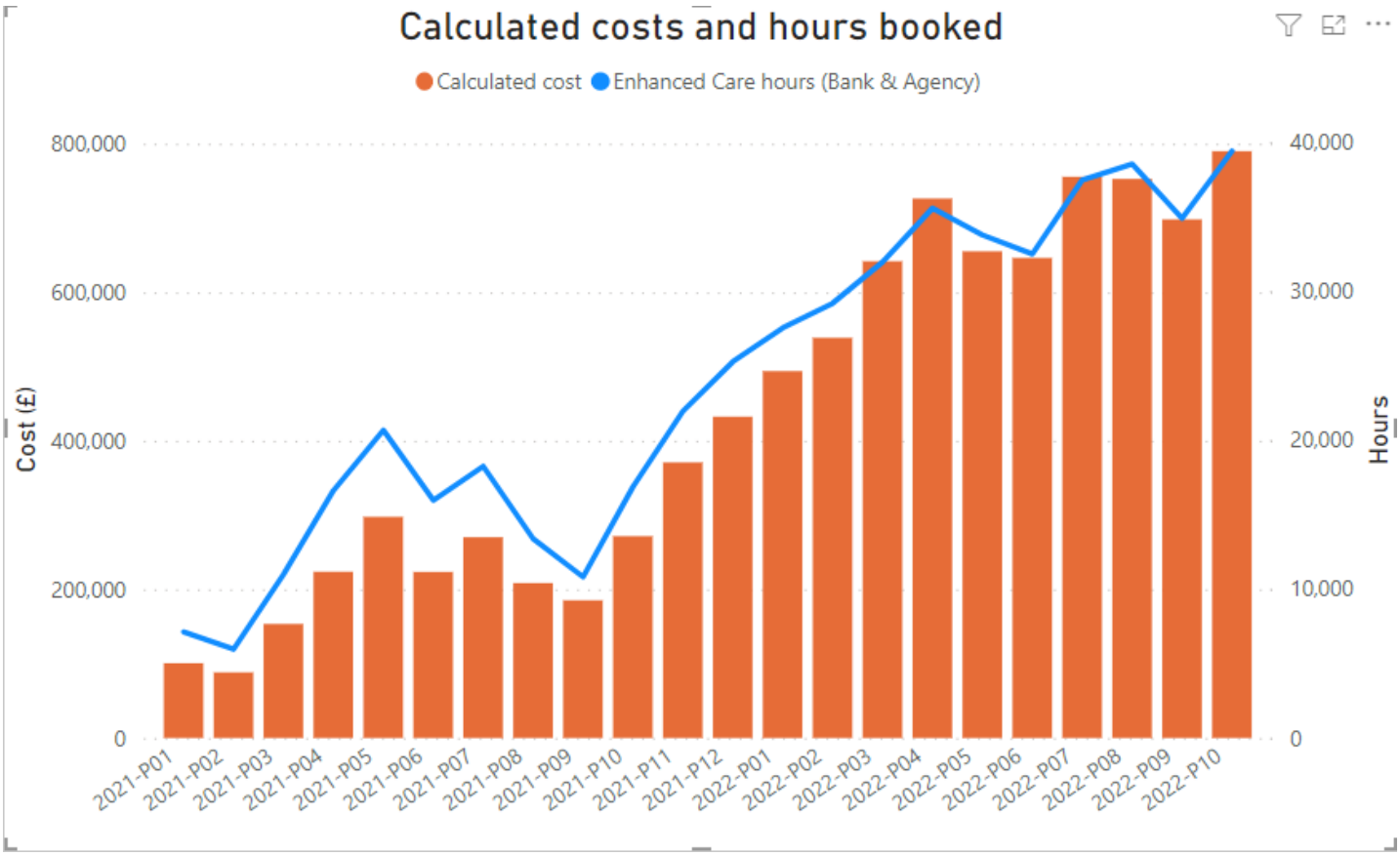
Enhanced Care

Enhanced Care, also known as 'specialling', can include a spectrum of interventions ranging from the provision of assistance to help a patient mobilise, through to one-to-one patient monitoring. Enhanced care is designed to ensure a patient centred safe approach for patients with additional care needs whilst also managing any associated impact on established staffing levels.

An initial review of the financial impact of 'enhanced care' – including the use of bank and agency staff – has identified the following use of nursing staff:

	2020/21	**2021/22**	**Increase**
Average number of hours used per month	15,305	34,095	123%
Increase in average cost per month compared to prior year			**£0.4m**
Estimated increase in the calculated annual cost based on current trend			**£5.2m**

The following graph highlights the increase in hours attributed to enhanced care for the period April 2020 (P01-2021) to January 2022 (P10-2022) using bank and agency registered nurse and health care support workers. In January (P10-2022), enhanced care hours and associated costs increased mainly within the Medicine and Mental Health Divisions.



Non-Pay

Non-Pay spend (excluding capital) increased by £4.2m in January compared with December due to additional WHSSC funded Cystic Fibrosis drugs, increased prescribing costs as well as increased ICF and 111 costs.

Other areas of increase to note are:

- CHC Mental Health – there has been a net increase of 1 LD patient in month within high cost packages. The newer packages increase the overall average weekly cost per package compared to the previous financial year. The overall total patient numbers have increased by 19 since April 2021 (LD increase by 9, Mental Health increase by 10).
- CHC Adult / Complex Care –

Activity	December 2021	January 2022	Movement
D2A	83	72	-11
Step Closer to Home (A cost of £0.7m is included in the forecast spend.)	27	36	+9
All Other CHC	544	544	0
Total	654	652	-2

- For FNC - currently 840 active placements, which is a decrease of 22 from December.

- Primary Care medicines - the full year forecast is an over-spend of £1.2m. The year to date growth on items is 2.1% and the forecast is based on continued growth of 2.1%. In addition there has been an increase in the average cost per item and Category M drugs prices resulting in an overall forecast increase of c.£0.9m.

Service Pressures & Activity Performance

Bed Capacity

Additional medical beds have been opened as part of responding to the system pressures described previously. Additional capacity beds in Medicine were 220 in January as described in the table below:

No. of Additional Beds								
Site	**Ward**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Description**
RGH	B3 Winter Ward	28	28	28	28	28	26	28 Additional Capacity
	C5E	4	4	0	0	0	0	28 (flexed up from 24)
NHH	3rd Floor	4	4	10	10	11	11	28 (flexed up from 24)
	4th Floor	4	4	11	7	5	4	28 (flexed up from 24)
	4/1 winter					32	32	Winter ward from 27th Dec (flexed up from 28)
GUH	C4	8	12	16	16	8	8	8 Covid beds in December
	A4			2	2	2	2	Using Ringfenced beds
YYF	Risca	30	30	30	30	30	30	30 Covid Ward (funded ward)
	Bargoed		30	30	15	0	0	30 Covid Ward (funded ward)
	Oakdale			15	0	0	30	50%->100% Covid Ward (funded ward)
	Rhymney				14	14	28	Supporting 50% of SC ward for Winter capacity. Wef 7/1 100% Medicine additional capacity for Winter
	Penallta						28	100% of Ward (Red capacity under Dr Davies, Cons)
RGH AMU	D1W		15	15	17	23	21	15 Beds 2 additional RN 24/7
Total		**78**	**127**	**157**	**139**	**153**	**220**	

It should be noted that ward D1W is now assumed to be open for the remainder of the 2021/22 financial year.

There was also a continued use of surge beds throughout the Community hospitals. These are described as follows:-

No. of Additional Beds						
Site	**Ward**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**
STW	Ruperra	12	20	20	24	24
	Holly					10
YAB	Tyleri	10	15	15	15	15
Total		**22**	**35**	**35**	**39**	**49**

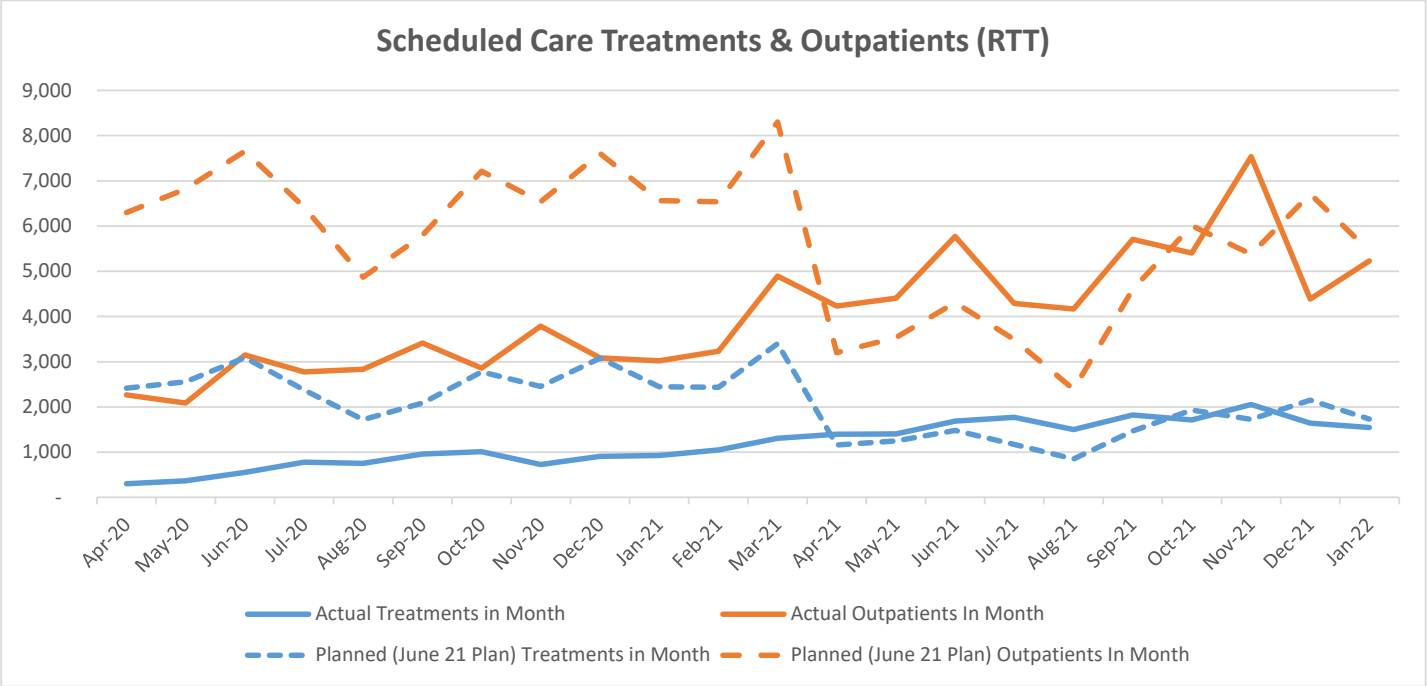
Scheduled Care treatments and outpatients

Elective activity was variable in January due to the impact of the Omicron variant of Covid-19. Activity remained below plan but was sustained in a number of specialities. Whilst most routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

Scheduled Care elective activity for new outpatients has increased significantly in comparison to December where activity was reduced due to the Omicron variant and holiday period. Increases

in almost all specialities including T&O (+319), General Surgery (+272), Dermatology (+132) and Ophthalmology (+41). The number of new outpatients were below plan in month by 222 appointments due to the ENT, T&O and Dermatology specialities off-set by General Surgery, Urology and Ophthalmology being above plan.

Treatments are also lower compared with December. Key movements include T&O (-55), Dermatology (-43) and General Surgery (-14). The decrease in treatments is through core time with a slight increase in WLI sessions.



- Elective Treatments for January '22 were 1,545 with year-to-date treatments of 16,535.
- Outpatient appointments for January '22 were 5,228 with year-to-date activity of 51,109.

Medicine Outpatient Activity

Medicine Outpatient activity for January '22 was 1,092 attendances with year-to-date activity of 13,037; this is presented by specialty below:

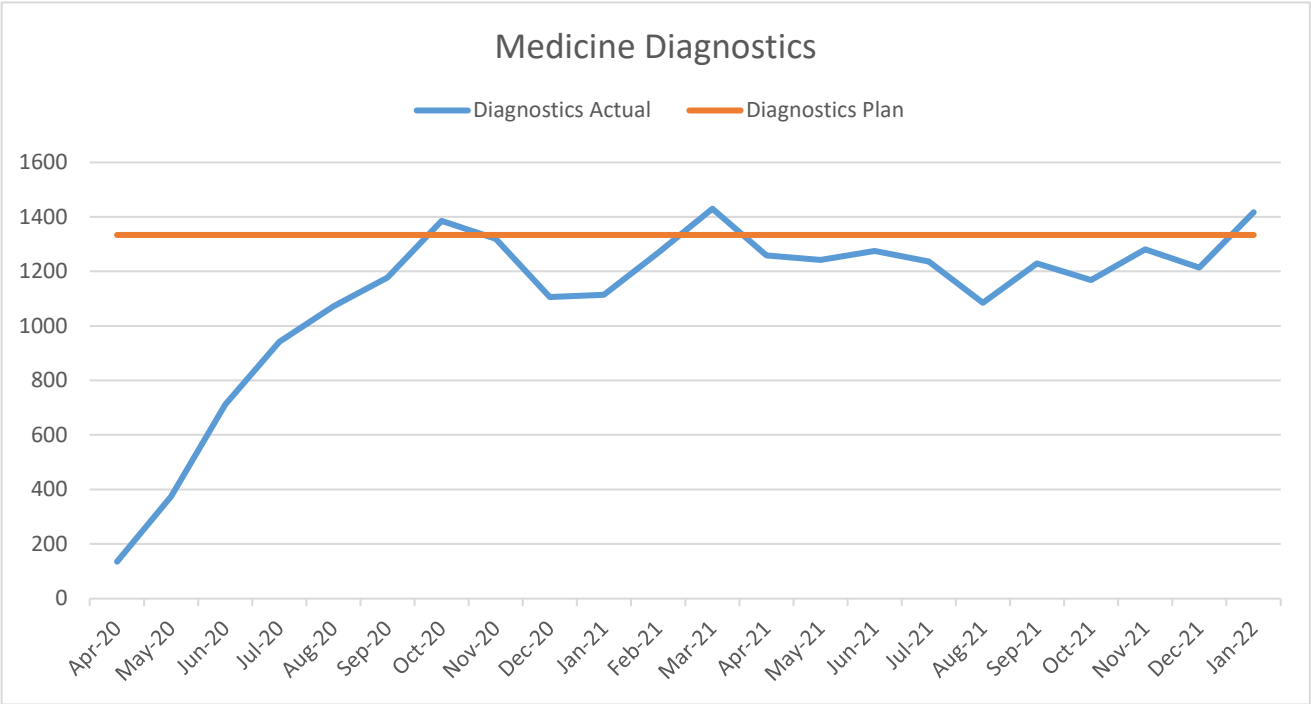
YTD January 22	Assumed monthly activity	Actual activity	Variance	Variance
Gastroenterology	5,100	2,333	- 2,767	54%
Cardiology	5,530	2,456	- 3,074	56%
Respiratory (inc Sleep)	6,060	2,605	- 3,455	57%
Neurology	2,590	2,247	- 343	13%
Endocrinology	2,420	1,516	- 904	37%
Geriatric Medicine	2,310	1,880	- 430	19%
Total	**24,010**	**13,037**	**- 10,973**	**46%**

A year to date underperformance of 46% is presented.

Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for January '22 was 1,417 procedures with year-to-date activity of 12,406 which is 934 cases less than planned for the year to date. Endoscopy insourcing plans started in October and a step-up in activity has been achieved despite the reduction in December. The expectation remains activity will continue at an increased rate for the remaining months of the financial year.

The activity undertaken since April '20 is shown below;



Service Recovery Plans 2021/22

The Health Board received recovery funding allocations as part of recovering the backlogs in routine elective services because of the Covid-19 pandemic. The Health Board has assessed the forecast spend associated with recovery bids as £24m. Performance needs to be closely monitored given the level of slippage identified.

Slippage was identified by Divisions and has been taken back into reserves so further recovery options can be developed. The revised reserves position is £2.574m for any further schemes. The Divisional summary of these delegations are shown below:-

	£'000		
Recovery funding delegated - Division	**Bids approved**	**Clawback (to M10)**	**Funding delegated**
Scheduled Care	11,856	(2,201)	9,655
Family & Therapies	2,043	(299)	1,744
Mental Health	1,840	(67)	1,773
Primary Care & Community	3,284	(536)	2,748
Medicine	2,397	(305)	2,092
Estates & Facilities	131	0	131
CHC	502	0	502
Corporate	138	0	138
Commissioning	2,200	0	2,200
Sub-total	**24,393**	**(3,408)**	**20,985**
	Balance of funding in Reserves		2,574
Total			**23,559**

Any recurrent proposals will need to be considered alongside other IMTP priorities.

Covid-19 – Revenue Financial Assessment

Covid-19 reporting can be broken down into the following categories.

- Covid-19 costs: £167.99m
- WG Funding: £176.56m (as at Month 10)

The Health Board is assuming funding of £176.6m for Covid-19 service responses and Covid-19 recovery for the 2021/22 financial year.

Confirmed and received funding has been a mixture of reimbursement for actual costs and forecast costs and formula shares.

At this stage the Health Board is including expenditure for the whole year for all areas of Covid-19. This is in line with the guidance provided by Welsh Government finance colleagues.

The table below summarises the funding assumed, delegated, and held in reserve relating to Covid-19.

Type	Covid-19 Specific Allocations - As at January 2022	£m
HCHS	Initial Recovery Plan Covid19	16.27
HCHS	Covid19 response April-September 2021	32.02
HCHS	Testing (inc Community Testing) Qtr 1	1.63
HCHS	Tracing Qtr 1	3.47
HCHS	PPE Qtr 1	1.04
HCHS	Mass COVID-19 Vaccination QTR 1	1.98
GMS	Mass COVID-19 Vaccination QTR 1	1.58
HCHS	Tracing - Q2 (M1-6 less June funding)	3.00
HCHS	Covid 19 Mass Vaccination costs Q2	2.20
GMS	Covid 19 Mass Vaccination costs Q2	0.09
HCHS	Covid 19 Impact on b/f underlying position	8.57
HCHS	Covid 19 Cleaning standards Q1 + Q2	0.95
HCHS	Covid 19 Testing Q2	2.03
HCHS	Covid 19 Adferiad Programme	0.94
HCHS	Covid 19 response funding Oct 21 to Mar 22	56.58
HCHS	Covid 19 support - Tranche 2 Revenue Recovery	7.14
HCHS	Covid 19 - PPE Q2	1.50
HCHS	Covid 19 - Additional Flu programme yrs 7-11	0.78
HCHS	Community Infrastructure Programme (UEC-C19)	0.18
HCHS	Additional Covid Response funding	7.38
HCHS	C19-Adult Social Care Package	2.01
HCHS	C19 Support for Comm Health Checks	0.19
HCHS	C19 Recovery funding - Planned Care Recovery Fund	0.14
HCHS	C19 Cluster funding	0.38
HCHS	C19 Recovery - Healthchecks Learning Disability	0.11
HCHS	MCA Funding-Gwent Consortium-C19 recovery-DoLS	0.17
HCHS	Recovery of balance of NHS Bonus accrual	(1.44)
HCHS	C19 - Tracing Funding balance	7.07
HCHS	C19 - Winter Pressures - ICF (RPBs)	1.85
HCHS	C19 - Testing Qtr 3 and 4	5.37
HCHS	C19 - PPE Q3 and Q4	2.98
HCHS	C19 - Cleaning Standards Q3 and Q4	1.16
HCHS	C19 - Mass Vaccinations Q3 and Q4	4.25
HCHS	C19-Adult Social Care Package Qtr 3&4	1.12
	Total Confirmed Covid-19 Allocations	**174.70**
HCHS	Urgent & Emergency Care	1.51
HCHS	Extended Flu	0.35
	Total Anticipated Covid-19 Allocations	**1.86**
	Total Covid-19 Allocations	**176.56**

Covid Funding Delegated v Held in Reserves @ Month	Period covered	Delegated as at Month 10 (£m)
Covid Funding Delegated		
Testing	M1-12	9.04
Tracing	M1-12	13.55
Mass Vaccs	M1-12	10.10
Cleaning Standards	M1-12	2.11
PPE	M1-12	5.52
CHC Provider payments	M1-12	3.13
Recovery funding (tranche 1 & 2)	M1-12	20.85
Recovery funding - Planned Care Recovery Fund	M9-12	0.13
Urgent Primary Care Centre Pathfinder	M1-12	1.51
Adferiad Programme	M1-12	0.94
Covid response funding	M1-12	103.27
Additional Flu Programme	M7-12	0.78
Recovery of balance of NHS Bonus accrual	M7-12	(1.44)
Winter Pressures (ICF)	M9-12	1.85
LD and Community health checks	M9-12	0.30
MCA Funding-Gwent Consortium-C19 recovery-DoLS	M9-12	0.17
Community Infrastructure Prog (UEC-C19)	M9-12	0.18
Cluster funding	M1-12	0.38
Extended Flu	M1-12	0.35
Covid element of 21-22 Pay award	M1-12	0.88
Total Covid funding delegated		**173.60**
Retained in reserves		
Recovery funding (tranche 1 & 2)		2.57
Covid response funding		0.39
Total Covid funding held in reserves		**2.97**
Total reported Covid funding		**176.56**

- **Revenue Reserves**

Health Board reserves are held by the Board, until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer. Some funding allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific purpose.

The following reserves, relating to WG Funding, were approved for delegation by the CEO;

£16k R&D pay award uplift	£22k Outpatient Transformation – Dermatology Specialist advice and guidance
£4k Outpatient Transformation – Dermatology Nurses surgical skills	£8.2m Covid-19 quarter 4 funding
£-22k DDRB pay award 19-20 funding	£2.3m 1% non-consolidated pay award Bands 1-5
£1.6m Clawback of recovery funding from Divisions	£614k (+£530k 22/23) Digital priority investment fund
£64k Learning Disability – improving lives programme	£657k 111 First
£-400k Urgent Primary Care Centre	£41k Research and Development
£247k Environmental Fund	£73k Diabetes Pumps (Adult)
£201k Recovery funding – Audiology	£2.8m Vertex WHSSC
£66k Recovery funding – Person Centred Care team	£70k Neighbourhood District Nursing

The Health Board has received the majority of Covid monies with an additional £1.86m anticipated mainly for National priorities held in reserves and the balance of recovery monies which will be delegated as plans are approved by the Executive Team.

- **Underlying Financial Position (ULP)**

As at month 10 the underlying financial position is a **deficit of £20.9m**.

This is based on the current assessment of available recurrent funding and the recurrent financial impact of existing service and workforce commitments. It excludes areas that are regarded as "choices" as well as any potential recurrent impact of Covid-19 decisions.

The Health Board's Annual Plan identifies a number of key priorities where the application of Value-Based Health Care principles – improving patient outcomes along with better use of resources – should result in delivering greater service, workforce and financial sustainability whilst improving the health of the population. The actions being taken to improve financial sustainability are integral to this approach.

The Health Board has considered the 2022/23 Allocation letter which includes a discretionary funding uplift of 2.8%. This funding provides the Health Board with some certainty in helping to address its underlying financial position and prioritising commitments as part of the 2022/23 IMTP.

The 2022/23 financial plan will be aligned with the IMTP service and workforce plans, including both recurrent and non-recurrent challenges and risks that the Health Board need to consider.

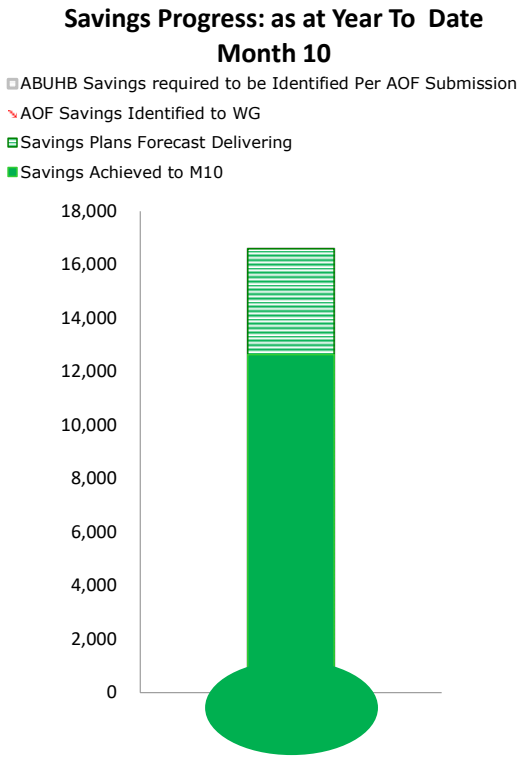
Further recurrent savings schemes for 2022/23 are currently being developed as part of the IMTP financial plan but are considered at this point to be required to manage future cost pressures rather than impact beneficially on the underlying position. This position is reviewed along with further intelligence as part of the IMTP process.

Savings delivery

As part of the Annual Plan submitted by the Board to Welsh Government (June 2021), the financial plan for 2021/22 identified a savings requirement of £16.6m for 2021/22. Recurrent full year effect of savings are identified as £13.6m.

Actual savings delivered to January '22 amounted to £12.6m, which is in line with plan profile.

The following tables present the progress against the full year target.



Month 10 Savings Plans

Green Savings schemes	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	3,198	202	2,996	3,322
Commissioned Services	126	4	122	122
Medicines Management (Primary and Secondary Care)	2,736	69	2,667	3,082
Pay	5,619	951	4,668	6,755
Non Pay	4,917	4,130	788	305
Total	16,596	5,355	11,241	13,586

Month 03 Savings Plans

M03 Green Savings schemes	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	3,500	500	3,000	3,002
Commissioned Services	122	0	122	122
Medicines Management (Primary and Secondary Care)	2,446	44	2,402	2,406
Pay	6,191	10	6,181	7,428
Non Pay	4,336	3,865	471	627
Total	16,596	4,419	12,177	13,586

Total savings plans remain in line with the AOF agreed earlier in the financial year; however, recurrent schemes have slipped and have been replaced by non-recurring schemes, this has particularly impacted on Pay savings plans. At this stage the full year recurring impact has remained unchanged, however, this movement from recurrent to non-recurrent does put the underlying savings position at risk of not being achieved.

To deliver greater levels of savings and to achieve better use of resources, which improves health outcomes – and doesn't adversely impact on safety and quality – a greater focus is required on savings and efficiency improvement related to:

- Eliminating unwarranted clinical variation - e.g. in the use of medicines where there have been some savings, medical devices and consumables,

- Transformational service change – e.g. savings and efficiency improvement resulting from changes in service models which reduce use of hospital beds (admission, timely discharge, reduce length of hospital stay), reduce the requirement for workforce (particularly agency / locum), reduce spend on clinical interventions which have no positive effect on health outcomes.

The Health Board can no longer just rely on transactional efficiency savings and future plans also need to focus on shifting resources to improve health outcomes, support reinvestment and deliver recurrent savings. This will require transformational change in the way the Health Board delivers services so that it is more effective for patients and more financially sustainable.

Opportunities exist within the Annual Plan priorities agreed by the Health Board, including the following areas:

- MSK pathway redesign,
- Eye Care integration,
- Outpatients' transformation, and
- Digital solutions as an enabler to service change and financial improvement.

These programmes have been affected by unprecedented systems pressures over the last 2 years but given the challenging funding settlements in future years, progress in delivering transformational change is required to improve the underlying financial position in 2022/23 and onwards, as part of the future IMTP priority work.

Risks & Opportunities

There remain significant risks and opportunities to managing the financial position during 2021/22, which include:

- Responding to the ongoing impact of Covid-19 – both direct and indirect consequences of the pandemic,
- Responding to any specific Covid-19 impacts e.g. current and further new variants, outbreaks,
- Workforce absence and self-isolation, availability of staff for priority areas alongside re-deployment and reduction in elective recovery activity,
- Risks associated with anticipating the remaining Covid-19 funding,
- Addressing backlogs in waiting times for some services, due to the Covid-19 pandemic – restart and recovery,
- Continued and potential increasing use of additional capacity,
- Addressing any surge in Covid-19,
- Maximising the opportunity to change services resulting in improved health outcomes for the population,
- Addressing the underlying financial deficit, through reducing costs and increasing recurrent savings, and
- Implications of the Ukraine crisis.

Capital

The approved Capital Resource Limit as at Month 10 totals £50.03m. In addition, the Health Board has confirmed asset disposals generating further funding of £1.39m. The Capital Resource Limit was agreed and fixed with Welsh Government at the end of October. The Health Board is now required to manage any subsequent variations from the fixed resource limits via brokerage with the Discretionary Capital Programme (DCP). The current forecast outturn is breakeven; however, this position now includes brokerage of £1.35m with the DCP to manage slippage against All Wales Capital Programme schemes described below.

The Grange University Hospital forecast outturn has been reduced by £0.722m in month to reflect the delays anticipated in the Well-being and Admin Centre and Temporary Car park works. The Same Day Emergency Care works are currently progressing as planned but will be monitored closely to end of year to ensure the outturn is achieved.

Slippage totalling £228k is being reported against the NHH Satellite Radiotherapy (£50k) and Mental Health SISU (£178k) schemes as the completion of these cases has slipped to 2022/23. In addition, the NHH SRU Enabling works to the Ante Natal Department are now expected to run into the new year creating further anticipated slippage of £400k.

The forecast outturn for the HSDU scheme is expected to be an overspend of £713k. As additional funding cannot be secured from Welsh Government for the scheme, the overspend will be met from the Discretionary Capital Programme. Practical completion on the scheme has been delayed due to issues that have arisen during the commissioning testing of the facility.

The Full Business Case for Newport East Health and Well-being Centre has been submitted to Welsh Government for approval. The Full Business Case for the Unified Breast Unit at YYF has been approved by Welsh Government. As a result of the delay in obtaining planning consent and funding approval, discussions are underway with the contractor to reconfirm contract prices and a start on site date.

Welsh Government have approved additional imaging equipment purchases in month to allow the Health Board to retain the previously reported saving of £540k against the Imaging National Programme scheme.

All the original DCP funding, and the additional £1.35m of allocations required to offset the AWCP brokerage requirements, have been released as approved schemes. All divisions have submitted updated end of year priority schemes which will be used to address any further slippage against approved schemes that may occur.

The Health Board has received notification that the annual Discretionary budget allocation for 2022/23 has been reduced by 24% to £8.227m (expected allocation - £10.814m). The decrease results from a significant reduction in the Welsh Government Overall All Wales Capital Programme budget for 2022/23. When the brokerage of AWCP scheme slippage of £1.35m is deducted from the confirmed budget, only £6.877m remains to address existing Discretionary scheme commitments and new 2022/23 proposals.

The draft 2022/23 Discretionary programme is being developed in the context of the reduced funding and will be presented to Board for approval in March.

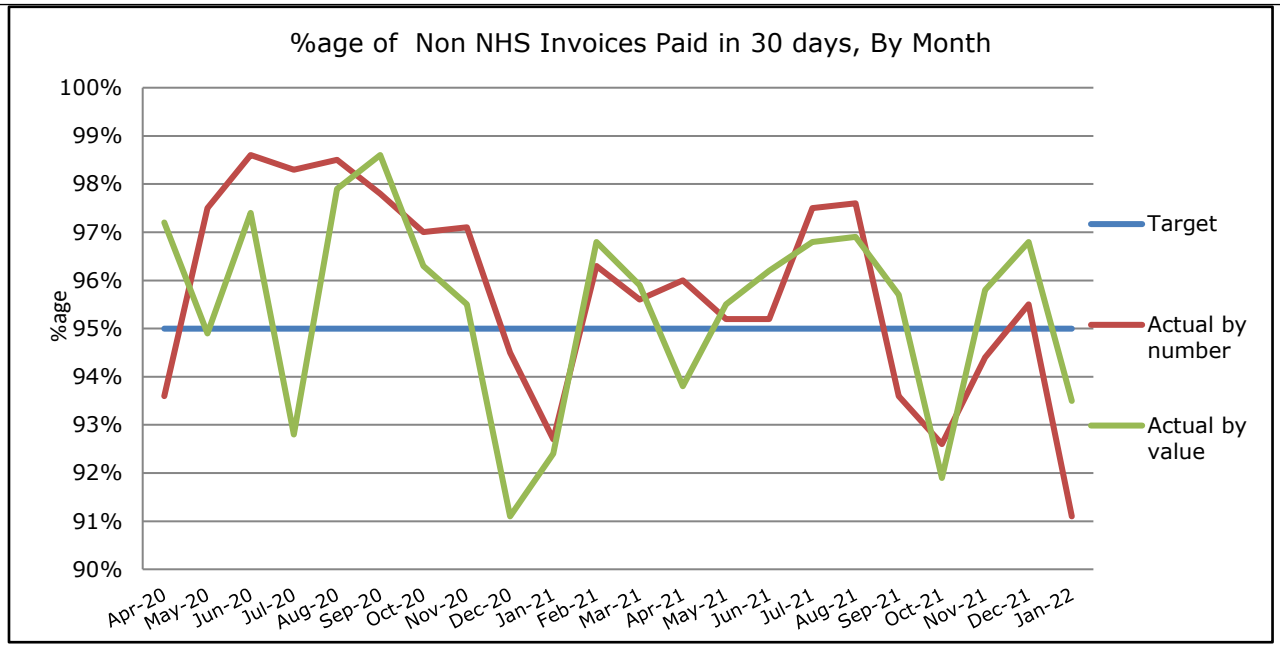
Cash

The cash balance on the 31st of January is £4.82m, which is below the advisory figure set by Welsh Government of £6m.

PSPP

The Health Board has dropped slightly below the target to pay 95% of the number of non-NHS creditors within 30 days of delivery of goods on a cumulative basis achieving 94.9%. This has been due to processing agency and pharmacy invoices where some staff were re-deployed to assist with Covid-19 schemes. Work is being undertaken with the department to rectify this issue to ensure compliance with the target for future months.

Although not a statutory target, with regard to paying NHS invoices the majority of organisations in Wales are not achieving payment within 30 days. ABUHB is currently at 87.3% year to date and is working with the All-Wales TAG group to improve this.



Recommendation

The Board is asked to note:

- The financial performance at the end of January 2022 and forecast for 2021/22 – against the statutory revenue and capital resource limits,
- The revenue reserve position on the 31st of January 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy, and
- A financial assessment of the risks and opportunities which may impact on delivering the financial forecast for 2021/22.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	Risks of achieving the Health Board's statutory financial duties and other financial targets are detailed within this paper.
Financial Assessment, including Value for Money	This paper provides details of the year to date and forecast financial position of the Health Board for the 2021/22 financial year.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its AOF/IMTP priorities and opportunities to improve efficiency and effectiveness.
Equality and Diversity Impact Assessment (including child impact assessment)	The Assessment forms part of the AOF service plan.

Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the financial position that supports the Health Board's 3 year plan & Annual Plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Long-term financial linked to IMTP completion **Integration –** Regional partnership and integration with other NHS Wales organisations **Involvement –** use of environmental fund and specific investment as well as on-going links with services for engagement **Collaboration** – collaboration with external partners **Prevention** – long-term strategy in order to provide investment and savings through preventative measures across the UHB. The Health Board Financial Plan has been developed based on the approved AOF/IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	See Below
Public Interest	Circulated to board members and available as a public document.

Glossary

A		
A&C – Administration & Clerical	A&E – Accident & Emergency	A4C - Agenda for Change
AME – (WG) Annually Managed Expenditure	AQF – Annual Quality Framework	AWCP – All Wales Capital Programme
AP – Accounts Payable	AOF – Annual Operating Framework	ATMP – Advanced Therapeutic Medicinal Products
B		
B/F – Brought Forward	BH – Bank Holiday	
C		
C&V – Cardiff and Vale	CAMHS – Child & Adolescent Mental Health Services	CCG – Clinical Commissioning Group
C/F – Carried Forward	CHC – Continuing Health Care	Commissioned Services – Services purchased external to ABUHB both within and outside Wales
COTE – Care of the Elderly	CRL – Capital Resource Limit	Category M – category of drugs
CEO – Chief Executive Officer		
D		
DHR – Digital Health Record	DNA – Did Not Attend	DOSA – Day of Surgery Admission
D2A – Discharge to Assess	DoLS - Deprivation of Liberty Safeguards	DoH – Department of Health
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	eLGH – Enhanced Local general Hospital
ENT – Ear, Nose and Throat specialty	EoY – End of Year	ETTF – Enabling Through Technology Fund
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		

GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital	GIRFT – Getting it Right First Time	
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus
HSDU – Hospital Sterilisation and Disinfection Unit	H&WBC – Health and Well-Being Centre	
I	IMTP – Integrated Medium Term Plan	INNU – Interventions not normally undertaken
IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure	ICF – Integrated Care Fund
L		
LoS – Length of Stay	LTA – Long Term Agreement	LD – Learning Disabilities
M		
MH **–** Mental Health	MSK - Musculoskeletal	Med – Medicine (Division)
MCA – Mental Capacity Act		
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre		
P		
PAR – Prescribing Audit Report	PCN – Primary Care Networks (Primary Care Division)	PER – Prescribing Incentive Scheme
PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis	PSNC –Pharmaceutical Services Negotiating Committee
PSPP – Public Sector Payment Policy	PCR – Patient Charges Revenue	PPE – Personal Protective Equipment
R		
RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit

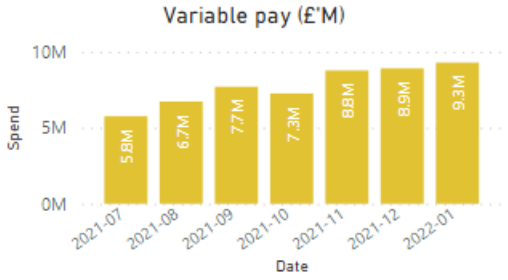
RTT – Referral to Treatment	RPB – Regional Partnership Board	
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	TAG – Technical Accounting Group
U		
UHB / HB – University Health Board / Health Board	USC – Unscheduled Care (Division)	UC – Urgent Care (Division)
ULP – Underlying Financial Position		
V		
VCCC – Velindre Cancer Care Centre		
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	YYF – Ysbyty Ystrad Fawr

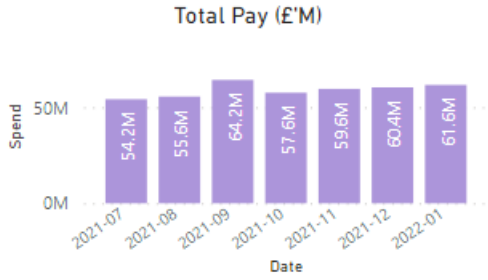
Aneurin Bevan University Health Board

Finance Report – January (Month 10) 2021/22

Appendices

Pay Summary (1):





Substantive (£'000)

Pay category	22-P04	22-P05	22-P06	22-P07	22-P08	22-P09	22-P10	Change	%	Avg 20/21
ADD PROF SCIENTIFIC AND TECHNICAL	2,053	2,129	2,456	2,191	2,226	2,253	2,258	5	0.2%	2,137
ADDITIONAL CLINICAL SERVICES	6,294	6,307	7,285	6,410	6,431	6,616	6,922	306	4.6%	5,946
ADMINISTRATIVE & CLERICAL	7,692	7,975	9,183	8,251	8,301	8,342	8,948	606	7.3%	7,412
ALLIED HEALTH PROFESSIONALS	3,110	3,190	3,649	3,205	3,339	3,287	3,284	-3	-0.1%	2,997
ESTATES AND ANCILLIARY	2,382	2,570	2,908	2,511	2,572	2,600	2,805	205	7.9%	2,516
HEALTHCARE SCIENTISTS	978	999	1,101	1,106	996	972	975	3	0.3%	956
MEDICAL AND DENTAL	11,282	11,360	13,031	11,817	11,845	11,866	11,801	-65	-0.5%	10,780
NURSING AND MIDWIFERY REGISTERED	14,618	14,310	16,917	14,827	15,075	15,538	15,329	-209	-1.3%	13,932
STUDENTS	4	2	0	2	2	2	2	0	14.0%	218
Total	**48,415**	**48,843**	**56,530**	**50,321**	**50,786**	**51,478**	**52,324**	**846**	**1.6%**	**46,894**

Variable pay (£'000)

Pay category	22-P04	22-P05	22-P06	22-P07	22-P08	22-P09	22-P10	Change	%	Avg 20/21
Agency	3,369	4,228	5,015	4,232	5,674	5,594	5,711	117	2.1%	3,385
Bank	2,295	2,386	2,500	2,828	2,987	3,155	3,359	204	6.5%	2,072
Locum	93	116	187	199	115	158	221	63	40.0%	163
Total	**5,757**	**6,729**	**7,702**	**7,259**	**8,775**	**8,907**	**9,292**	**384**	**4.3%**	**5,620**

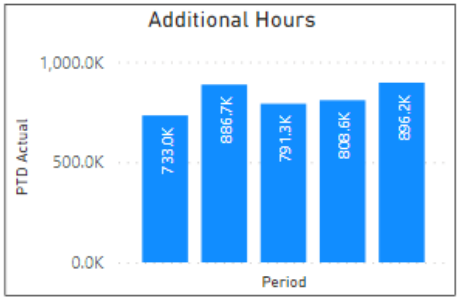
Total pay (£'000)

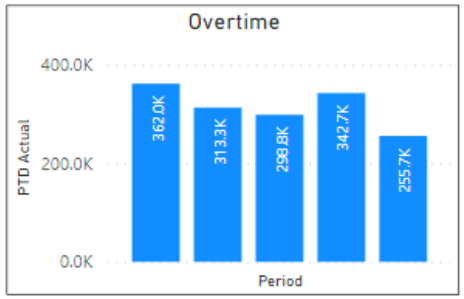
Pay category	22-P04	22-P05	22-P06	22-P07	22-P08	22-P09	22-P10	Change	%	Avg 20/21
Pay	54,172	55,572	64,232	57,580	59,561	60,385	61,616	1,231	2.0%	52,514

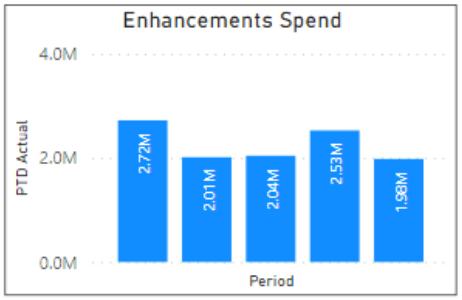
Pay Summary (2): Substantive Pay

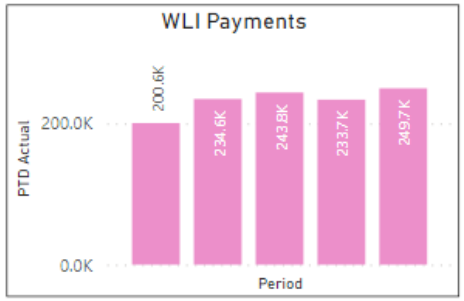
Substantive pay by analysis code

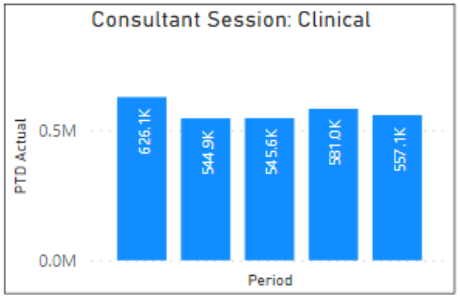
01/09/2021 | 31/01/2022 | ABUHB

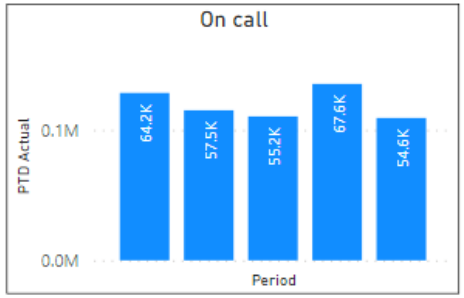










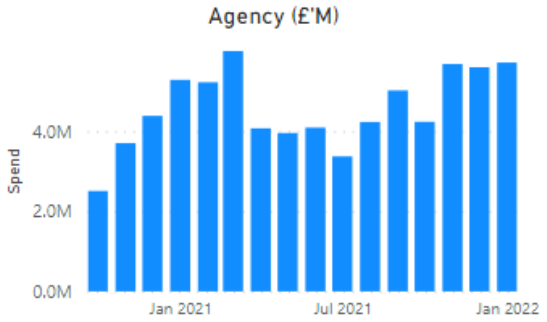


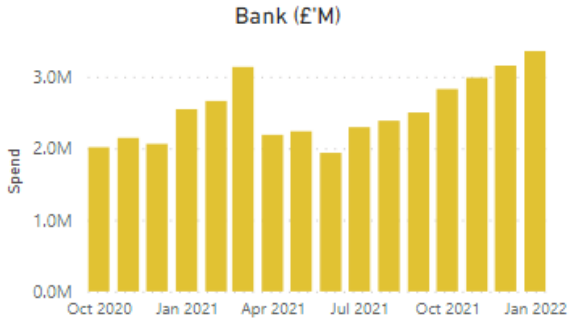
Analysis type by Division

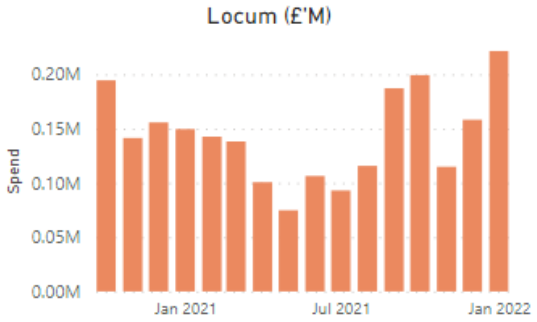
Analysis type	22-P06	22-P07	22-P08	22-P09	22-P10	Total
Enhancements						
Scheduled Care	543	277	399	512	388	**2,118**
Medicine	434	334	321	398	312	**1,798**
Estates and Facilities	378	304	288	352	289	**1,610**
Primary Care & Community	349	306	271	314	243	**1,484**
Family & Therapies	347	267	262	329	254	**1,459**
Mental Health	226	182	173	207	166	**954**
Urgent Care	219	166	157	201	157	**899**
CHC/FNC	128	95	94	116	89	**522**
Corporate	101	84	79	100	86	**450**
Total	**2,724**	**2,015**	**2,043**	**2,529**	**1,982**	**11,293**
ADDITIONAL HOURS						
Scheduled Care	256	350	309	284	313	**1,511**
Medicine	207	238	217	236	238	**1,134**
Urgent Care	156	162	145	138	196	**797**
Family & Therapies	105	92	113	115	116	**541**
Mental Health	6	31	7	14	15	**73**
Corporate	3	0	6	15	7	**31**
Primary Care & Community	1	14	-6	7	12	**29**
Total	**733**	**887**	**791**	**809**	**896**	**4,116**
CONSULTANTS SESSION: CLINICAL	**626**	**545**	**546**	**581**	**557**	**2,855**
Overtime	**362**	**313**	**299**	**343**	**256**	**1,572**
WAITING LIST PAYMENTS: CONSULTANTS	**201**	**235**	**244**	**234**	**250**	**1,162**
ON CALL	**64**	**58**	**55**	**68**	**55**	**299**
Total	**4,710**	**4,052**	**3,978**	**4,563**	**3,996**	**21,298**

Pay Summary (3): Variable Pay

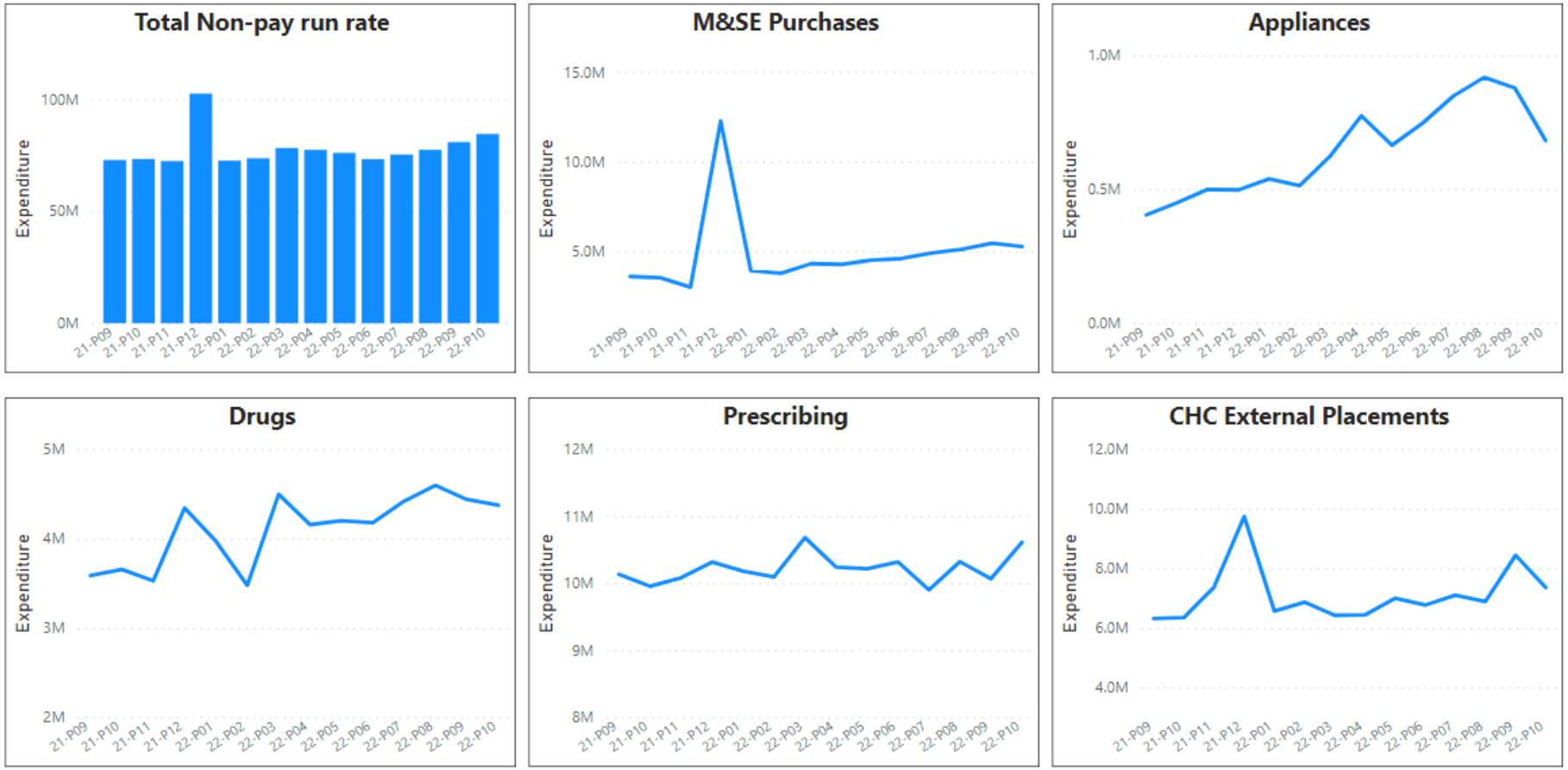
Pay category	21-P07	21-P08	21-P09	21-P10	21-P11	21-P12	22-P01	22-P02	22-P03	22-P04	22-P05	22-P06	22-P07	22-P08	22-P09	22-P10	Change	%
Agency																		
Admin & Clerical Agency	108	193	137	189	301	386	183	227	222	128	208	82	182	115	191	243	52	27.2%
Allied Health Prof Agency	12	101	140	104	108	186	45	3	-31	76	91	124	88	104	172	144	-27	-15.8%
Estates & Ancilliary Agency	371	693	870	1,160	937	1,417	585	726	643	483	465	717	422	428	807	474	-333	-41.2%
Medical Agency	732	927	870	1,093	923	1,085	866	1,043	1,027	531	1,272	1,238	1,318	1,920	1,704	1,278	-426	-25.0%
Nurse HCA/HCSW Agency	13	82	173	151	97	162	166	261	358	611	590	756	729	880	67	917	850	1266.9%
Other Agency	27	39	124	170	84	142	89	114	110	71	59	92	103	128	114	180	67	58.8%
Registered Nurse Agency	1,243	1,666	2,066	2,412	2,767	2,620	2,138	1,579	1,759	1,469	1,544	2,006	1,390	2,100	2,540	2,475	-66	-2.6%
Total	**2,506**	**3,700**	**4,380**	**5,279**	**5,217**	**5,998**	**4,070**	**3,953**	**4,088**	**3,369**	**4,228**	**5,015**	**4,232**	**5,674**	**5,594**	**5,711**	**117**	**2.1%**
Bank																		
Admin & Clerical Bank	85	109	103	116	121	166	98	97	132	129	120	111	134	111	108	131	23	21.3%
Estates & Ancilliary Bank	99	101	119	120	113	138	86	80	89	119	142	145	154	146	148	153	4	2.9%
Nurse HCA/HCSW Bank	902	885	934	1,058	1,064	1,250	972	1,013	812	1,005	1,079	1,102	1,185	1,114	1,193	1,217	25	2.1%
Other Bank	0		1	0	-1	2	1	1	0	-2	2	-1	0	0	0	0	0	67.6%
Registered Nurse Bank	928	1,050	905	1,253	1,365	1,581	1,031	1,046	903	1,044	1,043	1,144	1,355	1,616	1,706	1,858	152	8.9%
Total	**2,015**	**2,146**	**2,062**	**2,547**	**2,661**	**3,137**	**2,188**	**2,238**	**1,936**	**2,295**	**2,386**	**2,500**	**2,828**	**2,987**	**3,155**	**3,359**	**204**	**6.5%**
Locum																		
Medical Locum	194	141	156	150	143	138	101	75	106	93	116	187	199	115	158	221	63	40.0%
Total	**194**	**141**	**156**	**150**	**143**	**138**	**101**	**75**	**106**	**93**	**116**	**187**	**199**	**115**	**158**	**221**	**63**	**40.0%**
Total	**4,715**	**5,987**	**6,597**	**7,976**	**8,021**	**9,273**	**6,359**	**6,265**	**6,130**	**5,757**	**6,729**	**7,702**	**7,259**	**8,775**	**8,907**	**9,292**	**384**	**4.3%**







Non-Pay Summary:



Referral to Treatment (RTT):

Elective activity has significantly reduced as part of the Health Board's Covid-19 planned response. Whilst some routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

- Elective Treatments for January '22 were 1,545 with year-to-date Treatments of 16,535.

Planned Treatments YTD					
Treatment	Core	Backfill	WLI	Other	Total
Derm	1,158	0	108	0	1,266
ENT	752	0	48	0	800
GS	2,530	240	320	0	3,090
Max Fax	1,330	0	0	0	1,330
Ophth	1,331	0	60	0	1,391
Rheum	0	0	0	0	0
T&O	2,126	854	245	0	3,225
Urology	3,685	100	24	0	3,809
	12,912	1,194	805	0	14,911

Actual Treatments YTD					
Treatment	Core	Backfill	WLI	Other	Total
Derm	1,411	0	144	0	1,555
ENT	757	6	0	0	763
GS	3,182	196	0	0	3,378
Max Fax	1,659	11	0	0	1,670
Ophth	2,078	73	0	0	2,151
Rheum	0	0	0	0	0
T&O	2,742	283	59	0	3,084
Urology	3,642	154	138	0	3,934
	15,471	723	341	0	16,535

Treatment Variance YTD					
Treatment	Core	Backfill	WLI	Other	Total
Derm	253	0	36	0	289
ENT	5	6	(48)	0	(37)
GS	652	(44)	(320)	0	288
Max Fax	329	11	0	0	340
Ophth	747	73	(60)	0	760
Rheum	0	0	0	0	0
T&O	616	(571)	(186)	0	(141)
Urology	(43)	54	114	0	125
	2,559	(471)	(464)	0	1,624

- Outpatient activity for January '22 was 5,228 with year-to-date activity of 51,109.

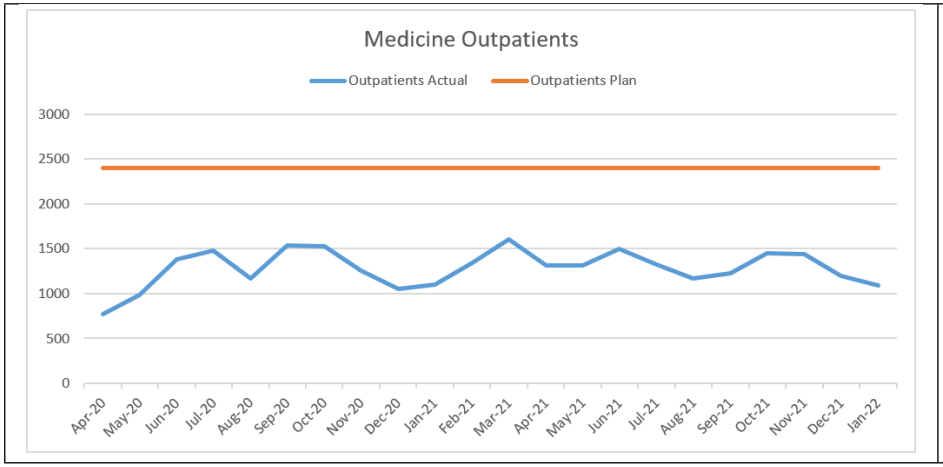
Planned Outpatients YTD M01-10					
Outpatient	Core	Backfill	WLI	Other	Total
Derm	10,377	0	240	0	10,617
ENT	4,779	0	200	0	4,979
GS	9,197	400	120	0	9,717
Max Fax	1,987	610	0	0	2,597
Ophth	4,136	0	360	0	4,496
Rheum	1,543	0	0	0	1,543
T&O	6,240	0	1,520	0	7,761
Urology	3,214	0	140	0	3,354
	41,474	1,010	2,581	0	45,065

Actual Outpatients YTD M01-M10					
Outpatient	Core	Backfill	WLI	Other	Total
Derm	11,373	73	0	0	11,446
ENT	4,124	0	0	0	4,124
GS	11,816	28	190	0	12,034
Max Fax	2,609	0	36	0	2,645
Ophth	7,145	133	216	0	7,494
Rheum	2,048	0	0	0	2,048
T&O	4,905	87	1,826	0	6,818
Urology	4,199	0	301	0	4,500
	48,219	321	2,569	0	51,109

Outpatient Variance YTD M01-M10					
Outpatient	Core	Backfill	WLI	Other	Total
Derm	996	73	(240)	0	829
ENT	(655)	0	(200)	0	(855)
GS	2,619	(372)	70	0	2,317
Max Fax	622	(610)	36	0	48
Ophth	3,009	133	(144)	0	2,998
Rheum	505	0	0	0	505
T&O	(1,335)	87	306	0	(943)
Urology	985	0	161	0	1,146
	6,745	(689)	(12)	0	6,044

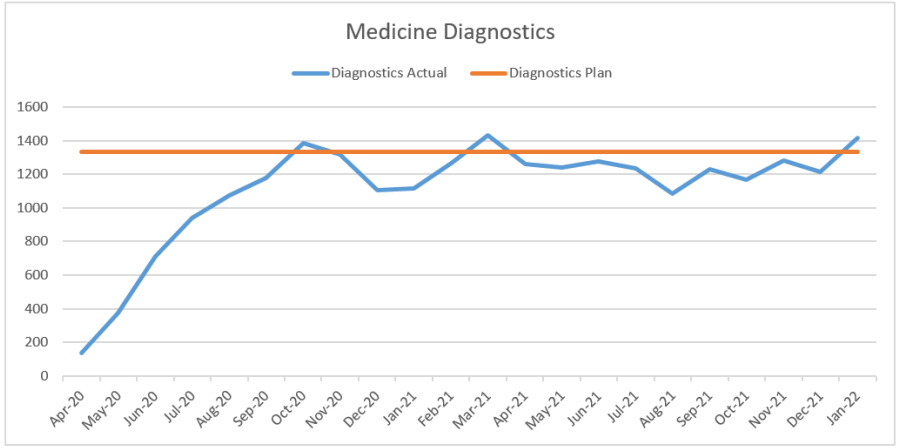
As a result of reduced elective activity compared to previous years, costs have been avoided however, this is at a decreasing rate.

- Medicine Outpatients activity for January '22 was 1,092 with year-to-date activity of 13,037 this is shown by specialty below:



YTD January 22	Assumed monthly activity	Actual activity	Variance	Variance
Gastroenterology	5,100	2,333	- 2,767	54%
Cardiology	5,530	2,456	- 3,074	56%
Respiratory (inc Sleep)	6,060	2,605	- 3,455	57%
Neurology	2,590	2,247	- 343	13%
Endocrinology	2,420	1,516	- 904	37%
Geriatric Medicine	2,310	1,880	- 430	19%
Total	**24,010**	**13,037**	**- 10,973**	**46%**

- Medicine Diagnostics activity for January '22 was 1,417 with year-to-date activity of 12,406 presented below:



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YTD January 22	Assumed monthly activity	Actual activity	Variance	Variance
Endoscopy	13340	12406	-934	7%
Total	**13340**	**12406**	**-934**	**7%**

Waiting List Initiatives:

Medicine have spent £148k in January 22:

- Gastroenterology (£144k): the number of endoscopy lists undertaken was 82 (61 in December). Patients seen in January 2022 was 381 (267 in December)
- Cardiology (£39k): for 26 clinic sessions (20 in December) seeing 264 patients (132 in December), plus 12 Cath lab sessions treating 36 patients (11 sessions and 34 patients in December),
- Diabetes £6k, Neurology £5.7k

Scheduled Care Division have spent £153k in January:

- Radiology (£72k)
- Pathology (£16k)
- Ophthalmology (£-1k)
- Trauma & Orthopaedics (£58k)
- Dermatology (6k)
- General Surgery (4k)
- Urology (5k)
- ENT (1k)

Family & Therapies Division have spent £3k, for Gynaecology Medical Staffing (£3k).

Covid-19 Funding Assumptions & Delegation

The Health Board is expecting WG funding for Covid-19 as listed below;

Type	Covid-19 Specific Allocations - As at January 2022	£m
HCHS	Initial Recovery Plan Covid19	16.27
HCHS	Covid19 response April-September 2021	32.02
HCHS	Testing (inc Community Testing) Qtr 1	1.63
HCHS	Tracing Qtr 1	3.47
HCHS	PPE Qtr 1	1.04
HCHS	Mass COVID-19 Vaccination QTR 1	1.98
GMS	Mass COVID-19 Vaccination QTR 1	1.58
HCHS	Tracing - Q2 (M1-6 less June funding)	3.00
HCHS	Covid 19 Mass Vaccination costs Q2	2.20
GMS	Covid 19 Mass Vaccination costs Q2	0.09
HCHS	Covid 19 Impact on b/f underlying position	8.57
HCHS	Covid 19 Cleaning standards Q1 + Q2	0.95
HCHS	Covid 19 Testing Q2	2.03
HCHS	Covid 19 Adferiad Programme	0.94
HCHS	Covid 19 response funding Oct 21 to Mar 22	56.58
HCHS	Covid 19 support - Tranche 2 Revenue Recovery	7.14
HCHS	Covid 19 - PPE Q2	1.50
HCHS	Covid 19 - Additional Flu programme yrs 7-11	0.78
HCHS	Community Infrastructure Programme (UEC-C19)	0.18
HCHS	Additional Covid Response funding	7.38
HCHS	C19-Adult Social Care Package	2.01
HCHS	C19 Support for Comm Health Checks	0.19
HCHS	C19 Recovery funding - Planned Care Recovery Fund	0.14
HCHS	C19 Cluster funding	0.38
HCHS	C19 Recovery - Healthchecks Learning Disability	0.11
HCHS	MCA Funding-Gwent Consortium-C19 recovery-DoLS	0.17
HCHS	Recovery of balance of NHS Bonus accrual	(1.44)
HCHS	C19 - Tracing Funding balance	7.07
HCHS	C19 - Winter Pressures - ICF (RPBs)	1.85
HCHS	C19 - Testing Qtr 3 and 4	5.37
HCHS	C19 - PPE Q3 and Q4	2.98
HCHS	C19 - Cleaning Standards Q3 and Q4	1.16
HCHS	C19 - Mass Vaccinations Q3 and Q4	4.25
HCHS	C19-Adult Social Care Package Qtr 3&4	1.12
	Total Confirmed Covid-19 Allocations	**174.70**
HCHS	Urgent & Emergency Care	1.51
HCHS	Extended Flu	0.35
	Total Anticipated Covid-19 Allocations	**1.86**
	Total Covid-19 Allocations	**176.56**

Covid-19 Funding & Delegation

The HB has received Covid funding totalling £174.7m and is expecting further funding of £1.86m to cover Covid related pressures and costs for the remainder of 21/22 financial year.

Savings

Division	Business Unit	Savings Scheme Number (i.e. DA1 onwards)	Scheme / Opportunity Title	Recurrent/ Non Recurrent	Current Year Forecast £'000	Forecast FYE (Recurring Schemes only) £'000
Complex Care	Community CHC & FNC	CHC01	Reduction of RN Agency	R	41	139
Complex Care	Community CHC & FNC	CHC02	OT Therapy Hub	R	36	36
Complex Care	Community CHC & FNC	CHC03	Costs avoided from reduction in demand	NR	202	0
Estates and Facilities	Estates and Facilities	FAC1	Rates Rebates - NHH, YYF & YAB	NR	2,700	0
Estates and Facilities	Estates and Facilities	FAC2	Rates Rebates - STW, CTY & YTC	NR	329	0
Estates and Facilities	Estates and Facilities	FAC3	Rates Rebates - Health Centres	NR	70	0
Estates and Facilities	Estates and Facilities	FAC4	Agency usage review	NR	583	0
Estates and Facilities	Estates and Facilities	FAC5	Procurement - local - commercial advertising income	R	30	130
Estates and Facilities	Estates and Facilities	FAC6	Procurement - local - workwear/staff clothing	R	10	10
Estates and Facilities	Estates and Facilities	FAC8	Procurement - central - Castell Howell Butter	R	11	11
Estates and Facilities	Estates and Facilities	FAC9	E&F Contracts Team - HB coffee beans, teas and hot chocolate	R	9	9
Estates and Facilities	Estates and Facilities	FAC10	E&F Contracts Team - BMS maintenance	R	24	26
Estates and Facilities	Estates and Facilities	FAC11	E&F Contracts Team - GUH Coffee Shop	R	21	40
Estates and Facilities	Estates and Facilities	FAC13	E&F Contracts Team - Water Coolers	R	5	5
Estates and Facilities	Estates and Facilities	FAC14	Remote training	R	5	5
Estates and Facilities	Estates and Facilities	FAC16	Inter-site transport revised cost base	R	295	295
Estates and Facilities	Estates and Facilities	FAC17	Excess travel 2 year lump sum vs 4 year monthly payments (Sta	R	10	40
Estates and Facilities	Estates and Facilities	FAC18	Otis lift spend review (Jen Green)	NR	10	0
Estates and Facilities	Estates and Facilities	FAC20	Grounds and Gardens contacts review (Jen Green)	R	3	5
Estates and Facilities	Estates and Facilities	FAC21	Water Coolers (Jen Green)	R	0	0
Estates and Facilities	Estates and Facilities	FAC23	Aquafund Water Management Net Savings (Matt Lane)	R	100	100
Estates and Facilities	Estates and Facilities	FAC24	LED YYF, RGH & NHH	R	14	56
Families and Therapies	FT-Maternity Services	FT1	Maternity Information System	R	12	52
Families and Therapies	Obs&Gynae / Paeds / Neonates	FT2	Reduction in Medical Staffing costs	NR	164	0
Families and Therapies	Division	MM FT1	Booster Regime	R	60	60
Families and Therapies	Division	MM FT2	Peripheral Maintenance bags Neonatal PN	R	15	15
Families and Therapies	Division	MM FT3	Antibiotic savings	R	0	0
Families and Therapies	Family & Therapies	Proc03	Buyer Savings - Family & Therapies	NR	6	0
Families and Therapies	Family & Therapies	Proc20	Digital Assessments and Text Remind Service - F&T	NR	120	0
Families and Therapies	Families and Therapies	WORK01	Agency & Workforce cost management	R	33	33
Medicine	Medicine	RET Med 1	Retinue Savings	NR	148	0
Medicine	Medicine	Medical 1	Medical Agency	NR	194	0
Medicine	Medicine	Medical 2	Reduction in Nursing Agency spend	NR	270	0
Medicine	Medicine	MM Med1	Antibiotic savings	NR	10	0
Medicine	Medicine	MM Med2	Vedolizumab IV rebate	R	185	185
Medicine	Medicine	MM Med3	Benralizumab	R	6	10
Medicine	Medicine	MM Med4	Cannabidiol (Homecare)	R	6	9
Medicine	Medicine	MM Med5	Galcanezumab (Homecare)	R	15	15
Medicine	Medicine	MM Med7	Fremanezumab	NR	1	0
Medicine	Medicine	MM Med8	Erenumab FOC	NR	20	0
Medicine	Medicine	MM Med9	Vedolizumab IV rebate (reclaim on quarterly basis)	R	133	133
Medicine	Medicine	MM Med10	Infliximab Biosimilar Switch (Flixabi)	R	50	51
Medicine	Medicine	WORK02	Agency & Workforce cost management	R	2,117	2,904
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 1	CHC Eligibility Reviews	R	220	221
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 2	CHC Repatriations to in house wards	R	754	754
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 3	CHC Right Size Packages	R	120	120
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 4	CHC Step Down	R	51	375
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 5	CHC Change in Need	R	1,556	1,556
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 6	Structured Clinical Management	R	260	260
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 7	CHC Savings to be identified - green based on previous delivery	R	0	0
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 8	Agency Medical savings Retinue VAT (achieving part Work03)	R	122	122
Mental Health and Learning Dis	MHLD-CHC Commissioning	MHLD 9	Agency Retinue reduced usage	NR	4	0
Mental Health and Learning Dis	Mental Health and Learning Disab	WORK03	Agency & Workforce cost management	R	82	82
Primary Care and Community	Primary Care and Community	PCC01	Prescribing support dieticians (Prescribing)	R	86	188
Primary Care and Community	Primary Care and Community	PCC02	Waste reduction scheme (Prescribing)	R	179	179
Primary Care and Community	Primary Care and Community	PCC03	Pharmacy led savings (Prescribing)	R	0	0
Primary Care and Community	Primary Care and Community	PCC04	LOE (Prescribing)	R	0	0
Primary Care and Community	Primary Care and Community	PCC05	Scriptswitch (acute) (Prescribing)	R	194	194
Primary Care and Community	Primary Care and Community	PCC06	Scriptswitch (repeat) (Prescribing)	R	420	717
Primary Care and Community	Primary Care and Community	PCC07	Antimicrobial Savings (Prescribing)	R	212	212
Primary Care and Community	Primary Care and Community	PCC08	Rebate - total (Prescribing)	R	900	900
Primary Care and Community	Primary Care and Community	PCC09	Agency Retinue reduced usage	NR	20	0
Primary Care and Community	Primary Care and Community	WORK04	Agency & Workforce cost management	R	303	326
Scheduled Care	Scheduled Care	MM SCD1	Antibiotic savings	R	12	12
Scheduled Care	Scheduled Care	MM SCD2	Teriparatide Switch	NR	1	0
Scheduled Care	Scheduled Care	MM SCD3	Baracitinib Atopic Dermatitis	NR	4	0
Scheduled Care	Scheduled Care	MM SCD4	Baractinib to Filgotinib switch	NR	26	0
Scheduled Care	Scheduled Care	MM SCD5	Baracitinib to Upadacitinib switch	NR	7	0
Scheduled Care	Scheduled Care	MM SCD6	Azacitidine Price	R	57	57
Scheduled Care	Scheduled Care	MM SCD7	Critical care: Nacsys switch	R	0	1
Scheduled Care	Scheduled Care	MM SCD16	Acalabrutinib HC Switch	R	14	24
Scheduled Care	Scheduled Care	MM SCD17	Ibrutinib to Acalabrutinib Switch	R	33	33
Scheduled Care	Scheduled Care	MM SCD18	Baracitinib rebate	R	1	1
Scheduled Care	Scheduled Care	MM SCD19	Cytarabine repatriation	R	17	18
Scheduled Care	Scheduled Care	MM SCD20	Rituximab biosimilar switch to Rixathon	R	55	55
Scheduled Care	Scheduled Care	MM SCD 21	Ponatinib Switch to Homecare	R	5	5
Scheduled Care	Scheduled Care	DA15	Atovaquone	NR	0	0
Scheduled Care	Scheduled Care	DA16	Retinue Reduction in Medical Agency	NR	250	0
Scheduled Care	Scheduled Care	DA17	Reduction to Kensington Court Contract	NR	20	0
Scheduled Care	Scheduled Care	DA18	Llanwenarth PFI contract reduction	R	69	69
Scheduled Care	Scheduled Care	DA19	Llanwenarth PFI contract reduction	NR	91	0
Scheduled Care	Scheduled Care	DA20	PACS - MSC Savings - Equipment Removed -DEVO and Workstati	R	46	46
Scheduled Care	Scheduled Care	DA21	Review of Medical secretarial staffing reduction NHH	R	12	30
Scheduled Care	Scheduled Care	DA22	Radiology Outsourcing Contract Ceased	R	135	180
Scheduled Care	Scheduled Care	DA23	Pathology - Rebate for LINC Q3 and Q4 2021-22	NR	63	0
Scheduled Care	Scheduled Care	WORK05	Agency & Workforce cost management	R	1,072	1,241
Urgent Care	UNSCH-UC	MC UC1	Antibiotic Savings	R	10	11
Urgent Care	UNSCH-UC	RET UC2	Retinue Savings	NR	32	0
Urgent Care	UNSCH-UC	UC3	Reduced Usage - Retinue	NR	11	0
Urgent Care	Urgent Care	WORK06	Agency & Workforce cost management	R	998	1,222

Approved Proposals Against WG Tranche 1 Recovery Funding

Division	Description	WG funding and approved funding bids 2021/22
		£
	Original WG funding	17,000,000
	Balance of WG funding	**17,000,000**
	Bids approved - Chort 1	
Scheduled Care	Wet AMD - increase capacity / drug costs	3,207,987
Commissioning	Opthalmology - Outpatients & Treatments	2,200,000
Scheduled Care	OP/Trans - Outpatient new review capacity	1,249,093
Scheduled Care	OP/Trans - Outpatient follow-up review capacity	126,000
Medicine	Alcohol Care Team - Intervention capacity / reduce OP and ED demand	216,000
Primary Care & Community	GDS - Sedation services	37,200
Primary Care & Community	GDS - Out Of Hours	26,040
Primary Care & Community	GDS - Oral surgery capacity	341,960
Primary Care & Community	GDS - In-hours capacity (Prisons)	33,000
Mental Health	Mental Health primary care capacity	271,000
Mental Health	Autism diagnostic capacity	34,000
Mental Health	Psychology assessments / interventions	439,000
Mental Health	Older Adult MH - Memory Assessment Clinic capacity	108,000
Family & Therapies	Sexual Health-Treatment capacity	89,964
Family & Therapies	Gynaecology-Outpatient capacity	16,355
Family & Therapies	CAMHS-Outpatient / assessment capacity	215,595
Family & Therapies	CAMHS-Outpatient / assessment capacity	29,872
Family & Therapies	CAMHS-Neurodevelopment assessment capacity	90,507
Family & Therapies	Health visiting-Caseload capacity / reduce hospital demand	185,141
Family & Therapies	Paediatrics - Outpatient capacity	24,894
Family & Therapies	Paediatrics - Outpatient capacity (Epilepsy)	18,621
Family & Therapies	Paediatrics - Neurodevelopment assessment capacity	9,342
Family & Therapies	Dietetic capacity	217,603
Family & Therapies	Speech & Language Therapy capacity	78,000
Family & Therapies	Podiatry & Orthotics - Outpatient capacity	194,221
Family & Therapies	Occupational Therapy - OT capacity	30,967
Family & Therapies	Weight Management Service - Upstream service capacity	226,439
Primary Care & Community	Pharmacy Inhaler Technique	196,300
Primary Care & Community	Pharmacy Care Home Meds review	93,200
Medicine	COTE - Treatment capacity	49,830
Medicine	COTE - Outpatient capacity / reduce re-attendances	16,670
Medicine	Neurology - Outpatient capacity	21,000
Medicine	Neurology - Outpatient capacity	24,000
Medicine	Cardiology - Echo diagnostic capacity	90,000
Medicine	Cardiology - Ambulatory monitoring capacity	142,000
Medicine	Cardiology - Outpatient capacity	248,000
Medicine	Diabetes - Outpatient capacity	37,000
Medicine	Gastroenterology - Outpatient / diagnostic capacity	369,479
Scheduled Care	T&O	2,402,428
Scheduled Care	General Surgery	504,783
Scheduled Care	Dermatology	427,315
Scheduled Care	Urology	111,303
Scheduled Care	Ophthalmology	121,112
Scheduled Care	ENT	188,912
Scheduled Care	Max Fax	275,021
Scheduled Care	Rheumatology	44,140
Scheduled Care	Haematology	61,254
Scheduled Care	Theatres	1,182,631
Scheduled Care	Anaesthetics	502,245
Estates & Facilities	T&O	75,380
Estates & Facilities	General Surgery	27,756
Estates & Facilities	Urology	498
Estates & Facilities	Ophthalmology	890
Estates & Facilities	ENT	1,594
Estates & Facilities	Max Fax	403
	Total commitment approved and delegated - Tranche 1	**16,931,945**
	Total unallocated funding in reserves - Tranche 1	**68,055**

Approved Proposals Against WG Tranche 2 Recovery Funding

Division	Description	WG funding and approved funding bids 2021/22
		£
	Original WG funding	9,935,085
	Bids approved - Chort 1	
Medicine	Straight to Test	40,382
Primary Care & Community	Pharmacy Locums – Winter Pressures	664,890
Primary Care & Community	Pharmacy Locum - ED	30,000
Primary Care & Community	Polypharmacy (7 wte)	140,000
Primary Care & Community	Diagnostic spirometry	159,000
Scheduled Care	Virtual ENT Reviews	17,950
Scheduled Care	Telemax	49,064
Family & Therapies	Additional Physio Recovery Activity: MSK - T&O redirected MDT Recovery triage	186,083
Family & Therapies	Improving Cancer Outcomes - Gynae Ambulatory Care	117,387
Estates & Facilities	Wheel chair replacements	24,729
Scheduled Care	Improving Cancer Outcomes - Diagnostic Efficiency	216,000
Medicine	Gastroenterology	225,523
CHC	Additional commissioning of 25 community nursing beds - Step Care Closer to H	501,979
Scheduled Care	Virtual Rheumatology	63,340
Mental Health	Mental Health	988,327
	Total commitment approved to 18-10-21 - COHORT 1	**3,424,654**
	Bids approved - Chort 2	
Scheduled Care	Resourcing Recovery	58,000
Medicine	Resourcing Recovery	22,917
Corporate	Robotics for Bank worker annual leave processing	9,965
Family & Therapies	Capacity for extra physiotherapy demand (IP and OP)	86,400
Family & Therapies	Podiatric & Orthotics	83,441
Family & Therapies	LAC Assessment	47,537
Family & Therapies	Gynae and fertility additional activity	86,913
Medicine	Spasticity service increasing capacity	120,000
Medicine	Respiratory additional capacity	72,000
Primary Care & Community	General Dental Access Capacity increase	84,756
Primary Care & Community	Primary Care Orthodontic Service - Capacity Increase	348,075
Primary Care & Community	Cervical Screening in Primary Care Capacity increase	20,000
Scheduled Care	Histopathology/Micro insourcing and capacity	334,705
Scheduled Care	Radiology Outsourcing and Capacity	388,000
	Total commitment approved to 25-10-21 - COHORT 2	**1,762,708**
	Bids approved - Chort 3	
Medicine	Cardiology Outsourcing - PCI Overperformance	685,000
	Total commitment approved to 18-10-21 - COHORT 1	**685,000**
	Bids approved - Chort 4	
Primary Care & Community	Additional GMS capacity	700,000
	Total commitment approved to 08-11-21 - COHORT 4	**700,000**
	Bids approved - Chort 5	
Medicine	Reclining Chairs for A1 GUH	17,136
Family & Therapies	Pilot study - Involving young people in recruitment	8,000
Corporate	Sign Live' Trial	6,000
Scheduled Care	Locum Consultant for Breast	36,000
Primary Care & Community	Incr. GMS access through additonal reception hours	410,000
	Total commitment approved to 02-12-21 - COHORT 5	**477,136**
	Bids approved - Chort 6	
Scheduled Care	Audiology Reassessments	163,324
Scheduled Care	Audiology Paediatric Clinic	37,230
Corporate	Person Centred Care team	66,468
	Total commitment approved to 02-12-21 - COHORT 6	**267,022**
	Total commitment approved and delegated - Tranche 2	**7,316,520**
	Total unallocated funding in reserves - Tranche 2	**2,618,565**

Reserves

7769-ALLOCATIONS TO BE DELEGATED

Confirmed or Anticipated	R / NR	Description	21/22
Confirmed	NR	National Director of planned care (balance of funding)	90,417
Confirmed	NR	COVID - 21-22 Recovery funding	2,573,866
Confirmed	NR	COVID - Underlying deficit funding	588,765
		Confirmed Allocations to be apportioned	**3,253,048**

7788-COMMITMENTS TO BE DELEGATED

Description	21/22
Environmental Fund 21/22	736,580
21/22 Wage Award Commitment	481,252
Total Commitments	**1,217,832**

7565-CONTINGENCY

Description	21/22
Contingency (general)	14,277
Confirmed Allocations to be apportioned	**14,277**

Reserves Delegation:

Total Reserves as at month 10 is £4.5m

During month 10 reserves have been delegated relating to allocations relating to a range of issues including confirmed quarter 4 Covid-19 national and local funding.

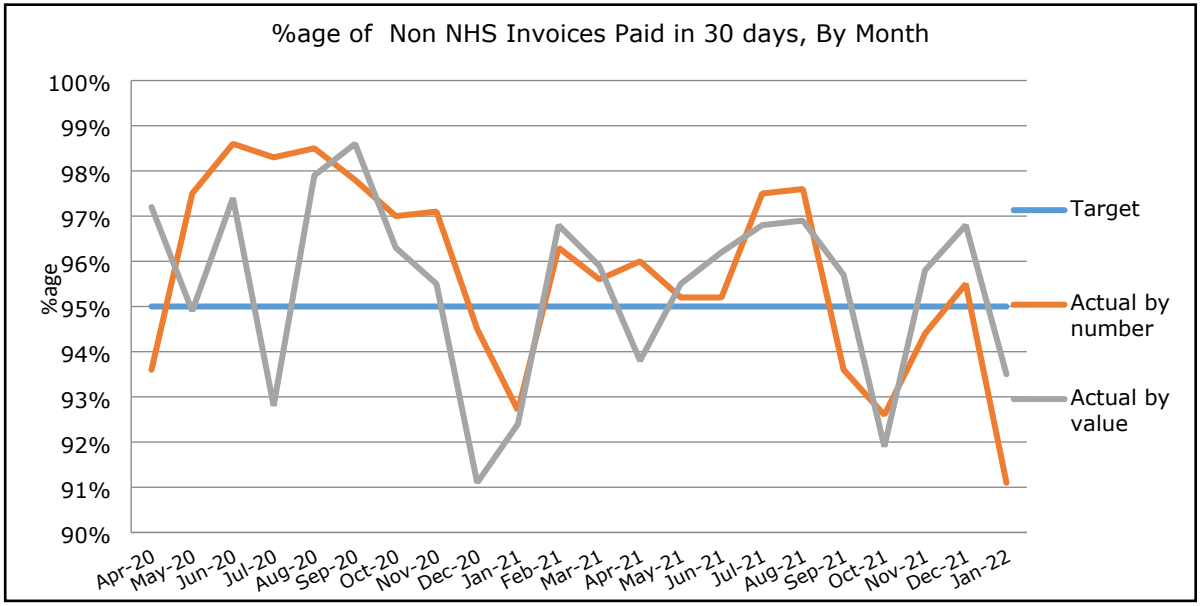
There is currently £2.6m of recovery funding which has been clawed back from divisions. This will be utilised in the final two months as necessary.

Cash Position

- The cash balance at the 31st January is £4.818m, which is below the advisory figure set by Welsh Government of £6m.
- The cash balance is made up of £1.169m revenue and £3.649m capital.

Public Sector Payment Policy (PSPP)

- This month the HB has dropped slightly below the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods on a cumulative basis achieving 94.9%. This has been due to staff shortages within the pharmacy department and in the processing of Homecare invoices. We are working with the department concerned to rectify this issue to ensure compliance with the target for future months.

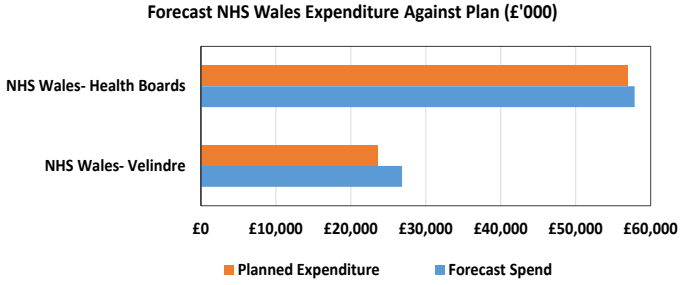


Contracting and Commissioning – LTA Spend & Income

Month/Financial Year: Month 10 (January) 2021-22

At Month 10 the financial performance for Contracting and Commissioning is a year to date adverse position of £2.5m and a forecast year-end adverse variance of £3.2m

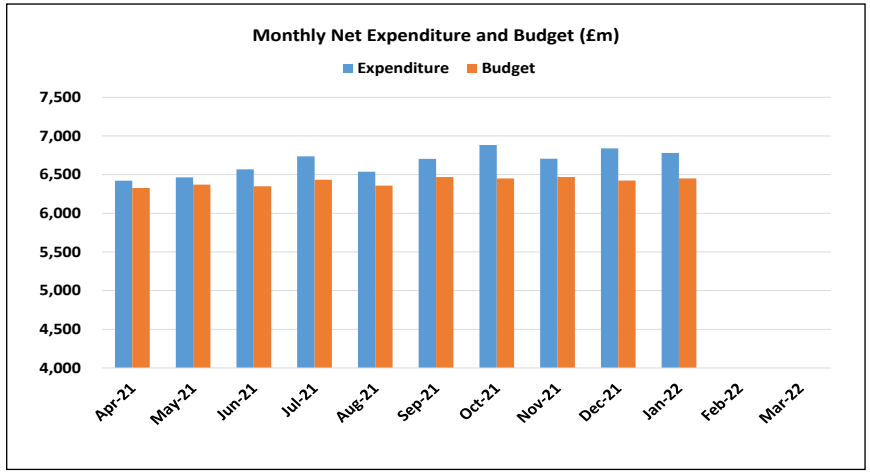
The key elements contributing to this position at Month 10 are as follows:

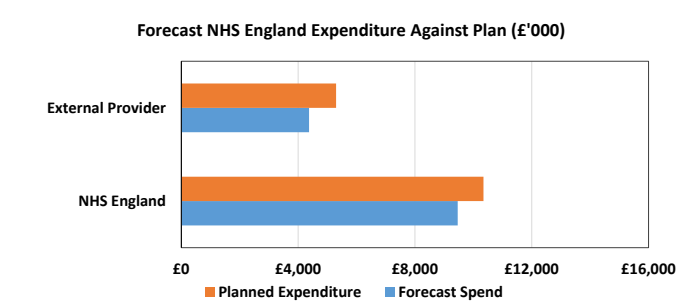


NHS Wales Expenditure

Commissioning Expenditure within NHS Wales has been agreed to be managed on a block basis for 2021-22 due to COVID pressures.

£500k of non-recurrent recovery expenditure in Velindre was included in the forecast from Month 7

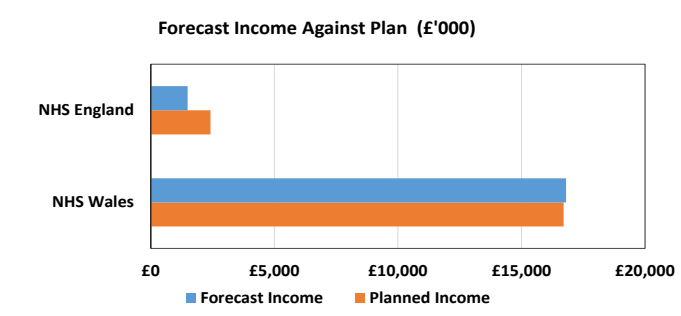




NHS England Expenditure

Contract Expenditure with NHS England organisations has been agreed on a block basis for 2021-22.

Providers in NHS England are currently delivering c80-100% of the block contract value.



Provider Income

Contract income with NHS Wales commissioners has been protected with a block agreement for 2021-22

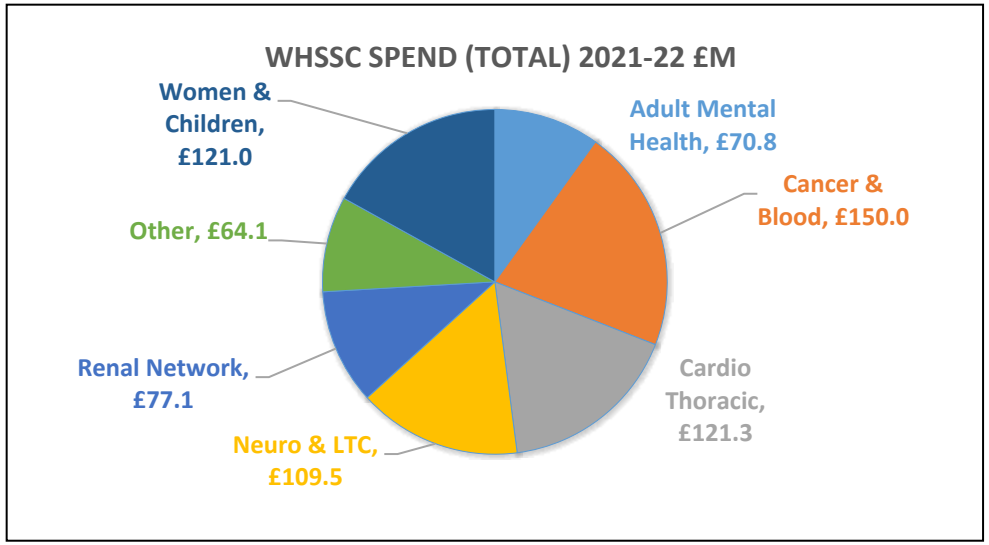
The impact of service reconfiguration following the opening of GUH on provider income is currently being reviewed

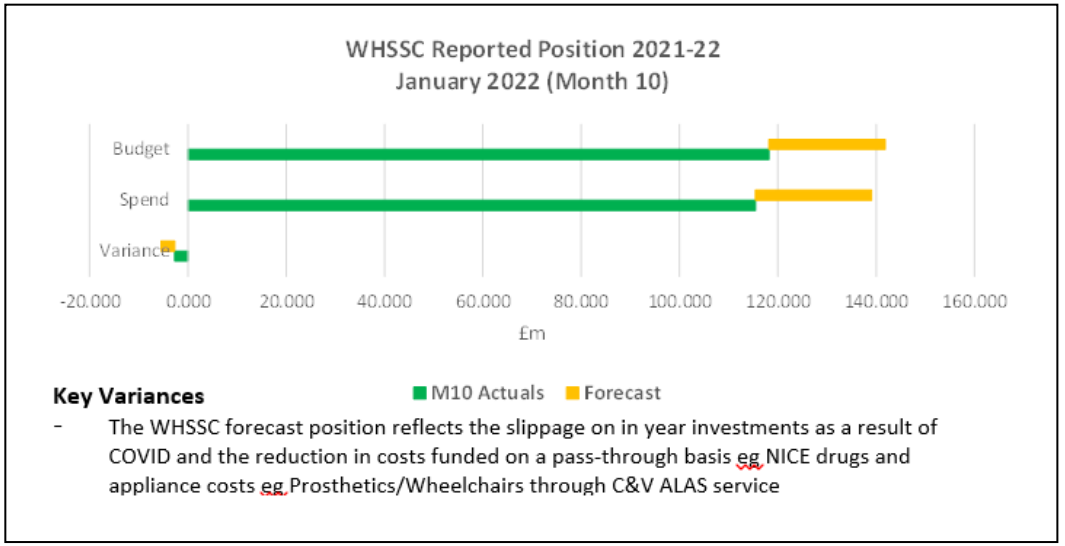
Key Issues 2021-22

- All LTAs were agreed and signed by ABUHB and other Welsh organisations in line with the Welsh Government deadline of 31st May 2021
- The nationally agreed inflationary uplift of 2% and the impact of the first 1% of the NHS Pay Award has been funded and is reflected in the above position
- COVID 19 has resulted in 'block' agreements for all contracts for 2021/22 so no variance on activity is incurred. NICE/High-cost drug spend and other recharges will be based on actuals for this period and are reviewed and validated upon receipt
- Guidance for contracting arrangements with NHS England for H2 was issued in October 2021 and is consistent with the Health Boards planning assumptions
- There is a deficit of £3,205k forecast which primarily relates to the reduction in budget allocated for the New Treatment Fund (c£1.1m), Velindre and Cardiff NICE Growth (c£2.9m including £0.5m of recovery expenditure at Velindre) and NAS (c£0.045m) offset by non-recurrent accrual releases (c£0.5m) and a reduction in planned transport spend (£0.4m)
- Outsourcing treatment costs and delegated budget are included in the year to date as per the plan and forecast in line with provider expected delivery

WHSSC & EASC Analysis

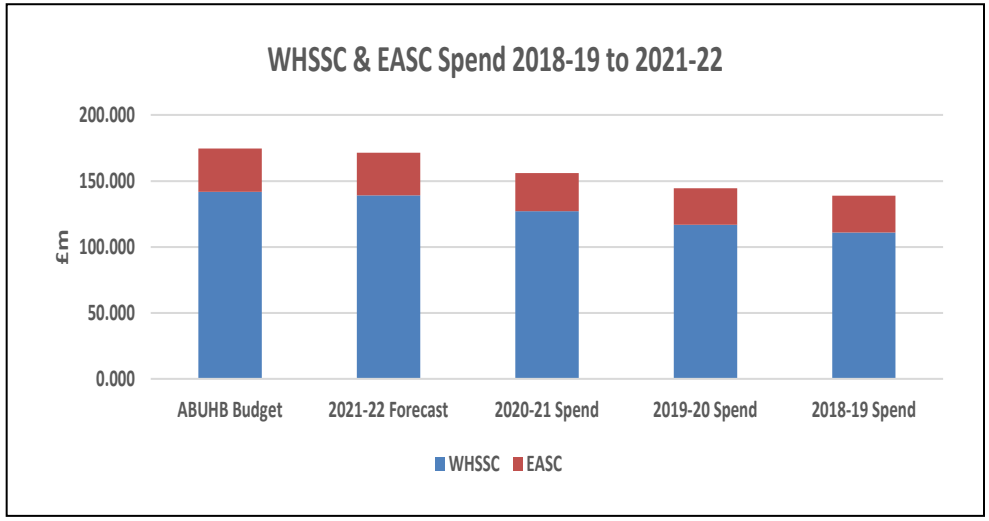
Period: The Month 10 financial performance for WHSSC & EASC is a YTD underspend of £3.049m, with a forecast underspend at year end of £3.176m. The Month 10 position reflects the agreed IMTP & block LTA agreements with providers.

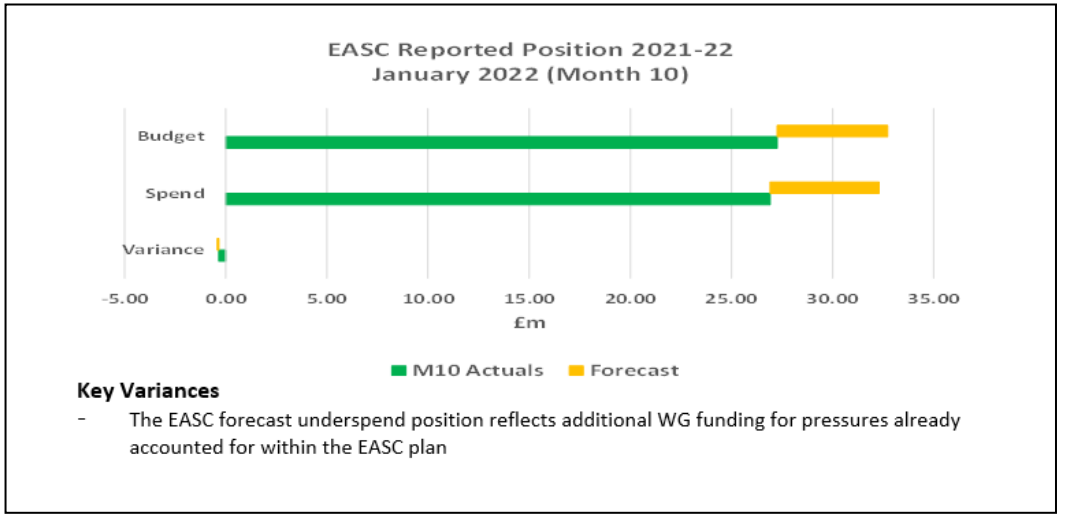




Key Variances

- The WHSSC forecast position reflects the slippage on in year investments as a result of COVID and the reduction in costs funded on a pass-through basis eg NICE drugs and appliance costs eg Prosthetics/Wheelchairs through C&V ALAS service





Key Variances

- The EASC forecast underspend position reflects additional WG funding for pressures already accounted for within the EASC plan

Balance Sheet

Balance sheet as at 31st January 2022

	2021/22 Opening balance £000s	31st January 2022 £000s	Movement £000s
Fixed Assets	779,935	806,203	26,268
Other Non current assets	125,540	139,244	13,704
Current Assets			
Inventories	9,857	9,714	-143
Trade and other receivables	95,919	136,675	40,756
Cash	1,821	4,818	2,997
Non-current assets 'Held for Sale'	1,205	0	-1,205
Total Current Assets	108,802	151,207	42,405
Liabilities			
Trade and other payables	206,759	224,181	17,422
Provisions	170,941	232,640	61,699
	377,700	456,821	79,121
	636,577	**639,833**	**3,256**
Financed by:-			
General Fund	512,572	506,614	-5,958
Revaluation Reserve	124,005	133,219	9,214
	636,577	**639,833**	**3,256**

Other Non-Current Assets:
- This relates to an increase in Welsh Risk Pool claims due in more than one year £15.8m and a decrease in intangible assets £2.1m since the end of 2020/21.

Current Assets, Inventories:
- The decrease in year relates to changes in stock held within the divisions.

Current Assets, Trade & Other Receivables:
- An increase in the value of debts outstanding on the Accounts Receivable system since 2020/21 to the end of January £5.3m
- An increase in the value of both NHS & Non-NHS accruals of £33.8m, of which £39.1m relates to an increase of Welsh Risk Pool claims due in less than one year, £3.9m relates to a decrease in NHS & Non NHS accruals & £1.4m relates to a decrease in VAT and other debtors since the end of 2020/21.
- An increase in the value of prepayments held £1.7m.

Cash:
- The cash balance held in month 10 is £4.818m

Liabilities, Trade & Other Payables:
- A decrease in Capital accruals (£5.9m)
- An increase in NHS Creditor accruals (£3.7m)
- A decrease in the level of invoices held for payment from the year end (£0.7m)
- An increase in non NHS accruals (£20.3m)
- An increase in Tax & Superannuation (£9.0m)
- A decrease in other creditors (£10.4m)
- A decrease in payments on account (£1.4m)

Liabilities, Provisions:
- Due to the increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £62.5m and the decrease of other provisions of £0.8m since the end of 2020/21.

General Fund:
- This represents the difference in the year-to-date resource allocation budget and actual cash draw down including capital.

Health Board Income
WG Funding Allocations: £1.57bn

Confirmed Allocations as at January 2022 (M10 2021/22)

	£'000
HCHS	1,370,613
GMS	107,407
Pharmacy	33,905
Dental	31,271
Total Confirmed Allocations - January 2022	**1,543,197**
Plus Anticipated Allocation - January 2022	**22,935**
Total Allocations - January 2022	**1,566,132**

Anticipated allocations are detailed opposite

Other Income:

The HB receives income from a number of sources other than WG, based on the year-to-date income, this will be approximately £101m for 21/22 (£97m in 20/21). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Based on the year to date month 10 position and estimates total funding (allocations & income) for the HB is expected to total £1.67bn for 21/22.

WG Revenue Resource Limit : Anticipated Allocations (January)

Funding Type	Description	Value £'000
HCHS	(Provider) SPR's	51
HCHS	(Provider) Clinical Excellence Awards (CDA's)	55
HCHS	Technology Enabled Care National Programme (ETTF)	786
HCHS	Informatics - Virtual Consultations	1,106
HCHS	Clinical Consultant Services Mr S Wood Planned Care	18
HCHS	Transformation Programme 21-22	4,987
HCHS	Capital-DEL Strategic Depn	17,796
HCHS	Capital-DEL Bline Shortfall Depn	1,378
HCHS	Capital-AME Impairment	(12,654)
HCHS	Capital-AME Donated Assets Depn	406
GMS	GMS Refresh	1,603
HCHS	Covid: Increase in Covid stability funding	351
HCHS	RPB - Wales Community Care Information System (WCCIS)	251
HCHS	Capital-AME Donated Assets Receipts	(250)
HCHS	Strategic Programme for Primary Care-Acceleration of Cluster working	200
HCHS	Urgent Primary Care Centre Pathfinder 21-22	1,513
HCHS	Transformation Scaling funding (D2RA)	1,137
HCHS	Transformation funding-Increase for Gwent Seamless system	300
HCHS	Flu vaccine Frontline PC Health workers	49
HCHS	Increase in IRP Provision	139
HCHS	1pct non-consolidated pay award B1-5	2,436
HCHS	Digital Priority investment fund	614
HCHS	111 First programme	665
	Total Anticipated: Per Ledger	**22,935**

Capital Planning & Performance

- The approved Capital Resource Limit as at Month 10 totals £50.03m. In addition, the Health Board has confirmed asset disposals generating further funding of £1.39m. The Capital Resource Limit was agreed and fixed with Welsh Government at the end of October. The Health Board is now required to manage any subsequent variations from the fixed resource limits via brokerage with the Discretionary Capital Programme (DCP). The current forecast outturn is breakeven; however, this position now includes brokerage of £1.35m with the DCP to manage slippage against All Wales Capital Programme schemes described below.

- The Grange University Hospital forecast outturn has been reduced by £0.72m in month to reflect the delays anticipated in the Well-being and Admin and Temporary Carpark works. The Same Day Emergency Care works are currently progressing as planned but will be monitored closely to end of year to ensure the outturn is achieved.

- Slippage is being reported against the NHH Satellite Radiotherapy and Mental Health SISU schemes as the completion of these cases has slipped. The forecast outturn for the HSDU scheme is expected to be an overspend of £0.71m. Practical completion on the scheme has been delayed due to issues that have arisen during the commissioning testing of the facility.

- The Full Business Case for Newport East Health and Well-being Centre has been submitted to Welsh Government for approval. The Full Business Case for the Unified Breast Unit at YYF has been approved by Welsh Government. Welsh Government have approved additional imaging equipment purchases in month to allow the Health Board to retain the previously reported saving of £540k against the Imaging National Programme scheme.

- All the original DCP funding, and the additional £1.350m of allocations required to offset the AWCP brokerage requirements, have been released as approved schemes.

- The Health Board has received notification that the annual Discretionary budget allocation for 2022/23 has been reduced by 24% to £8.227m (expected allocation - £10.814m). The decrease results from a significant reduction in the Welsh Government Overall All Wales Capital Programme budget for 2022/23. When the brokerage of AWCP scheme slippage of £1.350m is deducted from the confirmed budget, only £6.877m remains to address existing Discretionary scheme commitments and new 2022/23 proposals. The draft 2022/23 Discretionary programme is being developed in the context of the reduced funding and will be presented to Board for approval in March.

Summary Capital Plan Month 10 2021/22				
	2021/22			
	Original Plan £000	Revised Plan £000	Spend to Date £000	Forecast Outturn £000
Source:				
Discretionary Capital:-				
Approved Discretionary Capital Funding Allocation	8,214	8,159		8,159
Newport East H&WBC reimbursement from AWCP	0	51		51
NBV of Assets Disposed	1,119	1,390		1,390
Total Approved and Anticipated Discretionary Funding	9,333	9,600		9,600
All Wales Capital Programme Funding: -				
AWCP Approved & Anticipated Funding	8,722	41,871		41,871
Newport East H&WBC reimbursement to DCP	0	-51		-51
Total Approved & Antcipated AWCP Funding	8,722	41,820		41,820
Total Capital Funding / Capital Resource Limit (CRL)	**18,055**	**51,420**		**51,420**
Applications:				
Discretionary Capital:-				
Commitments B/f From 2020/21	3,286	2,239	2,077	2,156
Statutory Allocations	672	777	491	773
Divisional Priorities	2,237	4,356	1,153	4,542
Informatics National Priority & Sustainability	2,230	2,846	1,890	2,738
Remaining DCP Contingency	908	0	0	9
Total Discretionary Capital	**9,333**	**10,218**	**5,610**	**10,218**
All Wales Capital Programme:-				
Grange University Hospital (after DCP brokerage reimbursement)	2,374	4,824	2,826	4,102
Fees for East Newport Health & Wellbeing Centre Development	0	960	793	909
Fees for Tredegar Health & Wellbeing Centre Development	1,267	3,895	3,217	3,898
Fees for HSDU	2,344	2,719	3,432	3,432
Fees for NHH Satellite Radiotherapy Centre Development	1,439	1,334	958	1,284
Fees for MH SISU	1,115	1,178	805	1,000
Fees to develop YYF Breast Centralisation Unit	183	34	46	46
ICF Serennu Rebound Facility	0	424	336	424
Digital Eyecare	0	141	31	141
National Programme - Infrastructure	0	1,398	1,064	1,398
National Programme - Fire Safety	0	728	676	728
National Programme - Mental Health	0	1,397	1,112	1,397
National Programme - Decarbonisation	0	2,288	1,826	2,288
National Programme - Imaging	0	4,985	1,992	4,985
NHH SRU Enabling Works	0	1,337	433	937
Covid-19 Recovery Funding	0	8,040	4,067	8,043
EOY Funding 2021/22	0	3,810	1,923	3,802
SDEC Equipment	0	254	26	254
Pharmacy Funding - Zebra Printer	0	6	4	4
Digital Priorities Investment Fund	0	1,693	192	1,703
LINC Funding	0	306	75	306
ICF Discretionary Fund Schemes	0	120	0	120
Total AWCP Capital	**8,722**	**41,871**	**25,833**	**41,202**
Total Programme Allocation and Expenditure	**18,055**	**52,089**	**31,443**	**51,420**
Forecast Underspend against Overall Capital Resource Limit				**0**

Aneurin Bevan University Health Board

Performance Report

Executive Summary

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	
Executive Sponsor: Nicola Prygodzicz**,** Director of Planning, Digital and IT and interim Performance	
Report Author: Lloyd Bishop, Assistant Director of Performance and Information Sue Shepherd, Head of Corporate Performance and Compliance	
Report Received consideration and supported by:	

Executive Team		**Committee of the Board [Committee Name]**	**Public Board**
Date of the Report: 7th March 2022			
Supplementary Papers Attached: Dashboard attached and supplementary graphs			

Purpose of the Report

This report provides a high-level overview of activity and performance at the end of January 2022, with a focus on delivery against key national targets included in the performance dashboard. The report focuses on Referral to Treatment Times, Diagnostics, Urgent Care, Cancer Services, Stroke Care and Mental Health.

Report Narrative

Background and context

The Health Board continues to manage the direct and indirect effects of the COVID-19 pandemic, to include: increasing demand across the urgent care system, increased pressure on primary care services, high walk-in demand at emergency departments, significant pressures in social care and high levels of sickness across our workforce. This is in the context of the restart of many routine services despite continued reduced capacity for elective surgery overall, when compared with pre-COVID-19 activity levels during the same time period.

It is important that the performance reported for January 2022 is not compared 'like-for-like' with previous months/year's performance and should be viewed as a snapshot as to how services are managing at present in the context of the continued system response to the pandemic and restart and recovery. The accompanying dashboard reflects performance for key services still being delivered through the COVID-19 pandemic.

Elective care

The Health Board continues to monitor closely the implementation of the prioritisation framework. Elective activity undertaken is defined by the clinical prioritisation of the patient, rather than a time based approach, this enables timely care for the most urgent patients and clinically led decision making. This will have an impact on Referral to Treatment Time (RTT) waits in some services.

Services have embraced new ways of working due to COVID-19, especially within outpatient services, where the focus has been on virtual clinics and reviews and office-based decisions. New outpatient activity increased in January from December but is still below pre-pandemic levels. However, face to face attendances have been more evident. Virtual activity as services are still dealing with the backlog of long wait referrals received before and during the pandemic and are having to ensure the most appropriate use of virtual attendances. The challenge for the services is to ensure that there is sufficient accommodation across the Health Board to undertake these clinics and to ensure that the clinic capacity is used for face to face attendances only and for all virtual activity to be undertaken in non-clinic settings.

The Outpatients Improvement Programme continues to build on the new ways of working and modernisation, which was established through necessity after surge 1 of the pandemic. This includes the outpatient improvement measures outlined by the National Planned Care Programme Board, with key targets regarding risk-management of long waiting follow-up patients.

The requirements around social distancing that have been in place have had an impact on the physical capacity of clinics and the relatively small numbers of patients that can be seen. Progress has been made in recent months in clinics where social distancing requirements could safely be reduced from 2 metres to 1 metre, as agreed by the Executive Team.

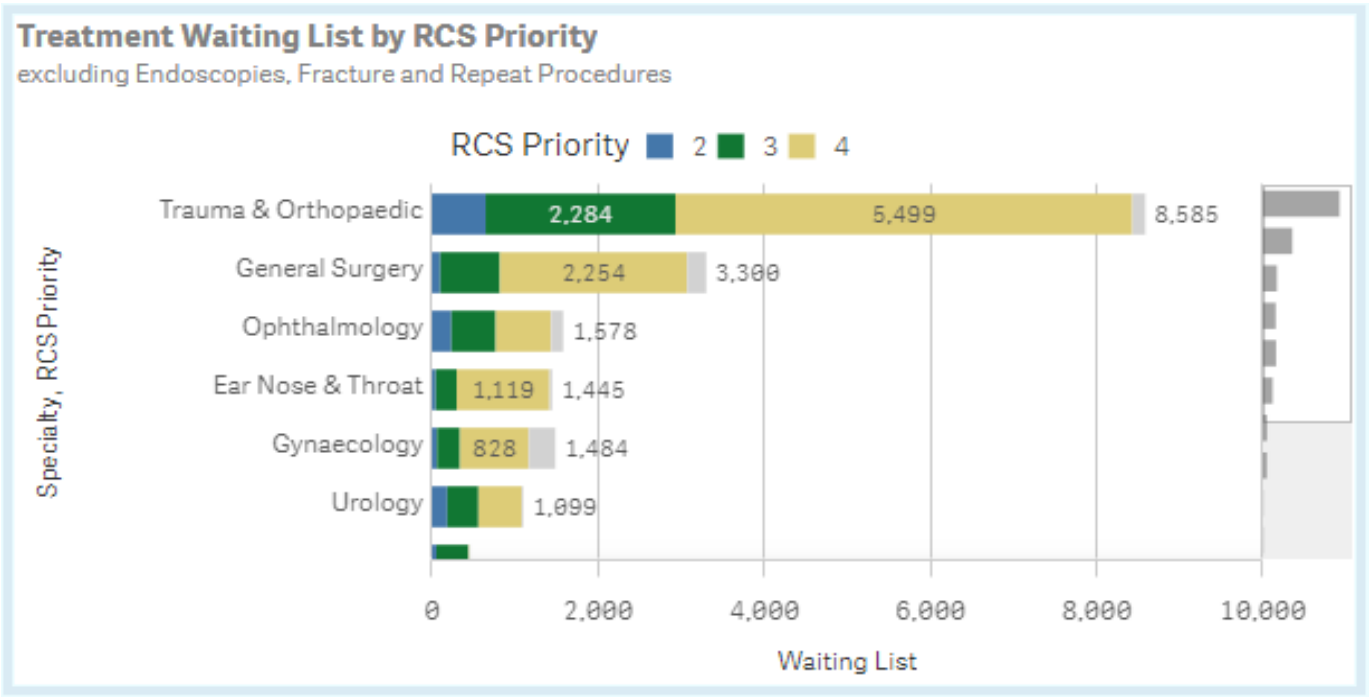
The outpatient programme focuses on driving improvement and change. The key to 'outpatient' sustainability is the ability to modernise its delivery through, for example, maximising non- face to face consultations via telephone, video, group consultations, attend anywhere, virtual consultations or assessments and advice only, embedding new processes such as See on Symptom (SoS) and Patient Initiated Follow-ups (PIFU), streamlining pathways and use of technology. The focus has been on the 52+ week new Outpatient waiting list clinical assessment process which will establish whether long waiting patients still require their appointment along with a clinical assessment. There is a robust process in place which has been underpinned by Welsh Government and which ensures that the patient and referrer are notified if a patient has indicated that they wish to be removed from the waiting list. This process is being rolled out to contact those patients who have been waiting over 36 to 51 weeks. Some other initiatives include determining where future services can be delivered, a communication strategy to keep in touch with patients who are on Health Board waiting lists, exploring new ways of working through technology, for example, a specialist advice system and roll out of video group consultations and the use of alternate staff groups whilst ensuring that there are close working links between Primary, Community and Secondary Care. The benefits of the programme will be an outpatient service that is designed around the needs of the patient, has access to services that is is timely and that patients are fully engaged in their treatment, promoting a culture of self-help and what matters?.

Operational divisions and support teams have worked collaboratively to restart services wherever possible, embracing new ways of working to maximise capacity and treat those at greatest risk. The Elective treatment plans are evolving with capacity gradually improving as the requirement for Theatre staff to support both wards and Critical Care diminishes. In addition, the Scheduled Care Division has introduced a number of measures to support the management of a "green" pathway within the Health Board across hospital sites. These measures protect some treatment capacity, but as national restrictions change over the next couple of months, these are likely to be reviewed to maintain this protection.

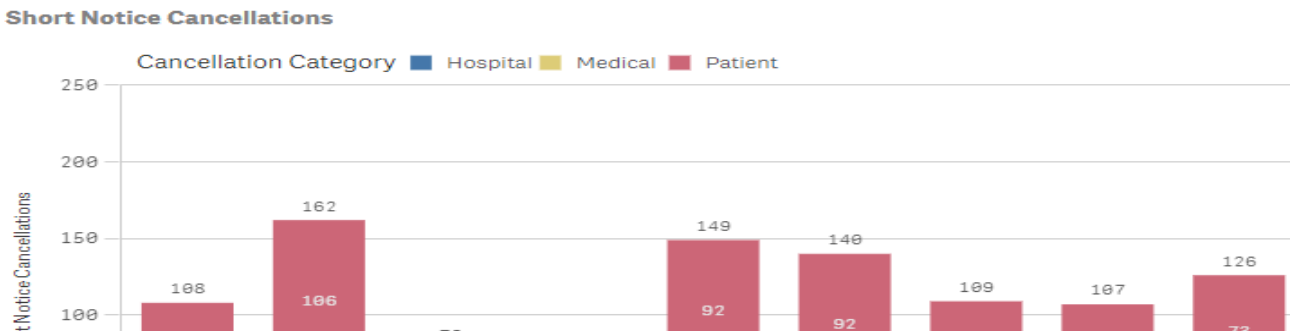
Elective inpatient admissions have been increasing but remain at a lower level than pre-COVID-19. This continued increase in routine elective services has been affected by the Omicron variant of COVID-19 which had been circulating widely, with decisions made to cancel or delay plans for some services in January. Elective activity dropped to a level last seen in September 2020 and was approximately 51% compared with a typical month prior to the commencement of the pandemic. Plans are expected to improve over the next few months; however, any additional work that will need to be undertaken to deal with the significant backlog may also still be affected by the implications of the current pension/tax issues for some of the Health Board's clinical staff.

The Royal College of Surgeons (RCS) introduced guidance on how and what pathways should be prioritised. Changes to incorporate the agreed RCS risk prioritisation on the national Welsh Patient Administration System (WPAS) has enabled services to apply a risk code of P2, P3 or P4 to those patients waiting for treatment on an inpatient or daycase waiting list with P2 being the highest risk.

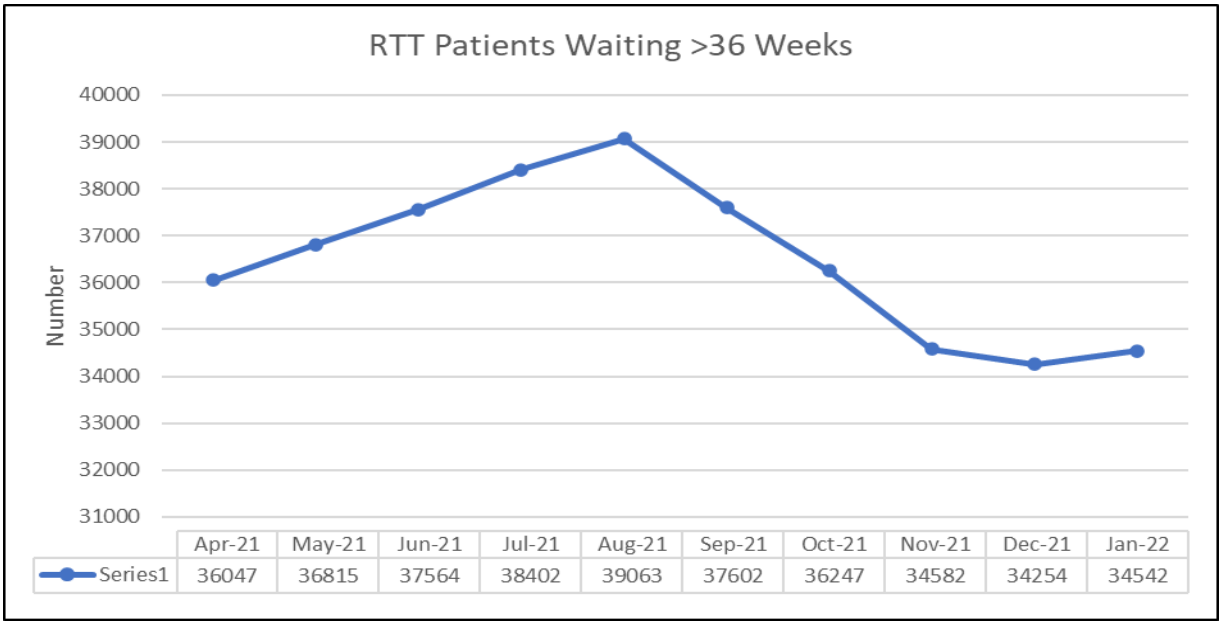
Capacity is planned and focused on treating those patients where they have been prioritised as being most at risk from harm. As part of the risk stratification process, patients must be re-assessed when they reach the priority target date. Current overall compliance of a risk priority applied to the inpatient and daycase waiting lists is 93% with 9% being prioritised as P2. The graphs below show the waiting list for the top six surgical specialties with a priority level and the number of P2 priorities that are within each specialty.



P2 patients are prioritised for admission. There are, however, a number of patients who decline the offer of treatment due to the pandemic or pre-admission Covid isolation requirements and prefer to remain on the waiting list. The breakdown of cancellations is shown below with patient cancellations making up the majority of cancellations each week. The actual numbers of cancellations each week are less than pre-pandemic levels, which were approximately 160 per week, but as a rate compared with activity, the numbers are similar. The number of short notice cancellations attributed to Covid-19 issues is minimal compared with the overall numbers. The Community Health Council are going to be undertaking a review to explore the reasons why patients are cancelling.



The most complex elective patients will be treated at the Grange University Hospital where some patients have been cancelled due to emergency pressures. The volume of elective patients waiting beyond 36 weeks increased slightly in January 2022 with 34,542 compared with 34,254 in December 2021. This is an improvement on the same period last year (37,680) and the position remains relatively static despite a reduction in the number of elective patients treated in December and January compared with the previous quarter. The chart below illustrates the decrease in the 36+ week breach patients which reflects the incremental increase overall, in the number of patients the Health Board has treated each month:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Series1	36047	36815	37564	38402	39063	37602	36247	34582	34254	34542

Of the patients waiting over 36 weeks at the end of January, approximately 20,728 of those are at the new outpatient waiting list stage. The table below shows that the Health Board currently has 111,114 open pathways at the end of January with 76,041 at the new outpatient waiting list stage. There are also 22,243 waiting over 52 weeks with 12,009 of those at the new outpatient waiting list stage. Of the 22,243 patients waiting over 52 weeks, 6,345 of those patients have been waiting over 104 weeks with 1,630 of those at the new outpatient waiting list stage.

Week Bands	1 Outpatient WL	2 Diagnostic	2 Therapy	3 Follow Up	4 Daycase WL	4 Inpatient WL	Grand Total
0 to 25	45002	2481	162	3565	8300	2303	61813
26 to 35	10311	797	61	948	1891	751	14759
36 to 51	8719	552	50	415	1670	893	12299
52 to 103	10379	486	82	674	2363	1914	15898
104 +	1630	334	58	245	2255	1823	6345
Grand Total	**76041**	**4650**	**413**	**5847**	**16479**	**7684**	**111114**

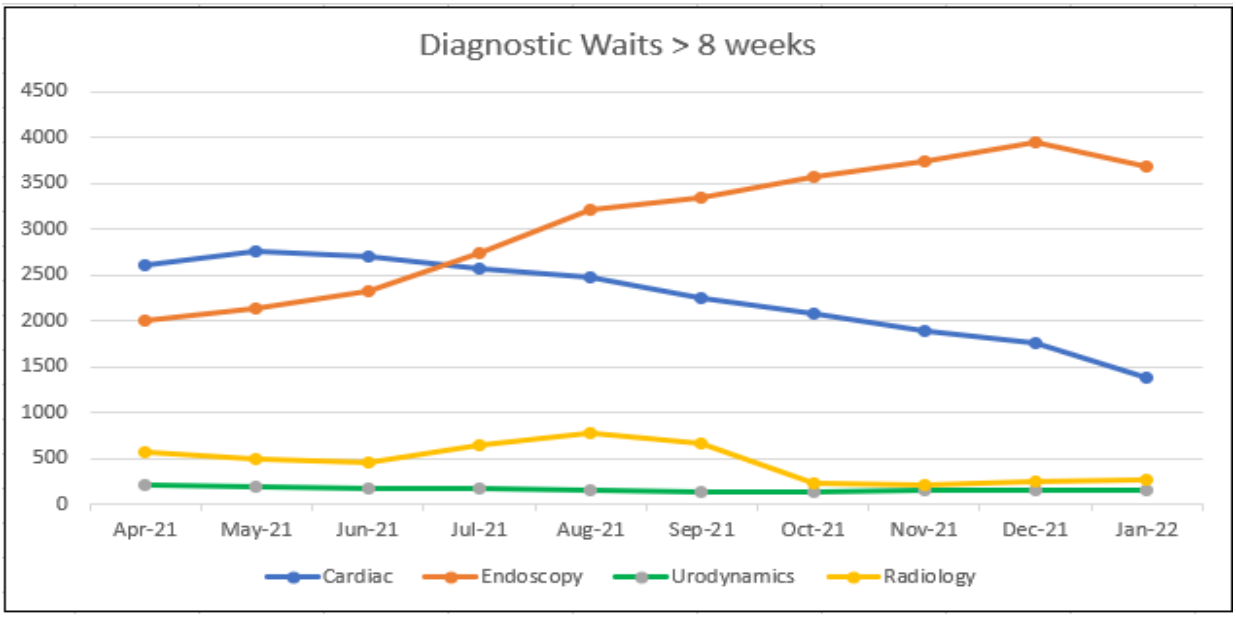
The impact of social isolation, social distancing and PPE requirements results in fewer patients being treated in a theatre session or outpatient clinic. It is envisaged this will continue to have an impact on waiting times for the near future.

The Health Board continues to commission elective treatments and outpatients with St. Joseph's Hospital and ophthalmology treatments with Care UK. Opportunities continue to be explored for additional capacity, along with other outsourcing / insourcing opportunities. This will be key in ensuring that the Health Board will be able to respond to the programme of revised Ministerial Priorities that have been introduced to tackle the backlog for the new financial year and longer term.

Diagnostic access

Service capacity is gradually increasing for all patients, although the backlog in patients needing to be seen and consequently requiring diagnostics is putting pressure on the services. The over 8 week position decreased in January 2022, with 5,495 waiting over 8 weeks compared with 6,120 in December.

The chart below illustrates the trend in the 8 week diagnostic waiting times since April. Endoscopy is the main area of concern and plans to address the backlog are being developed by the Division.



The following areas are noted as high risk in this month's report:

- The increase in the number of colorectal cancer referrals has increased the wait for more routine diagnostics. The FIT10 test was rolled out with a new pathway for lower GI USC and clinically assessed urgent referrals as part of demand management. The service continues to

insource additional capacity and the above graph indicates a slight reduction in the 8-week backlog. Despite further pressures with availability of staff which is affecting delivery through core theatres, the service anticipates that with service improvement and the additional insourcing capacity, the 8 week breach position will continue to improve over the next few months.

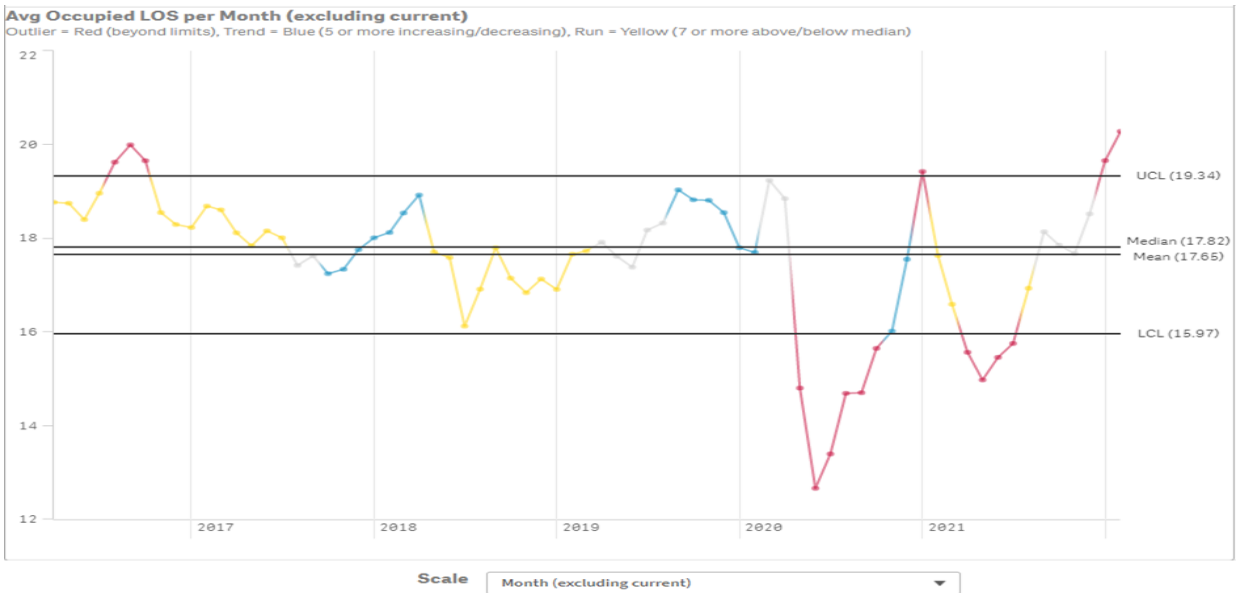
- Cardiology diagnostics have also been a concern. The numbers over 8 weeks, particularly for Echocardiograms, had increased month on month. With the procurement of an insourcing company to deliver additional echo capacity, there has been a reduction in the number of 8 week breach patients in January, the impact of which is evident in the graph above. This significant improvement is likely to continue particularly with the approval to continue the insourcing capacity next year.

- Radiology diagnostics continue to recover well, with a few areas of exception. The main backlog is in MSK ultrasound although the current performance is the best in Wales. Some areas where there have been some longer waits are with those patients who require a general anaesthetic and a dedicated session to proceed with the diagnostic. Cardiac Mibi remains an issue nationally and has been for a few years particularly with the isotope availability.

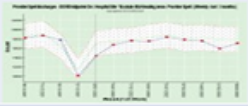
Unscheduled Care access

The urgent care system continues be under significant pressure both nationally, regionally and locally. This is in the context of significant workforce challenges, increasing demand for urgent primary care, increased ambulance call demand, increasing self-presenters at Emergency Departments and minor injury units, increased acuity linked to post lockdown impact, increased bed occupancy for emergency care and high levels of delayed discharges linked to significant social care workforce challenges. All of this is also in the context of ongoing presentations of COVID-19 and the need to maintain appropriate streaming of patients and increasing levels of elective work as part of the recovery programme.

This pressure on the urgent care system has resulted in patients staying in hospital for longer. Currently the average length of stay for patients admitted as an emergency is at its highest point since October 2016. The chart below illustrates the monthly average length of stay for patients admitted as an emergency:



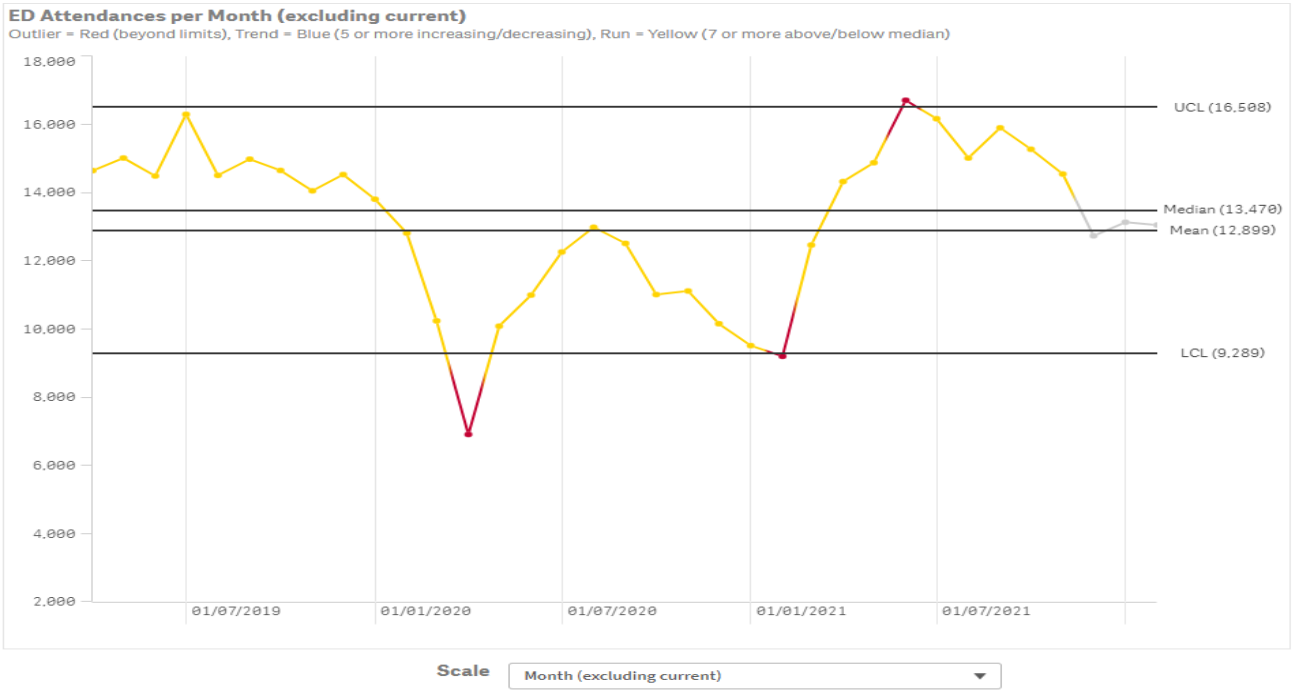
Other key metrics which are used to monitor the emergency care pressure include, length of stay over 21 days and delayed transfers of care (DToC). There have been recent improvements in both of these, illustrated in the table below:

Key Metric	Update	Signal explanation/ Comment	Chart/Graph
Ambulance lost hours <70hopes day			
ED Triage Time (0.25our target, weekly average)	**w/c 28.02.22** 0.55 hour weekly average	• Within projected profile.	
LOS over 21 days (weekly average)	**w/c 28.02.22:** 604 occupied beds	• Decrease in LOS over 21 days and back within profile.	
Ave Daily discharges (weekly)	**w/c 28.02.22** 243 daily average	• Lower range of projected profile	
DTOCS	**w/c 21.02.22:** Acute 55 Community 112	• Decrease in DTOCs • Acute daily average 55, 385 weekly total • Community daily average 88, 617weekly total	

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

- ***Emergency Demand***

Attendance at the Health Board's Emergency Departments (ED) had been increasing since the start of February 2021; however, December and January attendances decreased with just over 13,100 in January 2022 compared with over 14,500 attendances in November 2021, slightly lower than pre-pandemic monthly figures. The graph below provides an overview of the overall monthly ED attendances across the Health Board since April 2019. Attendances are expected to follow the typical seasonal trends in the coming months.



The Grange University Hospital continues to see a higher rate of patients being admitted than is the case for other emergency departments. The typical rate is 20% compared with 25% at the Grange University Hospital. This higher admission rate reflects the higher acuity of patients attending the Emergency Department, which consequently results in more patients staying longer than 12 and 24 hours.

The ambulance handovers over 60 minutes has increased compared with previous months. In January 2022, 791 patients waited over 60 minutes compared to the December position, where 720 were reported. The challenge in meeting this target is one that is experienced nationally and when compared with other Health Boards in Wales, Aneurin Bevan ranks in the higher performing Health Boards for January 2022.

Proactive steps have been taken to deliver improvement plans to support timely ambulance crew handovers. The following measures / actions are been implemented to support our ability to achieve the above:

- Cross site and Divisional Safety Huddles to ensure that there is a focus on and plans for patients who are delaying moves.
- Pre-empting to definite and/or potential discharges will then be instigated when crews are delayed for 2 hours (with no plans).
- A continued focus on delivering 3 – 5 moves per hour across the First Floor of the Grange University Hospital; these moves will be tracked and recorded at every site meeting.
- Patients must not be held on an ambulance for tests / investigations with a view to discharge. The patient will be brought in to the department, undergo their tests and then will be accommodated to either the Transfer Lounge or Fox Pod whilst they await their transport home.
- Proactive use of Launchpad. At cross-site meetings, Launchpad (Stack) numbers (Community demand) will be identified to support a forward plan, potentially pre-empting moves to accommodate the in-coming demand. The COM and NIC will aim to create plans to clear 6 x trolley spaces by 16.00hrs for late afternoon surge.
- Zero tolerance for 60 minute crew delays at eLGHs

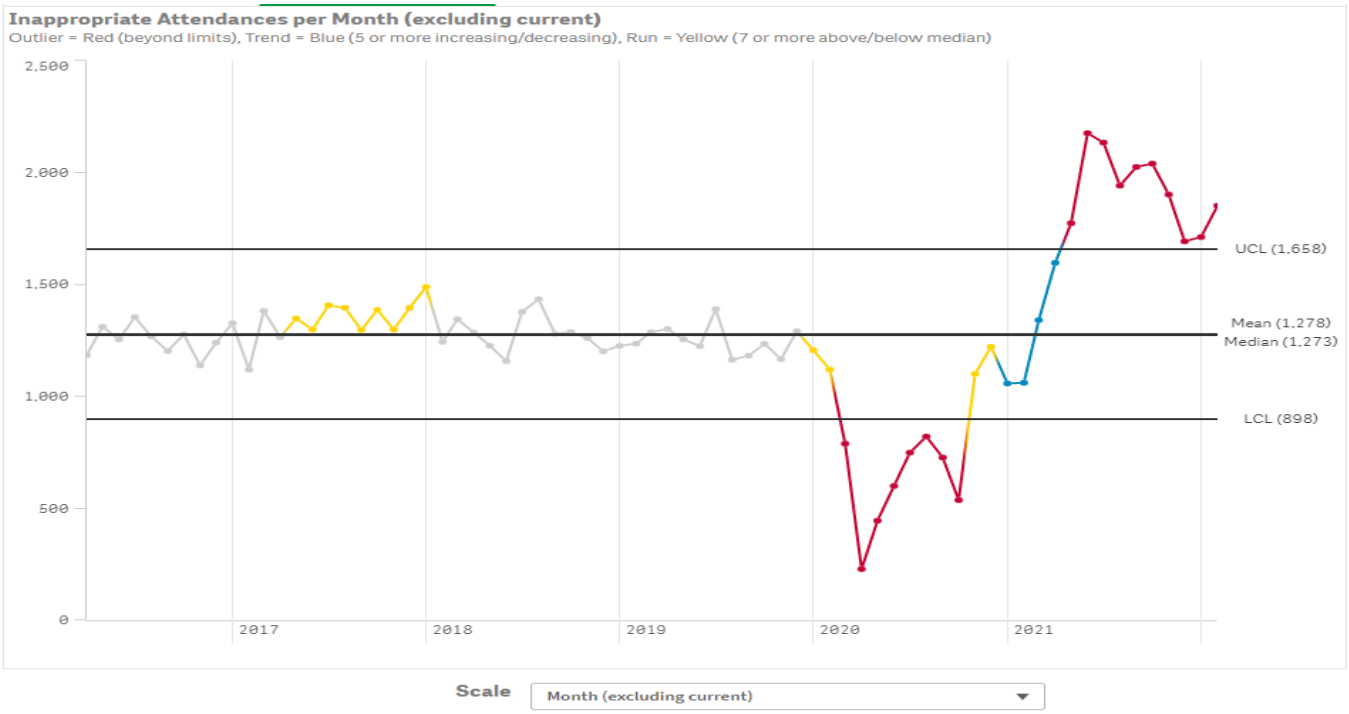
4 and 12 Hour Performance

The 4 hour compliance target improved in January 2022 with performance at 76.3% compared with 74.1% for December 2021. This was the highest performance of all 6 Health Boards with a major Emergency Department.

The performance measures are taken across all of the ED and Minor Injuries Units in the Health Board and it is performance at the Grange University Hospital that has been the most challenging. Performance against the number of 12 hour breaches has improved slightly with 1241 waiting over 12 hours in January 2022, compared with 1270 in December 2021. Performance at other sites in relation to the 4 hour waits are consistently in the high ninety percent.

There are a number of factors that impact on the flow of patients within the Grange University Hospital (GUH). The type of patients attending at the Emergency department are those with more serious conditions. Consequently, these patients tend to flow through the system at slower pace,

depending on the number and type of diagnostics required and working within Covid-19 guidelines. Given the clinical condition of patients, they are more likely to be admitted to the GUH or may require step down to e-LGH sites. However, as already referred to above, there may be a number of patients attending who could be seen more appropriately in other health settings. The graph below illustrates that the number of patients attending the Health Boards Emergency Departments (including MIU's) each month who are deemed 'inappropriate'. An inappropriate attendance is when the patient has been reviewed by a clinician and the condition the patient is presenting with is deemed as more appropriate to be seen in another health care setting. This number has increased significantly from the typical monthly median of 1250 prior to April 2021 to approximately between 1800 and 2000 each month since April 2021.



Other factors that can delay patients in ED are the turnaround times for Covid-19 testing, bed availability and conveyance of patients to other sites. However, the level of focus provide assurance that the Health Board is fully committed to ensuring the delivery of safe and effective urgent and emergency care services.

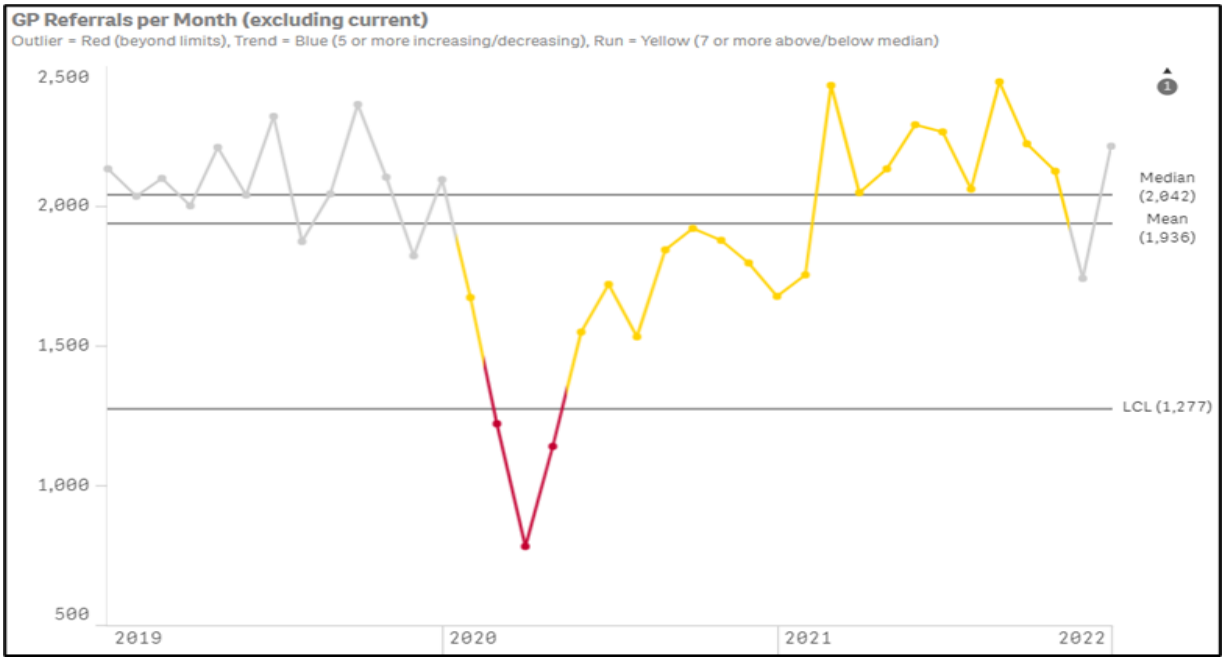
It should be noted the community health and social care system is under intense pressure with a significant gap in the availability of domiciliary care provision, rehabilitation placements and Care Home access.

Continued pressures on bed capacity and staffing levels across the hospital system is a significant issue which continues to impact on flow and capacity.

The Urgent Care Plan is a fundamental component of the Health Board's Winter Plan and is overseen by the Urgent Care Transformation Board. Through March NHS Wales has been engaged in a process of 're-set' to try and rebalance pressures and reduce the risk across the health care system.

Cancer Access, including Single Cancer Pathway

Suspected cancer referrals in January have continued to exceed 2k referrals per month. The rapid sustained demand this year is having an onward impact on performance, creating capacity challenges throughout the pathway both in the Health Board and for those patients requiring surgery at tertiary centres



The variance seen in referral rates between tumour sites continued into January's figures. Despite the biggest drop in referrals being seen within colorectal and breast, the referral numbers are still well above what may have been expected in 2020.

Managing this sustained level of demand in these busy tumour sites is the primary focus of delivery teams with considerable recruitment plans in place to support the services. Maintaining diagnostic waiting times remains a challenge.

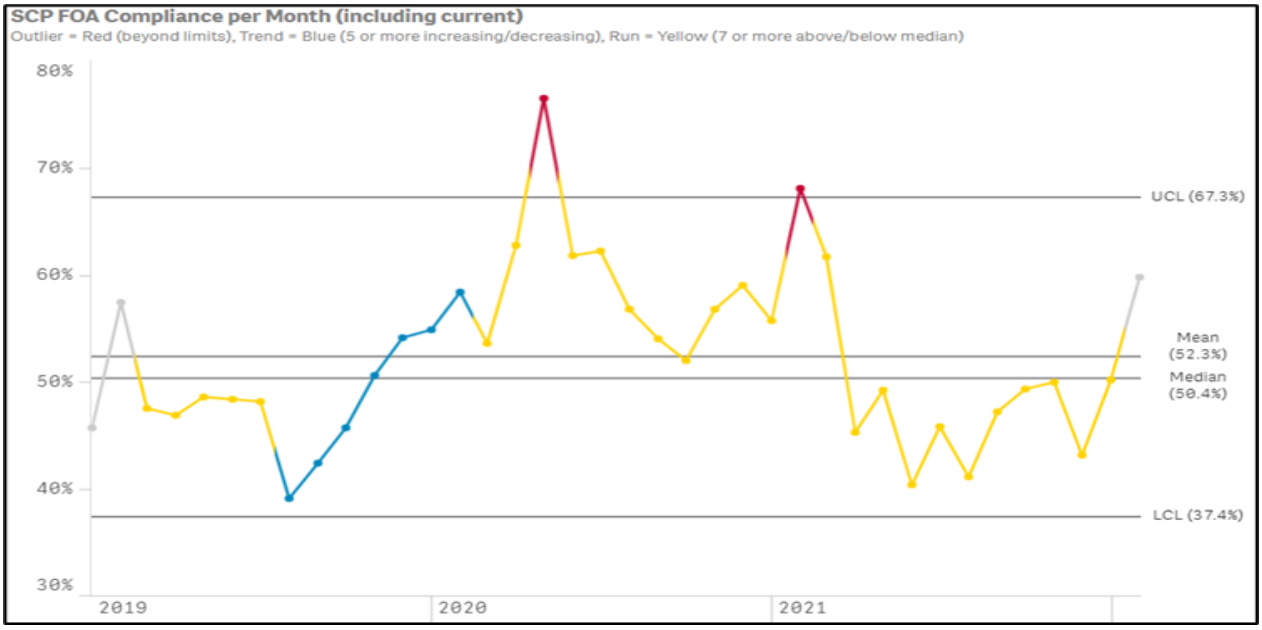
	Breast	Colorectal	Gynae	Haem	H&N	Lung	Skin	UGI	Urology
Jan-22	445	582	227	25	211	77	404	379	250
Jan-20	339	420	301	41	234	127	365	376	203
% diff	31.3%	38.6%	-8%	-39%	-9.8%	-39.4%	10.7%	0.8%	25.2%

The Omicron variant has had a noticeable impact on Cancer Pathways with increasing numbers of patients being unable to attend appointments due to positive cases or the need to self-isolate. There are also increasing rates of staff absenteeism which, whilst being actively managed, is influencing deliverable capacity.

The Single Cancer Pathway performance position closed at 56.6% in January. This position reflects the considerable challenges being faced by teams in managing the current levels of demand, whilst recovering the routine position and maintaining high pressure urgent care demand The effect of the festive period in combination with the COVID case rates in January has impacted on the anticipated improvement. Workforce has been the biggest challenge to delivery of cancer services, which is being exacerbated by the current infection rates and the need for self-isolation. Despite these challenges, cancer activity has been sustained and treatment numbers continue to be delivered which are aligned to previous years.

The pressure within Breast and Colorectal, stemming from high referrals rates and staffing shortages, particularly in Breast, is having a disproportionate effect on the performance position with higher than usual breach numbers. Lung is the only tumour site with a level of demand significantly below pre-covid numbers and this is reflected in the treatment numbers.

This referral demand will have an impact on other measures and future performance particularly the 2 week first seen compliance. However, the graph below highlights that meeting the 2 week target is currently challenging. There have been significant improvements in timely access to first appointments in LGI, Gynaecology, Lung and Head and Neck. The bottlenecks for outpatients are primarily within specialist tumour subsites including Maxfax and Haematuria. Breast pathways are struggling more than ever to accommodate the demand given the reduction in workforce.



Cancer delivery task and finish groups are now embedded within Breast, Urology and Colorectal tumour sites with a focus on recovering the SCP performance position. Pathway development work continues within Gynaecology, Head and Neck, and Lung.

Capacity challenges at the Grange University Hospital have resulted in delayed treatment for some patients requiring more intensive recovery beds and "green" beds resulting in some on the day cancellations. Delays to the start of the pathway continue to be the largest contributing factor to breaches along with limitations in certain diagnostic capacity which mainly affects those pathways requiring multiple diagnostics. The high demand for colorectal services continues to have a significant impact on CT rates in radiology and, in addition to a shortage of radiologists, the loss of the outsourcing reporting company has resulted in slower reporting times and is causing considerable delays to the cancer pathway. Reducing this wait remains a priority for tumour sites whilst managing the influx of referrals and restarting routine work.

Delivery of a 62-day optimal cancer pathway is complex involving multiple divisions, departments, clinical and administrative teams and increasingly involves diagnostics and treatments within tertiary centres. SCP capacity, however, is competing with the urgent clinical pathways, which have also been affected significantly by Covid. The implementation of optimal pathways to resolve the current cancer position requires broader planning given its potential impact on other services. The Optimal Pathway manager has focused on delivering pathway efficiencies alongside tumour site clinical and administrative teams, to help meet the National Optimal Pathways.

The Health Board's wider ongoing developments including Breast Cancer Unit, Satellite Radiotherapy Centre and delivering of specialist services under the Clinical Futures strategy are all underpinned by successful optimal cancer pathways. Services will need to consider a broader planning approach to be able to implement these optimal pathways and how these could improve the current cancer position and its potential impact on other services.

Stroke Care

The Hyper Acute Stroke Unit (HASU) at the Grange University Hospital (GUH) opened on 16th November 2020 with 15 beds plus 1 therapy room. The entire ward has 32 beds, with the other 16 beds are normally occupied with Haematology and Surgical patients. Since opening the HASU at GUH, the main challenge has been maintaining available acute stroke capacity when a stroke patient is first admitted and then providing timely transfers onto the e-LGHS. The urgent pressures have made it particularly difficult to protect beds for acute stroke patients and the performance has been severely impacted.

The proportion of stroke patients directly admitted within 4 hours dropped to 12.5% in January 2022 compared with 18.5% in December. The service has identified several challenges that continue to impact on flow through the stroke pathway. Transferring patients from GUH to the eLGHs on a timely basis has been persistently difficult, due to availability of stroke rehabilitation capacity. The service continues to try to resolve these issues but acknowledges that this is particularly difficult when stroke capacity is not ringfenced.

In January 2022, the performance dropped for only the second time since 2018 with the percentage of patients assessed by a stroke consultant within 24 hours at 78.9% against a target of 85%. The percentage of stroke patients receiving the required minutes for speech and language therapy improved in January with 28.1%, however earlier in the year performance was around 40-50% compliant. The Health Board has agreed additional funding for speech and language services which should help to continue to improve performance in this area. A review of therapy services across the stroke pathway has been undertaken to map the existing therapy workforce against clinically recommended levels in each setting. The report highlighted that gaps in specialist stroke therapy cover varied between professions and between sites which is further complicated by those staff having to travel between sites where hyper-acute and rehabilitation services are not delivered on the same site. The review forms part of the stroke recovery plan and the focus will be to ensure that there is equitable therapy provision and for the stroke service to determine the best use of its finite resources and the requirement for future stroke therapy provision.

Thrombolysis rates for all stroke patients were lower in January at 11%. The weekly thrombolysis review is still ongoing to identify any opportunities to improve thrombolysis performance. An earlier review of the data identified that patients have not arrived at the Grange University Hospital on a timely basis and in some cases, there have been delays in referral to the HASU and stroke team.

The service has struggled to recruit into a vacancy for a Stroke Consultant. However, it has been agreed for the service to develop a joint post to cover Acute Medicine and Stroke which it is anticipated will attract a wider interest from applicants and will support both the Stroke service and the Medical Assessment unit.

As part of the ongoing improvement work the Stroke Directorate has engaged with an external provider called "Getting it Right First Time" for a specialty review. The specialty review will involve a local data pack being produced detailing ABUHB's stroke performance data, followed by a series of meetings with members of the Stroke MDT including Senior Operational Managers and Divisional Leads. The review will examine a wide range of factors, from length of stay, access to the HASU and rehabilitation sites, patient mortality, sharing of best practice, areas for improvement and individual service costs through to overall budgets.

The first meeting was planned for January 2022 and the peer review will be undertaken in May 2022. The findings of the review will be discussed and taken forward in the Stroke Directorate

Meeting and progress will monitored through the Stroke Delivery Board with assurance to the Patient Quality, Safety & Outcomes Committee.

Mental Health

CAMHS

Sustained performance of the CAMHS measure of 80% is reported, with 96.2% of patients waiting less than 28 days for a first appointment at the end of January 2022. The implementation of the SPACE wellbeing (development of single point of access, multi-agency panels) which is operational in all five local authority areas has continued to have a positive impact on access to services.

Access to services on the CAMHS Neurodevelopmental (ND) pathway of children waiting less than 26 weeks to start an ADHD or ASD neurodevelopmental assessment deteriorated in January 2022 to 65.7% compared with 68.1% in December 2021 against the target of 80%. During the COVID 19 pandemic, the core ND team was able to maintain the pathway by carrying out virtual initial assessments but as lockdown has eased and face to face appointments re-started, this has resulted in a backlog of follow up appointments for the children undergoing a neuro-developmental assessment and has inevitably delayed the conclusion of the assessments. A recovery plan was implemented to support the core ND team and it was agreed that the focus would be on managing the backlog through initiatives to allow the core team to clear ongoing caseloads.

From September 2021, the booking of ND assessments has been streamlined i.e., booking the initial appointment and clinical observation appointment within 4 weeks. All children and young people undergoing an ADHD assessment will automatically have a school observation rather than a 1:1 clinical observation. The aim is to be able to keep the waiting list moving more fluidly acknowledging that there will be more complex cases that require school observations to gather more evidence and additional ADOS (Autism Diagnostic Observation Schedule assessments).

Primary Care Mental Health

Performance against the 80% target for Primary Care Mental Health Measures for assessment and intervention within 28 days has deteriorated significantly in January 2022 with 48.2% and 14.1% respectively.

Compliance with the 80% assessment target had been maintained until December mainly as a result of the service being able to carry out assessments utilising non face to face methods. The number of assessments carried out in January 2022 was significantly lower than the last two years due to the scheduled redeployment of one third of the staff to support secondary care services during the Omicron wave. A full re-deployment was prepared for, which meant cancelling assessment and therapy appointments but as only a partial re-deployment was required, the patients that were re-booked could not all be booked within the 28-day window. In addition, the service had absences not only with the service Practitioners but also with the administrative support teams and the secondary care practitioners who regularly provide assessment clinics.

The continued deterioration in intervention performance is in part due to the service focusing on the assessment part of the pathway. Consistent with Welsh Government guidance, there has been an enhanced focus on ensuring that all patients receive the initial assessment with a registered mental health practitioner. This is an approach which aims to minimise the number of interactions with different practitioners and to direct patients to the most appropriate care and support first time. Where therapy is indicated, the aim has been to maintain care interventions with the same practitioner. As these longer waiting patients have started their intervention, this has consequently, had a negative impact on performance. A recovery plan was developed to reduce

waiting lists for therapeutic intervention by March 2022 whereby the service would again be compliant with the Initial Intervention performance target. However, whilst waiting lists for counselling and low intensity intervention have reduced to some extent, it is unlikely that that the target can be achieved by the end of the year due to the numbers waiting for trauma based therapy remaining a key challenge.

The MELO website which offers free, self-help resources in looking after mental wellbeing, is fully up and running, offering a strong Foundation Tier. This has been co-developed with Public Health Wales, with funding for continued revision, development and marketing. Virtual stress control classes have also been running and is promoted through the MELO social media platform and practitioners to improve take-up.

Where face to face appointments have resumed, issues remain with suitable accommodation to hold clinics which allow for appropriate social distancing. Room availability to provide face to face therapy has remained an issue with more services competing for the same accommodation. This is in part due to a lack of rooms available in GP surgeries and many community premises remaining closed. This is a recurring theme across directorates within the Mental Health and Learning Disability Division and with Family and Therapies for children and young people. Transforming the service to provide therapy remotely requires significant changes to clinician practice.

A recovery plan is being implemented which focuses on reducing waiting list volumes and reducing waiting times in both measures and arrangements are in place for approximately two thirds of the PCMHSS waiting list to be addressed. Commissioned services have struggled to employ therapists in the numbers required. Any recovery will be later than planned due to the provider being unable to implement the contract. This is being looked at with procurement with the intention of setting up a framework. In addition, recruitment to the vacant posts is key in being able to provide a sustainable service. This will support continuation of service delivery in line with contracts that have been awarded but these would need to continue at least for the first nine months of the new financial year to ensure that waiting lists do not increase further.

Despite the many challenges described, and loss of some staff, the service is focussed on improving performance, although it is anticipated that the position will not start to improve for some interventions not fully met until the new financial year.

Psychological Therapy

A sustained improvement in performance since April 2021 is reported for psychological therapy in Specialist Adult Mental Health, with 77.2% of patients waiting less than 26 weeks for treatment at the end of January 2022, an improvement on December performance of 75.7% against a target of 80%.

Performance is calculated based on combined compliance for Adult, Older Adult and Learning Disabilities (LD) services. However, the Older Adult service has achieved performance levels above 80% with 94% in January consistently. This has been the case following the re-introduction of face-to-face contacts. The Older Adult group has similar rates of mental health challenges as working age adults, yet referrals to primary and secondary care mental health services are at a much lower rate. The challenge ahead is to identify the factors that influence this situation and to ensure that the plans address this.

With regards to Adult Services, the service has plans to continue to improve performance and reduce long waiters. The service has introduced new procedures to see service users whilst at the same time making better use of clinical resource. Going forward, an important part of the service strategy is to continue to increase access to proportionate interventions in a timely way through the provision of interventions in a group format. The work includes piloting a centralised group

quality improvement program which will aim to pool resources for delivering group interventions and increase service user involvement in design and delivery. This has the potential to free resource within the Community Mental Health Teams (CMHT) therefore improving access to person-centred individual tailored approaches for those that need it. In addition to general improvement plans, each area is currently working on developing improvement plans relevant to local need. This initiative has also ensured easier access to group interventions by offering service provision in the evenings. Furthermore, the provision of evidence-based psychological intervention outside of CMHTs (within Part one of the Mental Health Measure) has facilitated some flow through internal waiting lists.

The service has benefitted from increased provision of highly specialist practitioner psychologist sessions providing assessment and intervention for those with more complex and enduring psychological needs and guiding intervention plans for those with moderate needs. The provision of these extra sessions has ensured that the service can maintain quality assurance through clinical supervision and outcomes monitoring and is an approach that is being considered to continue into the next financial year and, if possible, on a permanent basis.

It is widely anticipated that there will continue to be significant mental health consequences of the COVID-19 pandemic and public health control measures. Isolation, loneliness and disconnection are commonly reported. Many people within the community have experienced significant loss and trauma. Psychological therapies are the indicated intervention in such circumstances and the service still anticipates a significant rise in referrals once services return to a more normal state. Long-term, the aim is to provide and promote accessible and preventative mental health care. An action plan is under development, which may require increased workforce and financial support.

Care and Treatment Plan Compliance

An improvement in performance in the overall percentage compliance of valid care treatment plans completed is reported, with 85.7% of patients having a care treatment plan in January 2022 against the target of 90%. The reporting in the Delivery Framework is now split by age band in over and under 18 years of age. The under 18 compliance is 98% for January, above the target of 90% and 82% for 18 years and over. There has been a significant amount of work undertaken over the past couple of months to clear the backlog of care treatment plans to improve compliance, which should see sustainable improvement.

Service Recovery Plans

In addition to restarting many routine services, the Health Board is implementing a range of recovery plans – further details are set out in the finance report. These include increasing acute, community based and mental health services, along with investing in alternative services, such as weight management, alcohol care services based on greater preventative support and improving health outcomes.

Outcome measures

In the Health Board's Annual Plan 2021-2022, focus is placed on the patient first so that every individual using the services whether at home, in the community or in hospital, has a positive experience. To do this the quality and safety of the care and services is core throughout all of the Health Board's plans and which will have a focus on enabling a safety culture that minimises preventable harm, improves outcomes and experience and eliminates variation and waste.

There is a time lag to the data but to introduce this approach, 2 outcome measures have been included in the attached graphs:

- Emergency readmission within 28 days following hip fracture
- Heart failure readmissions within 30 days

It is anticipated that future reports will include an update from relevant services to provide some context

This provides a summary of the actions being undertaken to deliver and/or improve performance against the range of organisational and national targets.

Recommendation
The Board is asked to: • NOTE current Health Board performance to include trends against the national performance measures and targets and progress with service recovery.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report highlights key risks for target delivery.
Financial Assessment	The delivery of key performance targets and risk management is a key part of the Health Board's service and financial plans.
Quality, Safety and Patient Experience Assessment	There are no adverse implications for QPS.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no implications for Equality and Diversity impact.
Health and Care Standards	This proposal supports the delivery of Standards 1, 6 and 22.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides a progress report on delivery of the key operational targets
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	An implementation programme, specific to ABUHB has been established to support the long term sustainable change needed to achieve the ambitions of the Act. The programme, will support the Health Board to adopt the five ways of working and self-assessment tool has been developed, and working with corporate divisions through a phased approach sets our ambition statements for each of the five ways of working specific to the Division and the action plan required to achieve the ambitions.
	Long Term – *can you evidence that the long term needs of the population and organisation have been considered in this work?*
	Integration – *can you evidence that this work supports the objectives and goals of either internal or external partners?*
	Involvement – *can you evidence involvement of people with an interest in the service change/development and this reflects the diversity of our population?*
	Collaboration – *can you evidence working with internal or external partners to produce and deliver this piece of work?*
	Prevention – *can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health?*
Glossary of New Terms	

Integrated Performance Dashboard — January 22

Domain	Sub Domain	Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend	Performance Trend (13 Months)	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement	RTT	Patients w aiting less than 26 w eeks for treatment	Jan-22	95%	58.3%	58.4%	↓		54.4%	54.8%	56.2%	56.6%	55.9%	57.5%	59.0%	59.0%	58.5%	58.5%	59.4%	58.4%	58.3%
		Patients w aiting more than 36 w eeks for treatment	Jan-22	0	34542	34254	↓		37680	36283	35367	36047	36815	37564	38402	39063	37602	36247	34582	34254	34542
		Patients w aiting more than 8 w eeks for a specified diagnostic	Jan-22	0	5495	6120	↑		10523	7978	5707	5375	5581	5675	6128	6605	6406	6015	5979	6120	5495
		Patients w aiting more than 14 w eeks for a specified therapy	Jan-22	0	1111	891	↓		484	547	838	366	245	256	311	460	506	526	629	891	1111
	Follow Up	Number of patients w aiting for a follow -up outpatient appointment	Jan-22	69268	112312	113705	↑		107596	104356	104511	105936	107248	107236	108392	109467	111078	112419	112915	113705	112312
		Number of patients w aiting for a follow -up outpatient appointment w ho are delayed by over 100%	Jan-22	3903	18604	18504	↓		13679	13520	12739	14047	14583	15338	16153	16691	17449	18293	17805	18504	18604
	HRF	% of R1 patients w ho are w aiting w ithin 25% in excess of their clinical target date	Jan-22	95%	58.6%	59.4%	↓		40.6%	42.3%	43.4%	46.3%	46.8%	49.4%	54.7%	56.2%	58.3%	57.3%	60.0%	59.4%	58.6%
	STROKE	% stroke patients directly admitted to acute stroke unit ≤4 hours	Jan-22	50%	12.5%	18.5%	↓		30.8%	20.0%	40.0%	49.2%	32.7%	31.7%	26.5%	26.8%	24.6%	19.3%	8.2%	18.5%	12.5%
		% of stroke patients assessed by a stroke consultant ≤24 hours	Jan-22	85%	78.9%	77.8%	↑		98.5%	100.0%	97.2%	100.0%	94.6%	96.7%	94.2%	93.1%	96.8%	91.5%	87.1%	77.8%	78.9%
		% of stroke patients receiving the required minutes for speech and language therapy	Jan-22	57%	28.1%	13.1%	↑		43.3%	24.0%	50.8%	45.2%	41.5%	25.8%	33.0%	30.4%	27.9%	27.8%	15.5%	13.1%	28.1%
	ED	Category A ambulance response times w ithin 8 minutes.	Jan-22	65%	56.5%	57.6%	↓		59.2%	64.6%	62.0%	60.3%	56.6%	60.1%	61.5%	64.4%	55.1%	56.3%	57.2%	57.6%	56.5%
		Number of ambulance handovers over one hour	Jan-22	0	791	720	↓		773	590	853	880	925	744	698	711	674	694	804	720	791
		% patients w aiting < 4 hrs in A&E figures inc. YAB & YYF	Jan-22	95%	76.3%	74.1%	↑		80.4%	79.7%	76.8%	78.3%	74.5%	76.0%	73.1%	70.0%	68.4%	66.9%	71.9%	74.1%	76.3%
		Number patients w aiting > 12 hrs in ABUHB A&E departments	Jan-22	0	1241	1270	↑		922	796	963	933	1055	1101	1339	1303	1499	1724	1413	1270	1241
	Cancer	Percentage of patients starting first definitive cancer treatment w ithin 62 days from point of suspicion	Jan-22	75%	56.6%	66.7%	↓		58.9%	57.1%	65.9%	67.4%	71.9%	67.7%	65.8%	71.1%	58.4%	59.1%	58.1%	66.7%	56.6%
	MENTAL HEALTH	Assessment by LPMHSS w ithin 28 days of referral.	Jan-22	80%	48.2%	86.3%	↓		80.2%	94.3%	88.3%	86.3%	83.1%	92.2%	88.1%	82.5%	84.4%	89.9%	88.9%	86.3%	48.2%
		Interventions ≤ 28 days follow ing assessment by LPMHSS.	Jan-22	80%	14.1%	22.3%	↓		54.0%	67.9%	62.6%	47.6%	57.8%	58.7%	50.4%	37.5%	29.3%	20.7%	22.6%	22.3%	14.1%
		Percentage of patients w aiting less than 26 w eeks to start a psychological therapy in Specialist Adult Mental Health	Jan-22	80%	77.2%	75.7%	↑		64.6%	65.8%	64.6%	61.4%	62.7%	66.7%	70.0%	71.6%	68.8%	74.6%	77.5%	75.7%	77.2%
	CAMHS	4+ Weeks Waiting List	Jan-22	80%	96.2%	94.7%	↑		98.2%	100.0%	100.0%	100.0%	100.0%	98.7%	98.7%	92.6%	100.0%	98.2%	100.0%	94.7%	96.2%
		Neurodevelopmental (iSCAN) Waiting List	Jan-22	80%	65.7%	68.1%	↓		89.9%	89.9%	90.4%	87.9%	80.0%	80.9%	94.8%	76.3%	71.5%	77.2%	76.8%	68.1%	65.7%
	HCAIS	Cases of e coli per 100k population (rolling 12m)	Jan-22	67	56.34	55.5	↓		52.46	49.1	49.65	52.34	52.68	54.03	53.66	52.66	51.99	54.16	54.66	55.5	56.34
		Cases of staph aureus per 100k pop (rolling 12m)	Jan-22	20	22.57	23.91	↑		23.86	25.21	26.42	26.76	27.27	27.43	24.74	24.24	24.91	24.57	24.24	23.91	22.57
		Clostridium difficile cases per 100k pop (rolling 12m)	Jan-22	25	31.76	32.26	↑		25.04	24.9	24.6	25.08	24.74	27.27	28.42	29.6	29.9	29.92	31.43	32.26	31.76
		Cases of klebisella per 100k population (rolling 12m)	Jan-22		16.38	17.55	↑		20.14	18.95	19.5	18.85	18.85	19.86	19.56	17.7	16.55	17.22	17.55	17.55	16.38
		Cases of aeruginosa per 100k population (rolling 12m)	Jan-22		5.02	5.18	↑		4.23	3.72	4	4.54	4.21	4.7	4.68	4.9	5.18	5.18	5.52	5.18	5.02
	HIP FRACTURE	Percentage of survival w ithin 30 days of emergency admission for a hip fracture	Oct-21	93.33%	90.7%	88.9%	↑		92.3%	92.4%	89.4%	100.0%	94.9%	95.1%	92.1%	97.5%	88.9%	90.7%			
Aim 1: People in Wales have improved health and well-being with better prevention and self-management	SMOKING CESSATION	Percentage of adult smokers w ho make a quit attempt via smoking cessation services	Sep-21	1.25%	2.2%	NA	↓				3.3%			1.1%			2.2%				
	CHILDHOOD IMMUNISATION	Percentage of children w ho received 2 doses of the MMR vaccine by age 5	Sep-21	95%	91%	NA	↓				93%			91%			91%				
		Percentage of children w ho received 3 doses of the hexavalent '6 in 1' vaccine by age 1	Sep-21	95%	96%	na	↓				96%			96%			96%				
	MENTAL HEALTH	Percentage of health board residents in receipt of secondary mental health services w ho have a valid care and treatment plan (under 18)	Jan-22	90%	98%	94%	↑		54%	54%	64%	74%	90%	92%	95%	98%	93%	98%	98%	94%	98%
		Percentage of health board residents in receipt of secondary mental health services w ho have a valid care and treatment plan (18 years and over)	Jan-22	90%	82%	83%	↓		58%	60%	64%	72%	76%	77%	83%	85%	84%	88%	87%	83%	82%
Aim 3:The health and social care workforce is motivated and sustainable	COMP	Timely (30 day) handling of concerns and complaints	Sep-21	75%	76%	77%	↓		64%	65%	74%	78%	78%	75%	70%	77%	76%				
	W&D	% PADR / medical appraisal in the previous 12 months	Dec-21	85%	59%	59%	↓		58%	56%	58%	60%	60%	60%	58%	57%	58%	58%	59%	59%	
		Monthly % hours lost due to sickness absence	Dec-21	6%	7%	7%	↓		7%	6%	5%	5%	5%	5%	6%	6%	7%	7%	7%	7%	
		Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framew ork by organisation	Aug-21	85%	77%	77%	↑		76%	76%	76%	76%	76%	77%	77%	77%					
Aim 4:Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes	CRITICAL CARE	Critical care delayed transfers of care (4 hrs) days lost - GUH	Dec-21	76.3	65.0	67.0	↑		30	37	55	76	91	117	98	109	87	83	67	65	
	HIP FRACTURE	Prompt Orthogeriatric Assessment	Dec-21	93%	91%	91%	↑		96%	96%	96%	94%	93%	93%	93%	92%	92%	91%	91%	91%	
	MORTALITY	Crude hospital mortality rate (74 years of aged or less)	Dec-21	1.24%	1.16%	1.15%	↓		1.4%	1.5%	1.4%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	
	SEPSIS SIX	Percentage of in-patients w ith a positive sepsis screening w ho have received all elements of the 'Sepsis Six' first hour care bundle w ithin 1 hour of positive screening	Nov-21	50%	100%	0%	↑		35%	44%	29%	43%	38%	67%	86%	43%	63%	0%	100%		
		Percentage of patients w ho presented to the Emergency Department w ith a positive screening w ho have received all elements of the 'Sepsis Six' first hour care bundle w ithin 1 hour of positive screening	Nov-21	30%	0%	8%	↓		54%	36%	55%	43%	33%	39%	33%	32%	3%	8%	0%		
	CODING	Percentage of episodes clinically coded w ithin one reporting month post episode discharge end date	Nov-21	95%	86%	87%	↓		84%	85%	79%	73%	60%	86%	87%	86%	87%	87%	86%		
	AGENCY	Agency spend as a percentage of total pay bill	Aug-21	8%	8%	6%	↓		10%	9%	11%	8%	6%	8%	6%	8%					
Efficiency & Productivity	Theatre	Theatre Utilisation (RGH)	Jan-22	85%	81.0%	83.7%	↓		78.9%	81.5%	80.7%	85.0%	85.6%	87.8%	86.3%	88.0%	84.7%	86.2%	86.7%	83.7%	81.0%
		Theatre Utilisation (NHH)	Jan-22	82%	84.3%	81.8%	↑		82.1%	91.9%	85.6%	84.0%	78.5%	79.8%	76.3%	86.0%	75.5%	75.7%	83.5%	81.8%	84.3%
		Theatre Utilisation (GUH)	Jan-22	66%	68.9%	67.1%	↑		55.2%	60.3%	63.4%	67.0%	68.9%	68.9%	70.0%	72.0%	65.4%	71.5%	65.6%	67.1%	68.9%
	Average LoS	Elective Surgical AvLoS (RGH)	Jan-22	3.24	2.6	3.9	↑		2.30	4.10	2.30	2.70	3.80	2.70	3.18	3.30	3.50	3.30	3.80	3.90	2.60
		Elective Surgical AvLoS (NHH)	Jan-22	2.16	1.0	0.9	↓		0.40	3.80	1.00	1.00	2.50	7.60	1.00	4.00	1.00	1.00	1.70	0.90	1.00
		Elective Surgical AvLoS (GUH)	Jan-22	3.21	1.8	3.1	↑		3.80	3.20	2.70	2.30	3.60	3.00	2.97	5.30	2.70	3.20	2.70	3.10	1.80
		Emergency Medical AvLoS (RGH)	Jan-22	10.77	9.2	9.8	↑		15.40	11.90	11.10	10.20	9.80	10.20	10.15	9.80	10.00	10.00	10.90	9.80	9.20
		Emergency Medical AvLoS (NHH)	Jan-22	10.32	11.7	11.9	↑		13.20	11.20	10.10	10.20	10.30	8.80	9.91	8.40	9.80	8.80	11.20	11.90	11.70
		Emergency Medical AvLoS (GUH)	Jan-22	4.25	4.5	4.5	↑		4.20	4.50	3.60	3.40	4.00	4.00	4.33	4.30	4.50	4.70	5.00	4.50	4.50
	Readmissions	Readmission Rate Within 28 Days (CHKS)	Nov-21	0.11	0.10	10.2%	↑		11.9%	12.4%	12.9%	12.0%	12.0%	11.6%	11.9%	10.7%	10.4%	10.2%	10.3%		
	Cancellations	Elective Procedures Cancelled Due to No Bed	Jan-22	12	13.0	2.0	↓		0	2	0	4	22	9	38	14	33	18	5	2	13
	Hip Fracture	Prompt Surgery	Dec-21	66%	67%	67%	↑		61%	64%	65%	67%	66%	64%	66%	66%	68%	67%	67%	67%	
		NICE compliant surgery	Dec-21	80%	74%	75%	↑		86%	85%	84%	82%	81%	80%	80%	78%	77%	76%	75%	74%	
		Prompt Mobilisation After Surgery	Dec-21	76%	76%	78%	↑		71%	72%	74%	74%	77%	78%	78%	78%	78%	78%	78%	76%	
		Not Delirious When Tested	Dec-21	70%	77%	76%	↑		59%	63%	65%	68%	69%	69%	71%	72%	73%	74%	76%	77%	
		Return to Original Residence	Dec-21	76%	73%	75%	↑		77%	77%	77%	77%	76%	76%	76%	75%	76%	75%	75%	73%	

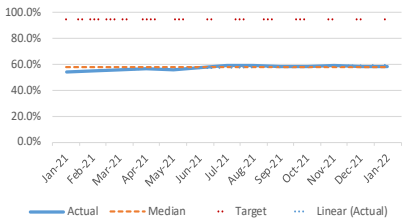
Trend Key

↑↓ Achieving rating target and improved against previous reported position
Achieving rating target but deteriorated against previous reported position
Not achieving rating target but improved against previous reported position
↓↑ Not achieving rating target and deteriorated against previous reported position

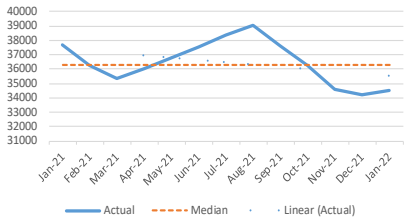
If measures are no longer in the Delivery Framework, current perfromance is measured against previous month

Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement

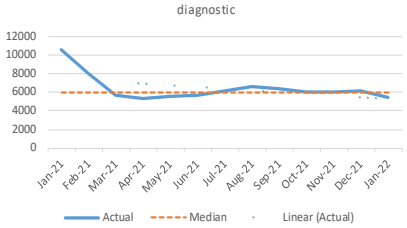
Patients waiting less than 26 weeks for treatment



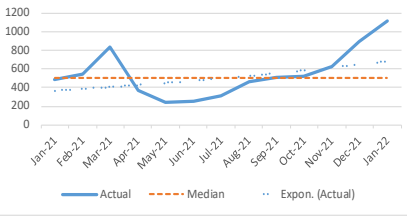
Patients waiting more than 36 weeks for treatment



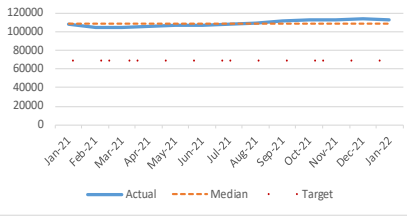
Patients waiting more than 8 weeks for a specified diagnostic



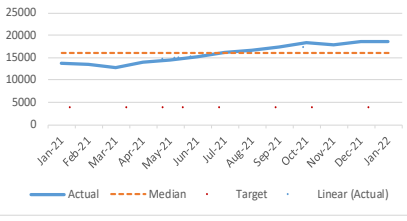
Patients waiting more than 14 weeks for a specified therapy



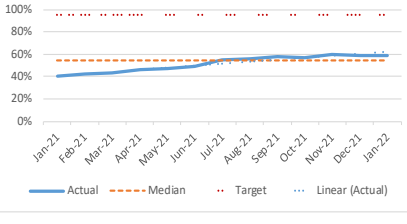
Number of patients waiting for a follow-up outpatient appointment



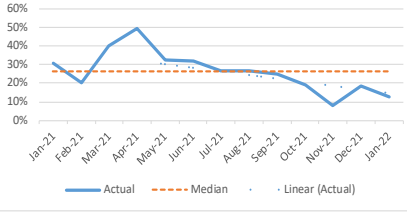
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%



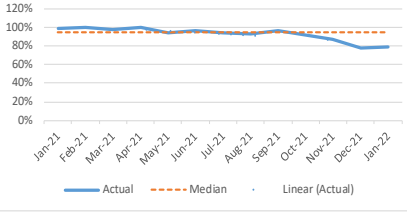
% of R1 patients who are waiting within 25% in excess of their clinical target date



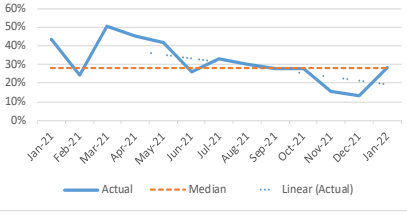
% stroke patients directly admitted to acute stroke unit ≤4 hours



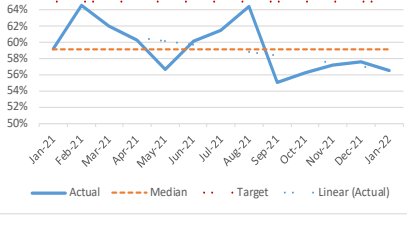
% of stroke patients assessed by a stroke consultant ≤24 hours



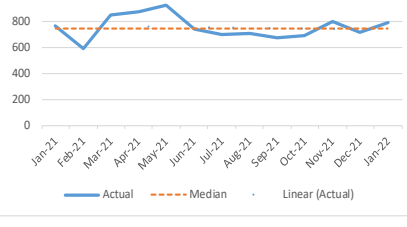
% of stroke patients assessed by a stroke consultant ≤24 hours



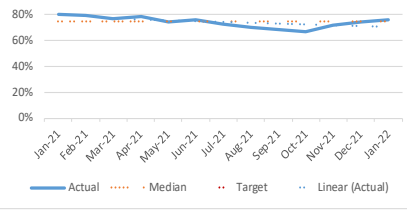
Category A ambulance response times within 8 minutes.



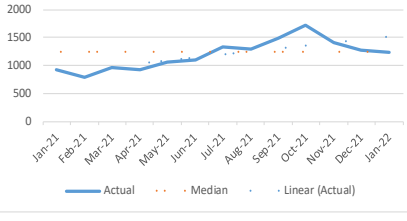
Number of ambulance handovers over one hour



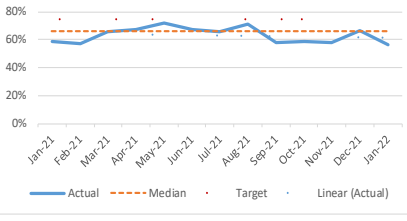
% patients waiting < 4 hrs in A&E figures inc. YAB & YYF



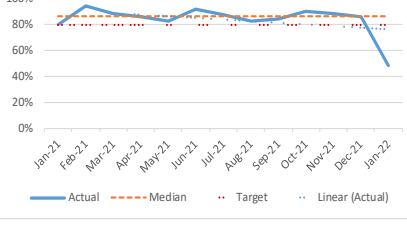
Number patients waiting > 12 hrs in ABUHB A&E departments



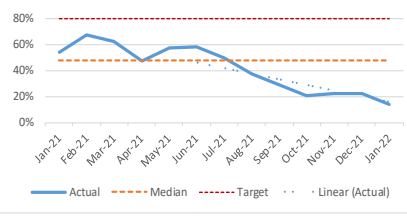
Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion



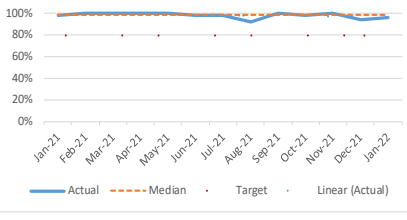
Assessment by LPMHSS within 28 days of referral.



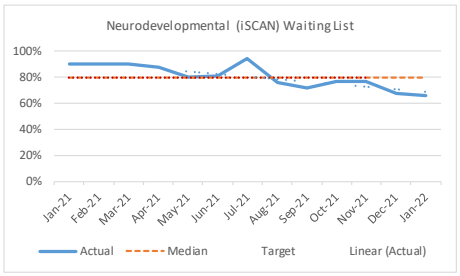
Interventions ≤ 28 days following assessment by LPMHSS.

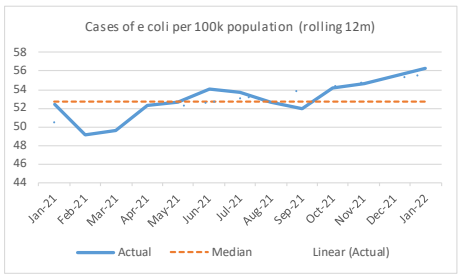


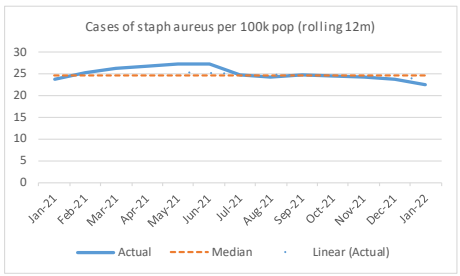
4+ Weeks Waiting List

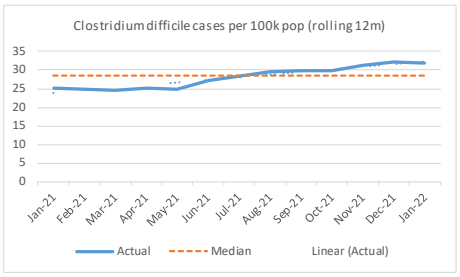


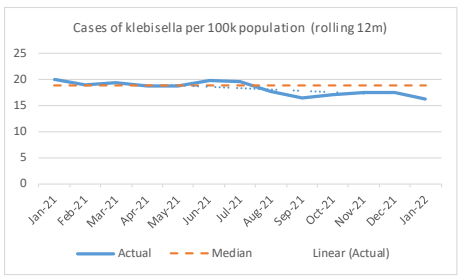
Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement

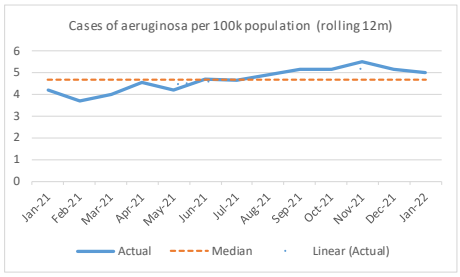


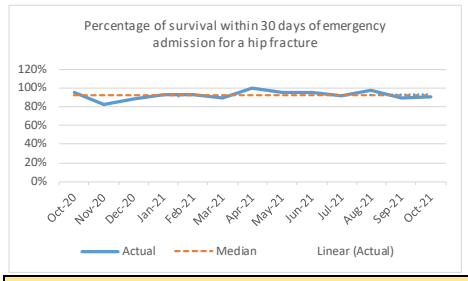


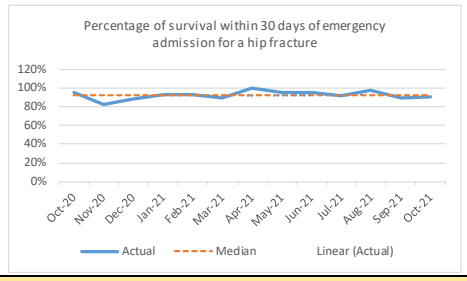




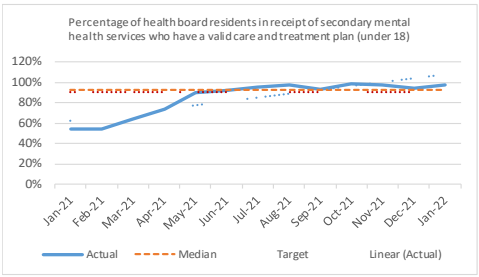


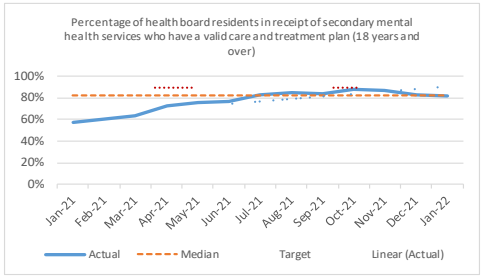




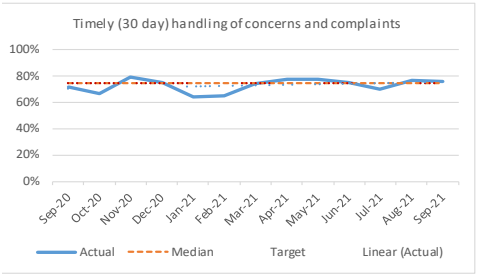


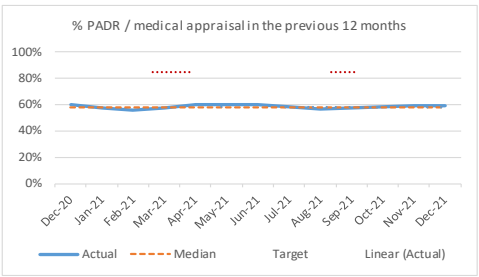
Aim 1: People in Wales have improved health and well-being with better prevention and self-management

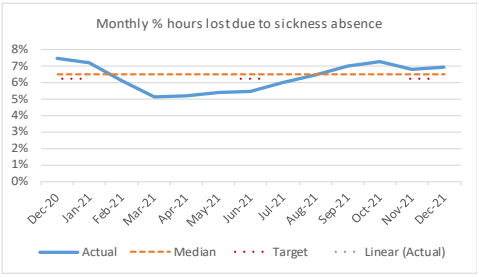


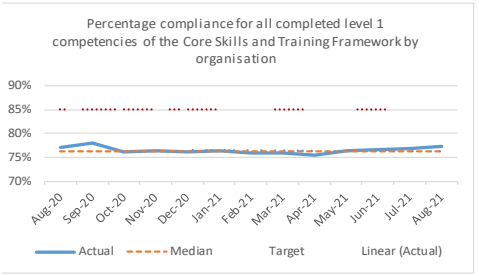


Aim 3: People in Wales have improved health and well-being with better prevention and self-management

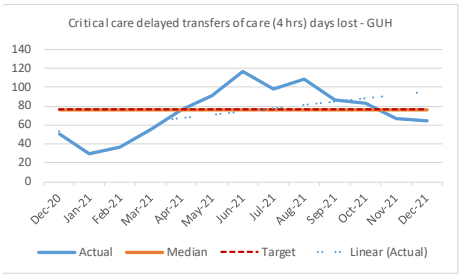


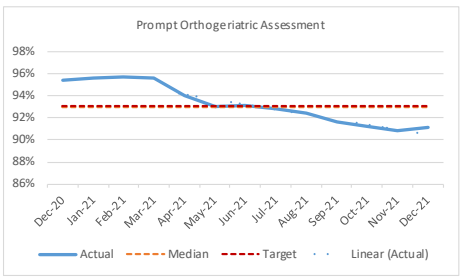


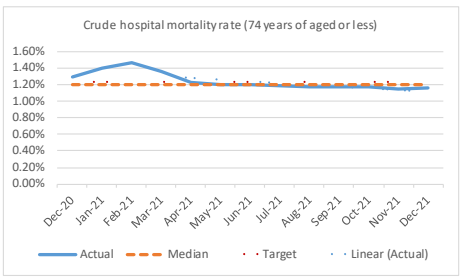


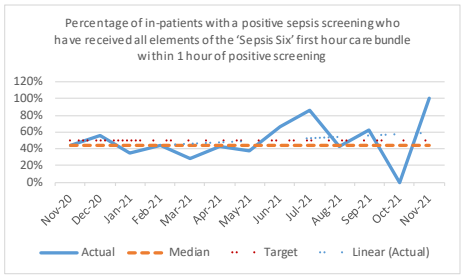


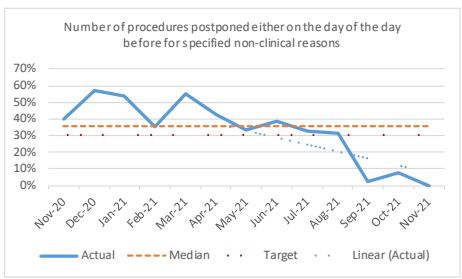
Aim 4:Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and

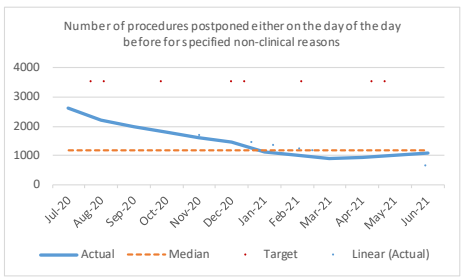


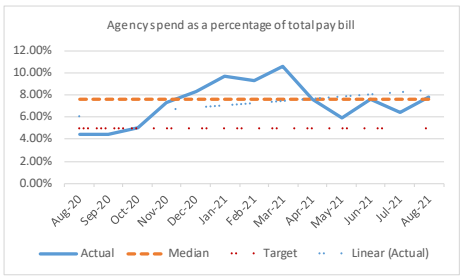




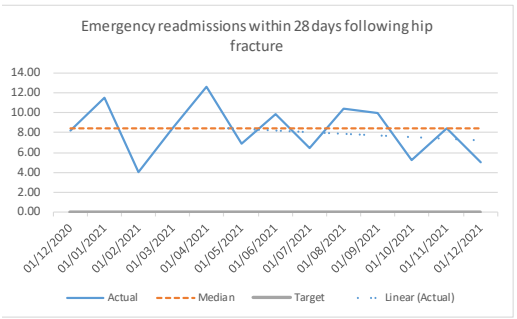


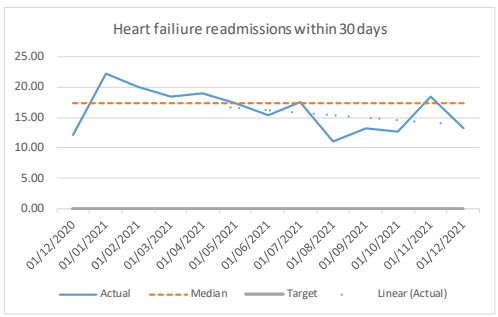






Local Measures





GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board 23rd March 2022 Agenda Item: 4.7

Aneurin Bevan University Health Board

STRATEGIC RISK REPORT

Executive Summary

This report provides an overview of all **22** strategic risks described in the Corporate Risk Register and makes recommendations to de-escalate some risks which have been managed down to an acceptable risk appetite level or are no longer perceived to be strategic risks and can be managed operationally within respective risk registers.

Response to the COVID-19 pandemic, through front line service delivery, vaccination and booster programmes and Test, Trace and Protect (TTP) and associated risks, continue to have the greatest impact on service delivery. This sustained response continues to represent the most significant risk to the Health Board's delivery of its non-COVID-19 services and the achievement of the objectives outlined within the Annual Plan 2021/22.

This reporting period has seen continued progress in embedding the revised Risk Management approach including a further meeting of the Health Board's Risk Managers Community of Practice where an update on the Once for Wales (OfW) RLDatix risk management module was presented.

The Board is asked to note the **22** risks which currently encompass the corporate risk register. The Board can be assured that it's Assurance Committees (Audit, Finance and Risk, Patient, Quality, Safety and Outcomes and People and Culture) have received and considered the risk profiles for which they are responsible for monitoring and reviewing. Further opportunity for escalation has been offered to risk owners and any change in position is reflected within the body of the report and the dashboard at ***Appendix 1***. Any concerns regarding these risk profiles will have been escalated to the Board via the aforementioned committee's Board Assurance Reports.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Rani Mallison, Board Secretary	
Report Author: Danielle O'Leary, Head of Corporate Services, Risk, and Assurance	
Report Received consideration and supported by :	

Executive Team	**X**	**Committee of the Board [Audit, Finance and Risk Committee Patient, Quality, Safety and Outcomes Committee People and Culture Committee]**	
Date of the Report: 10th March 2022			
Supplementary Papers Attached: Appendix 1 – Dashboard of Corporate Risk Register			

Purpose of the Report

This report provides an overview of the **22** strategic risks which currently comprise the Health Board's Corporate Risk Register. The report aims to provide assurance to the Board that all risks have been reviewed by respective Committees and, following Executive Team review, provides recommendations to remove some risks.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the revised Risk Management Approach, the Health Board is able to review and assess its strategic risks against the achievement of objectives as set out in the Annual Plan 2021/22.

The Health Board uses a Risk Matrix to assess the potential consequence and likelihood of occurrence of all predicted risks to form an overall risk score. In the risk identification and assessment process, a risk appetite level is agreed alongside a target score. Risks may then be **treated** or **mitigated** to a lower more manageable level or can be ***tolerated, transferred or terminated*** dependent upon the level of organisational benefit in undertaking a specific mitigation or course of action.

Internal controls and action plans are then developed to mitigate the risk and reduce either the likelihood, consequence, or both. Committees are then responsible for the active monitoring and review of all risks which receive oversight from each respective committee.

Assessment and Conclusion

Risk Management ensures that the Health Board focuses on the risks and concerns that may impact on the organisations ability to deliver its objectives. Whilst active risk management is performed daily at an operational level, the Health Board's risk management strategy and process ensures that the Board is informed, engaged and assured about the approach that Health Board uses to identify and respond to perceived risks.

Whilst the key risks and issues need to be considered regularly at each of the Board's Committees and at the Executive Team, the way in which the Health Board responds to the COVID-19 pandemic and the risks associated with that response have taken priority.

The Health Board has reviewed its reporting mechanisms in relation to risk management and, following internal reflection and comments received from Audit, Finance and Risk Committee, it was agreed that an overarching dashboard would be developed to provide a high level view of all strategic risks. Each delegated committee would then receive the more detailed risk profile information for each risk which receives oversight at that committee.

It is anticipated that this approach will strengthen the alignment between Board and committee business and the Board Assurance Framework, and provide a bedrock for Board and Committee business to be risk based and focussed on assurance needs, ensuring the correct business is directed to the most appropriate committee.

Current Organisational Risk Profile:

There are currently **22** Organisational Risk Profiles, of which **15** form Principal Risks due to the scoring being 15 or greater and are included within the Board Assurance Framework. The following table provides a breakdown of the risks and level of severity:

High	15
Moderate	5
Low	2

A high-level breakdown dashboard of all strategic risks including current score, target score, risk appetite level, risk treatment and trend since last reporting period is included at ***Appendix 1***. It is suggested that this will provide the Board with assurance that the risks which comprise the corporate risk register continue to be reviewed and monitored via the Executive Team with complimentary Health Board escalation arrangements in place.

Further Improvements Since the Last Reporting Period

A further meeting of the Health Board's Risk Manager Community of Practice has taken place where an update on the National work on Once for Wales (OfW) RLDatix Risk Management Module was provided. This work will be supplemented by a comprehensive plan to embed fully the Health Board risk management strategy and a further, detailed plan for implementation of the RLDatix risk management module. Once the plans have been approved by the Audit, Finance and Risk Committee, they will also be shared with the Board for information and assurance purposes.

The Head of Risk and Assurance also requested the risk management community of practice to identify lead/competent person(s) in each service area. The group also

approved the proposal to move to a more formalised group. Terms of reference will be developed and shared with the Audit, Finance and Risk Committee for information in due course.

Recommendation
The Board is requested to: • Note that delegated committees and Executive risk owners have reviewed their respective risks; • Acknowledge the further progress made in relation to risk management community of practice; • Note the development of an implementation plan including the OfW RLDatix risk management module implementation and, • Receive and approve the report for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of New Terms	Not required.
Public Interest	Report to be published.

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Operations**
CRR002 Failure to recruit and retain staff across all disciplines and specialities leading to adverse impacts on delivery of care to patients across acute and non-acute settings and non-compliance with safe staffing principles and standards **(re-**	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles.	**No**	**Treat** the impact of the risk by using internal controls.	**(Jan 2022 Board Report)** 	**P&C**	**Director of Workforce and OD**

framed Jan 2022)								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	15	10	**Zero or low** due to patient safety and quality of service.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Nursing**
CRR020 Failure to implement WCCIS leading to inaccessibility of essential patient information.	20	15	**High** level of appetite for risk on this areas to innovate in the area of digital technologies. **Low** level risk appetite for the realisation of this risk and to maintain patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 AFR Report)** 	**AFR**	**Director of Planning, Digital and ICT**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Operations**
CRR007 Inability to reflect demands of an increasingly ageing population.	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and	**(Jan 2022 Board Report)** 	**PSCC**[1]	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships**

[1] Subject to re-establishment of the Planning and Strategic Change Committee being endorsed by the Board.

					some are out of the Health Board's control.			
CRR010 Inpatients may fall and cause injury to themselves.	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR030 Limited contact with public and NHS services in	16	5	**Low** risk appetite in this area due to potential impact on quality, experience and patient outcomes.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 PQSO Report)**	**PQSO**	**Director of Nursing**

addition to clinical deployment to support Public Health Mass Vaccination programme contributing to a compromised Safeguarding position (**re-framed to reflect DoLs position**) ***links to Workforce risk – CRR002**								
CRR001 High levels of seasonal influenza	8	8	**Low** level of risk appetite in relation to patient experience. **Moderate** levels of risk appetite can be applied to pursue innovative models and technologies to encourage uptake.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work. ***Managed within agreed risk appetite level, therefore proposed to remove as a strategic risk and continue to be managed locally.***	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

CRR026 Risk to the general population and patients already within our services, due to less than adequate surge capacity to address any further exponential increase in pandemic response. ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 PQSO Report)** 	**PQSO**	**Director of Operations**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**(Feb 2022 AFR Report)** 	**AFR**	**Director of Public Health and Strategic Partnerships and Board Secretary**
CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 AFR Report)** 	**AFR**	**Director of Planning, Digital and ICT**
CRR016 Achievement of Financial Balance	4	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However responding to COVID 19	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 AFR Report)** 	**AFR**	**Director of Finance and Procurement**

			implications and maintaining safe services take precedence.					
CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Jan 2022 Board Report)** 	**PSCC**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate. **Moderate** risk appetite with regard to innovation and developments across the Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence should the risk be realised, is significant.***	**(Feb 2022 AFR Report)** 	**AFR**	**Director of Operations**
CRR032 Failure to achieve underlying	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 AFR Report)**	**AFR**	**Director of Finance and Procurement**

recurrent financial balance								
CRR033 Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Feb 2022 AFR Report)** 	**AFR**	**Director of Planning, Digital and ICT**
CRR021 Welsh Language Act Compliance	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Jan 2022 Board Report)** 	**P&C**	**Director of Workforce and OD**
CRR025 Well Being of Staff and normalisation of risk	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Jan 2022 Board Report)** 	**P&C**	**Director of Workforce and OD**

Aneurin Bevan University Health Board

Executive Team Report

Executive Summary
This report provides the Board with an overview of a range of activities regarding the Executive Team, including local, regional, and national issues. This report covers the period since the last Board meeting of 26th January 2022.

The Board is asked to:			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	✓		
Executive Sponsor: Glyn Jones, Interim Chief Executive			
Report Author: Rani Mallison, Board Secretary			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: March 2022			
Supplementary Papers Attached: None			

Purpose of the Report
This report provides the Board with an overview of a range of activities regarding the Executive Team, including local, regional, and national issues. The report also provides the opportunity to update the Board, in public achievements, issues and actions being taken which might not otherwise be brought to the attention of Board, as key discussion papers. This report also provides an opportunity to highlight areas that can be placed on the agenda for future Board meetings.

Highlights
Executive Team Business The Chief Executive Officer meets with the Executive Team on a weekly basis, in a formal capacity (Executive Team Business Meetings), with a view to ensuring the effective operational co-ordination of all functions of the organisation, and thus supporting the Chief Executive Officer to discharge the responsibilities delegated to them as Accountable Officer.

During February and March 2022, the Executive Team considered several updates, proposals and service developments, some of which include:

- Cardiology Diagnostic ECHOs
  Due to the current backlog for new and follow up ECHOs and the ongoing rising demand above established capacity, the Executive Team supported a continuation of insourcing capacity (from April 22 – March 23) to deliver circa 1,000 ECHOs per month, subject to the appropriate governance approvals.
- Medical Workforce
  The Executive Team received an update on work underway to review the Medical Workforce model, recognising the ongoing significant pressures on staff. This continues to be developed and will be further considered by the Executive Team in the coming weeks.
- Workforce Principles Impact Assessments
  The Director of Nursing presented the impact assessments for Health Visiting and Mental Health, associated with the extension of the Nurse Staffing Levels (Wales) Act. The assessments were noted with approval for submission to Welsh Government.
- High Care Respiratory Unit, Grange University Hospital (GUH)
  The Clinical Director (Respiratory) presented the Executive Team with proposal for the development of a High Care Respiratory Unit at GUH; supporting a right patient, right clinician, right place approach. The Executive Team was supportive of the approach and approved in principle the funding model, subject to the appropriate governance approvals.
- Urgent Care ETriage
  The ED Leadership Team presented the Executive Team with a proposal for implementing an electronic triage system within Urgent Care, specifically the Minor Injury Units and Emergency Department. The digital development will have a potential benefit for improved clinical triage and also has wider functionality. The ED Team are fully supportive and excited about its potential. The Executive Team supported ETriage, subject to the allocation of Welsh Government funding to support a pilot of two years, with full evaluation.
- The National Approach to Investigating Nosocomial COVID-19 and the Impact for ABUHB
  The Director of Nursing presented a proposal for the introduction of a substantive team for the investigation of nosocomial infections, following the allocation of funding from Welsh Government. The Executive Team approved the proposal to enable the Health Board to progress investigations with pace.
- Safety Briefing
  The Executive Team received regular safety briefings which included a summary of recent Patient Safety Incidents, Complaints, Never Events and Injurious Falls.

ABUHB Response - Request for written evidence: Health Visitor visits

The Health Board submitted written evidence on 26th January 2022 providing the Children, Young People and Education Committee with information on the proportion of standard contact Health Visitor visits that have been carried out.

The Health Board's response was published within the Committee's meeting papers of 10th March 2022
https://business.senedd.wales/ieListDocuments.aspx?CId=736&MId=12627&Ver=4

A Focus on Mental Health & Learning Development (MHLD)

- The MHLD 'Sanctuary in ED' service was launched in December 2021, with funding available until summer 2022. Peer Support Workers attend in the Emergency Department (ED) at GUH, Thursday to Sunday, between 4pm and Midnight. They provide support and information to individuals presenting in emotional distress. The outcomes are anticipated to reduce the number of patients leaving before assessment due to long waiting times and to improve the quality of information and support being received by patient requesting/ requiring MH support. 92 patients have been supported through this service to date and feedback from patients, ED staff and peer mentors has been really positive.

- Tŷ Cynnal – Our Crisis Support House for Gwent, has been visited by representatives from Welsh Government and Gwent Community Health Council. It opened its doors to service users in December 2021. Guests in Mental Health Crisis, for who this option is identified as safe and appropriate, stay for up to 14 days, as an alternative to an inpatient acute ward stay. Additional practical support is provided during the stay, with our Divisional Housing Team and other Partners such as Citizens Advice.
  The house has hosted 13 people experiencing mental health crisis during December and January. Constructive and positive feedback has been received. One family member of one guest has feedback *"I cannot thank you enough for your support - I feel that the house stay saved their life."*

- Shared Lives – Our Shared Lives service continues to expand. A collaborative service with Local Authority, where Service Users, who are assessed as safe and appropriate for this option, stay with host families, in the family's home. To date 86 individuals have stayed with host families; their stay is an alternative to inpatient acute ward.
  The average length of stay with families is currently 13 days. 81% of users are reporting a noticeable improvement in their ongoing recovery from stays. The service receives professional and general media recognition. WHO (World Health Organisation) had a recent article and the latest feature locally has been by Stacey Dooley, who visited a host household with longer term Guests. This is available to download from BBC Sounds

- National Mental Health Nurses Day – 21/02/2022
  This was proactively recognised and celebrated. Corporate Nursing gifted a beautiful poem to our Mental Health Nurses written by Tanya Strange. Covid safe activities were held virtually and on wards within pandemic guidance. The Wards held collaborative activities with patients, such as coffee and cake and Elvis was in the building in person 'twice' sharing a little music and joy on St Cadoc's Wards to celebrate.

Family & Therapies Services

- Co-production - understanding our services through the eyes of our young people
  Our Iceberg Transformation programme has enabled us to deliver, in partnership, a suite of services that has moved beyond the traditional models of Mental Health Services. As we move towards our whole system approach of the NEST/NYTH framework, the voices of our young people need to be at the heart of what we do and how we are doing it.

  The Families and Therapies Division has begun an exciting journey of discovery with the young people in the Gwent Regional Youth Forum around Mental Health. Teams hope to listen and understand what the term Mental Health really means to young

people, their experience of Mental Health Services, and coproduce a set of 'what matters' principles that can be put into action.

In addition to this piece of work, the Health Board is attending the Gwent Youth Question Time event alongside the Gwent Police Crime Commissioner. The online event, hosted by young people from the Gwent Regional Youth Forum, provides young people from across Gwent with the unique opportunity to ask questions of a panel of professionals who specialise in a wide range of issues that young people have said are important to them. We will be contributing to the area of Mental Health.

- Reconfiguration of Sexual Health Services
  The Directorate of Sexual Health has embarked on a major reconfiguration of sexual health services which has been approved by the Health Board's Executive Team and CHC during February 2022. The new model will mean that within each of the Gwent localities, there will be an integrated sexual health hub that will provide a broader range of sexual health services in the community. These hubs will also be supported by smaller clinics (spokes) in the community that target particular at risk/ vulnerable groups. The new model will embed a more comprehensive and holistic service in each community, improve access outside of normal working hours and provide an increased number of appointments to the population of Gwent. The Clinical Director, in conjunction with members of the Divisional Management Team, has worked closely with the Community Health Council and staff representatives to deliver a public communication and engagement and staff consultation exercise to support the introduction of the service model. The new model will be in place from April 2022.

- Child and Family Community Psychology in the Advancing Healthcare Awards Cymru 2021
  Dr Rhiannon Cobner and colleagues were winners in the category of 'New Ways of Working' and went on to win for Allied Health Professionals across Wales overall:
  1. The New Ways of Working shortlisted Projects and Winner – Award given by Eluned Morgan, Minister for Health and Social Services https://youtu.be/P4OBLw983M8
  2. The overall Allied Health Professions winner – Award given by Ruth Crowder, Chief Allied Health Professions Adviser for Welsh Government https://youtu.be/ZZlHDVYTjCg

Clinical Photography
The Health Board's Clinical Photography and Medical Illustration department was again successful last year at the Professional Institution's (Institute of Medical Illustrators) Annual Awards with a range of silver and bronze awards 2021 Awards Gallery and Conference - Institute of Medical Illustrators (imi.org.uk). Some clinical photographers also enjoyed collaborating with Studio Response, working with a brief to produce photographs of the local area that are proudly on display throughout GUH.

Estates & Facilities update to Exec – March 2022
Several large-scale projects are moving forward including the exciting development of the Garden of Reflection and Pond Walk ahead of the new Radiotherapy Satellite Centre at Nevill Hall Hospital. The HSDU building at the Grange and EV Charging points across sites are both expected to be completed in April 2022 with a further 12 charging points being added on top of 30 existing points.

The Care After Death team successfully helped accommodate charity "2 Wish" as they lit up the Royal Gwent, Grange and Nevill Hall Hospitals as part of a nationwide light up.
Recommendation
The Board is asked to note this report for information.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	COVID-19 and system pressures remain key risks on the Board's Corporate Risk Register.
Financial Assessment, including Value for Money	There are no direct implications arising from this report.
Quality, Safety and Patient Experience Assessment	There are no direct implications arising from this report.
Equality and Diversity Impact Assessment (including child impact assessment)	An EQIA has not been undertaken on the contents of this report.
Health and Care Standards	The range of activities outlined in the report will contribute to the Health Board's approach to Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The range of activities outlined in the report will contribute to the Health Board's strategic objectives.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The range of activities outlined in the report will contribute to the Health Board's approach to the Well Being of Future Generations Act.
Glossary of New Terms	No new terms have been identified.
Public Interest	This report is written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 23rd March 2022 Agenda Item: 4.9

Aneurin Bevan University Health Board

Committee and Advisory Group Update and Assurance Reports

Purpose of the Report

This report acts as a mechanism for Committees to provide assurance to the Board with regard to business undertaken in the last reporting period. It also allows the Committee to highlight any areas that require further consideration or approval by the Board.

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

The Board is asked to:	
Approve the Report.	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Board Secretary		
Report Author:	Bryony Codd, Head of Corporate Governance		
Report Received consideration and supported by:			
Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**As outlined.**
Date of the Report: 9th March 2022			
Supplementary Papers Attached: Committee Assurance Reports			

Background and Context

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:

Required Committees:

- Audit, Finance and Risk Committee
- Charitable Funds Committee
- Patient Safety, Quality and Outcomes Committee
- Mental Health Act Monitoring Committee
- Remuneration and Terms of Service Committee
- Stakeholder Reference Group
- Healthcare Professionals Forum

Additional Committees and Groups:

- Strategy, Planning, Partnerships and Wellbeing Group
- People and Culture Committee

Assurance Reporting

The following Committee assurance reports are included:

1. Audit, Finance and Risk Committee – 3rd February 2022

2. Patient Safety, Quality and Outcomes Committee – 8th February 2022
3. Mental Health Act Monitoring Committee – 1st March 2022
4. Charitable Funds Committee – 3rd March 2022

External Committees and Group

Representatives from the Health Board also attend a number of Joint sub-Committees or partnerships of the Health Board, these are:

- Emergency Ambulance Services Committee
- Welsh Health Specialised Services Committee
- Shared Services Partnership Committee

In order to provide the Board with an update on the work of these Committees and Groups the following minutes, assurance reports and briefings are included:

5. Welsh Health Specialised Services Committee – 18th January and 8th February 2022
6. Shared Services Partnership Committee – 20th January 2022

Assessment and Conclusion

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.

Recommendation

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report. However, it is good governance practice to ensure that Committee business and minutes are reported to the Board. Therefore, each of the assurance reports might include key risks being highlighted by Committees.
Financial Assessment, including Value for Money.	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	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.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within committee's considerations.
Glossary of New Terms	None
Public Interest	This report is written for the public domain.

Name of Committee:	**Audit Committee**
Chair of Committee:	**Shelley Bosson**
Reporting Period:	**3rd February 2022**
Key Decisions and Matters Considered by the Committee:	

"Taking Care of Carers How NHS bodies supported staff wellbeing during the COVID-19 Pandemic" Audit Wales – **ABUHB Management Response**

The Committee noted that the Health Board broadly agreed with the report's recommendations and would continue to develop the staff and wellbeing strategy in conjunction with the continued use of the COVID risk assessment tool, as well as promote further partnership working whilst acknowledging the duty of care to the staff.

A wide range of services are available, including a specialised pathway for employees who have suffered psychological trauma because of the pandemic. To determine the outcomes, an evaluation of the pathway was being conducted. Furthermore, it was confirmed that ABUHB was the only Health Board in Wales to offer this type of service for staff, noting that 96 percent of referrals were seen within 6 months, with a 93 percent recovery rate of those staff accessing and completing therapy. This service would continue to be offered to staff, and evaluation and monitoring would be carried out to explore additional ways of supporting staff.

Employee well-being would remain a permanent item on the agenda of the People and Culture Committee.

Counter Fraud

The Committee was informed that the Crown Prosecution Service (CPS) had reduced prosecution rates since the pandemic began. The Committee was assured that the way investigations were conducted, as well as the evidence provided to the CPS, had not changed. All cases presented to the CPS had to pass a two-tier test, the first being an evidential test and the second being a public interest test. It was confirmed that the cases that were rejected did not pass the second tier of the test***.*** The Committee requested further exploration to determine if this was also an emerging pattern across Wales.

The Committee was informed of the local and national challenges associated with salary overpayment and agreed that this was an area that required strong action and a revised approach to encourage managers to manage this issue appropriately. It was agreed that strengthened liaison with budget managers and links to their respective financial reports should provide some indication of where there may be salary overpayments. It was also agreed that key personnel would investigate ways to streamline the termination/new starter process for managers.

Muskulo Skeletal (MSK) Pathway Redesign

The Committee was apprised of developments regarding the MSK Pathway Redesign, noting that a Programme Management Office (PMO) function had been embedded within Corporate Planning, providing additional resilience to the MSK programme. Furthermore, MSK would be listed as an organisational priority in the IMTP, and risks associated with this priority would be managed locally at this time. In addition, an upstream, community-led, therapy-led pathway that provided 'end-to-end' care had been established.

The Committee noted the shift in focus from primary to secondary care, but was assured that the MSK programme's principles would remain as outlined below:

- Effective use of patient outcomes data (PROMS & PREMS)
- Engagement with all key stakeholders including GPs
- Engagement and liaison with Health Board related services

- Continued monitoring of Key Performance Indicators.
- Communicate any findings nationally for interest and ensure continued engagement for benchmarking and evidence of best practice.

The Committee approved the proposal and described the transformation as having significant potential. However, the Committee noted that the Health Board would need to agree the proposal and ensure that the benefits were realised, demonstrating successful influence on the national programme while continuing to deliver on key performance indicators (including cost avoidance/efficiencies), and key delivery risks.

Digital Systems, Efficiencies and Benefits Realisation Update Report
The addendum to the Audit Wales Annual Accounts Audit had identified a problem with the number of servers that the Health Board had been using. The Health Board had 120 servers in September 2018, which had been successfully reduced to 7, in accordance with the recommendation. More work was required to continue reducing the number of servers.

Additional recommendations were noted as below:

1. Capital funding had been provided by the Health Board to support eradication of remaining devices over the last few weeks. The Health Board was currently awaiting delivery of the equipment to replace these.
2. Key Performance Indicators would be included in the monthly/quarterly reporting to the ICT management team and in the next digital delivery oversight board.

In respect of the Digital Systems update and the Health Board's Digital Strategy, the following key points of further progress were noted:

1. A refresh of the infrastructure had been undertaken
2. Increased debate on Welsh Digital Portal and an enhanced national focus on this was anticipated for the next few years.
3. The informatics directorate had conducted its own internal review and as a result the department had been restructured and was currently in the strategy, planning and design phase.
4. Further discussion on priority areas needed to be instigated as there was a recognition that the resource was not available to prioritise all areas.

Further metrics were requested by the Committee to provide clarity on where the cash-releasing savings were being realised. A follow-up report would be provided to the Committee at a later date.

Audit Recommendations Tracker
The Committee received and approved the proposal to monitor and track recommendations in accordance with clear principles governing the timeliness and content of management responses. It was agreed that in the revised version to the Committee in April 2022, a specific process for the role of the Patient Quality, Safety, and Outcomes Committee in receiving oversight of recommendations raised via inspections and unannounced visits would be included.

Update on Governance, Financial Control Procedures and Technical Accounting
The Committee noted the key dates for final annual accounts consideration and submission, as well as end-of-year reporting.

The Committee was informed that the Health Board had continued to meet the Public Sector Payments target of 95% and that a number of Single Tender Actions had been conducted since the previous reporting period.

The Committee sought clarification on how the Health Board could be certain that it had received good value for money on some Single Tender Actions, particularly the expansion of The Grange car park. The Finance team agreed to conduct a retrospective review and provide a report to the Committee in April.

Losses and Special Payments
The Committee noted the financial situation as of the end of December 2021.

Finance Report
It was noted that the Health Board had reported a financial balance projection by year end with a favourable underspend of £100,000 for the year to date. It was explained that the financial balance is largely due to the Welsh Government's COVID funding.

The Committee was informed that the Welsh Government had recently issued the budget allocation letter, which would allow the Health Board to improve its underlying position. However, the Health Board, will not receive the same level of funding from the Welsh Government next year, which will pose a significant challenge.

The Committee noted the significant challenge associated with the emerging financial forecast for 2022/23 and was informed that the Executive Team has agreed to refresh the Health Board's approach to operating efficiently and re-engage with staff in relation to resource management. A work plan is being developed that includes organisational development, structural support, education, and reporting mechanisms to advance improved resource utilisation and efficiency through priority transformation programmes. An update report would be presented to the Committee in April.

Strategic Risk Report
The Committee received the report and noted the key updates, which are outlined below.

- National Once for Wales (OfW) development of a risk management specific module;
- Continued embedding of the Risk Management Strategy and associated delivery framework within operational and Divisional teams;
- Current, high level, status of all strategic risks; and,
- Update position of previous internal and external audit recommendations.

The Committee was informed that at the April meeting, an additional paper outlining the key milestones for delivering and implementing the risk management strategy, including the implementation of the Once for Wales (OfW) risk management module, would be provided.

NWSSP Audit and Assurance; Internal Audit Report
The Committee received the report and noted Internal Audit had requested the deferral of the following audits:

1. Catering
2. Agile Working
3. Monitoring Action Plans
4. Clinical Futures – Care Closer to Home
5. Quality Framework.

Internal Audit advised that the Board Assurance Framework and areas of greatest risk would be used to determine the priority of deferred audits.

The Director of Nursing had requested an advisory report on a current area of concern. If the Audit, Finance, and Risk Committee approves, an assessment of Continuing Healthcare (CHC) for Children will begin in quarter four

External Audit: Audit Wales
The Committee received the update and noted the reports scheduled for April.

Structured Assessment
The Committee was informed that the focus of the assessment was on 3 areas outlined below:

1. Governance arrangements
2. Financial management
3. Planning arrangements

The Structured Assessment resulted in five recommendations, and the Health Board has agreed on appropriate actions and implementation dates to move these forward.

The Strategy, Planning, Partnerships, and Wellbeing Group would become an assuring Committee of the Board during the Board and Committee effectiveness review in April 2022, with a particular focus on strategic partnerships.

Annual Audit Report 2021
Audit Wales presented the Committee with the Annual Audit report and clarified that the Auditor General had signed the financial statements on January 28th, 2022

Matters Requiring Board Level Consideration or Approval:
• There were no matters requiring consideration or approval.
Key Risks and Issues/Matters of Concern:
• There were no issues or matters of concern.
Planned Committee Business for the Next Reporting Period:
• Agile Working linked to Estates Efficiency Framework • Outpatient Transformation (effective and efficient use of resources and risk)
Date of Next Meeting: Thursday 7th April 2022 at 09:30am via Microsoft Teams

Name of Committee:	Patient Safety, Quality and Outcomes Committee
Chair of Committee:	Pippa Britton
Reporting Period:	8th February 2021

Key Decisions and Matters Considered by the Committee:

Update on Compliance with Cleaning Standards: The Committee received a verbal update on progress with Compliance with Cleaning Standards across the Health Board and current risk mitigation.

The Committee was informed that the Health Board Facilities Teams were implementing several actions to help improve staff experience and retention.

Members acknowledged the work that had been undertaken and requested a full report to be presented at the next Committee meeting.

Assurance Report: Infection Prevention and Control Management during the COVID Pandemic (including the Local Options Framework): The Committee received an overview of IPAC management during the COVID pandemic. The December 2021 changes to IPAC guidance were discussed.

Members were assured that the Local Options Framework enabled Health Boards in Wales to present flexibility based on demand and capacity. Any decisions were agreed and regularly reviewed by the Executive Team.

The Committee welcomed the report and requested any future COVID updates include Primary Care Services.

Patient Quality and Safety Outcomes Report

The Committee received an overview of the report, noting the report included the previous Committee recommendations of mapping it against the Health Board's Annual Plan. The update focused on two risk areas with a red rag rating; Urgent Care and Stoke Services.

Members were informed of the continued system pressures and concern regarding Urgent and Emergency care. There had been a continuation of handover delays and extreme ED pressure due to increased demand. Members were assured that the Health Board was working alongside WAST to improve patient experience.

Members were assured that the 111 service had increased telephone capacity and recruited staff; early data indicated a positive impact with lower abandonment rates. There was an intention to roll out the '111 service' across Wales by the end of March 2022, and the Health Board was involved in the national 111 programme.

Members were informed that the Stroke pathway required further strengthening and focus. The Stroke Directorate were working alongside 'Getting It Right First Time', who were completing an external review. Recommendations from this engagement would support the Health Board in improving future Stroke services. Members requested an update of the external audit be reported at a future meeting.

The Committee received the report and noted that Urgent Care and Stroke Services remain a high risk. The Committee would continue to have oversight of the improvement and action plans until experience, safety and outcomes were stabilised.

Patient Safety, Quality and Outcomes Committee Risk Report: The Committee received the report and an overview of risks. The Committee was assured that the risk report was used

to inform the Committee agenda, therefore all risks would have been covered during the meeting. Members requested further discussion around the management of pandemic risks during the next Committee meeting.
Matters Requiring Board Level Consideration or Approval:
None
Key Risks and Issues/Matters of Concern:
None
Planned Committee business for the Next Reporting Period: • Assurance Report: Compliance with Cleaning Standards, including Benchmarking Data, and Actions underway to address associated issues and risks • Quality Assurance Report - Primary Care Access • Audit Wales Quality Governance Review – report and management response • Quality Assurance Report – National Clinical Audit • Standard 2.1 assurance to PQSOC- Annual Assurance plan
Date of Next Meeting: Tuesday 5th April 2021

Name of Committee:	**Mental Health Act Monitoring Committee**
Chair of Committee:	**Pippa Britton**
Reporting Period:	**1st March 2021**

Key Decisions and Matters Considered by the Committee:

Mental Health Act Update- The Committee received a report on the use of the Mental Health Act from October-December 2021. The Committee was advised that a further look at comparative data pre-COVID and during COVID would be undertaken to establish any trends. The Committee was assured that the report captured data on the use of the Mental Health Act. It was reported that the Health Board did not have a separate Section 136 area for children and young people.

The Committee was assured that the Health Board were actively working with Local Authorities to provide safe accommodation for children in crisis. The Committee was advised that there was a gap in recruitment in Hospital Managers (volunteers),with a low number of Hospital Manager hearings in comparison with other Health Boards. The Committee requested an update on progress at the next meeting.

Matters Requiring Board Level Consideration or Approval:

None Noted.

Key Risks and Issues/Matters of Concern:

There were no issues or matters of concern.

Planned Committee Business for the Next Reporting Period:

- Mental Health Act Update.
- Power of Discharge Sub-Committee Update.

Date of Next Meeting: Tuesday 13th June 2022 at 10:00am via Microsoft Teams

Name of Committee:	**Charitable Funds Committee**
Chair of Committee:	**Katija Dew**
Reporting Period:	**3rd March 2022**

Key Decisions and Matters Considered by the Committee:

Administration Charge 2021-22: The Committee noted the administration charge for Charitable Funds and noted the slight increase in costs since first discussed in November 2021.

13 Clytha Square: The Committee received additional information on the current use and maintenance issues relating to 13 Clytha Square. The report outlined that the building is registered as owned by the Health Board and not the charity despite there being evidence that the property was gifted to the charity. Further investigation of the legal title is required, as well as a look at other options for the building and a timeline for any actions taken. If the investigation reveals that the Health Board owned the building, a report must be shared with the Board for further consideration.

Updates will be provided to the Committee.

Property Valuation Funds/Use of Unrealised Gain: The Committee approved the reinstatement of the market values of the non-liquid assets by utilising a one-off payment of £41K of the unrealised gain from 2021-22. Members also approved that future annual administration fees would not be charged against any non-liquid asset held by the Charity, ensuring that the values held within the accounts represented the market value.

The committee reviewed the following bids:

CFC-249 Children and Young People in COVID Recovery: The Committee supported this bid to be funded through COVID charitable funds.

CFC-252 Ophthalmology Teaching Imaging Modules The Committee supported this bid, to be funded from existing Ophthalmology charitable funds.

The Committee reviewed the following Small Grant Schemes;

SGS-001 Care After Death and SGS-002 Chapel Wall Screens: The Committee supported the bids and the format of the Small Grants Scheme application form.

Update of the Financial Control Procedure (FCP): The Committee received the updates to the FCP and approved the changes outlined in the report. Members requested an annual review of the FCP in order to reflect any organisational changes, to be included in CF team annual work plan.

Finance Report for the Period Ending 31st January 2022: The Finance Report for the Period Ending 31st January 2022 was received. The Committee noted the report and approved the request for six new funds.

Update on Grant Bid to NHS Charities Together: The meeting of NHS Charities Together had been postponed until the end of March. An update to come back to the Committee.

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:

- Update on Grant Bid to NHS Charities Together

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) JOINT COMMITTEE MEETING BRIEFING – 8 FEBRUARY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 8 February 2022. 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 Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Integrated Commissioning Plan (ICP) 2022-2025

Members received the WHSSC Integrated Commissioning Plan (ICP) 2022-2025 for approval prior to being submitted to Welsh Government.

Members discussed the financial elements of the ICP 2022-2025 and thanked colleagues in the specialist commissioning teams for their hard work in developing the plan in readiness for HBs to finalise their own Integrated Medium Term Plans (IMTP's).

Members were unanimous in approving the ICP and requested that minor updates be made to strengthen the document, to include WHSSC's commitment to the legislative framework on Welsh Language; and to be more explicit on how WHSSC are sufficiently representing the uncertainty presented by the COVID-19 pandemic as the operating context for the forthcoming year.

Members (1) **Noted** the discussions at Management Group on 20 January 2022 and their support on a revised risk profile; (2) **Noted** that the actions supported by Management Group reduced the total uplift required for non-recurrent funding for the 2022-2023 ICP to 4.97%, down by 1.6% (£11.4m) from the previous iteration of the ICP presented in December; (3) **Noted** that Management Group were supportive of the plan for approval by Joint Committee; (4) **Approved** the Integrated Commissioning Plan 2022-2025; **noting** the Joint Committee's request to strengthen the reference to supporting the Welsh language; and to be more explicit on how WHSSC are sufficiently representing the uncertainty presented by the COVID-19 pandemic as the operating context for the forthcoming year; (5) **Approved** the plan as the basis of information to be included in Health Board IMTPs; and (6) **Approved** the plan for submission to Welsh Government in response to the requirements set out in the Welsh Government Planning Guidance.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) JOINT COMMITTEE MEETING BRIEFING – 18 JANUARY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 18 January 2022. 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 Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings

The minutes of the meeting held on the 9 November 2021 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. Chair's Report

Members received the Chair's Report and **noted**:

- That a Chair's action had been undertaken to update the Terms of Reference (ToR) for the Welsh Renal Clinical Network (WRCN) to ensure effective governance and in the interest of expediency to commence the recruitment exercise for the role of the substantive Chair to the WRCN,
- The proposal to extend the Interim Chair Arrangements for the Chair of the Welsh Renal Clinical Network (WRCN) until the end of March 2022,
- an update concerning WHSSC Independent Member (IM) Remuneration,
- attendance at the Integrated Governance Committee (IGC) held on the 13 December 2021,
- an update on the Royal College of Nursing Wales – Nurse of the Year Awards 2021 ceremony held on the 10 November and that WHSSC had sponsored the Health Care Support Worker (HCSW) Award category,
- that Professor Vivienne Harpwood had appointed Dr Ruth Alcolado, Medical Director, NHS Wales Shared Services Partnership (NWSSP) as the new Vice Chair for the All Wales Individual Patient Funding Request (IPFR) Panel with effect from the 16 December 2021 for 2 years, in accordance with the Standing Orders,
- that the Chair had attended 1 to 1 meetings with Health Board (HB) CEOs.

Members (1) **Noted** the report, (2) **Ratified** the Chairs action undertaken to update the Terms of Reference (ToR) for the Welsh Renal Clinical Network (WRCN) to ensure effective governance and in the interest of expediency to commence the recruitment exercise for the role of the substantive Chair to the WRCN, and (3) **Approved** the extension of the interim WRCN Chair arrangement until 31 March 2022 to ensure business continuity whilst the substantive post is recruited to.

4. Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- Workshops held to consider options for WHSSC to commission Hepato-Pancreato-Biliary (HPB) Services,
- The extension of the Fast-Track Process for Military Personnel,
- Paediatric Inherited Metabolic Diseases (IMD),
- Discussions with SBUHB concerning the commissioning of Burns Treatment from the SBUHB Welsh Centre for Burns,
- The WHSSC Specialised Services Strategy,
- A request for WHSSC to support the National Collaborative Commissioning Unit (NCCU) to commission Surge Beds in response to the current omicron wave.

Members (1) **Noted** the report, (2) **Supported** that WHSSC provides support to the NCCU to enable them to commission mental health Surge Beds in response to the current omicron wave.

5. Individual Patient Funding Request (IPFR) Panel Update

Members received an update report on the Individual Patient Funding Request (IPFR) panel which outlined potential future proposals to change the terms of reference (ToR) of the All Wales Individual Patient Funding Request (IPFR) Panel, provided the JC with an update regarding the recent Judicial Review of an All Wales IPFR Panel decision, and provided an update on the outcome of a recent meeting with Welsh Government (WG) to discuss the governance arrangements of the All Wales IPFR Panel including the authority of the JC to amend the ToR of the Panel.

Members (1) **Noted** the issues with the current ToR of the All Wales IPFR Panel, (2) **Noted** the outcome of the recent Judicial Review and the implications for both the All Wales IPFR Panel and HB panels in Wales, (3) **Noted** the next steps agreed with Welsh Government regarding urgent changes to the existing All Wales IPFR Policy, (4) **Noted** the next steps agreed with Welsh Government regarding the authority of the Joint Committee to approve changes to the All Wales IPFR Panel ToR, and that a formal letter, from WG, confirming the position is awaited; and (5) **Noted** the suggestion from WHSSC officers regarding the need for a wider review of both the All Wales IPFR Policy and the governance arrangements for the policy.

6. Audit Wales WHSSC Committee Governance Arrangements Update

Members received an update on progress against the recommendations outlined in the Audit Wales "WHSSC Committee Governance Arrangements" report.

Audit Wales presented the report and advised that the management responses were comprehensive and well thought out and that positive progress had been made against the actions. The ongoing scrutiny being undertaken through the Integrated Governance Committee (IGC) was noted.

Members were informed that the updated audit tracker document will be shared with the NHS Wales Board Secretaries in HBs for inclusion on HB Audit Committee agendas in February/March 2022. This will ensure that all NHS bodies are able to maintain a line of sight on the progress being made, noting WHSSC's status as a Joint Committee (JC) of each HB in Wales.

Members (1) **Noted** the progress made against the WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, (2) **Noted** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and (3) **Approved** the updated audit tracker for submission to Audit Wales and to HB Audit Committees for assurance in February/March 2022.

7. Assurance on Patients Waiting for Specialised Services

Members received a report providing detail on the processes being used within WHSSC to seek assurance around how patients are being managed whilst on a waiting list.

Members (1) **Noted** the report, (2) **Noted** the robust processes in place to gain assurance that provider organisations are managing and supporting patients waiting for specialised care and treatment; and (3) **Noted** that the position in our NHS England specialised service providers has been generally more stable with recovery and activity across most contracts back to pre-pandemic levels. However given the rise in cases of the omicron variant and the reports in the media that Trusts in NHS England are suspending elective care, the WHSS Team will urgently ascertain the position in our main specialised service contractors in NHS England. This will be reported to Joint Committee in the routine activity report.

8. Independent Member Remuneration Update

Members received an update on discussions with Welsh Government (WG) to review the options to recruit and retain WHSSC Independent Members

(IMs) in response to the recommendation outlined in the Audit Wales report "WHSSC Committee Governance Arrangements".

Members (1)**Noted** the report, (2) **Discussed** and **approved** the proposal to transition to a fair and open selection process for appointing WHSSC IMs through advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs,
(3) **Discussed** and **approved** that the existing arrangements for appointing a CTM audit lead IM, could transition to advertising for an Audit/Finance IM through a fair and open selection process through advertising the vacancy through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs,
(4) **Discussed** and **approved** the suggested proposals to remunerate WHSSC IMs including the requirement for a review following the recruitment process,
(5) **Discussed** and **approved** the additional annual cost of remunerating WHSSC IMs; and **approved** an uplift to the Direct Running Costs (DRC) budget to enable a financial pool of resource to recurrently fund the remunerated IM positions.

9. COVID-19 Period Activity Report for Month 8 2021-2022 COVID-19 Period
Members received a report that highlighted the scale of decrease in specialised services activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales.

Members **noted** the report.

10. Financial Performance Report – Month 9 2021-2022
Members received a report providing the final outturn for the financial year. The financial position reported at Month 9 for WHSSC was a year-end outturn forecast under spend of £13,261k.

Members **noted** the report.

11. Corporate Governance Matters
Members received a report providing an update on corporate governance matters arising since the previous meeting.

Members **noted** the report.

12. Other reports
Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee (ARC)
- Management Group (MG),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR)Panel,

- Welsh Renal Clinical Network (WRCN).

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	20 January 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Support to Vaccination Booster Campaign

A presentation was received from Health Courier Services (HCS) on their role in supporting the booster campaign across Wales. Since Mid-December, almost 1m vaccines have been delivered to 155 separate sites with no delayed or failed deliveries. Over 8,500 journeys have been made to support the vaccination roll-out and 2.3 million miles driven by HCS staff to help NHS Wales to respond to the pandemic. The Committee were very appreciative of the presentation and the work to support their organisations and were keen to understand how they could assist in making the service even more effective through eliminating any unnecessary activities.

Procurement National Operating Model

The Committee also received a presentation on the new national operating model for Procurement Services which is currently out to staff consultation. This will facilitate a more regionalised approach and will enhance the relationship between national sourcing and frontline teams. It should also lead to a greater focus on strategic relationships with key suppliers and support the efforts to promote the Foundational Economy. The Committee were supportive of the proposed changes, and it was agreed that a summary information document would be produced for NHS bodies once the staff consultation period closes.

Chair's Report

This was the first meeting chaired by Tracy Myhill since her appointment to NWSSP on 1 December. Tracy outlined her delight in being appointed, the induction activities that she had undertaken to date, and her intention to meet regularly with key stakeholders across NHS Wales.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- In response to COVID and the Omicron variant, the NWSSP Planning and Response Group had been stepped up again. Thus far, no major issues have been noted and whilst there was an initial jump in sickness absence, figures have returned to the previous low levels. Where necessary, business continuity plans were implemented for drivers in Health Courier Services to ensure that services to the rest of NHS Wales were maintained;
- A Joint Executive Team meeting with Welsh Government was held on 14 January which generated a lot of positive feedback for NWSSP and during which NWSSP were requested to assist with the establishment of the Citizens Voice Body which will come into being from April 2023;
- The Medical Examiner Service, which is not devolved, is likely to become a statutory service from September 2022; and
- The NWSSP financial position is forecast to achieve a break-even position with all capital monies spent. The business case for the purchase of the Matrix House building in Swansea, has been signed off by the Minister.

Items Requiring SSPC Approval/Endorsement

IMTP

The Committee received the NWSSP IMTP for approval. The Director of Planning, Performance, and Informatics had met individually with SSPC members over recent weeks to inform the plan and has incorporated their comments and feedback into the final version. While, for now, there are no major changes to the overall goals and objectives, there is a greater focus on the Welsh Language, Equality and Diversity and outcome-based measures.

The IMTP is based on a solid foundation where NWSSP has continued to deliver all services despite the pandemic, and where we have a balanced financial plan. New services such as the Temporary Medicines Unit, Laundry Services, and more recently International Nurse Recruitment, have been introduced. The plan reflects ministerial priorities and positions NWSSP at the forefront of many national initiatives, particularly around climate change and the foundational economy.

In respect of the financial plan an additional savings target had been applied across directorates to generate a reserve to invest in IMTP priorities, but the plan will be challenging as it contains significant cost pressures including the hike in the price of energy and the O365 licences. The risk sharing agreement for clinical negligence claims is currently £16.5m but is forecast to rise to £28m in three years' time. The IMTP requires significant capital investment over the next five years particularly in respect of the laundry and TRAMs projects. The recently announced 24% cut in the discretionary budget will cause significant challenges for NWSSP in future years.

The Committee were supportive of the plan and highlighted NWSSP's role as an economic driver for change through the increased use of business intelligence to inform Health Boards and Trusts in both clinical and non-clinical settings. It also stressed the need for the various assurance processes (Internal Audit, Local Counter Fraud, National Counter Fraud, PPV) to be effectively co-ordinated to support delivery of the IMTP, and the Committee recommended that the current arrangements should be reviewed.

The Committee **APPROVED** the IMTP with the proviso that it may need to be revisited if there were any subsequent and significant changes to Health Board plans that impacted NWSSP.

Items For Noting

International Recruitment

The Committee received a paper relating to the recruitment of 436 nurses from overseas prior to financial year-end, to help fill vacancies within Health Boards and support the Covid recovery programme. Welsh Government have approved the funding for this initiative and contracts have been placed. Interviews are now being undertaken and although the deadline is challenging, there is confidence that this will be achieved. Invoices to the recruitment agencies will be paid at the offer acceptance stage, and if for any reason the recruitment is not followed through, the agencies have to find an acceptable replacement nurse or repay the amount. Nurses are only being recruited from countries with surplus staff and who are included on the Home Office Approved List.

The Committee **NOTED** and **ENDORSED** the paper.

Finance, Workforce, Programme and Governance Updates

Project Management Office Update – The Committee reviewed and noted the programme and projects monthly summary report, which highlighted the team's current progress and position on the schemes being managed. It was agreed that the consequences of any slippage in project timelines would be more meaningfully described in the report.

Finance Report – The Committee reviewed the finance report and noted the position at the end of Quarter 3. The outturn position is still forecast to be break-even and there is a plan in place to utilise any additional savings generated in the year. The paper also highlighted the significant sums spent on PPE, and the further donations of PPE to both India and Namibia. The Welsh Risk Pool position is still in line with the IMTP. Capital spend is on schedule, but a large proportion of the funding has only recently been confirmed and/or received. Stock values, which in a normal year would be approximately £3m are currently around £80m due to the need to maintain 16-weeks' stock of PPE. However, this value is reducing and was in excess of £100m last summer.

People & OD Update – sickness absence rates, after an initial spike due to the

impact of the Omicron variant, have now returned back to the lower levels seen over recent months and currently stands at 2.93% for the last quarter. Headcount continues to grow due mainly to the additional staff recruited as part of the Single Lead Employer Scheme. PADR rates were generally good although there were a few directorates where performance needed to be improved. The ESR database has now been modified such that the majority of the facilities it provides can be accessed and delivered in Welsh.

Corporate Risk Register – there is one red risk relating to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services.

Papers for Information

The following items were provided for information only:

- Annual Review 2020/21; and
- Finance Monitoring Returns (Months 8 & 9).

AOB

N/a

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.

Matters referred to other Committees

N/A

Date of next meeting	24 March 2022