

Aneurin Bevan University Public Board Meeting

Wed 25 September 2024, 09:30 - 12:30

Conference Centre, St Cadoc's Hospital



Agenda

1. Preliminary Matters

Board Consent Agenda 25th September 2024.pdf (3 pages)

1.1. Welcome and Introductions

Verbal Chair

1.2. Apologies for Absence for Noting

Verbal Chair

1.3. Declarations of Interest for Noting

Verbal Chair

2. Consent Agenda Business

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

3. Key Updates

3.1. Update from the Chair

Verbal Chair

3.2. Update from the Chief Executive

Verbal Chief Executive

4. Patient Experience and Public Engagement

4.1. Patient Experience Presentation

Presentation Director of Nursing

4.2. Report from Llais, Gwen Region

Attachment Regional Director, Llais

Agenda_Item_4.2_Llais Gwent Region - Report for ABUHB - September 2024.pdf (12 pages)

5. For Approval

5.1. Service Development Business Cases:

Attachment *Chief Operating Officer / Director of Digital*

a. Urgent and Emergency Care System

b. MRI Scanner, Grange University Hospital

c. Electronic Prescribing and Medicines Administration System

 Agenda_Item_5.1a_Urgent and Emergency Care Business Case_final.pdf (9 pages)

 Agenda_Item_5.1aii_Appendix B_Urgent and Emergency Care Business Case_ED Workforce.pdf (26 pages)

 Agenda_Item_5.1b_MRI Scanner GUH.pdf (5 pages)

 Agenda_Item_5.1bi_Appendix A_MRI Scanner GUH BJC.pdf (46 pages)

 Agenda_Item_5.1c_EPMA Business Case.pdf (11 pages)

 Agenda_Item_5.1ci_Appendix A_ePMA Full Business Case.pdf (117 pages)

5.2. Welsh Language Annual Report

Attachment *Director of Workforce and OD*

 Agenda_Item_5.2_Welsh Language Annual Report 2023-24.pdf (6 pages)

 Agenda_Item_5.2a_Welsh Language Annual Report 23-24 - English Copy.pdf (31 pages)

5.3. Annual Quality Report

Attachment *Director of Nursing*

 Agenda_Item_5.3_Annual Quality Report 2023-24.pdf (5 pages)

 Agenda_Item_5.3a_Appendix A_Quality Annual Report 2023-24.pdf (40 pages)

 Agenda_Item_5.3b_Appendix 1_Quality Strategy Implementation Plan 2023.24.pdf (33 pages)

5.4. Commissioning for Quality Approach

Attachment *Director of Nursing*

 Agenda_Item_5.4_QAF for Commissioned Services.pdf (6 pages)

 Agenda_Item_5.4a_Appendix ACommissioning Assurance Framework.pdf (12 pages)

6. Items for Discussion

6.1. 2024/25 Performance Reporting

Attachment *Executive Leads*

a. Integrated Performance Report, Q1

b. Quality Outcomes and Performance Report, Q1

c. Financial Performance at Month 5

 Agenda_Item_6.1a_Quarter 1 Integrated Performance Report.pdf (8 pages)

 Agenda_Item_6.1ai_Appendix A_Quarter 1 Integrated Performance Report.pdf (43 pages)

 Agenda_Item_6.1b_Quality Performance report Board Q1.pdf (6 pages)

 Agenda_Item_6.1bi_Appendix A_QOF and Performance Report Q1 2024-25.pdf (44 pages)

 Agenda_Item_6.1c_Board Finance Report 24-25 M5 final.pdf (35 pages)

 Agenda_Item_6.1c_Appendix 1.pdf (36 pages)

 Agenda_Item_6.1c_Appendix 2 MMR.pdf (48 pages)

 Agenda_Item_6.1c_Appendix 3.pdf (21 pages)

7. Consent Agenda

7.1. For Approval

7.1.1. Draft Minutes of the Health Board Meeting, held on 17th July 2024

Attachment Chair

 Agenda_Item_7.1.1_Draft Minutes of Public meeting held on 11.07.24. docx.pdf (4 pages)

7.1.2. Report on Sealed Documents and Chair's Actions

Attachment Chair

 Agenda_Item_7.1.2_Report on Sealed Documents and Chairs Actions.pdf (4 pages)

7.1.3. Patient Related Policies Reserved for Board

Attachment Director of Nursing

a. Putting Things Right Policy

b. Patient Safety Incident Management Policy

 Agenda_Item_7.1.3a_PTR Policy.pdf (7 pages)

 Agenda_Item_7.1.3ai_Appendix A_Draft PTR policy 10-9-24 V2.pdf (55 pages)

 Agenda_Item_7.1.3b_Patient Safety Incident Policy Version 3 - August 2024.pdf (6 pages)

 Agenda_Item_7.1.3bi_Appendix A_Patient Safety Incident Reporting Management Policy updated July 2024.pdf (34 pages)

7.1.4. Corporate Governance Framework

Attachment Director of Corporate Governance

a. Standards of Business Conduct Policy

b. Policy Management Framework

c. Scheme of Delegated Limits

 Agenda_Item_7.1.4a_Standards of Business Conduct Policy.pdf (5 pages)

 Agenda_Item_7.1.4ai_Appendix 1 Standards of Business Conduct Policy.pdf (28 pages)

 Agenda_Item_7.1.4b_Policy Management Framework.pdf (11 pages)

 Agenda_Item_7.1.4bi_Attachment 1_ABUHB Policy Management Framework.pdf (21 pages)

 Agenda_Item_7.1.4c_Scheme of Delegation Report.pdf (17 pages)

 Agenda_Item_7.1.4ci_Appendix 3a_RPB Scheme of Delegation Information_24-25.pdf (1 pages)

 Agenda_Item_7.1.4cii_Appendix 3b_RPB Capital Finance Summary_M1 2425.pdf (10 pages)

 Agenda_Item_7.1.4ciii_Appendix 3c_RPB Revenue Finance Summary_M1 2425.pdf (21 pages)

7.1.5. Joint Commissioning Committee Governance Framework

Attachment Director of Corporate Governance

 Agenda_Item_7.1.5_JCC Governance Framework.pdf (10 pages)

 Agenda_Item_7.1.5a_Appendix 1 - MEMORANDUM OF AGREEMENT.pdf (26 pages)

 Agenda_Item_7.1.5b_Appendix 2 - HOSTING AGREEMENT.pdf (26 pages)

 Agenda_Item_7.1.5c_Appendix 3 ToR Quality Safety and Outcomes SubCtte Sept 2024 1.pdf (14 pages)

 Agenda_Item_7.1.5d_Appendix 4 - ToR Planning Performance Finance 1.pdf (10 pages)

7.2. For Noting

7.2.1. Board Action Log with Updates

Attachment Chair

 Agenda_Item_7.2.1_Board Action Log_September 2024.pdf (2 pages)

7.2.2. Annual Report of the Senior Information Risk Owner (SIRO) 2023/24

Attachment Director of Digital

 Agenda_Item_7.2.2_SIRO_Annual_Report_2324.pdf (8 pages)

 Agenda_Item_7.2.2a_SIRO Report ABUHB 20232024.pdf (41 pages)

7.2.3. Public Service Ombudsman for Wales - Annual Letter

Attachment *Director of Nursing*

-  Agenda_Item_7.2.3_PSOW 2024 Letter.pdf (4 pages)
-  Agenda_Item_7.2.3a_Appendix A_PSOW Annual Letter.pdf (10 pages)

7.2.4. Strategic Risk Report, September 2024

Attachment *Chief Executive*

-  Agenda_Item_7.2.4_Strategic Risk Report_September 2024.pdf (10 pages)
-  Agenda_Item_7.2.4b_Appendix B_Strategic Risk Assessments.pdf (29 pages)

7.2.5. Strategic Partnership Updates

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

- a. Regional Partnership Board (Attachment)
 - b. Public Service Board (Verbal)
-  Agenda_Item_7.2.5a_RPB Update September 2024.pdf (9 pages)

7.2.6. Executive Committee Chair's Report

Attachment *Chief Executive*

-  Agenda_Item_7.2.6_Executive Committee Chair's Report September 2024.pdf (11 pages)

7.2.7. Key Matters from Committees of the Board

Attachment *Committee Chairs*

-  Agenda_Item_7.2.7_Key Matters from Committees of the Board.pdf (16 pages)

7.2.8. An overview of Joint and Partnership Committee Activity

Attachment *Chief Executive*

- a. Joint Commissioning Committee
 - b. NHS Wales Shared Services Partnership Committee
-  Agenda_Item_7.2.8a JCC Update Report.pdf (5 pages)
 -  Agenda_Item_7.2.8a_Appendix 1_JCC Briefing (Public) 16 July 2024.pdf (8 pages)
 -  Agenda_Item_7.2.8b_Shared Services Partnership Committee Update Report.pdf (3 pages)
 -  Agenda_Item_7.2.8bi_Appendix A_SSPC Assurance Report 18 July 2024.pdf (7 pages)

8. Other Matters

8.1. Any Other Business

8.2. Date of the Next Meeting

27th November 2024

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

AGENDA

Date and Time		Wednesday 25th September 2024 at 9.30 am	
Venue		Conference Centre, Headquarters, St Cadoc's Hospital	
Item	Title	Format	Presenter
1	PRELIMINARY MATTERS		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence for Noting	Oral	Chair
1.3	Declarations of Interest for Noting	Oral	Chair
2	CONSENT AGENDA BUSINESS		
2.1	The Chair will ask if there are any items from the Consent Agenda (Item 7) that Board Members wish to bring forward to the Main agenda for discussion		Chair
3	KEY UPDATES		
3.1	Update from the Chair	Oral	Chair
3.2	Update from the Chief Executive	Oral	Chief Executive
4	PATIENT EXPERIENCE AND PUBLIC ENGAGEMENT		
4.1	Patient Experience Presentation	Presentation	Director of Nursing
4.2	Report from Llais, Gwent Region	Attachment	Regional Director, Llais
5	FOR APPROVAL		
5.1	Service Development Business Cases: a. Urgent and Emergency Care System b. MRI Scanner, Grange University Hospital c. Electronic Prescribing and Medicines Administration System	Attachment	a & b - Chief Operating Officer c - Director of Digital
5.2	Welsh Language Annual Report 2023/24	Attachment	Director of Workforce & OD
5.3	Annual Quality Report 2023/24	Attachment	Director of Nursing

5.4	Commissioning for Quality Approach	Attachment	Director of Nursing
6	ITEMS FOR DISCUSSION		
6.1	2024/25 Performance Reporting: a. Integrated Performance Report, Q1 b. Quality Outcomes and Performance Report, Q1 c. Financial Performance at Month 5	Attachment	Executive Leads
7	CONSENT AGENDA		
7.1	FOR APPROVAL		
7.1.1	Draft Minutes of the Health Board Meeting, held on 17 th July 2024	Attachment	Chair
7.1.2	Report on Sealed Documents and Chair's Actions	Attachment	Chair
7.1.3	Patient Related Policies Reserved for Board: a. Putting Things Right Policy b. Patient Safety Incident Management Policy	Attachment	Director of Nursing
7.1.4	Corporate Governance Framework: a. Standards of Business Conduct Policy b. Policy Management Framework c. Scheme of Delegated Limits	Attachment	Director of Corporate Governance
7.1.5	Joint Commissioning Committee Governance Framework	Attachment	Director of Corporate Governance
7.2	FOR NOTING		
7.2.1	Board Action Log with Updates	Attachment	Chair
7.2.2	Annual Report of the Senior Information Risk Owner (SIRO) 2023/24	Attachment	Director of Digital
7.2.3	Public Service Ombudsman for Wales - Annual Letter	Attachment	Director of Nursing
7.2.4	Strategic Risk Report, September 2024	Attachment	Chief Executive
7.2.5	Strategic Partnership Updates: - a. Regional Partnership Board b. Public Service Board	Attachment Oral	Director of Strategy, Planning & Partnerships and Director of Public Health
7.2.6	Executive Committee Chair's report	Attachment	Chief Executive
7.2.7	Key Matters from Committees of the Board	Attachment	Committee Chairs

7.2.8	An overview of Joint and Partnership Committee Activity a. Joint Commissioning Committee b. NHS Wales Shared Services Partnership Committee	Attachment	Chief Executive
8	OTHER MATTERS		
8.1	Any Other Business		
8.2	Date of the Next Meetings: • 27th November 2024		
9.	PRIVATE/IN COMMITTEE SESSION		
	Motion to Exclude Members of the Public and the Press There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting: "Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." <i>Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960</i>		

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

September 2024



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

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.

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About Llais



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

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

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

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

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

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

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



Introduction



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

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

A National Conversation: Llais strategic plan 2024-



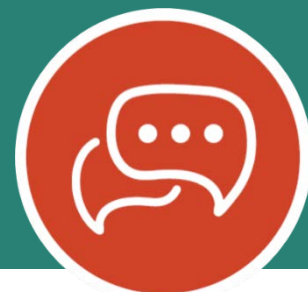
We now have our first national strategic plan. This plan has been created using what we have been told by the people of Wales, by our staff and volunteers and other bodies and groups we work with.

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

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

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

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



Current activities and feedback:

1. Public feedback from our Advocacy services

There were 77 contacts between 1st July 24 – 31st August 2024 of which 66 were concerns and 11 enquiries.

Of the 77 contacts, 21 have now been resolved, 55 are active and 1 signposted to other services.

Themes identified:

- Waiting times for NHS appointments (GP & hospital),
- Experience during hospital admission,
- Experience of Paediatric services

Client feedback:

“I certainly couldn’t have navigated the system alone”

“You are someone who cares”

2. Representations that we have made or been involved in

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

Since July 2024, we have been involved in or made **regional representations** about:

- Emergency Department handovers from ambulance crew and people’s experiences of waiting in the Emergency Department.
- Stroke rehabilitation service developments (ongoing conversations with the Planning Team following post urgent service change)

- ABUHB: Proposals for Respiratory Reconfiguration
- ABUHB: Keeping Well Service
- ABUHB: Sustainability Assessment Group
- ABUHB: Commission General Dental Services
- Primary Care Services, Chronic Fatigue Syndrome
- 19 Hills Wellbeing Centre Communication & Engagement
- eLGH department/unit reconfiguration proposals
- ABUHB: 'A conversation for a healthy future' -. We are eager to see the outcome and conclusions of the strategy.

Representation highlight:

We would like to further update progress of a focussed piece of work around people's waits for planned hip and knee surgery, and the impact this had on their mental health and wellbeing. Following our submission of a number of representations and powerful citizen's voice, we have received an informative action plan from the health board, designed to improve citizen experience moving forward.

Since July 2024, we have been involved in or made **representations across South-East Wales**, about:

- **Velindre Cancer Centre plans to increase Systemic anti-cancer therapies (SACT) capacity, to support improvement in the current waiting times for patients to start their treatment:**

Velindre University Trust are proposing a relocation of Immunotherapy patient treatments from Hospital based day case Units to Nantgarw Support Unit to address waiting times for SACT treatment due to waiting time. Research shows that there will be a growth of 10% by 2025. Most affected are Cwm Taff, Gwent, and some Powys patients. At present there are clinics at Prince Charles Hospital, there will be only a one-day service going forward for those who will find it difficult to travel. The plans we have been working on to increase SACT treatment capacity include:

- Increasing the capacity of the Nantgarw Support Unit from 2 days a week to 4 days a week by the end of September 2024, which will deliver an additional 52 treatments per week.
- Expanding internal Pharmacy capacity, which supports the Day case Units in Velindre, Prince Charles and Nevill Hall. These are at approval stage currently and would deliver an additional 80

treatments per week. Velindre are engaging with service users at present and will feed back to Llais their findings.

- **Digital Patient Portal:**

This project has seen the change of supplier from DrDoctor and PSL for SMS reminders and appointment letters and are undergoing the transition to a digital patient portal, where digitally they will enable patients to access communication.

3. Children and Young People

As part of our commitment within our Annual Plan 2024-25: Engage more young people. We're making it a priority to listen to and work with more groups and bodies that represent young people. We will get their advice on how to improve our own services to help us find out what young people really need and want from their health and social care.

Our National Focus: We want the voices of children and young people to be heard in health and social care discussions, ensuring that services are designed and adapted to be youth friendly and responsive to their needs. To do that we must also involve children and young people in developing our own ways of working to ensure that we can effectively represent their voices.

What could success look like by 2025: We've made strong relationships with young people, or groups that listen to young people and we have started making sure those young voices are heard by the people who plan and run health and social care, so they know what young people need and want.

4. Engagement in Gwent (July - August)

In July to August, we engaged with 105 people in community spaces, social care settings, and support groups.

We also completed visits to the following:

- 1) **Building relationships with Community Services:**

ABLE Day Centre: 100% of the feedback received reported support and activities provided were invaluable to individuals.

- 2) **GP Exit Surveys at Ringland Health Centre (2 of 4 visits complete):** This practice was keen to capture patient satisfaction here and now and explore knowledge and understanding of the new 19 Hills Wellbeing Centre. The survey is available to complete face-to-face or online. Full briefing to be prepared and shared in September 2024.
- 3) **Building relationships with care homes:** We went to Severn View Day Services and Wentwood Court to understand services and impact.

In response to our regional priority around mental health, we have engaged in early co-production with the health board about their mental health strategy, and connected with Whole Person, Whole System Programme Board.

Challenges continue around WAST Ambulance service and performance activities, in particular handover delays. This will feed part of our accessing emergency care project, designed to capture people's lived experiences with a purpose to shape change.

5. Emerging Themes

Following our previous report (July 2024) we highlighted emerging themes:

1) Maternity Services:

We shared early emerging maternity themes and now we plan to understand further individuals voice and their experience around maternity care in November 2024. We will do this by going into our communities face-to-face and digitally to ensure choice of engagement. This also extends the picture around service change requests received.

2) Hospital discharge:

We are planning release of our survey in December 2024 until March 2025. The focus of the survey will be around discharge from hospital back into community care. We will be working with our partners from health and social care to understand the extent of the challenge and explore solutions ensuring the citizens voice is at the heart.

6. Upcoming Activities

- 1) **Transition from child to adult services in health and social care:** In September we plan to launch this survey to understand young people's experiences of changing from child to adult services. We will use people's feedback to influence change and improve future services. The survey is due to end in December 2024.
- 2) **Accessing Emergency Care:** We are aware of high levels of concern regarding the Emergency Department at the Grange University Hospital, and the work that's being done to address this. However, moving forward, we are keen to work together to develop a more intense understanding of people's voice. This will build on our Winter Patient Experience 2023-24 project and enrich our plans to visit the Emergency Department, Acute Medical Unit and Minor Injury Units in October. Correspondence will be sent to the health board with further details about this plan, in September 2024.

In September and October, we are receiving presentations delivered by the health board and local authority on the following topics:

- 1) ABUHB: eLGH Service Reconfiguration including stroke
- 2) ABUHB: Nevill Hall Hospital Radiotherapy Centre
- 3) ABUHB: Care Closer to Home
- 4) Local Authority: Health pathways in the community (support for people on planned care lists)
- 5) ABUHB: 111 Option 2 for Mental Health support in a crisis
- 6) ABUHB: Veterans access to services (waiting times and quality of service) Covenant agreement presentation
- 7) ABUHB: IMTP/Annual plan update – look forward for 2025/26

Thanks



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

Feedback

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

Contact details

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DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Urgent & Emergency Care Update and Developments
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins – Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Richard Morgan-Evans – Deputy Chief Operating Officer

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This paper seeks to address two aspects of the urgent and emergency care (U&EC) agenda:

1. To provide a broad update as to the recent developments within U&EC, including enhanced monitoring escalation progress as well as sharing recent feedback from the national Getting it Right First Time (GIRFT) Emergency Department (ED) visit.
2. To receive Board agreement in order to progress two key aspects of the U&EC Plan as priority areas of improvement in the context of the Urgent and emergency care pressures at GUH. These include the GUH Transfer Lounge expansion and an increase in ED Consultant cover linked to rapid senior assessment and improved clinical safety.

Cefndir / Background

In January 2024, Welsh Government escalated the Health Board to 'Enhanced Monitoring' for performance and outcomes related to urgent and emergency care pathways at the Grange University Hospital (GUH). Prior to this the Health Board had already internally escalated Urgent Care into Enhanced Monitoring due to concerns around performance and a lack of sustained and demonstrable improvement.

The conditions for de-escalation set by Welsh Government were as follows:

- Three-month continuous reduction of at least 15% each month (from Oct-Dec baseline) for ambulance handovers over one hour.
- Continuous improvement towards no more than 5% of patients waiting over 12 hours at each individual site and across the health board.
- 100% of patients to be assessed by a senior clinical decision maker within 60 minutes from arrival.

Since the start of the year the Health Board has implemented a robust enhanced monitoring programme that is part of the 'Safety Flow' agenda. This ensures all key stakeholders are involved and improvements tracked.

The Six Goals of U&EC Programme is the overarching improvement agenda for the Health Board. The enhanced monitoring structure sits under this as the more immediate operational delivery arm ensuring that projects are delivering into business as usual to seek improvements.

On the 28th June, as part of a national Welsh review, the Health Board had a visit from the GIRFT ED team. The exercise looked intensively at Health Board data as well as conducting a site visit to the GUH. Key feedback from the GIRFT team is provided below:

- The team commented on what they described as a fantastic Emergency Department and how impressed they were by the visit and staff they met.
- The team shared that they were pleasantly surprised with how well the Health Board was doing despite the challenges and demands placed on the hospital.
- Reported on the performance challenges faced particularly around ambulance delays and long waits in the ED
- The Health Board has a low level of clinical consultant 'processing power' where annual admissions per whole time equivalent (WTE) of Health Board Consultants is 345 compared to a UK average of 280 per consultant. This shows that our consultants are looking after more patients per day in comparison with the UK average.
- Noting our step down model from the GUH to enhanced local general hospitals, it was shared that we were running a very 'hot' system and the data suggested we were under bedded within the GUH.
- The average age of our admitted patients was only 44 years. This suggests we serve a population of very high deprivation. However, our frequent attenders to ED is only 0.9% which is low against a UK average of 2%.

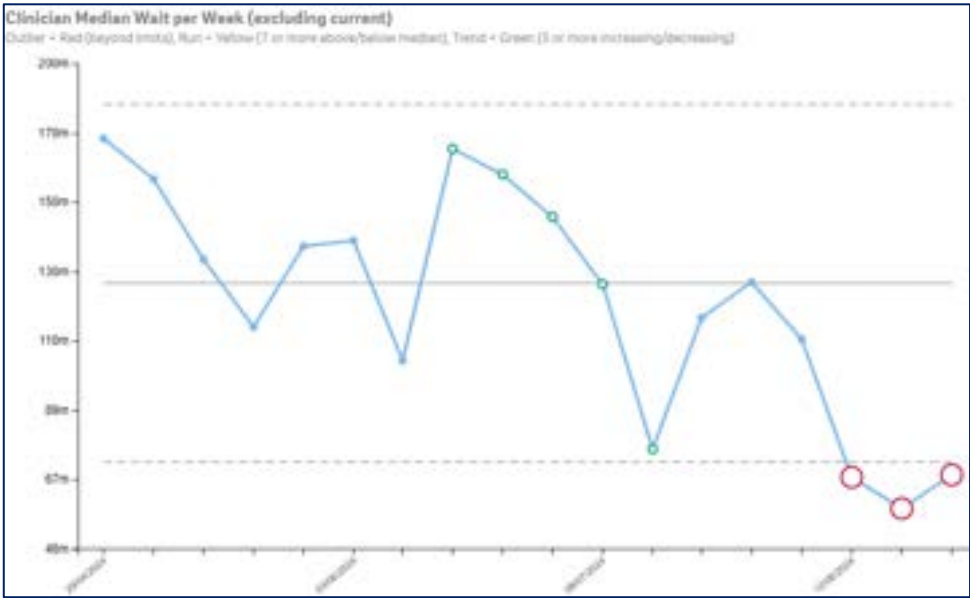
Asesiad / Assessment

Since the Health Board was placed into Enhanced Monitoring there have been positive performance improvements demonstrated. At a recent quarterly meeting with Welsh Government and NHS Executive colleagues the improvements and focus demonstrated was recognised.

- **Ambulance handover** metrics have been on a positive improving trend:

	April 24	May 24	June 24	July 24
Lost Hours	3269	3400	2702	2232
Total Arrivals	2694	2722	2554	2660
Average Handover (mins)	104	108	101	82
Average Lost Mins Per Arrival	73	75	64	50
Waits over 1 hour	1126	1205	1142	1074
Waits over 2 hours	684	757	667	566
Waits over 4 hours	366	392	298	202
Waits over 6 hours	171	206	135	86

- **Wait to be seen (WTBS)** by a clinician median wait has reduced since April:



- **Reducing >12 hour ED attendances** is on a positive downward trend and currently meeting the Welsh Government improvement trajectory:



The focus and improvement are a demonstration of positive progress over the last several months. There are a large number of initiatives and improvement projects underway within the U&EC work which are all contributing or will eventually help deliver a sustained improving position. Many of these initiatives are in progress and have not required specific additional funding or support to initiate.

Positive progress but a requirement to support additional schemes

Despite the positive progress and tremendous amount of work being invested into this priority, in order to drive performance improvement further to improve safety and experience and to de-escalate from Enhanced Monitoring there is a requirement for focussed investment in two key areas. Onward improvement to meet required standards will not be achieved without additional targeted investment.

There are two key schemes that have been developed that are ready to be taken forward, subject to funding approval. The full business cases for these schemes can be found within the appendices of this Board report for the full details.

GUH Transfer Lounge Expansion

The current transfer lounge within the GUH is only large enough to hold a maximum of 6 bedded patients and 4 chairs. Due to this very small size it is not able to be used reliably as a high throughput lounge to meet the needs of our discharges and transfers to other hospitals. The GUH has circa 50 discharges and 13 'step down' inter-site transfers a day.

As there is no location to proactively move patients to wait for discharge or transfer, it means that they currently wait within the wards which presents a major challenge for patient flow. If there was an ability to increase its size then a model could be enacted which would see patients identified for step down or discharge being moved down to the expanded lounge early in the day to enable continuous flow. This would ensure that ED and assessment units had onward flow from their departments and indirectly more space would be freed up to enable more timely ambulance handovers.

The expanded unit proposed would see a demountable built next to the current small transfer lounge at the back of the hospital, that would have the ability to house 10 beds and 15 chairs. This could be further flexed up to 12 beds and 20 chairs if required. This unit would work on a model of 12 hour opening from 8am to 8pm and would be a staffed high throughput unit where patients could complete their GUH journey. The staffing would ensure proactive 'pull' of patients into the lounge and would offer vital support such as pharmaceutical provision to enable patients to go home or transfer to another care setting.

In the development of this case, learning and evidence from Musgrove Park was used so that best practice benchmarks was available.

By having patients ready earlier in the day, would also have a positive impact for Welsh Ambulance colleagues and our inter site transfer contract where patients are located right next to the transfer ambulance car park. It is estimated this would reduce time of transfer or discharge by 30 minutes.

This project has gone through a full governance process and has an option available to either lease the unit with revenue funding or purchase the unit utilising capital funding, should capital be available.

Lease Option Revenue	Year 1 £'000	Year 2 £'000	Year 3 £'000	Total £'000
Revenue Costs				
Staff	58	176	132	366
Non Pay	30	81	61	172
Lease Cost	43	171	128	342
Enabling and Other works costs	58	231	174	463
Total Revenue	189	659	494	1,342

Purchase Option Revenue	Year 1 £'000	Year 2 £'000	Year 3 £'000	Total £'000
Revenue Costs				
Staff	58	176	132	366
Non Pay	30	81	61	172
Total Revenue	88	257	193	538

Lease Option Capital Cost	Year 1 £'000	Year 2 £'000	Year 3 £'000	Total £'000
Health Board Enabling Costs	26			26
Fees	7			7
Works Contingency	30			30
IT Costs	26			26
Total Capital Cost	89	0	0	89
Total Cost	278	659	494	1,432

Purchase Option Capital	Year 1 £'000	Year 2 £'000	Year 3 £'000	Total £'000
Purchase cost of Unit	958			958
Enabling and other Works Costs	452			452
Health Board Enabling Costs	26			26
Fees	7			7
Works Contingency	30			30
IT Costs	26			26
Total Capital Cost	1,500	0	0	1,500
Total Cost	1,588	257	193	2,038

The revenue cost under a purchase option is part year to give a like for like comparison to lease option. If the portacabin continues to operate past the 2 years as a transfer lounge there is an additional £64k revenue per annum in year 3 and beyond.

Subject to approval and onward financial agreements, this unit could be in place by January 2025. More details can be found in the attached business case for the scheme. It proposes that the Health Board proceeds with a revenue option without delay but with a potential to utilise capital to purchase the unit if it is successful in obtaining capital funding should that become available in the future. This is deemed to be an essential element of safe system operation over the winter period.

In summary the expansion of the GUH transfer lounge would result in a maximum revenue commitment of £189k in 2024/25 and a full year revenue cost of £659k in 2025/26 if capital is not secured.

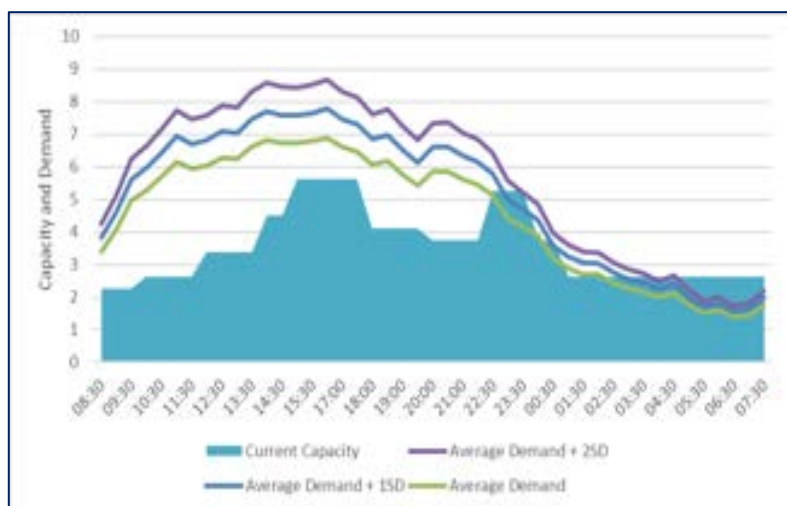
ED Consultant expansion aligned to increased safety and rapid assessment

Over the past 12 months there has been a great deal of effort analysing workforce requirements for the Emergency Department at the GUH. A proposal has been developed, learning from the recent industrial action this year, as well as from a senior rapid assessment pilot conducted within ED.

The current consultant workforce provides a wide range of coverage both to the GUH ED directly, as well as to the minor injury units and Physician Response Unit.

During pre-GUH planning work, the department was assumed to get between 100 - 170 attendances per day across the adult-only cohort. Since opening GUH, the reality is that ED experience an average of 263 attendances including the Children's Emergency Assessment Unit experiencing an average of 75. Current fully staffed capacity does not meet demand.

An example of this is shown below for weekends. This graph shows that during the day up until late evening there is a gap between demand and capacity within the unit based on the existing staffing levels.



This results in delays to the assessment and treatment of patients, demand 'pile ups' causing overcrowding and a resulting increase in additional pressure placed on the night shift to manage out of hours.

Available benchmarking shows ABUHB being cost effective against two other large Health Boards in terms of cost per urgent attendance, and Wales remains one of the lowest number of ED consultants across all four nations.

The Directorate has identified how 6 additional consultants would be deployed within ED in order to achieve some of the positive impacts recently experienced.

1. **Weekday Senior Rapid Assessment & Treatment 0800-2000.** Learning from recent experience in piloting and industrial action. This role would be put in to deliver a new service of Senior Rapid Assessment Team (SRAT) as an additional consultant covering 12 hours from 8am to 8pm. This would deliver significant improvements in WTBS and decongesting the department.

2. **Substantive Weekend Twilight shift 1430-2230** - Weekend twilight shifts are currently covered using additional locum spend costing circa £120k/annum. Providing this substantive cover would therefore avoid additional locum spend.
3. **Weekday Twilight Childrens Emergency Assessment Unit (CEAU) 1600-2230** - There are currently 2 x consultants rostered on in the evening for the entire ED incl. CEAU. This increased level of CEAU coverage would provide an evening consultant to match the daytime coverage. This would increase the safety of CEAU rather than spreading the current consultant resource between clinical areas at a time of peak demand. This consultant would work in ED adult majors if there was low demand in CEAU.

Through additional senior presence and rapid assessment the objective is to deliver the median wait to be seen within the ED to 1 hour or less.

The financial breakdown of this cost is provided below:

	WTE	Year 1	Year 2
ED Consultant	6	48,084	865,548
1 B4 Med Secretary (Nov 24 Start)	1	14,495	34,787
Sub Total	7	62,579	900,335
Less Savings		-5,000	-120,000
Total		57,579	780,335

Funding source

Whilst opportunities to seek external funding to support this agenda will be explored, there is an option to utilise a proportion of Health Board priority investment reserve funding to enable these developments.

2024/25 innovation reserve M5	£k	£k balance available	25/26 recurrent balance	
Innovation Reserve Annual Plan	3,000	3,000	3,000	3,000
M5 expansion (£543k rec)	(257)	2,743	-543	2,457
RTT improvement (May submission)	(1,000)	1,743	0	2,457
ED expansion (£780k rec)	(58)	1,685	-780	1,677
Transfer lounge (£659k fye if no WG funding)	(189)	1,496	-659	1,018
note:				
ED expansion full year recurrent cost of £780k from 25/26				
Transfer lounge 24 month cost 24/25 £278k, 25/26 £659k, 26/27 £494k if no WG capital funding received				

Given the importance of the Urgent and Emergency Care System, and the Enhanced Monitoring by Welsh Government, this investment is essential to support improvements across the GUH urgent and emergency pathways to improve patient safety and experience and support de-escalation from our enhanced monitoring status. The costs attached in the table represent the maximum cost for these

investments whilst other funding sources will be pursued. Welsh Government has been appraised of these plans and are supportive.

Argymhelliad / Recommendation

The Board is requested to NOTE the recent improvements in urgent and emergency care at GUH due to the focus and initiatives already enacted over the past year.

The Board is requested to APPROVE the additional investment set out in this summary paper and broken down in more detail within the two attached business cases.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Strategic Risk
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	5. Timely Care 5.1 Timely Access Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	• Getting it Right First Time (GIRFT) • Emergency Department (ED) • Urgent and Emergency Care (U&EC) • Whole Time Equivalent (WTE)

	• Senior Rapid Assessment Team (SRAT) • Childrens Emergency Assessment Unit (CEAU)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Board Briefing Session 17/9/2024

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Yes, outlined within the paper
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 May 2024
CYFARFOD O: MEETING OF:	Executive Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	ED Demand & Capacity – Increase in Consultants
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins – Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Dr Owain Chandler – Divisional Director Urgent Care Dr Alastair Richards – Clinical Director Emergency Medicine Richard Morgan-Evans – Deputy Chief Operating Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

For latest PIP comments and responses please see Appendix 3

Over the past 12 months there has been significant analysis to support improvement of our urgent and emergency care system. One key element of this is the demand and capacity work to review medical cover within the Emergency Department. The goal behind this is to improve patient safety as well as the timeliness of assessment and treatment. A business case valued at £5.12m was submitted to PIP to increase ED staffing and therefore improve key metrics such as wait to be seen by a clinician.

The PIP panel recommended a range of clarifications needed in order for the case to be suitable to take forward to Executives, given the scale of the financial ask, It was recommended that a more focussed discussion was had by involved members of the team before putting forward a proposal to the Executive Committee to avoid abortive work on the case. It is accepted that the original proposal ask was unpalatable given the wider financial context, despite the case being supported by detailed D&C modelling. This was recognised and supported by the department.

This revised proposal requests substantially less investment than the original case and encompasses learning from the feedback and outputs from recent industrial actions as well as the rapid assessment pilot.

The Executive Committee is being asked to support the substantive recruitment of 6 x Emergency Department Consultants to underpin the onward improvement ambition in line with our U&EC enhanced monitoring status.

Cefndir / Background

Since opening in November 2020, the Grange University Hospital (GUH) Emergency Department (ED) has experienced between 140 and 280 attendances per day, with an average of 263. During the same period, the Children's Emergency Assessment Unit (CEAU) has experienced between 52 and 141 attendances per day, with an average of 75. This overall demand far exceeds the 100 to 170 attendances across the adult-only cohort modelled in the original Clinical Futures Service Design. Despite system changes to mitigate against growing demand, ED attendances have continued to increase in both number and complexity.

ED has successfully recruited to the Clinical Futures model. However, the resulting capacity is not sufficient to meet the demand described above. Since the opening of GUH, changes to ED medical staffing have been approved on an ad-hoc basis using variable pay or existing workforce. These changes have been implemented in response to safety concerns arising from demand and capacity mismatch or changes to the ED footprint dictated by system changes (e.g. provision of a Respiratory Assessment Zone as a pandemic response).

In order to address the ongoing demand and capacity deficit in a more systematic way, the ED Directorate commissioned Aneurin Bevan Continuous Improvement (ABCi) to undertake an mathematical modelling exercise with the ambition of optimising GUH ED medical staffing (referenced in appendix 1). This exercise identified a significant gap between demand arriving at ED and the department's capacity to assess and treat these patients in a timely fashion.

The following shows summary graphical outputs from the ABCi D&C modelling showing a fundamental deficit between demand & capacity through the week:

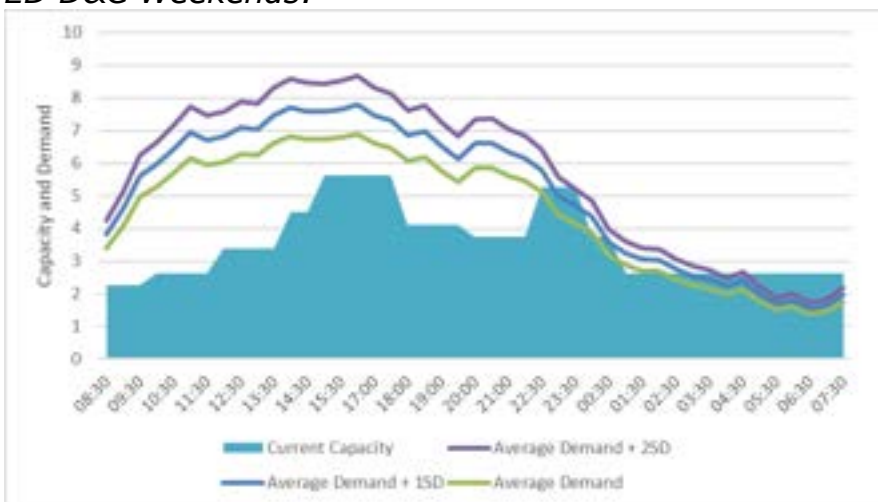
ED D&C – Mondays:



ED D&C Tuesday-Fridays:



ED D&C Weekends:



This capacity deficit was associated with:

- High clinical risk;
- Demand 'pile-ups' during the day;
- Additional pressure during night shifts to address daytime 'pile-ups.'

These risks can contribute to patient safety incidents and issues, including:

- Increased rates of adverse events, with departmental overcrowding and insufficient staffing arising as common these in serious incident investigations;
- Delays to assessment and treatment of patients as recorded by the reportable 'wait to be seen metric'
- Delays to diagnostic imaging, and delayed diagnosis of time-critical conditions with recent duty of candour cases including delayed diagnosis of ischaemic limb, acute coronary syndrome and head injury.
- A 2022 Emergency Medical Journal paper highlighted that there were worsening patient outcomes as the standardised mortality rate rises after five hours in the ED, with one extra death for every 82 patients delayed over six hours. It is estimated that since May 2021, delays in GUH ED have contributed to between six and nine deaths per month; it has been estimated that in 2023, 293 additional deaths were likely to have occurred.
- Unscheduled reattendance and patients who do not wait (or who discharge against medical advice); In 2023 11.3% patients did not complete their treatment episode with 8.4% leaving prior to assessment and 2.9% leaving before completing their treatment. The RCEM quality indicator standard for an ED is <5%.
- Reductions in patient satisfaction. Pre GUH the complaints numbered around 70 per year and this increased to > 1000 in the first year at GUH. Recent understand is that complaints are still not below pre-GUH levels.

NHS Wales benchmarking

Workforce costing statistics available from participating Health Boards in relation to the NHS benchmarking network show ABUHB's urgent care system having a lower workforce cost per attendance than both CTMUHB and HDUHB:

Health board	Total Costs	Total Attendances	Cost per 100k attendance	Cost per Attendance
Cwm Taff	£ 23,880,749	118,126	£ 20,216,336	£ 202
Hywel Dda	£ 27,274,975	148,625	£ 18,351,539	£ 184
Aneurin Bevan	£ 31,501,016	185,821	£ 16,952,344	£ 170
Betsi Cadwaladr	£ 37,556,663	227,236	£ 16,527,603	£ 165
Powys (MIU only)	£ 1,619,322	18,972	£ 8,535,326	£ 85
Grand Total	£ 121,832,725	698,780		

Note – C&VUHB and SBUHB did not submit benchmarking information.

It is also considered that the cost for Aneurin Bevan University Health Board is also inflated as a result of the MIU out of hours coverage.

RCEM 2018 Workforce report

The 2018 report from the Royal College of Emergency Medicine shows that Wales as a whole has the highest number of ED attendances per consultant. Although this report is now a number of years old the overarching point shows that Wales see's almost double the patients per consultant than England.

	Annual ED attendances 2016-17	Total number of Consultants (WTE)	Estimated number of new patient ED attendances per Consultant/year
England	15,262,758	1719	8,879
Scotland	1,627,412	220.6	7,300
Wales	1,003,710	67	15,000
Northern Ireland	797,666	68.3	11,700

The college has defined that this ratio should be 1 WTE Consultant to between 3,600-4,000 new attendances.

Escalation by Welsh Government

In January 2024, Aneurin Bevan University Health Board was escalated to enhanced monitoring for performance and outcomes related to urgent and emergency care pathways at the Grange University Hospital. Of particular note to this paper, Welsh Government have set the following targets as de-escalation criteria:

- A three-month continuous reduction of at least 15% in each month from the Oct-Dec 2023 baseline) for ambulance handovers.
- A continuous improvement towards no more than 5% of patients waiting over 12 hours at each individual site and across the health board.
- 100% of patients to be assessed by senior clinical decision maker within 60 mins from arrival.

The increasing focus on performance improvement expectation was followed up in a recent NHS Team Wales event where it was stated the following improvement trajectories were 'non-negotiable':

- The number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge - 20% reduction by September against March baseline before a further 20% reduction by March 2025.
- The number of ambulance patient handovers over 1 hour to reduce by 30% by December against March baseline.

In summary to the background, the Emergency Department does not have the clinical processing power to be able to effectively manage the demand experienced on a day to day basis. Although there are many challenges and solutions across the U&EC system, there is always going to be a fundamental bedrock issue around what we are currently able to deliver in terms of timeliness of assessment and treatment within ED. As between 70-80% of patients that arrive at an ED get managed and discharged out not requiring an inpatient stay, it is imperative that we ensure we provide the capacity to meet this demand in a sustainable and targeted way.

Asesiad / Assessment

Learning from recent industrial action:

There have been positive lessons learnt from changes in patient processing as a response to recent episodes of junior doctor industrial action and pilot projects undertaken by the Emergency Department team (e.g. Senior Rapid Assessment and Treatment (SRAT) Pilot (referenced in appendix 2), have shown that increased senior medical presence and early assessment resulted in an improvement of all reportable metrics of ED performance.

Most notably, the late March industrial action resulted in the best performing week since GUH's opening across several measures, and since Summer 2021 across others, with successes including:

- Lowest number of lost ambulance hours since GUH's opening (163 minutes);
- Shortest median handover since GUH's opening (22 minutes);
- More patients seen within 2 hours than usual (58% compared with a typical range of between 30 to 40%);
- Fewer patients with a bed request but no admission than usual (54 for Medicine compared with ~100 per week since 01/24) (with similar attendances and assess-out rate);
- Shortest median time in department for admitted patients since GUH's opening (6.3 hours);
- Shortest median time in department for non-admitted patients since Summer 2021 (4.2 hours);
- Fewest patients in ED over 12 hours since Summer 2021 (131 compared with a weekly average of 250).

Current consultant coverage

The 24.01 WTE current consultant team provides senior medical clinical leadership within ED from 08:00 to midnight, seven days per week. The model allows for an Emergency Physician in Charge (EPIC) and a Clinical Decision Maker (CDM) from 08:00 to midnight. A dedicated CEAU ED consultant is on shift from 08:00 to 16:30 each weekday. Due to increased demand, an additional consultant is on the Monday rota from 12:00 to 20:00.

One consultant undertakes non-DCC duties within GUH each weekday. These duties include: follow-up for patients who DNW or for those with abnormal test results; completing witness statements for the police; and addressing any urgent clinical administration tasks.

The consultant team also provides of in-person senior clinical cover to the MIUs five days per week from 09:00 to 17:00. The consultant team provides telephone clinical advice to the MIUs routinely seven days per week from 08:00 to midnight.

Weekend working frequency is one in six, which is the maximum frequency considered to be acceptable by RCEM. The weekend senior clinical cover remains the same hours of 08:00 to midnight. However, there is no dedicated CEAU consultant at the weekend.

The consultant team is predominantly under the age of 50. In recent recruitment efforts, the department have aimed to hire experienced consultants from other hospitals to balance the risks associated with a less experienced workforce.

The table below sets out where the current consultant workforce deliver direct clinical contact sessions:

Shift Name	Hours	PA Total
Weekday Emergency Physician in Charge	0800-1630	2.27
Weekday Clinical Decision Maker	0800-1630	2.27
Weekday CEAU	0800-1630	2.27
Weekday Twilight	1600-2230	2.68
Weekday Late	1600-2400	3.43
SSU & Clinical Admin	0800-1145	1
Weekday eLGH	0900-1700	2.13
<i>Physician Response Unit</i>	<i>0900-1700</i>	<i>2.13</i>
Weekend Long Day	0800-1630	4.13
Weekend Short Day	0800-1430	3.25
Weekend Twilight	1430-2230	4
Weekend Late	1600-2400	4

The enhanced consultant proposal

The Directorate has identified how 6 x additional consultant resource would be deployed within ED in order to achieve some of the positive impacts recently experienced. 6 x WTE on a standard NHS Wales Consultant Contract would provide 32.75 DCC sessions per week.

No.	Consultant Shift	Sessional Tariff	Total
1.	Weekday Senior Rapid Assessment & Treatment 0800-1630 (utilising existing resource to extend this to 2000hrs each night). <i>Learning from recent experience in piloting and industrial action. This role would be put in to deliver a new service of SRAT as an additional consultant covering as much as 12 hours from 8am. This would deliver significant improvements in WTBS and decongesting the department.</i>	2.27	11.35
2.	Substantive Weekend Twilight shift 1430-2230 <i>Weekend twilight shifts are currently covered using additional locum spend costing c.</i>	4	8

	<i>£120k/annum. This was based on 656 hours being filled for weekends in 2023/24.</i> <i>This coverage can be inconsistent and requires existing consultants to perform additional shifts beyond their job plan. Providing this substantive cover would therefore avoid additional locum spend.</i> Note: <i>Weekends pose a challenge in terms of sustainability and financial impact. The Royal College of Emergency Medicine (RCEM) suggests a maximum of 1 in 8 weekends for sustainability, while the consultant body prefers a 1 in 6 rotation with safer staffing for better patient care and service. The mandate from Health Education and Improvement Wales (HEIW) is a maximum of 1 in 3 weekends for trainees. However, some current medical staff are working 1 in 2 weekends. Achieving true 7-day service is difficult under these conditions, and it is a challenge to accomplish this without further investment. For the benefits of a Senior Reviewer at Triage (SRAT) model to be realised, along with prompt patient assessments, admitting teams need the capacity to see incoming patients and complete their admission processes, as they won't have the traditional comprehensive workup.</i>		
3	Weekday Twilight CEAU 1600-2230 <i>There are currently 2 x consultants rostered on in the evening for the entire ED incl. CEAU. This dedicated level of CEAU coverage would provide an evening consultant to match the daytime coverage.</i> <i>This would increase the safety of CEAU rather than spreading the current consultant resource between clinical areas at a time of peak demand.</i> <i>It has been recognised that lack of dedicated senior evening cover in CEAU poses a significant risk for both demand and capacity mismatch and clinical safety. The additional consultant CEAU evening shift will alleviate this risk but also allows the flexibility to redeploy resource to the main department based on the demand profile as required.</i>	2.68	13.4
Total			32.75

This investment in the consultant workforce will require robust administration support to fully function. Historically, the ED Secretarial team has been under resourced which has led to unsafe backlogs of administration work. To provide context, in 1995 the ED had 3.5 wte secretaries for 3 Consultants and now in 2024, there are 2.86 wte secretaries for 26 Consultants and 1 Consultant Nurse.

Consequentially, there is an impact on patient outcomes and experience through facing delays in receiving results and an impact on medical and nursing staff who are picking up additional work to support. This not only has a financial impact with the payment of clinical staff to complete tasks but it also affects staff well-being and morale with increased workload and pressure.

The role of an ED medical secretary holds many familiar duties as well as the duties of reviewing and actioning x-rays, liaising with the Coroner, Police, Medical Examiner and Care After Death teams and supporting the daily Consultant with administration duties with includes providing the 'Did Not Wait' paperwork. Further responsibilities that the ED Consultant body require support with include organising Continuous Personal Development (CPD) sessions and supporting medical recruitment, induction and student shadow days, the Physician Response Unit (PRU), the Children's Emergency Unit and keeping track of the department's guidelines and protocol.

Guidance from the British Medical Association (BMA) suggests there should be at least 1.0 wte secretary per 2 ED Consultants. Staffing the medical workforce to the preferred option, would necessitate 5.0 wte secretaries. However, it is recommended that a more prudent approach is taken and the secretarial staff increase by 1 x WTE due to the financial context.

Increasing the number of secretaries in the team will ensure that administrative tasks are managed promptly and efficiently, allowing the consultants to focus on their core responsibilities. This proactive approach will contribute to smoother workflow, improved patient outcomes and experience and better overall performance in the Emergency Department.

Breakdown of proposed investment

Shifts	DCC's	Admin	A/L Uplift	SPA	Total Sessions	WTE
Weekend Extra	8.00	0.32	1.98	4.41	14.72	1.47
SRATS	11.33	0.45	2.81	6.25	20.85	2.08
Paeds Evening	13.42	0.54	3.32	7.40	24.68	2.47
Total	32.75	3.28	8.11	18.07	60.24	6.02

Financial breakdown of requested investment over two years:

	WTE	Year 1	Year 2
ED Consultant	6	48,084	865,548
1 B4 Med Secretary (Nov 24 Start)	1	14,495	34,787
Sub Total	7	62,579	900,335
Less Savings		-5,000	-120,000
Total		57,579	780,335

Profiled 1 x Consultant from Nov and remaining 5 from April. Med Sec has a Nov start date

Expectation of performance improvement

The SRATs pilot (referenced in appendix 2) demonstrated performance improvement across a range of key metrics. These are listed in the table below. Noting this was a limited pilot with a very short timeframe and less operating hours per day, the data shows that if we run a substantive 8-8 weekday SRATs model we should expect to bring down average WTBS to around 2 hours.

	Baseline	During Pilot	Impact
1: Time to clinician during SRAT operating hours 8am-4pm, Mon-Friday.	3.3hrs	2.7hrs	0.6hrs
2: Time to clinician during the 24-hour period following which SRAT was operational:	4.1hrs	3.9hrs	0.2hrs
3: Overall length of stay in the ED:	7 (AVG)	6 (AVG)	1 Hour (AVG)
4: Overall admission rates from 8am-4pm during pilot:	23.1	21.1	2
5: Number of did not waits:	568	442	126

The opportunity we have with the coming new internal ambulatory area within the ED capital extension sets the conditions to run a new flexible model of care to conduct more effective assessments and being able to bring down WTBS, protect assessment spaces and ultimately increase throughput through the department. To that end it is the ambition of the Health Board to set a direction to bring average WTBS times down to one hour in line with recent urgent and emergency care standards. This consultant investment will play a significant part in how we do this. However to achieve this fully and sustainably this ambition will be delivered in conjunction with wider improvement work within the GUH as well as throughout the current ABUHB system. As the new ED extension comes online with the reformed and reconfigured internal layout, this will further support adapting models of care to be able to support increased assessment and therefore WTBS.

This will ensure a positive compounding factor if done substantively. Ensuring rapid assessment up until 8pm will ensure the department goes into the night time in a much better state having been decongested effectively.

With regards to ambulance vs 'walk in' priorities, patients are always seen based on clinical priority rather than mode of arrival as per national standards. However the service recognises the patient risk in the community and the importance of freeing up ambulance resource to respond to these patients. If there was ever a scenario that there were two identical presentations with one arriving by ambulance and one walking in, the priority would go to the ambulance patient due to the community risk of holding ambulances. This investment in an increased senior decision maker presence at the front door will allow us to work dynamically and deploy resource appropriately to ensure timely assessment of patients held on ambulances and maximise the prospects of releasing crews where practicable.

Timelines

Local departmental intelligence suggests that four to five of the potential consultant appointments could be recruited very quickly pending a competitive recruitment process and associated panels. Pending this process, all six consultant could be recruited for in advance of the next winter period. The interest in potential positions is mainly from individuals nearing the end of their training.

If the right quality of candidates apply, it would be cost-effective to appoint directly rather than operating the model with variable pay and phasing the recruitment. However, this approach does bring the challenge of integrating a significant number of new starters at once. This challenge is somewhat lessened by the fact that two of the potential appointees have already worked with the department as locum consultants, and others have been senior trainees in the department. If the model's operation is time-sensitive, it may justify the immediate appointment of qualified candidates to avoid the costs and complexities associated with variable pay and staggered recruitment.

Organising consultant interview panels is a challenging task, and after discussing with workforce, it seems unlikely we could conduct interviews before September, considering the necessary processes and the summer period. This timeline would allow new hires to be settled in by next winter, which could help manage some of the more difficult aspects of the build. An alternative could be to appoint some as locum consultants and others in substantive roles, with the possibility of holding another interview panel at a later date.

24hr consultant working

There has been discussion around 24 hour a day consultant delivered presence in ED during the creation of this proposal. Currently the only hospital site that has 24 hours a day coverage is UHW in Cardiff due to the major trauma centre requirements and commitment. It is understood that this set up has a consultant rostered in the department until midnight and then the informal routine is the consultant becomes resident on call from within the hospital.

This

It is not proposed to seek funding for a 24/7 consultant presence in ED due to the expense of the ask and rather focusing on where the demand is strongest over a 24 hour period. It is accepted that the department does not have the processing power during the day and into the evening period to be able to de-escalate before overnight. Therefore, a patient backlog is built up which does not allow for the medical staff working overnight to manage effectively before the following day

where new demand presents. This view has been supported by the ABCi team modelling data for overnight periods where it showed that demand and capacity were in balance.

By seeking to enhance the medical staffing position during busy periods, it will result in a more de-congested environment out of hours.

Job planning

The department are operating under the agreement of a 7/3 split for Supporting Professional Activities (SPA), as is standard practice. The high levels of training, governance, and the ongoing improvement initiatives mean that the department are already exceeding its capacity for SPA, with most individuals only receiving 1 personal Continuing Professional Development (CPD) SPA instead of the 2 that are recommended in the job planning guidelines issued by the Medical Director's office. This will remain under review to ensure all SPA's deliver appropriate outcomes for the Emergency Department.

The nature of Emergency Medicine work in a department the size of GUH generates a large amount of SPA activity in areas such as teaching, training, governance and service development. It is therefore likely that a 7:3 split will be appropriate for the vast majority of full time ED consultants and so the service model described is planned on this. However the division does recognise that this is not a prerequisite and that any new appointments would need to demonstrate the value of SPA activity through the job planning process. As an example, if more experienced consultants were recruited they may have skills and experience that warranted 3 SPAs on appointment, however for junior consultants the expectation would be to start on an 8/2 set up and review at a later date. Due to the annualised rostering for ED consultants, if any additional DCC time was available this could easily be translated into additional shop floor cover.

Future developments

ED Short stay option – Discussions have already begun regarding the potential for bringing online an ED 'Short stay' unit which have involved multiple services. This has focused on the current Respiratory Assessment Zone (RAZ) space within AMU2 in the GUH. This work is proposed to be captured under the weekly enhanced monitoring / safety flow agenda and tracked on a weekly basis.

Under the enhanced monitoring structure as well as within the 6 goals programme there will be close monitoring of this investment. It is proposed that a full review is conducted after the winter period with regular updates on a fortnightly basis as part of enhanced monitoring.

There are many other developments and opportunities within the U&EC space and it is acknowledged that there will continue to be a changing nature of how we deliver urgent and emergency care, including developing other resource including ACPs as well as Physician Associates.

Argymhelliad / Recommendation

The Executive Committee is requested to support this paper enabling the recruitment of 6 x substantive ED consultants and associated support. This

recruitment will be delivered over the summer period to have all consultants in post in advance of next winter 2024/2025 to improve the performance of the Emergency Department.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Improve the wellbeing and engagement of our staff Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive

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

Appendix 1 – ABCi Modelling summary slides

ABCi Mathematical Modelling Summary

- Mathematical modelling exercise carried out by the ABCi team: Scope was to analyse the number of patients attending the ED per hour v's the available clinician time.
- Team visited ED and also shadowed the Medical Staffing Officer and met with clinical staff.
- ED attendance data from 16th November 2020 to 2nd October 2022 (n=164,384) was used to determine the demand over a two year period.
- The capacity was then modelling by calculating the number of staff allocated per shift on Monday, Tuesday-Friday and Saturday and Sunday.

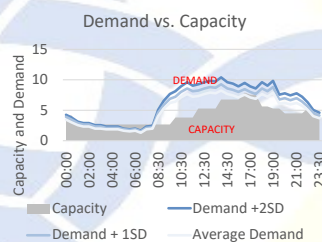


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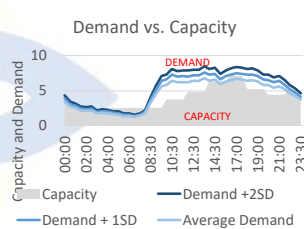
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Aneurin Bevan
University Health Board

Demand and Capacity Review

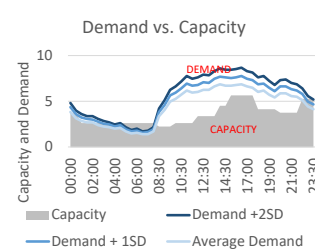
MONDAY 31 STAFF



TUESDAY – FRIDAY 30 STAFF



SATURDAY – SUNDAY 24 STAFF



- There is a gap between demand and capacity on most of the busy periods (Mondays are the busiest)
- Demand constantly piles up during the day time.
- Night shifts have to cope with patients that have not been seen during the day.



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Assessment Space Modelling

- The ABCi team then looked at how many assessment spaces are required for optimal function within the existing demand and capacity model.
- The Length of Stay in the assessment cubicle was calculated by looking at the time difference between Start Time of Triage and the ED Discharge.
- At present there are **28 cubicles** in ED + **8 resus** cubicles which comes up to 36 in total.
- Paediatrics demand was excluded because a separate set of cubicles is used for this patient category.
- *Data showed that on average, each patient arrival generates a 4h LOS utilisation of a cubicle. Need to explain this in more detail*



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Findings from the review

- Findings from the data showed that on average & across clinician types, **0.75** patients can be seen per clinician per hour.
- To meet the average daily demand and capacity the clinician workforce needs to increase to **41-46** per day. This excludes any standard variation. To include 1 std variation would increase the staffing requirements to approx. **51** clinicians per day.
- Demand for cubicle space is at its highest peak from midday to midnight.
- Within the current environment there is a requirement for an additional **19** cubicles per day (55 in total)



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Points for Discussion

- Where do we take this next? Recognising, that the additionality required is nearly impossible to recruit... Consultant posts are sometimes easier to recruit than other grades, do we fill the gap with Consultants?
- Additional Assessment Space will not eliminate the problem. However, with increased flow the demand for assessment space will significantly reduce.
- Small efficiencies can be made by rostering staff on the busier periods throughout the day. Plan to launch amended roster with 6 shift patterns in August 2023 with the new intakes.
- Recruitment and Retention Plan to be developed to create a sustainable workforce model for the next 5 years?



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Appendix 2 – Rapid Assessment pilot

Senior Rapid Assessment and Treatment (SRAT) Pilot Report

The Grange University Hospital

Emergency Department

1. Background

The Emergency Department at The Grange University Hospital is most often fully occupied and this prevents the team from assessing patients in a timely and efficient manner. The time to clinician is unacceptably long, and this inevitably leads to poor patient experience, delayed diagnostics and ultimately, delay to diagnosis.

The ED received Executive support for a pilot of SRAT for a period in November and December 2023. The aim being to improve the “time to clinician” metric (WG Targeted and reported KPI); and deliver safer, more efficient care. The shifts were offered to consultant colleagues as extra work, mindful of the fatigue and pressure that the workforce is experiencing. We managed to fill most shifts, with 35 sessions covered during the pilot phase.

Investment Summary

The request for the pilot was that we would operate between 8am and 4pm, Monday to Friday. This was felt to be the most cost-efficient strategy due to lower daytime rates of remuneration. Going forward, all agreed that the shift should match the other daytime consultant shifts, of 8am to 4.30pm, which is equivalent to 2.27 programmed activities (PA), per day, or 11.35 PAs for a week; the investment required would be approx. 2.2 WTE. We need assurance that the cubicle nurse can be free to act as SRAT support, this would mitigate against any additional nursing costings. Otherwise, we will need to include an additional nurse for the same hours.

The Pilot

The pilot began on 15th November and ended on the 8th December. 35 4-hour sessions of SRAT were undertaken during the pilot phase. A total of three hundred and four patients were processed via the SRAT pilot. Regrettably, we were unable to fill all the SRAT shifts, with no SRAT on Weds 6th December and only half-days on 7th and 8th of December. It is therefore most meaningful to consider the impact of SRAT in full operation from 15th Nov to 5th Dec.

Results

The below table indicates the impact of change through key indicators relating to this pilot.

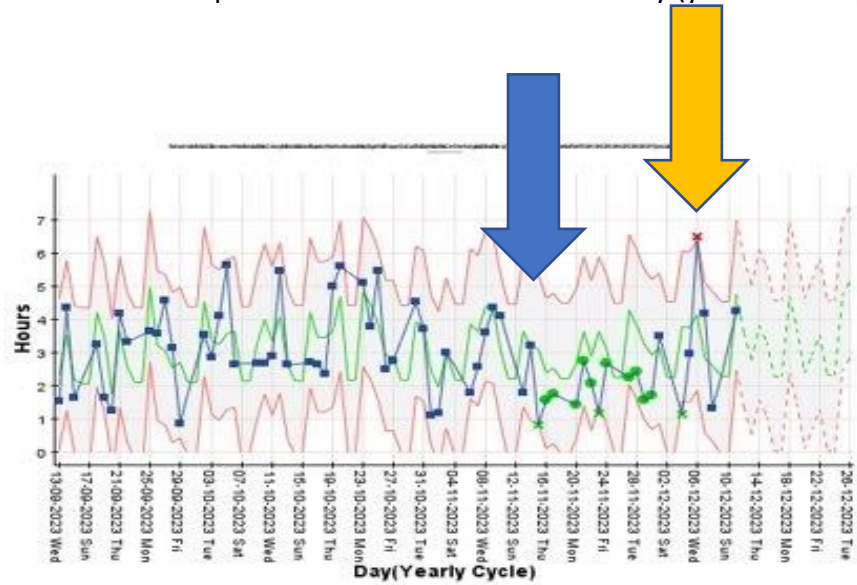
	Baseline	During Pilot	Impact
1: Time to clinician during SRAT operating hours 8am-4pm, Mon-Friday.	3.3hrs	2.7hrs	0.6hrs
2: Time to clinician during the 24-hour period following which SRAT was operational:	4.1hrs	3.9hrs	0.2hrs
3: Overall length of stay in the ED:	7 (AVG)	6 (AVG)	1 Hour (AVG)
4: Overall admission rates from 8am-4pm during pilot:	23.1	21.1	2
5: Number of DNW (did not waits):	568	442	126

Primary and secondary outcome measures are further described below. The comparator being the period of time, immediately before the SRAT pilot.

Primary Outcomes:

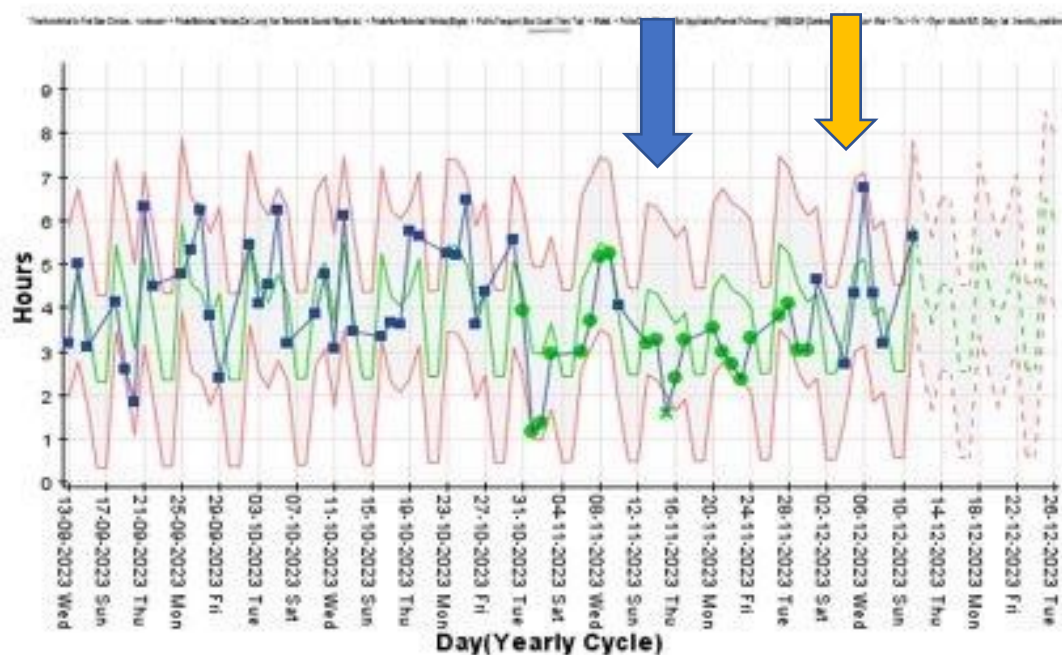
1: Time to clinician during SRAT operating hours 8am-4pm, Mon-Friday.

Since 15th Nov (blue arrow), there was a consistent improvement to time to see clinician. There was consistent improvement in average time to see clinician between 15th Nov and 5th Dec. This corresponded to an improvement in the “time to clinician” for the whole 24hr period during which 8 hours of SRAT occurred. The team reported back that the impact of SRAT was indeed noticeable on the shop floor both during, and after, the shift ended. The rapid assessment of the SRAT patients reduces overall crowding in the department, leading to more efficient use of space and staff. Wednesday 6th December was the longest time since August for daily average time to clinician between 8am and 4pm. There was no SRAT on this day (yellow arrow).



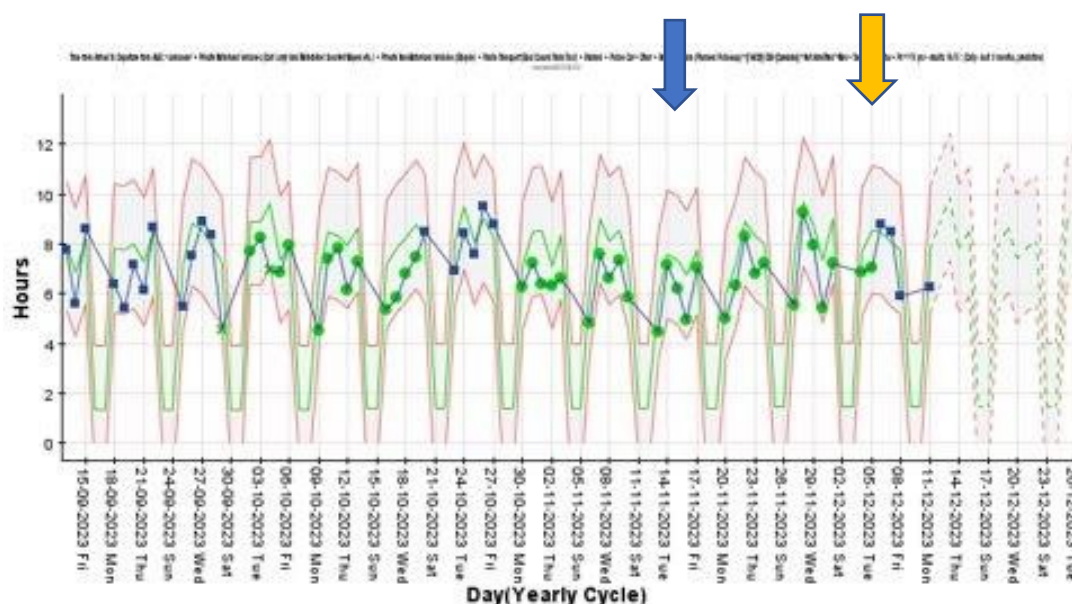
2: Time to clinician during the 24-hour period following which SRAT was operational:

There was consistent improvement over the entire 24-hour period. Blue – start, yellow – end.



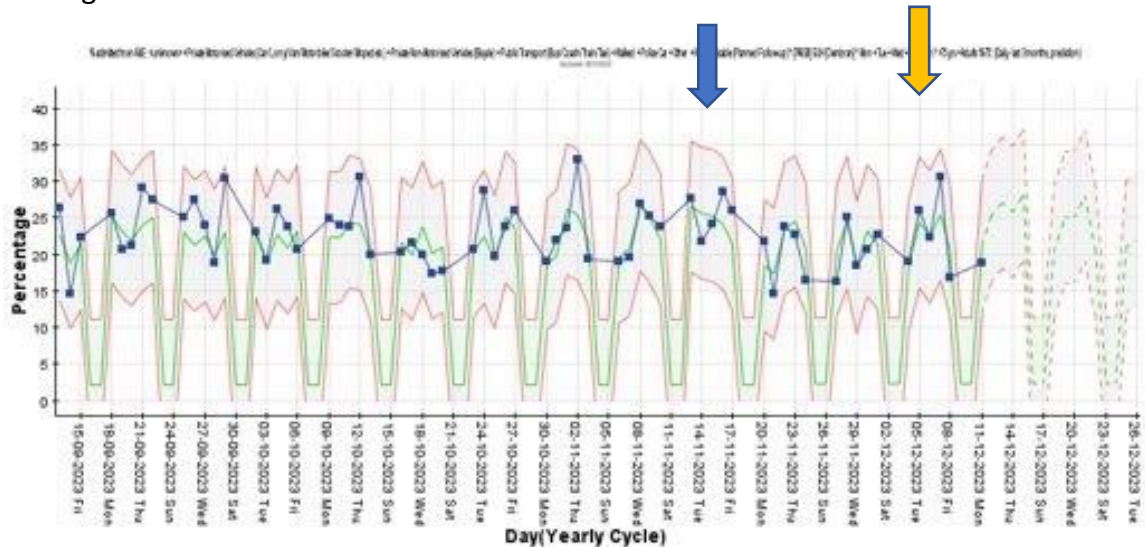
3: Overall length of stay in the ED:

Time in ED for non-admitted patients was consistently below the established average time from before the beginning of the pilot and was generally 5-9 hours. Timings have returned to the typical average time from arrival to departure for non-admitted patients since the 6th, 6-9 hours since the pilot ended. Overall length of stay is an important factor in whole-department crowding. SRAT can have a significant impact on the patients who are discharged home, but it doesn't impact the LOS for those patients awaiting admission. The delay to admission is linked to whole-system flow (and dependent on discharges downstream of the ED).



4: Overall admission rates from 8am-4pm during pilot:

This remained unchanged but showed a slight reduction in the numbers of admitted patients. It is acknowledged that senior input, sooner, can reduce unnecessary investigations and admission.



5: Number of DNW (did not wait):

We measure the number of patients who do not wait to see a clinician. A list of DNW patients are reviewed by an ED consultant each week-day, to ensure safety of those patients who decided to leave before being seen. Every day we have to contact patients and ask them to return due to concerns that they might have had a serious health issue e.g. a stroke or a heart attack. From the moment of 'booking in' we have a duty of care to these patients, and we must recognise that the lower the DNW rate, the safer the service we provide.

The first 19 days of the trial the DNW's were 442. The 19 days before the trial the DNW's were 568. They have reduced by 126 (or 22%).

6: Re-attender rate:

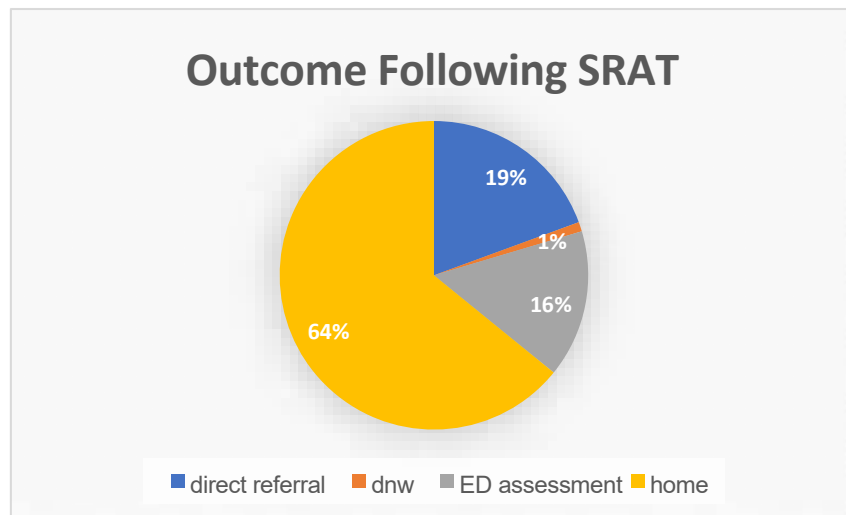
Following a clinical review of patients labelled as "re-attenders" it has been established that there was an error in the data analysis, and that very few patients truly did re-attend. Those patients are understood to have been suffering with mental health related concerns or have experienced an unrelated medical issue, as a result they have been deemed unlikely to have re-presented due to a failure in the SRAT process.

Secondary Outcomes:

1: Understanding the 'outcome' from SRAT:

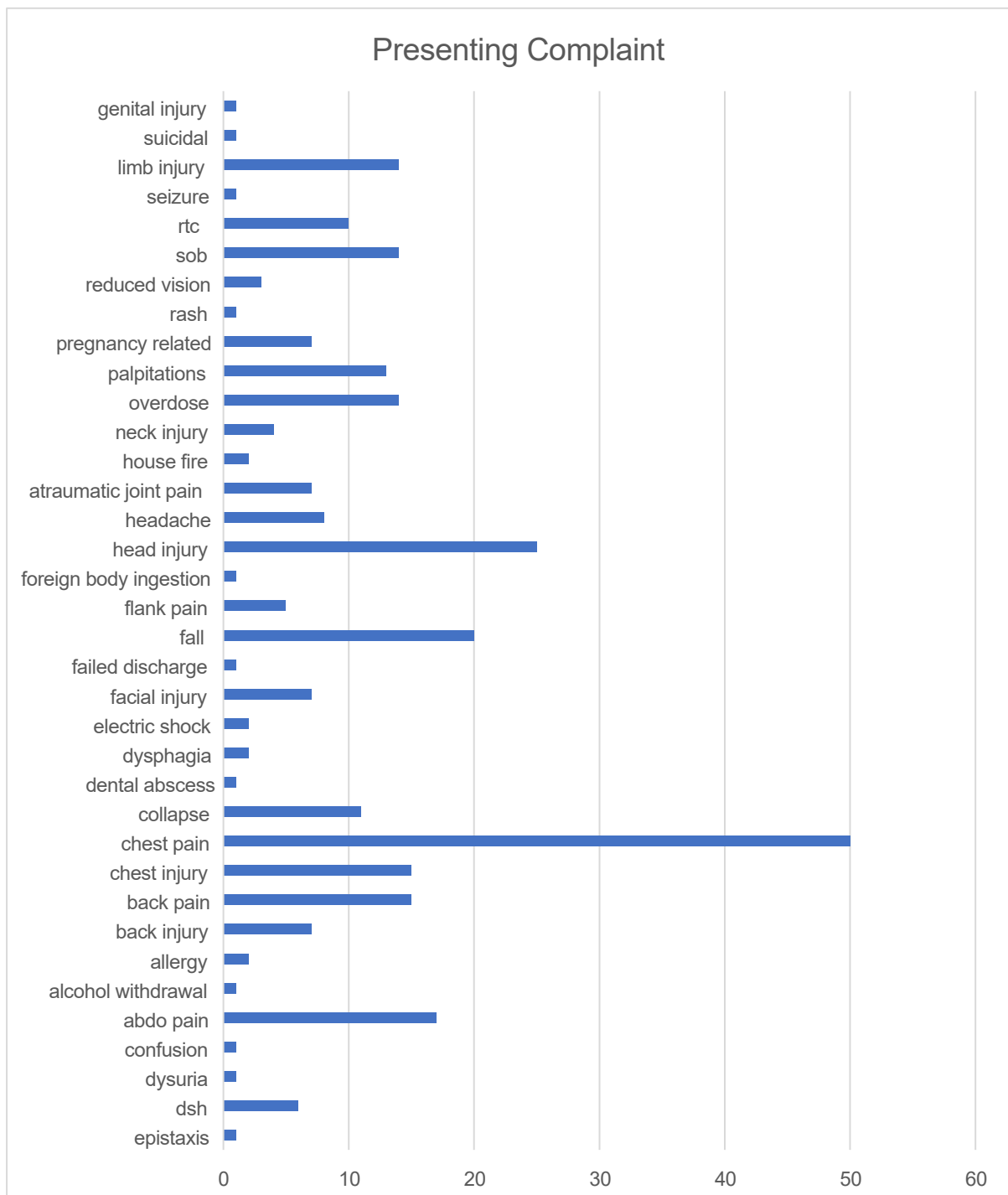
As demonstrated on the graph below, 64% (195 patients) were discharged following assessment by the SRAT team only. This often included some basic investigations, that were followed up by the SRAT team themselves, and led to direct ED discharge. 19% of patients (n=59) were referred directly to the relevant speciality team. Only 16% of patients were placed back into the ED 'queue' for completion of treatment/onward

referral. These patients were typically more complex and needed further ED care e.g. joint dislocations or deep wounds that needed time-consuming treatment.



2: Range of presentations:

The SRAT team were able to see a vast array of presenting complaints, as shown below. For interest: 39/50 chest pains were discharged home; 23/25 head injuries were discharged home; 8/12 overdose patients were referred directly to mental health; 11/12 palpitations patients were discharged; 5/7 pregnancy related problems were referred directly to obs/gynae.



3: Feedback from team: Medical, nursing, PFC, AHP

Reduced patient numbers in the waiting room=improving patient comfort, easing congestion in that area and reduction in rapid assessment staff workload.

Lead nurse: Staff gave positive feedback when supporting the rapid assessment trial.

I found it very productive with a quick turnaround of patients.

It certainly works well is there's allocated space.

I found it useful from an educational point of view because it's reassuring that the consultant has confirmed what you're thinking!

Reduced wait to be seen overnight and the day after RATs was in progress.

Disappointed that the trial is finishing.

Loved it, for the first time in ages I have felt like I was making a real difference. It was excellent to work alongside the senior team, with such a high discharge rate. It felt efficient and good quality care was given.

Found room 4 being a walkthrough frustrating, as nursing staff were still using the space for observations, venepuncture and oral medication administration.

The computer in cubicle 7 worked only intermittently and was not linked to a printer.

PFC: It made such a difference to the overcrowding and the flow of patients in the department. We would love to see it continued.

NIC: My recommendations would be: The trial continues. We ring fence a minimum of 2 assessment trolleys (7 and 8).

In addition to this written feedback, the NIC (nurse in charge) collated data each day that SRAT was operational, to capture any unintended consequences. Data was captured on time to triage; longest wait; longest ambulance wait; length of stay; number of ambulances; assessment areas blocked. The NIC was satisfied that there was no detrimental impact on the running of the rest of the Emergency Department. The Lead Nurse has asked if we can re-start SRAT as soon as possible.

4: Adverse events – none yet recorded.

2. Lessons learned

If the process is to operate at maximal efficiency it requires dedicated space (ring-fenced) and dedicated nursing support. It also requires better IT support.

Regrettably, the wider system was unable to protect cubicles 7-10, and that hampered our ability to see patients in a timely and organised fashion. For example, on every morning (bar the first two), the cubicles were all occupied with patients awaiting medical in-patient beds. The SRAT consultant therefore was delayed in starting, because they had to first clear a space.

The pilot did not include funding for additional nursing staff but we had collaboratively planned with the NIC to allocate the cubicle 7-10 nurse for the SRAT process. Unfortunately, because cubicles 8/9/10 had bedded patients, the nurse was required to provide care for these, and was unable to support the SRAT. On the two days when a staff nurse was involved with SRAT, the feedback was excellent, and they enjoyed the process immensely.

The computers in cubicle 7&8 (SRAT cubicles) were prone to failure and would not link to printers. We worked around this by using the computer on wheels, but the process could be improved to save minutes of time.

We used assessment room 4 as a direct link to the waiting room, but because the cubicles 7-12 were not held as assessment capacity, the nursing team were tempted to use room 4 for taking observations. This was not intended, nor desired, but the nursing team were lacking in physical capacity because the doctors were using the

other assessment rooms to see patients. The SOP described the need to protect (ring-fence) cubicles 7-12, for doctors to have space to see patients, whilst leaving the existing rooms for the nursing team to perform observations and deliver medication etc.

3.

4. **Summary**

The ED team would like to see the SRAT process continued, indefinitely. It has improved the time to clinician and provided significantly better patient experience. The adoption of this scheme improved staff morale, as they felt that for the first time since GUH opened, that they were given physical space (albeit limited – and diminishing as the time progressed) to do their work; fundamentally, we require space to deliver care.

If the scheme is funded to continue, we must ensure that the [efficiency is maximised to deliver the best value](#). To maximise efficiency, assessment cubicles 7-12 [must be ring-fenced](#), we must have dedicated nursing support and fully operational technology. The ringfencing of the cubicles will be required for a temporary period pending progress of the extension build which includes dedicated capacity for SRAT.

Appendix 3 – Latest PIP comments and responses:

No.	Feedback from PIP	Response / Update
1	'PIP' has made some minor tracked changes in the paper up front in the intro section to better lay out the role of PIP etc.	Accepted all changes
2	How this investment fits with wider urgent care initiatives	Wider work covered in the paper. Key wider areas under U&EC: • Safety Flow agenda • 6 goals agenda • Expanded ED waiting area and internal reconfiguration • Expanded discharge lounge • E-triage • Bed reconfiguration in line with wider work with NHH and GUH
3	Assessment of how sessions could be reconfigured (i.e. moving sessions away from the eLGHs	The service have given a suggested pattern for the additional shifts that would be covered by the investment. This focusses on additional evening cover and Senior Rapid Assessment in the day. The annualised nature of rostering means that there is inherent flexibility and we would look to reconfigure sessions if/when needed based on the impact of the planned changes. With specific reference to MIU cover, these shifts provide an essential training and governance function for our MIUs, and in addition are when we undertake our review clinics and manipulation lists. The service therefore do not have any immediate plans to change this, but will keep all activity under review to ensure we are maximising efficiency and patient care opportunities.

4	Points received via email: Just re-reading the case and it would be useful if they included these visuals (below) for how they would expect it to look if the additional investment was agreed. Reading through the times when they are looking to roster on the additional staffing I can see how they are pointed to the times of the weekday with the biggest gap between capacity and demand but if I'm reading it right not necessarily for the biggest gap at the weekend which appears to be 08.30 to 14.30. I think seeing how these appointments impact these graphs visually would be really useful. Not clear if the national recommendation is 8/2 or 7/3 spa's, but recognise this paper is saying it will be reviewed – wonder if there will be some discussion on this area and how differently this would impact the model / numbers required to be appointed. Obviously more palatable cost wise so that is positive, but would probably benefit from a bit of narrative around the savings / variable pay.	Regarding the weekend cover shift timings: The D&C graph is based purely on patient arrivals and does not take into account other factors such as the number of patients already in the department and the reduced flow experienced at the weekend. We already have this shift in place (covered by variable pay) and practical experience of tells us that this is the correct timing to maximise impact but we will keep this under review. It should be reinforced that this request is only a small proportion of the total investment that the original D&C case stated was required so it would not be expected to cover all of the demonstrated gaps. It should be reinforced that this is a paper requesting additional investment and is not about financial savings, although it is clearly stated that this investment would offset a level of variable pay by converting weekend 'extra' into a substantive regular shift.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	MRI Scanner at the Grange University Hospital
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins – Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Arvind Kumar, General Manager – Clinical Support Services

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

Ar Gyfer Penderfyniad/For Decision

This report provides an update on the capital and revenue requirements associated with the installation of a second MRI scanner at the Grange University hospital and requests Board approval for the onward submission of the capital business case to Welsh Government with a view to securing national capital funding when final capital costs have been confirmed.

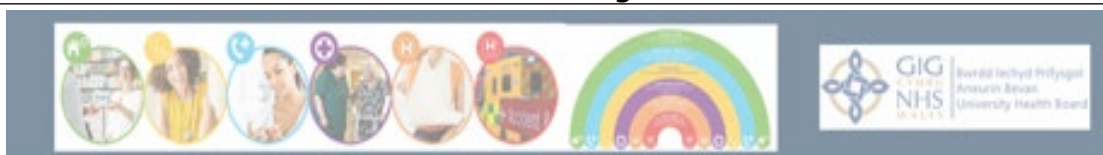
ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The original business for the second MRI for the GUH outlined a revenue requirement of £0.9-£1m and capital funding of circa £2m. Since the development of the original business case, a decision has been made to procure a turn key solution i.e. appointment of a single contractor to design, build and fully equip the project, before handing it over to the Health Board ready to commission. In addition, the revenue requirements have been updated to enable the additional diagnostic capacity to be delivered within the Divisions agreed financial envelope. The updated case attached in **Appendix 1** has been approved by Executive team, and costs are currently being finalised following decision to move to turn key ahead of submission to Welsh Government.

Cefndir / Background

As part of the original Clinical Futures Service Model, only one scanner was commissioned for GUH, with accommodation for a second scanner in the future. The existing MRI scanner is now running at full capacity (12hrs X 7 days/week) and represents a 'single point of failure' as any breakdown would require acutely ill patients to be transferred to other sites for urgent scans. The scanner at GUH is also



4 years old. In addition, all MRI scanners within ABUHB are now operating at full capacity.

Consequently, it has only been possible to balance increased demand by utilising additional non-recurrent capacity i.e. mobile scanners have been leased to maintain the 8 week target. As accommodation provision was made for a second scanner at GUH, a business case was developed by the Division clearly demonstrating the increased demand and impact on the diagnostic waiting times. The case which requested funding of £2.95m was subsequently approved by the Executive Team subject to the availability of the WG capital funding.

Since the approval of the business case, £750k recurrent revenue funding has been allocated to the Division to cover the MR capacity shortfall for 24/25 to cover the leasing costs of the scanner. Until such time as capital funding is secured for the second MRI, this is being used to procure additional capacity through a mobile scanner at YAB. In addition, due to existing pressures on the Works and Estates Department and for ease of completion, a turn key capital development has been identified as the preferred capital solution.

This solution has been accepted as an element of the Aneurin Bevan University Health Board Community Based Diagnostic Hub that has been agreed as part of the regional planning work on Diagnostics.

Asesiad / Assessment

Revenue Requirements

A review and refresh of the demand and capacity plan for 2024/25 (initially completed December 2023) indicates that demand has decreased due a reduction in the backlog through the use of the mobile scanner in Qtr 4.

The table below summaries the changes in demand and capacity. This demonstrates that additional capacity of 6,000 scans would be sufficient to meet the 8 week target. This would require the second scanner to operate 07:30 -20:00 5 days a week (Monday – Friday), rather than 7 days a week in the original business case.

	2024/25 BC Predicted	2024/25 D&C model Dec 23	2024/25 Actual
Total demand	39,646	40,597	39,187
Current capacity	32,250	32,250	32,250
Deficit	-7,396	-8,347	-6,937
Additional MRI Scanner	8,000	8,000	6000
Remaining Deficit	-604	-347	-937

The table below shows the breakdown of the revenue costs associated with the second scanner as outlined in the original business case compared to the revised demand and capacity modelling and a 07:30 -20:00 5 day a week service.



	Original Business Case			Revised Requirements		
	WTE	Gross Cost TOS £'000	Gross Cost MPOS £'000	WTE	Gross Cost TOS £'000	Gross Cost MPOS £'000
Consultant	2.0	311	275	2.0	311	275
Band 7	0.5	32	32	0.5	32	32
Band 6	5.46	335	335	3.9	212	212
Band 3	2.73	96	96	1.95	60	60
Non pay		170	170		121	121
Energy		40	40		35	35
W&E Mtcs		6	6		6	6
Total	10.69	990	954	7.85	777	741

Capital Requirements

The original business case outlined a capital requirement of circa £2m based on the procurement of a scanner and local enabling works. Since the original business case was developed, due to Works and Estates capacity to complete the project and ease of completion, it has been agreed to commission a turn key solution.

Whilst the Health Board is currently working with procurement to finalise the tender for a turn key solution, the indicative working costs are anticipated to be no more than £2.5m.

Conclusion

Development of a second MRI at the Grange would negate the requirement for a mobile. The above analysis demonstrates that the revenue currently being utilised to secure additional capacity through the mobile MR and associated reporting costs, would be sufficient to support a 07:30 -20:00 5 day a week service (Monday - Friday) and would deliver an additional 6,000 scans.

Argymhelliad / Recommendation

This paper outlines the updated demand and capacity model and the associated revenue and capital requirements. It confirms that the Division will manage the revenue consequences associated with the second scanner from within its current financial allocation (assuming no further funding reduction made) and that a turn key capital solution is the preferred option.

It is recognised that a 7-day service will be required in the medium to longer term due to increasing demand, but that this would be subject to the outputs of future demand and capacity modelling and the associated Annual Plan / IMTP process.

Given the surplus weekend capacity that would be available in the short term, it is proposed that the development is taken forward in the context of the regional response to collaborative diagnostic planning.

It is recommended that the Board:



- NOTES the updated revenue requirements which will be managed by the Division from within its current financial allocation;
- NOTES that the case in Appendix 1 will be updated when the costs of turn key are received; and
- APPROVES the onward submission of the turn key capital business case (which is currently under development) to Welsh Government to a maximum value of £2.5m.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 5. Timely Care 7. Staff and Resources
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse

Gwybodaeth Ychwanegol:

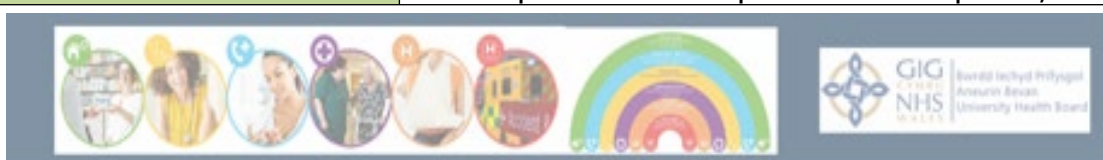
Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	MRI: Magnetic Resonance Imaging GUH: Grange University Hospital COO: Chief Operating Officer
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee

Effaith: (rhaid cwblhau)

Impact: (must be completed)

Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans;



	investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Yes, outlined within the paper
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Establishment of a second MRI scanner at The Grange University Hospital

Business Justification Case

Version No: 2.0
Issue Date: 19/08/2024

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Executive Summary

The purpose of the Business Case is to seek approval for a capital investment of £2 million to support the development of a fully staffed second MRI scanner at the Grange University Hospital (GUH), Cwmbran. The £750k recurrent revenue costs associated with the scanner are covered within the Divisions financial plan for 2024/25.

Aneurin Bevan University Health Board has responded robustly to operational pressures that have impacted MRI service provision and have maintained waiting times that benchmark well across the rest of Wales.

All current MRI scanners across the Health Board are at maximum capacity and future demand is expected to grow from a number of key service specialty areas such as cardiology and stroke. Despite the MRI service implementing multiple efficiency changes, demand continues to exceed capacity with the GUH scanner experiencing a significant increase in the in-patient/ED demand. It is anticipated that this overall increase in demand will continue, and urgent action is required to enhance capacity to meet the additional demand.

In addition to the existing capacity challenges across sites, the GUH scanner represents a single point of failure for the acute site and any breakdown in operation would require acutely ill patients to be transferred to other sites for urgent scans. The length of unplanned downtime can be considerable with MRI lasting up to 7 days and possibly longer due to the complexity of the overall MRI system and reliance on the parts to be delivered from overseas. No other site in ABUHB can offer the levels of care required for some of the critical patients, consequently transfers may need to be to Cardiff & Vale UHB if the MRI service is not available.

Services to date have managed planned down time with a risk mitigation from other sites, however, there is an increasing risk that any unplanned downtime for a significant period can cause major disruption and significant patient harm. In addition to the increased demand a second MRI at GUH is required for the resilience of the service in case of any downtime, planned or non-planned with the existing scanner.

The Health Board is committed – in collaboration with colleague Health Boards in South East Wales - to the development of community diagnostic centres (CDCs), in accordance with Welsh Government policy in respect of regional planning and the provision of diagnostic services. It has been determined that we are in a position to deliver a

cost-effective CDC through an in-house management model, meeting the CDC criteria through the use of an enhanced local general hospital (eLGH) site.

The Health Board is well-placed to progress an in-house CDC programme, with Ysbyty Ystrad Fawr in Ystrad Mynach identified as the preferred site. Establishment of the second scanner at GUH would remove an MRI capacity barrier by enabling capacity to be released at YYF. Any surplus capacity delivered in the short / medium term can be made available to colleague Health Boards as part of the collaborative regional programme agreement.

It is therefore proposed that a second MRI scanner is procured and installed within identified available accommodation at GUH to provide resilience to MR Services in GUH and as an additional benefit to allow capacity for elective scanning in the proposed CDH at YYF.

1.0 INTRODUCTION/ BACKGROUND

- 1.1 The purpose of the Business Case is to seek approval for a capital investment of £2 million to support the development of a fully staffed second MRI scanner at the Grange University Hospital (GUH), Cwmbran. The £750k recurrent revenue costs associated with the scanner are covered within the Divisions financial plan for 2024/25.

Magnetic resonance imaging (MRI) is a Medical imaging technique used in radiology to form images of the anatomy and the physiological processes of the body. MRI scanners use strong magnetic fields to generate images of the organs in the body, in contrast to CT and PET scans, which use X-rays / ionizing radiation.

- 1.2 Aneurin Bevan University Health Board has responded robustly to operational pressures that have impacted MRI service provision and have maintained waiting times that benchmark well across the rest of Wales. However, the service recognises several ongoing risks for future service provision, including:

- All current MRI scanners across the Health Board are at maximum capacity and future demand is expected to grow from a number of key service specialty areas.

Even though the MRI department have implemented multiple efficiency changes, the demand exceeds the maximum available capacity. The additional capacity is required to meet the increasing demand. Increase in activity is expected to continue. To achieve future state there is a need to procure additional MRI capacity.

- The existing GUH scanner represents a 'single point of failure' for the Health Board; any breakdown in operation would require acutely ill patients to be transferred to other sites for urgent scans.
- The Health Board is committed – in collaboration with colleague Health Boards in South East Wales – to the development of community diagnostic centres (CDCs), in accordance with Welsh Government policy, in respect of regional planning and the provision of diagnostic services. It has been determined that we are in a position to deliver a cost-effective CDC through an in-house management model, meeting the CDC criteria through the use of an enhanced local general hospital (eLGH) site.

However, existing MRI capacity is a key barrier to delivery as this will not enable the provision of the new required capacity on an eLGH site.

- 1.3 It is therefore proposed that a second MRI scanner is procured and installed within identified available accommodation at GUH. Originally it was planned to have two scanners at the GUH site, however at that time there would not have been enough work to operate the scanner five days a week. The decision was therefore made at risk to install only one scanner initially, but to include accommodation for a second scanner in the future. The existing MRI scanner at the GUH is running at full capacity and there has been a significant increase in the in-patient/ED demand. Services to date have managed planned down time with a risk mitigation from other sites, however we are at increasing risk that any unplanned downtime for a significant period can cause major disruption and significant patient harm. In addition to the increased demand a second scanner is required for the resilience of the service in case of any downtime, planned or non-planned with the scanner in situ.

Structure of Document

- 1.4 This BJC has been prepared using the agreed standards and format for Business Cases, as set out in:
- HM Treasury Guide to Developing the Project Business Case 2018
 - NHS Wales Infrastructure Planning Guidance (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)
- 1.5 The approved format is the Five 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 the Health Board 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.

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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 The Health Board serves an estimated population of over 639,000, approximately 21% of the total Welsh population. Approximately 30% of the population live in the Caerphilly local authority area and 25% live in the Newport local authority area.
- 2.1.3 With a budget of £1.535 billion the Health Board delivers healthcare services to people in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen and provide some services to the people of South Powys.
- 2.1.4 The Health Board covers diverse geographical areas and must 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 over 14,000 staff and is the largest employer in Gwent. There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers.

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

- 30 Locality based Community clinics

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

2.1.8 There are 258 WTE General Practitioners and Salaried GPs providing general medical services from 70 General Practices. Supporting these are 199.6 WTE practice nurses, 175 health care support workers, 712 WTE administrative staff, including practice managers, receptionists, secretaries and IT officers. Around 390 General Dental Practitioners provide general dental services from 80 practices. There are 131 Community Pharmacies and 54 Optometry premises across the 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 seven 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 ***The Diagnostics recovery and transformation strategy for Wales 2023-2025*** established 9 themes of focus supported by six objectives to achieve the vision. It is aimed at leading and coordinating supportive actions to aid recovery of diagnostic services as we move away from the acute phase of the pandemic. This will also ensure that interventions and commitments implemented in the immediate term align with foreseeable future demand and shift towards optimised delivery models as the foundation of long-term sustainable transformation.

To recover diagnostic services by 2025 and set the groundwork for longer term sustainability, we will:

- Catch-up unmet diagnostics demand for urgent conditions in alignment with the Planned Care Recovery Plan.
- Transform services and move beyond traditional boundaries to put patients at the centre, reduce

inequality, improve outcomes and reduce secondary care demand.

- Create and sustain safe services with prudent value-based pathways and workforce models.
- Be informed by evidence and be data driven.
- Create an enabling environment where research and innovation improve outcomes and patient experiences.
- Connect seamlessly with the National Clinical Plan¹⁰ and relevant enabling programmes (e.g., National Clinical Research Framework, National Data Resource) and government commitments

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**'.

2.3 Regional Context

2.3.1 Aneurin Bevan UHB (ABUHB), Cardiff and Vale UHB (CAVUHB) and Cwm Taf Morgannwg (CTMUHB) have reviewed and renewed their commitment to regional working where clinically appropriate. Four collaborative programmes of work have been established, with each Health Board taking responsibility to 'host' one of these. The programmes operate under the umbrella of a single portfolio to ensure consistency of approach and direct Executive level line of sight to delivery.

2.3.2 In September 2022 the Chief Executives collectively supported the principle of progressing a series of regional diagnostic solutions through the implementation of Community Diagnostic Hubs (CDH) across South East Wales. There is clinical consensus that any service development undertaken regionally must meet the following key criteria:

- Delivery is more accessible to residents living in areas of deprivation and able to deliver to more than one health board population in the region
- Developments deliver an increase in capacity
- Developments will be founded on seeking sustainable solutions to demand backlogs.

A business case is under development for the procurement of a number of CDHs.

This proposed development is therefore being taken forward in the context of the regional response to collaborative diagnostic planning. Although the ABUHB approach remains part of the wider regional plan there is an acknowledgement that other Health Boards are looking to adopt a managed service model. ABUHB currently considers that considerable work is required to ensure delivery of a cost- effective option in a regional context that provides accessible services consistent with local requirements and priorities. However, the option of a future community diagnostic centre at YYF receiving patients from other health boards remains open. It is acknowledged in regional discussion that provision of each community diagnostic hub delivering MR, CT, plain film and ultrasound services (if procured through a managed service contract) will require a seven-year commitment with a total cost over that period in excess of £18M per hub.

2.4 Local Policy Context

- 2.4.1 The Health Board's Integrated Medium-Term Plan (IMTP) for the next three years April 2023 – March 2026 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 as a key enabler in achieving change.
- 2.4.2 During the last year the Health Board has continued to progress its overall strategic Clinical Futures plan, further developing the complementary roles of The Grange University Hospital (GUH) and the supporting enhanced local general hospitals (eLGHs). Whilst GUH is a centre of excellence for specialist and critical care and will help to deliver the long-standing clinical strategy designed to provide 21st century healthcare, there is a parallel need to provide more services in the community and closer to the people who need to use them. This priority is central to the investment aims of this business case.

2.4.3 Colleagues within Cwm Taf Morgannwg UHB are undertaking feasibility studies regarding the 'Concorde' site in Llantrisant, which has been purchased with a view to support and facilitate additional regional service capacity as / where clinically and practically appropriate. For diagnostics, the proposal for the site would involve a managed service option, as a contract arrangement with a private sector partner. Aneurin Bevan UHB currently consider that it is impractical for this site to form a managed service community diagnostic centre option for our residents due to issues of accessibility, cost, clinical governance, informatics support, public engagement, deliverability and exit strategy. The priority for the health board is therefore to progress plans for a local community diagnostic centre consistent with the strategic vision, utilising an existing site and in-house delivery / provision. We are well-placed locally to deliver a cost-effective model, with separate existing inpatient / outpatient pathways, manageable recruitment and a relatively strong baseline waiting list position. The preferred site for the centre is Ysbyty Ystrad Fawr in the Rhymney Valley, potentially supplemented by additional CT / ultrasound capacity.

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 provide additional MRI capacity for the Health Board to build resilience within the system to comply where possible with the diagnostic waiting time targets on a sustainable basis
Investment Objective 2	To address and eliminate the risks associated with the existing MRI scanner at GUH being a single point of failure for the service
Investment Objective 3	To enable the service to meet future demand resulting from specific specialty developments and to comply with the National Optimal Pathways
Investment Objective 4	To optimise MRI capacity across sites and enable the development of a community diagnostic centre on an eLGH site (potentially Ysbyty Ystrad Fawr) in accordance with Welsh Government policy
Investment Objective 5	To reduce the need to outsource MRI activity and the risks associated with this

2.6 Business Needs

Current Service Provision

2.6.1 The Radiology Department provides MRI services from four locations (detailed below). All existing scanners are currently working at full capacity; the following is a summary of existing service provision:

2.6.2 The service works to agreed national/pathway targets as below:

- Eight-week diagnostic RTT
- Single cancer pathway which includes diagnostics referral to report within 14 days.

It should be noted that according to the new Welsh Government diagnostic target, the service is expected to comply with 8 weeks referral to report turn around target which means referral to exam time will reduce from 8 weeks to less than 6 weeks.

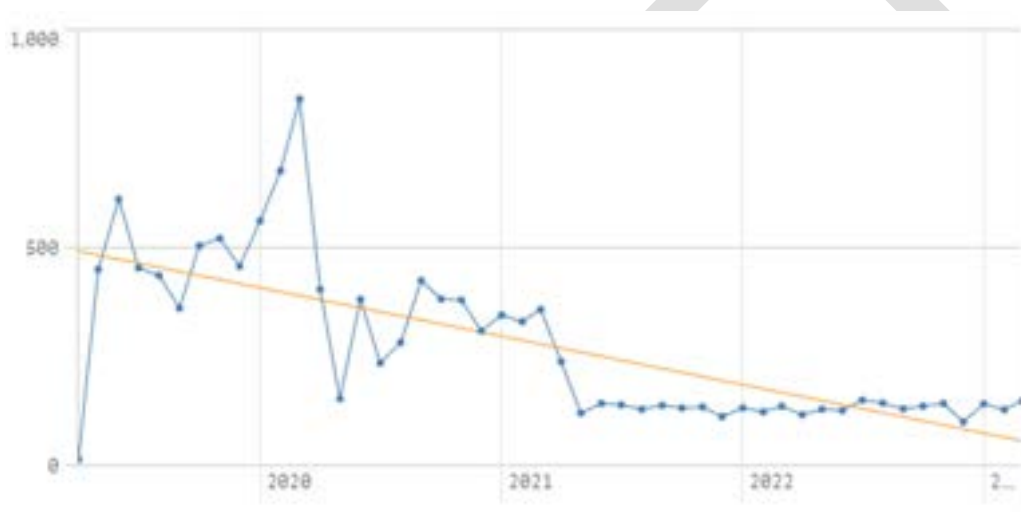
Site	Operational	Activity	Comments
RGH	07:30-20:00 7 days a week	Inpatient 975 Outpatient 7201 ED 313	Service at full capacity. No spare capacity available. Any planned/unplanned downtime significantly affects capacity. Single scanner, single point of failure.
YYF	07:30-20:00 7 days a week	Inpatient 458 Outpatient 7974 ED 172	Service at full capacity. No spare capacity available. Any planned/unplanned downtime significantly affects capacity. Single scanner, single point of failure.
NHH	07:30-20:00 7 days a week	Inpatient 686 Outpatient 7662 ED 191	Service at full capacity. No spare capacity available. Any planned/unplanned downtime significantly affects capacity. Single scanner, single point of failure.
GUH	07:30-20:00 7 days a week plus 24/7 on-site MRI provision to cover emergency	Inpatient 3676 Outpatient 2164 ED 1414	Single scanner, single point failure Service at full capacity. Patients to be transferred to Cardiff for CES and any neurological emergencies.

The initial planned scanner opening hours for the GUH MRI scanner in 2020 was a 9am-5pm service. However, it was established by the service that this would not meet demand. Therefore the opening hours were increased to 12.5-hours, seven days a week. All MRI scanners within ABUHB are at full capacity working seven days a week and 12.5 hours per day as a service model. ABUHB MRI scanning hours compare favourably in comparison with other Health Boards / NHS Trusts operating similar scanning service hours. Additionally, ABUHB is the only Health Board in Wales to be fully compliant with the

requirement of 24/7 on site cover for the spinal MRI emergencies i.e. Cauda equina

2.6.3 For several years MRI services have maintained a broad balance of capacity and demand, utilising additional non-recurrent capacity at significant premium cost, for example mobile scanning and independent providers. Over the last four years this has averaged £350k-£400k per annum for scanning only service. We anticipate a financial spend of £750k in this financial year.

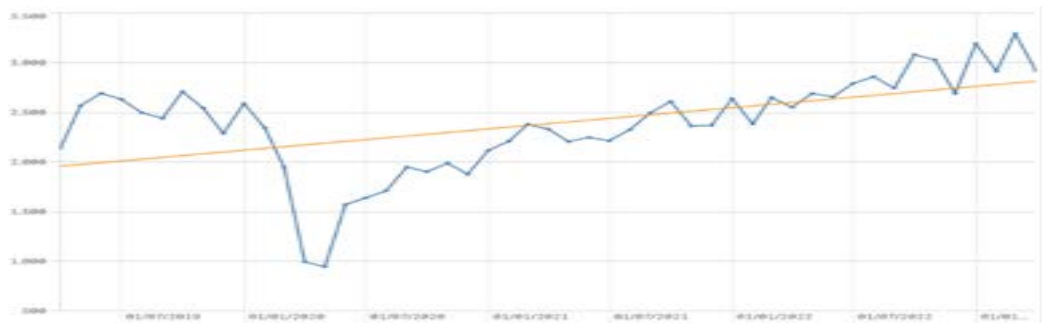
Fig.1: Outsourced scanning activity (inc mobile & static independent providers)



2.6.4 All four of our MRI scanners continue to work at full capacity providing a 12.5-hour day, seven days a week service. To meet the current capacity gap of circa 7,000 cases, we have engaged in a contract for a mobile scanner with reporting activity undertaken as WLI and outsourcing reporting.

2.6.5 The MRI service within ABUHB has been under significant pressure due to the exponential increase in the demand within the last 3-4 years. The graph below (Fig. 2) demonstrates the increase of up to 30% in MRI activity which equates to 34,506 scans in 2022/23 as compared with 29,407 scans in 2019/20 (pre covid).

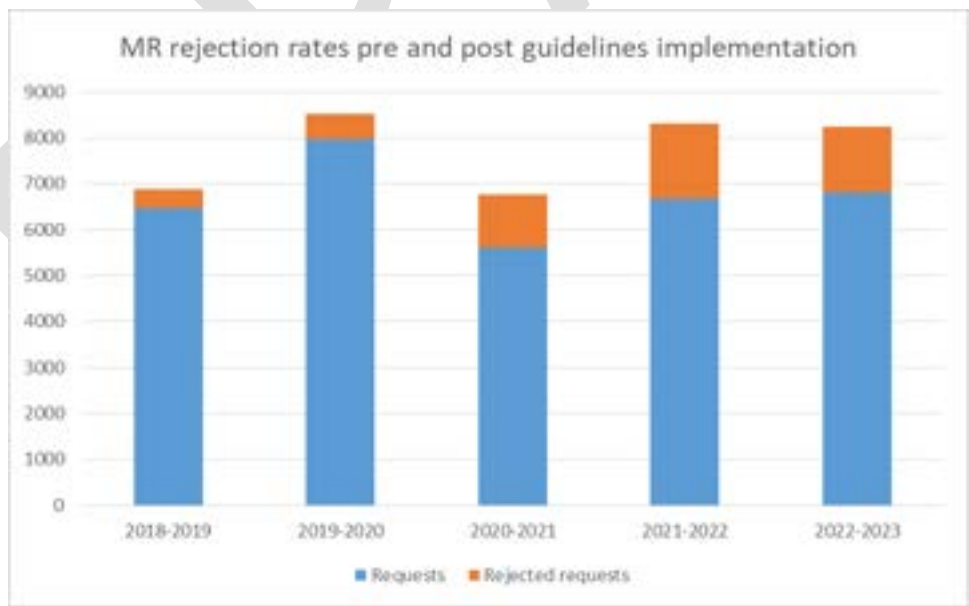
Fig. 2: MRI Activity comparison: 2019-2023



It is important to note that the Radiology directorate introduced MSK guidelines in November 2020 to improve imaging referral compliance which has helped in reducing unnecessary referrals.

The graph below (Fig 3) demonstrates the effect of the introduction of the MSK imaging guidelines in 2020/2021, where the referral rejection rate increased from 7% (pre implementation) up to 25% post implementation of the guidelines. It is important to note that the target audience for these guidelines was Primary Care and it is evident that the quality of referrals has now improved, and the rejection rate is stable.

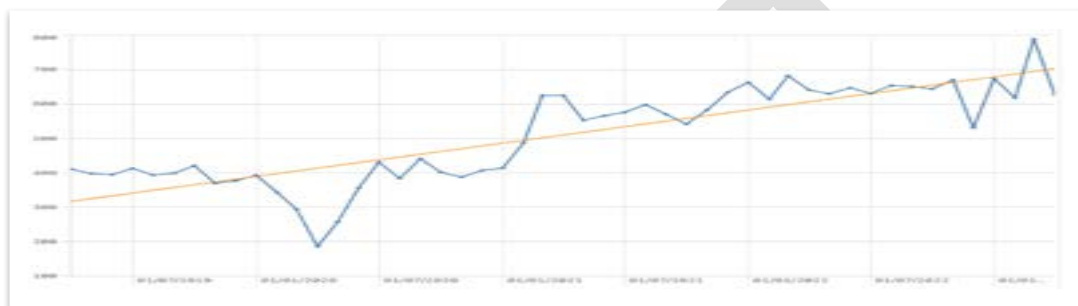
Fig 3: MRI GP referrals/ rejection rates



Referral scrutiny and rejection protocols are also in place for other specialties, and these are seen to benchmark consistently with other services. However, despite all these measures and higher rejection rates, the demand continues to rise.

2.6.6 A major contributing factor to the increased workload is the demand of referrals Radiology receive from the Emergency Department and In-Patients sources (Fig.4).

Fig.4: ED and In-Patient MRI Activity: 2019-2023

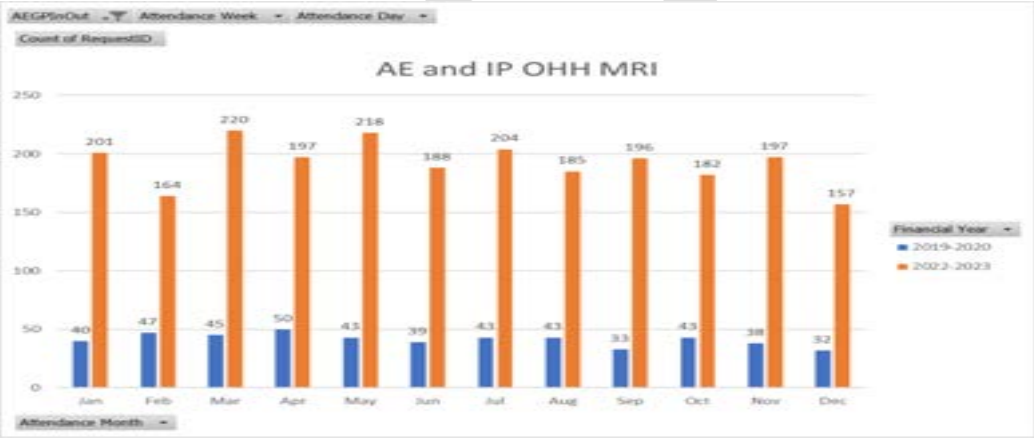


Prior to the opening of GUH, the majority of the workload from ED and IP was accommodated at RGH and NHH. This activity was maintained at around 400 scans per month and addressed the demand at that time. Since the opening of GUH and the diversion of the acute work to this site, we have seen an exponential growth in activity which peaked in March 2023 at 789 scans per month, representing an increase of almost 100% in activity compared to pre-COVID activity.

Although GUH opened with one scanner the risks associated with this have changed since the GUH opening because of a number of factors. The contingency scanner at RGH is several years older than it was when the decision was made to open with the single GUH scanner, the RGH scanner is now nearly 7 years old which increases the risk of failure and a higher number of days lost due to unplanned downtime which is evident in recent failures lasting up to 7-8 days in a single instance. Repair times have also been impacted by Brexit as parts for the scanners are now taking significantly longer to be sourced from overseas than they were pre-Brexit. These sourcing difficulties are being experienced by all Health Boards and Trusts in the UK but our reliance on an older contingency scanner increases our risk. During periods of downtime 8-10 patients a day would need to be transferred to other Health Board sites for MR scanning. If

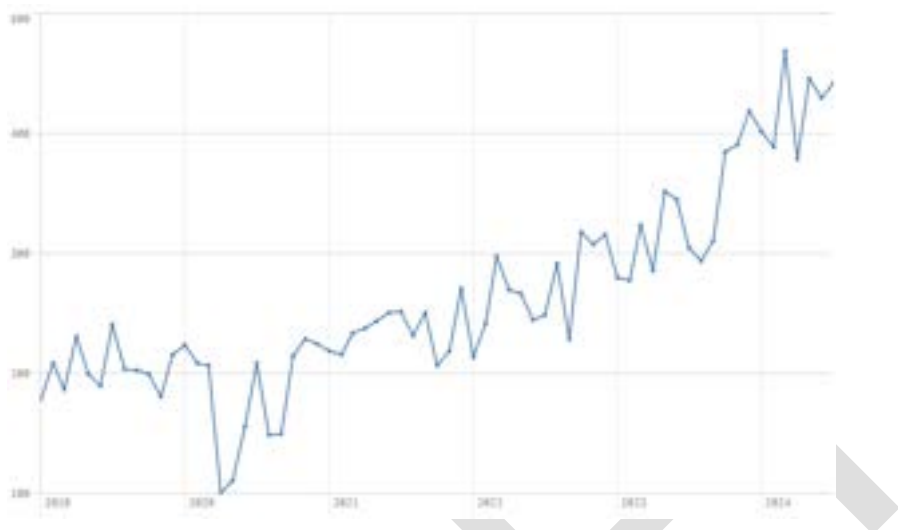
the patient was for a query Cauda equina then the transfer would have to be to the University Hospital of Wales, Cardiff. Consideration has been given in the past to mobile business continuity and contingency options, with a view to costs being shared across health boards. However, a Mobile MR scanner would be unable to provide a sustainable inpatient service in GUH due to the logistics of transferring the patients across a car park and via an external lift to access scanning. There would also be additional risks from the difficulties of the crash team responding to a unit separate from the hospital building. Furthermore, there is significant increase in the out of hours inpatient/ED referrals which is demonstrated in Fig. 5. Comparing to pre covid there is almost an increase of up to 450% MR scanning demand out of hours for in-patients and ED patients. In line with the Welsh Risk Pool recommendation, we now provide 24/7 on-site cover for cauda equina patients in the GUH.

Fig.5: ED and In-Patient MRI Out-of-Hours Activity: 2019 & 2023



2.6.7 A significant increase in the number of urgent suspected cancer referrals is also a contributing factor in the high demand for MRI services (Fig.6). There is an increase of almost 74% in the USC MRI demand in 2023/24 in comparison with pre-covid 2019/20 and almost 30% increase in comparison with 2022/23.

Fig.6: Urgent Suspect Cancer Referrals for MRI 2019-2024



2.6.8 The total MRI activity across the Health Board in 2023/24 was as follows;

Department	GUH	RGH	NHH	YYF	Mobile	Total
ED	1088	334	220	182	0	1824
IP	3846	985	724	497	4	6056
OP	3159	7597	8079	8440	1251	28526
Total	8093	8916	9023	9119	1255	36406

2.6.9 In 2024/25, demand is projected to outstrip capacity for a service already under considerable utilisation pressure. The chart below (Fig. 7) shows the MRI waiting list position and number of patients breaching the 8-week target over the past five years. 8 weeks RTT compliance maintained at high levels with additional capacity procured from Private Providers.

Fig.7: MRI Waiting List / 8 Week Wait Breachers



Demand & Capacity

OECD 2020 report on the requirement of MRI scans for the population highlighted that the UK scan average per 1000 population is on a lower denominator than Germany, France Italy and USA.

UK averages 50 scans per 1000 population which is significantly lower than Germany, around 150/1000 population. However, it is imperative to note that these figures do not specify any COVID impact. Considering Professor Sir Mike Richards' report (Diagnostics: Recovery and Renewal – Report of the Independent review of diagnostic services for NHS England) and enhanced role of Diagnostics to support planned care recovery by new ways of working such as straight to test services etc. It is expected that the demand for MRI services will rise.

Conservative estimate is that the minimum requirement would be at least 80-100/1000 population. This means that ABUHB should expect approximately 52,000 requests per annum if the population demand is 80/1000 and 65,000 requests per annum if the demand rises to 100/1000.

2.6.10 In addition to general population led core increases in demand, the service has to consider the demand generated by new guidelines for cardiac imaging, stroke and lung cancer as detailed below:

Cardiology

2.6.11 There is currently a limited service for Cardiac MRI in-patients. In 2022/23 the Health Board outsourced patients to North Bristol NHS Trust. This is considered untenable for a centre operating two cardiac catheter laboratories and presents a

significant service risk. Anticipated additional specialty requirements have therefore been incorporated into future demand projections. The planning assumption for the purposes of the case is that the additional demand will be 500 per annum initially, followed by 250 per annum thereafter with the intention of repatriating this cardiac activity in-house with the addition of a second scanner at GUH. Information has been requested but we have been unable to acquire this detail at present however, based on the national indicative tariff excluding any market forced factors, a single cardiac MRI costs £564. This equates to approximate spend of £280,000 for 500 MRI cardiac scans. It is important to note that the capacity for Cardiac MRI is only available at a premium and it is likely for the Health Board / Trust / Independent providers to ask for a significant premium for their Cardiac MRI service.

Stroke

2.6.12 Revised National Clinical Guidelines for stroke have been agreed in 2023. Key within these is the move from CT to MRI as the diagnostic modality of choice in a range of circumstances such as TIA pathway. The planning assumption for the purposes of the case is that the additional demand will be 1,000 per annum.

Lung Cancer Screening

2.6.13 NICE guidelines for the diagnosis and management of lung cancer have been updated in 2023 with implications for imaging services. Whilst CT scanning remains the core diagnostic tool for lung cancer patients, MRI scanning is recommended in a number of scenarios such as superior sulcus tumours and secondary brain metastases. As the screening programme is at a very early stage, it is difficult to provide an accurate projection of future MRI demand implications

2.6.14 Anticipated additional service demand arising from the above has been incorporated into future service requirements. As a result, baseline recurrent demand for the service over the next five years (NET of a referral rejection rate of 3%) is projected to be as follows;

	Year 1 2024/25	Year 2 2025/26	Year 3 2026/27	Year 4 2027/28
Demand brought forward	39,187	39,187	41,396	43,716
Annual baseline 5% increase		1959	2070	2186
Additional Key Service (Cardiac)	0	250	250	250
Additional Key Service (Stroke)	0	0	0	0
Total recurrent demand	39,187	41,396	43,716	46,152

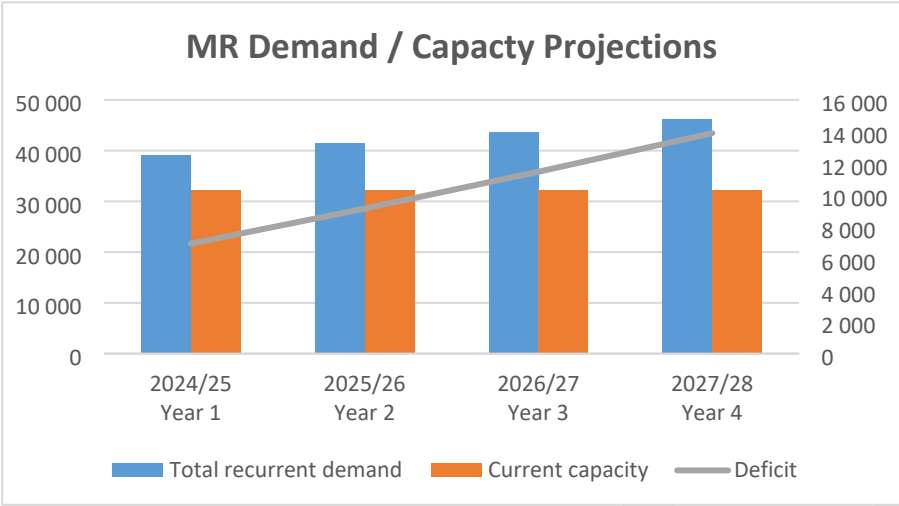
2.6.15 Total recurrent capacity for the existing service (Appendix 1) has been modelled using the following assumptions;

- All existing scanners operate 07:30-20:00, 7 days a week with average lists comprising of 23 scans
- Patient cancellations totalling 3%
- Scanner downtime percentage of 1%

2.6.16 The table and graph (Fig. 8) below demonstrate the growing demand and capacity shortfall year on year from capacity deficit of 6,937 MRI slots in 2024/25, projecting up to 14,000 capacity shortfall within 4 years if no investment is made to procure additional MRI. This means significant patient safety issues and inability of the services to comply with the WG RTT and single cancer pathways.

Fig.8: MRI Demand/Capacity Projections

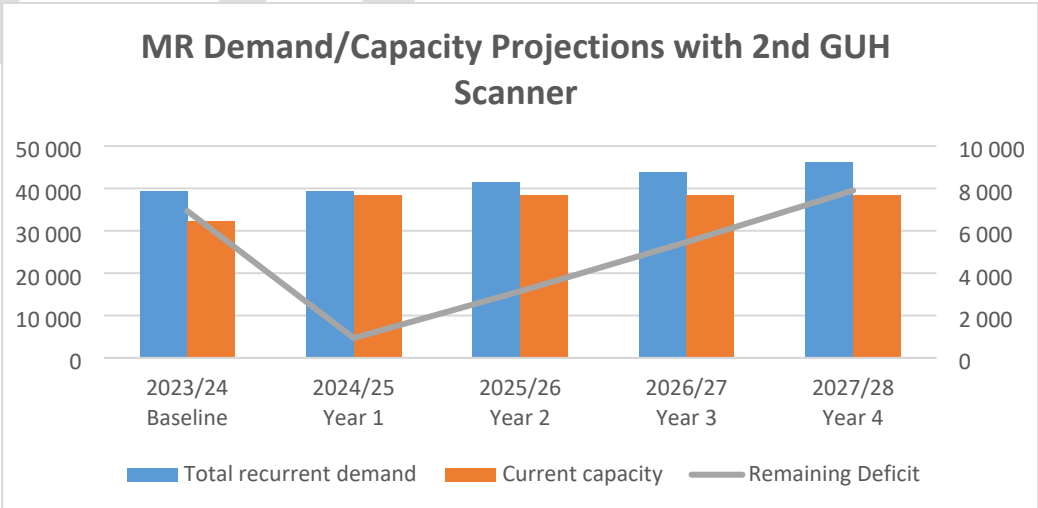
Capacity and Demand	Year 1 2024/25	Year 2 2025/26	Year 3 2026/27	Year 4 2027/28
Total recurrent demand	39,187	41,396	43,719	46,152
Current capacity	32,250	32,250	32,250	32,250
Deficit	(6,973)	(9146)	(11,469)	(13,902)



2.6.17 The provision of a second MRI scanner would operate 07:30-20:00, 5 days a week with average lists comprising of 23 scans, delivering additional activity of approximately 6,000 scans per annum as per Fig 9.

Fig 9: MR demand/capacity projections

Capacity and Demand	Year 1	Year 2	Year 3	Year 4
	2024/25	2025/26	2026/27	2027/28
Total recurrent demand	39,187	41,396	43,719	46,152
Current capacity	32,250	32,250	32,250	32,250
<i>Deficit</i>	<i>(6,973)</i>	<i>(9146)</i>	<i>(11,469)</i>	<i>(13,902)</i>
Additional MRI Scanner	6,000	6,000	6,000	6,000
Remaining Deficit	(937)	(3,146)	(5,469)	(7,902)



Service Resilience and Failure Risk within the Clinical Futures Model

2.6.18 The vision of the radiology service in support of the Health Board's Clinical Futures model centres on providing access to the right diagnostics at the right stage in the pathway, enabling prompt diagnosis for patients. To ensure delivery of the vision, the specific aims of the service are;

- To offer appropriate imaging and reporting in a speedy environment based around prudent health care
- To provide a flexible diagnostic service to support Acute Care Model
- To improve cancer diagnosis waiting times and reporting with the introduction of the Single Cancer Pathway
- To be able to respond to the developing service models
- To be a lead diagnostic service provision for the health board and the Gwent population

2.6.19 Whilst the service is recognised as having largely delivered on these aims, the current situation at GUH - whereby effective delivery of the entire MRI service is dependent upon a single scanner – is considered to be a major service and clinical risk. In order to ensure effective and efficient operation of the GUH site, it is essential to maintain patient flow through timely and reliable clinical interventions. Diagnostic tests are central to this flow, and it is recognised that the current position represents a single point of failure risk for the MRI service. In the event of scanner breakdown 8 – 10 acutely ill patients per day would require transferring to another hospital for urgent MRI scans. This would place extreme pressure on the Health Board's remaining capacity, transport provision, bed utilisation and patients flow through the urgent care system. In the context of severe and ongoing operational pressures, it is considered that addressing this risk is a major priority for the Health Board to ensure resilient and reliable MRI services in the future.

Development of a Community Diagnostic Centre

2.6.20 Following a commitment of the Chief Executives across Aneurin Bevan University Health Board (ABUHB), Cardiff & Vale University Health Board (CAVUHB), and Cwm Taf Morgannwg University Health Board (CTMUHB) and Aneurin Bevan (ABUHB) to work regionally where clinically appropriate, a portfolio of

programmes including Orthopaedics, Ophthalmology and Diagnostics has been agreed along with the creation of a Regional Programme Director role to facilitate delivery.

2.6.21 A number of guiding principles have been agreed by the three Chief Executives, including;

- Reduce unwarranted variation and inequality in health outcomes and access to services and experience
- Improve resilience in the system
- Make effective use of capacity and capability in whichever organisation it sits
- Create critical mass for effective high-quality care
- Accepting service delivery occurs when and where it makes sense to do so and accepting that may not reside in every organisation
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity, and use of finite resources
- Enable clinical leaders, and others to work together, lead together and learn together.

2.6.22 During 2022, Welsh Government issued direction to Health Boards as part of the regional work stream to work collaboratively to deliver a regional diagnostic programme and the ministerial priorities in the NHS Wales Planning Framework 2023-2026 includes a requirement to implement diagnostic hubs / centres, to reduce secondary care waiting times and meet waiting time ambition in spring 2024. In discussion, regional consensus was reached that any developments undertaken must meet the following key criteria:

- Delivery is more accessible to residents living in areas of deprivation and able to deliver to more than one health board population in the region
- Developments deliver an increase in capacity
- Developments will be founded on seeking sustainable solutions to demand backlogs.

2.6.23 In progressing Welsh Government direction and the above criteria, the Health Board is committed – in collaboration with colleague Health Boards in south east Wales – to the development of community diagnostic centres (CDCs). However, whilst colleague Health Boards are progressing a managed service contract model as the basis for a CDC, Aneurin Bevan University Health Board is in a position to deliver a cost-

effective CDC through an in-house management model, meeting the CDC criteria through the use of an enhanced local general hospital (eLGH) site. This can be demonstrated through the following;

- Inpatient and outpatient capacity is already readily separated within service provision
- The enhanced local general hospital (eLGH) sites already meet the Richards Report CDC criteria with space available for development
- The eLGH Sites already provide a full array of CDC diagnostics (endoscopy, echo, radiology, audiology, MI) to enhance future pathway work
- There is an ability to stage growth over the year
- The Health Board is in a sustainable recruitment and retention position and is well placed to attract additional staff required for a CDC
- Local access for patients already benchmarks well in a regional context
- The Health Board is in a relatively strong position in respect of its current waiting list position (notwithstanding anticipated future demand increases)

2.6.24 The Health Board is therefore well-placed to progress an in-house CDC programme, with Ysbyty Ystrad Fawr in Ystrad Mynach identified as the preferred site. Financial assessment has shown that this would also be highly cost effective in comparison with a managed service contract option over the likely seven-year viability requirement for the latter. Furthermore, in-house provision aligns more closely with the agreed principle that developments should be founded on seeking sustainable solutions to demand backlogs. However, existing total MRI capacity is a key barrier to delivery as this will not enable the provision of the new required capacity on an eLGH site. Establishment of the second scanner at GUH would remove this final barrier by enabling capacity to be released at YYF. Any surplus capacity delivered in the short / medium term can be made available to colleague Health Boards as part of the collaborative regional programme agreement. The second MR scanner at GUH would be able to support complex imaging investigations such as Prostate, dynamic Livers and Cardiac MRI scans so freeing up capacity in YYF to deal with the simple, ambulatory high-volume cases, this will enable us to keep the workflow for such cases in GUH low and manageable.

Workforce

2.6.25 MRI scans are undertaken by a team of HCPC Registered Radiographers, Consultant Radiologists and Healthcare support workers. Staff are trained on the job to achieve the required established competency framework. In house training is undertaken as required and any specialist training, i.e. cardiac scanning would be facilitated through external providers.

2.6.26 There is a requirement for Consultant Radiologists and 2x W.T.E Radiographer to support an MRI list, with additional staff required such as Nursing, OPD and Anaesthetist to support complex / GA / emergency procedures.

The Estate

2.6.27 The existing MRI scanner at GUH is located on level one within the radiology department.

2.6.28 Accommodation for a second scanner was designed into the original plans for the GUH. The space was developed into administrative space on an interim basis until the need arose for the second MRI scanner to be installed. Installation of a second scanner will require a range of enabling estates and physical works. Some of these are already in place e.g. ventilation requirements, quench pipe (for management of helium expulsion), but others will need to be included in the procurement specification, e.g RF cage. There are no issues anticipated in freeing up the allocated space as required for the scanner.

Summary and Conclusion of Business Needs

2.6.29 The above information sets out the key issues that need to be addressed within the Health Board to offer high-quality, sustainable and effective MRI services. These include:

- The inability of the Health Board to manage the future projected demand without additional capacity, as a result of general population-based needs and developments in a number of key specialties
- The risk of failure to meet required waiting time targets unless the future capacity can be increased on a timely basis and in a sustainable manner
- The high risk associated with the scanner at GUH which

represents a single point of failure for the service on its most critical clinical site, where patients with the highest acuity levels are managed.

- The opportunity arising from a second scanner for the Health Board to facilitate and deliver a community diagnostic centre, in accordance with Welsh Government direction and regional collaborative policy

2.7 Benefits

2.7.1 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. The investment objectives are as follows:

Investment Objective 1	To provide additional MRI capacity for the Health Board to build resilience within the system to comply where possible with the diagnostic waiting time targets on a sustainable basis
Investment Objective 2	To address and eliminate the risks associated with the existing MRI scanner at GUH being a single point of failure for the service
Investment Objective 3	To enable the service to meet future demand resulting from specific specialty developments and to comply with the National Optimal Pathways
Investment Objective 4	To optimise MRI capacity across sites and enable the development of a community diagnostic centre on an eLGH site (potentially Ysbyty Ystrad Fawr) in accordance with Welsh Government policy
Investment Objective 5	To reduce the need to outsource MRI activity and the risks associated with this

2.8 Risks

2.8.1 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.

2.8.2 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	4	20	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	2	2	4	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.	2	2	4	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	2	2	4	Engagement with clinical services on programme of works, on-site communication

Recruitment of additional staff	May prevent full utilisation of capacity	3	3	9	Strategy to address current and future workforce needs required from service
Revenue Affordability	May prevent full utilisation of capacity	5	4	20	Clear assessment of revenue affordability offset by reductions in premium cost non-core activity

2.9 Constraints

2.9.1 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. However, it is recognised by the service that there has been significant success recently in recruiting and retaining. Overseas recruitment has been very successful and Directorate has employed four locum Consultants in the last year. All of these are currently progressing through the CESAR route and once on the specialists register they are all eligible for substantive NHS positions. Similarly, overseas recruitment to employ specialist cross sectional Radiographers has been very successful. The Directorate is confident that the specialist radiography and Radiologist recruitment could be achieved in a timely manner within the UK and international recruitment drive.

2.10 Dependencies

2.10.1 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 if / as appropriate
- **Leadership** - A commitment from the Board and within the Division is required to implement the additional facility. Commitment to drive through the required changes is paramount.

3.0 OPTION APPRAISAL

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.

3.1 Critical Success factors

The key Critical Success Factors (CSF) are based on those embedded in the Health Board's Clinical Futures Programme and Strategy. They have been identified to allow evaluation of the potential options for the development of MRI 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, Llais (formerly CHC) and staff • Meets expectations in terms of patient safety, quality and accessibility • Reduces identified service provision risks • Compliance with legislation • Improved environment
CSF3: Sustainability	• Sustained delivery of reduced waiting times targets • Allows for flexibility of use & adaptable to future changes • Improves recruitment and retention of clinical staff
CSF4: Efficiency	• Facilitates one stop diagnostic assessment & investigation • Diagnosis to treatment time minimised through streamlined pathways in line with current evidence & 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.

3.2 Options Framework

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 has been used by the project 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

Category of Choice	1	2	3	4	5
Service Scoping Option	SO1 Continue to maintain existing MRI provision in GUH at current physical capacity levels.	SO2 Explore Additional Capacity from Regional/Neighbouring Health Boards	SO3 Commission additional MRI activity from external provider	SO4 Procure second MRI scanner at GUH as part of managed service contract	SO5 Procure second MRI scanner at GUH as a capital purchase
Estate Solutions	ES1 Utilise existing unit capacity	ES2 Utilise provider's existing unit capacity	ES3 Utilise providers existing unit capacity	ES4 Enable utilisation of allocated space in GUH	ES5 Enable utilisation of allocated space in GUH
Service Delivery	SD1 Total service provision by ABUHB	SD2 Total service provision by neighbouring HB's	SD3 Some clinical services are outsourced	SD4 Some clinical services are outsourced	SD5 Total service provision by ABUHB

Implementation Options	<u>I01</u> Single Phase	<u>I02</u> Service Level Agreements subject to capacity availability	<u>I03</u> Competitive Procurement	<u>I04</u> Competitive Procurement	<u>I05</u> Capital Procurement
Funding	<u>F1</u> N/A	<u>F2</u> Public sector revenue	<u>F3</u> Public sector revenue	<u>F4</u> Private Sector Capital -	<u>F5</u> Public Sector Capital/revenue

3.3 Long List

The long list has identified the possible options above. A summary of findings and conclusions is given in the table below:

Options	Finding
1.0 Scoping Options	
S01 - Continue to maintain existing MRI provision in GUH at current physical 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 single point of failure risks. <u>This option is discounted (x)</u>
S02 – Procure additional capacity from Neighbouring Health Boards/ NHS Partners	This option would not meet the majority of critical success factors, as there is no regional Capacity available. In addition, this option does not address the single point of failure risk and does not facilitate the development of a cost-effective CDC within the Health Board <u>This option is discounted (x)</u>
S03 – Commission additional MRI activity from external provider	This option would potentially meet some of the critical success factors but it does not fully address the single point of failure risk and does not facilitate the development of a cost-effective CDC within the Health Board <u>This option is possible and is carried forward to the shortlist.</u>
S04 – Procure second MRI scanner at GUH as part of managed service contract	This option would potentially meet many of the critical success factors but it would not be the most cost-effective solution and would have a significant revenue cost implication for the Health Board. It would also be less aligned to the agreed principle that developments should be founded on seeking sustainable solutions to demand backlogs.

	<u>This option is possible and is carried forward to the shortlist.</u>
S05 – Procure second MRI scanner at GUH as a capital purchase	This option would potentially meet the vast majority of the critical success factors and provide the most cost-effective solution. It also enables closest alignment to the agreed principle that developments should be founded on seeking sustainable solutions to demand backlogs <u>This is the preferred option and is carried forward to the shortlist.</u>

3.4 Short-listed Options

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.

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

Service Options	Estate Solution	Service Delivery	Implement action	Funding Source
Option 3 - Commission additional MRI activity from external provider static or Mobile	N/A for static sites Required for Mobile solution	Fully staffed service	6-9 months	Revenue
Option 4 - Procure second MRI scanner at GUH as part of managed service contract	Estate is available to accommodate the new MRI scanner	Managed service contract fully staffed	12-18 months	Revenue
Option 5 - Procure second MRI scanner at GUH as a capital purchase	Estate is available to accommodate the new MRI scanner	Inhouse service delivery	The programme of works including full space fitout will be approx. 6 months	Capital & Revenue

3.5 Qualitative Benefits Appraisal of the Shortlisted Options

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	15%
CSF2: Acceptability	20%
CSF3: Sustainability	25%
CSF4: Efficiency	25%
CSF5: Achievability	15%

The ranking and weighting exercise is carried out by a group of relevant stakeholders.

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

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 3			Option 4		Option 5	
	W	S	T	S	T	S	T
Strategic Fit	15	2	30	5	75	5	75
Acceptability	20	2	40	5	100	5	100
Sustainability	25	1	25	3	75	5	125
Efficiency	25	2	50	5	125	5	125
Achievability	15	5	75	5	75	5	75
Totals		12	220	23	450	25	500
Ranking		3		2		1	

3.6 Cost Comparison:

To scan and report 6,000/8,000 patients a year on the mobile MR scanner assuming the scanner was operational 7 days a week, 12 hours a day, scanning 23 patients a day. In addition to the costs identified below there would be utility costs and potential delivery/removal costs.

The mobile option has a greater impact on the patients and not all patients will be able to access the mobile scanner, also not all examinations will be able to be undertaken on the mobile. There is also a greater risk from breakdown and theft from the mobile. The safety of patients using the mobile is compromised due to the difficulty accessing the scanner and only the most mobile patients would be able to use it. For inpatients it would be necessary to transport them outside to access the mobile scanner which would bring in weather implications. Table below provides the financial indicative comparison of option 3, 4 and 5. Option 5 seems to be most cost-effective solution.

	6/8000 scans	MR	Indicative 7-year costs
Static Private provider scanning and reporting (option3)	£1.76m pa		£12.32m
Mobile MR scanning and reporting (option 3)	£1.44m pa		£10.08m
Procurement of additional MR scanner including revenue costs (option 5)	£2.95m pa		£8.7m
Procurement of managed service provision contract (based on 6000 scans per annum)	£2.2m pa		£15.4m

3.6 Preferred Option

Based on the non-financial appraisal and the capital cost comparison, the preferred option to be carried forward is Option 5 i.e. the procurement of a second MRI scanner at GUH through a capital purchase

It is important to note that the option 5 solution cost is high in the initial year due to procurement of equipment and associated revenue costs.

4.0 PROCUREMENT ROUTE

4.1 Tender Process

The second MRI scanner at GUH 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.

4.2 Risk

A risk register has been prepared and has been included in the Estates Annex.

4.3 Procurement Strategy and Implementation Timescales.

The timescales for implementation will be provided once confirmation to proceed has been given. A 6 month build programme is anticipated once approval has been given, but this will be very much dependent on lead in times from suppliers.

The BJC has been prepared on the assumption that capital funding will be available in financial year 2024/25

5.0 FUNDING AND AFFORDABILITY

Introduction

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.

5.1 Capital Costs

The preferred option is Option 5 - the procurement of a second MRI scanner at GUH as a capital purchase. The estimated cost for the preferred option is estimated at £2,030,172 the detail of which is set out below:

	Option 5 – Procurement of second MRI scanner at GUH as a Capital purchase
Works Cost	493,175
Fees	
Non-Works	
Equipment	1,100,000
Contingency	98,635
Total Option Costs	1,691,810
VAT (net of reclaim)	338,362
Total Option Costs (including VAT)	£2,030,172

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 £98,635 has been included

- 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.

5.2 Revenue Costs

The table below summarises the revenue costs associated with the preferred option (Option 5). These costs are included within the Divisions financial plan and, in the absence of the second scanner, are currently being used to support delivery of diagnostic waiting times through the use of a mobile MR.

	WTE	Gross Cost TOS £'000	Gross Cost MPOS £'000
Consultant	2.0	311	275
Band 7	0.5	32	32
Band 6	3.9	212	212
Band 3	1.95	60	60
Non pay costs		121	121
Energy costs		35	35
W&E Mtcs Costs		6	6
Total	7.85	777	741

5.3 Preferred Option Expenditure

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

- Clinical and service models
- Workforce requirements
- Estate and Non-pay implications

The new scanner will be operational 12.5 hrs/day, 5 days per week.

5.4 Affordability

This investment in a second MRI scanner at GUH enables 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 the

Health Board as part of its strategic plans and Clinical Futures programme.

The demand for MRI scanning is set to increase steadily and additional capacity will be required regardless of delivery model. This case supports delivery of a sustainable future service, removes a key clinical risk and facilitates the implementation of Welsh Government policy in respect of regional collaboration and efficient accessible diagnostic services for optimum patient benefit.

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 regional diagnostic programme.

6. MANAGEMENT ARRANGEMENTS

6.1 Introduction

This section sets out information on the management arrangements for the project to establish a second MRI scanner at GUH.

6.2 Project Management Arrangements

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.

The project will have a project manager and dedicated Project Team.

6.3 Project Roles and Responsibilities

The Senior Responsible Owner (SRO), Dr Chris Chick, 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 Team ensuring that the Project Management structure is appropriate to ensure the project objectives are delivered and that the benefits are realised.

The Project Director – Hannah Capel is accountable to the SRO and has specific responsibility for the project management structures and organisation of the project, including appropriate controls and monitoring mechanisms. The Project Director is supported by an External Project Manager for the day-to-day planning and design phases of the project as well the technical, procurement and construction phases.

The Service / Clinical Lead – Arvind Kumar, is accountable for the effective co-ordination of clinical and user professional input to the project from the perspective of the service / clinical provision.

Other key project team members include key internal Health Board estates and operational service managers and input from finance, workforce, planning and procurement.

6.4 Outline Project Plan

The table below lists the indicative main milestones for the MRI scanner development dependent on when approval is received and delivery time for the magnet:

Milestone	Completion Date
Sign off of Draft BJC by the Executive Team	August 2024
Submission of Draft BJC to Health Board	August 2024
Submission of Draft BJC to WG	September 2024
Anticipated WG approval of BJC	October 2024
Contractor appointment/start on site	November 2024
Construction work completion / Occupation	March 2025

6.5 Risk Management

The Project Team will oversee the risk management process.

6.6 Post Project Evaluation

The project will be evaluated by undertaking the following investigations:

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

Appendix: 1 Option Appraisal
(Advantage/Disadvantage Matrix)

Option	Advantage	Disadvantage
1. Do Nothing	Status Quo	GUH MR scanner remains single point of failure. Inability to meet RTT and SCP targets due to capacity shortfall Inability to expand service portfolio to support O/P Cardiac MR's and Stroke Pathway
2. Exploring Regional Capacity	Promoting Collaborative working	No Regional Capacity available
3. Commission additional activity from Mobile/Static sites	No Capital Outlay No staffing and maintenance cost Subject to Market availability quick option to implement	Static Private Provider unless commissioned exclusively not able to meet demand. Potential inability to perform examinations on non-ambulant patients and inpatients due to access issues. Mobile Scanners not able support high quality specialist scans requirements. Ongoing significant revenue costs to cover Electricity and connectivity usage charges for Mobile Scanners Mobile units tend to be less robust than their static equivalents. GUH Single Point Failure remains option not compliant with service safety net requirement to consolidate MRI services at GUH Not cost effective
4. Procure Second MR at GUH via Managed Service Contract	No Capital outlay Maintenance cost covered within the contract Quick option : Subject to procurement and revenue fundings	Complicated Model End of contract arrangements asset transfer issues. Expanding services footprint requires negotiation with the MES provider.

	Addresses lack of Second MR safety issue	Staffed MES service difficult to manage due to lack of operational control
5.Procure second MRI at GUH as Capital Purchase	Major reconfiguration of the GUH will not be Required. Second MRI Space identified and reserved (albeit currently used as office space) in CF plan. New build would allow for bespoke modern facilities to be developed. Ability to address GUH safety net issues Ability to ensure compliance with the WG RTT and SCP targets Ability to expand service provision to ensure support for Cardiac MR and Stroke Pathways where possible. Further cost savings by expatriating Cardiac MRIs from Bristol. Potential savings by avoiding non-recurrent MR Capacity Solutions such as Mobile scanners etc required to meet RTT and SCP targets. Value for Money/Cost effective solution in comparison with other options listed above.	Significant Capital Outlay. Displacing staff currently in GUH second MRI space Staff recruitment

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Electronic Prescribing & Medicines Administration Programme Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Solloway – Director of Digital
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Solloway – Director of Digital

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

Ar Gyfer Penderfyniad/For Decision

To request approval of the business case for the implementation of electronic prescribing and medicines administration (ePMA) in secondary care to improve safety and patient experience.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Health Board is running a digital programme of work, overseen by a national Digital Health & Care Wales (DHCW) programme, to procure a new ePMA solution. The primary aim of the ePMA solution is to remove paper-based processes from prescribing and medicines administration to significantly improve patient safety and quality of care. In addition, an electronic system will improve the Health Boards medicine management processes and enhance medicines optimisation and drug expenditure. This will enable greater control over what is prescribed, where it is prescribed and how it is prescribed and administered.

The implementation of a new ePMA solution will be a significant transformational change for the Health Board. It is estimated that the ePMA system will be accessed by approximately 6,500 members of staff. The successful implementation will be heavily reliant on the buy in and support of staff from all clinical areas covering Medicine, Nursing and Pharmacy.



To date, Welsh Government has fully funded the staffing for the pre implementation phase of the local programme, to support a procurement exercise and business case development. As part of the business case development, a bid for Welsh Government funding has been submitted and confirmation received that they support in principle and don't see any challenges in granting the funding requested. To date, Welsh Government are only committing to funding for the financial years 2024/25 and 2025/26, however, should future funding become available, the Health Boards programme team will bid for additional funding to offset local spend.

The Health Board has undertaken a tender exercise inclusive of supplier evaluation. The outcome of which is the identification of a preferred supplier. The next step is to seek approval from the Health Board and Welsh Government to proceed. Following this a contract will be awarded to the preferred supplier.

Cefndir / Background

In September 2021, following an independent review, a Ministerial statement was published regarding e-prescribing in Wales. Subsequently, Digital Health and Care Wales were directed by Welsh Government to establish a national programme to deliver digital medicines transformation across NHS Wales.

The aim of this programme is to fully digitalise the electronic prescribing environment across all care settings in Wales, and associated processes to increase efficiency and safety, as described in the recommendations from the Strategic Review on The Future of Electronic Prescribing in Wales, 2021.

The programme comprises of four elements:

1. Seamless primary care e-prescribing capability

Establishing a seamless digital communication and sharing of prescription information between prescribing and dispensing systems from GPs and non-medical prescribers to a community pharmacy of choice, including the necessary business change to adopt new ways of working. This capability will be delivered via the Primary Care Electronic Prescription Service (EPS) programme. The EPS programme is now in pilot phase in a number of practices in Gwent and a further update will be provided to the Board in November 2024.

2. Seamless secondary care e-prescribing capability

Procuring and implementing hospital e-prescribing and medicines administration (ePMA) systems across all secondary care settings in NHS Wales that builds on a set of common open standards and principles that provide end-to-end e-prescribing secondary care capabilities together with interoperability with other care settings in Wales and the Shared Medicines Record. The capability to transfer Outpatient prescriptions electronically to community pharmacists is included. This capability will



be delivered via the Secondary Care electronic Prescribing and Medicines Administration (ePMA) programme.

3. Patient Access development

Provision of a patient application that allows data sharing from GP, community pharmacy and hospital systems to patients. This is to support patients to understand which medicines to take and when, to record their choices, record any problems they are experiencing with medicines, and how and when their medicines are supplied.

This capability will be delivered via functionality within the NHS Wales App. The project is working closely with the Digital Services for Patients and the Public programme.

4. Shared Medicines Record

Provision of a Shared Medicines Record, supported by a centralised medicine repository that allows access to the list of medicines a patient has previously or is currently taking, regardless of where these originated from or are managed, (e.g. GP, homecare, mental health services, over the counter or other source). This will enhance patient safety and streamline the delivery of care, particularly at the interface between primary and secondary care. This capability will be delivered via the Shared Medicines Record Project and where the project is working closely with the National Data Resource Programme.

The ePMA programme seeks to implement an electronic platform for prescribing and medicines administration within secondary care, including providing electronic medicines charts to simplify administration of medicines. A new ePMA system will provide:

- Greater knowledge through improved data recording and availability of rich, routinely collected data, for clinical surveillance, audits and analytics
- A reduction in adverse events made through prescribing, transcribing and administration
- Improved monitoring, recording and checking by having a single source of truth e.g., for prescribed medications and allergies
- Time saving - accessing paper charts, admission assessments, drug rounds and re-writing charts
- Increased time available for direct patient care
- Improved administration records
- Reduction in omitted medications / doses
- Improved pharmacy order management
- Reduced expenditure – annual drug and paper related spend (purchasing and filing)

The ePMA solution scope will be hospital-based services including, but not limited to inpatients, outpatients, paediatrics including neonatal, Mental Health and Urgent / Unscheduled / Emergency Care. Scope also includes community hospital sites and Minor Injury Units where medicines are administered and prescribed.



The strategic drivers for the programme are multi-faceted. The delivery of a high-quality service to patients in Wales in the future will increasingly rely on the provision of efficient and effective information systems to underpin care delivery; *Informed Health and Care – A digital health and social care strategy for Wales* within the Welsh Government Programme details this.

Developing ePMA systems in hospitals is one way to promote the safe and effective use of medicines for patients and is in line with the principles of prudent healthcare set out by Welsh Government. Introducing an ePMA solution is also one of the planned outcomes in the All-Wales Medicines Strategy Group's (AWMSG) five-year strategy 2013-2018 to improve patient care and the patient's experience of medicines in Wales.

Having suitable ePMA systems in place was also promoted by the World Health Organisation (WHO) in their report of May 2024 "Digital prescriptions – good for patients, good for prescribers and good for dispensers". They summarised that digital prescriptions form an essential part of the digital transformation of health systems. By improving patient safety and quality of care, especially for vulnerable communities, the service boosts efficiency and advances progress towards universal health coverage.

In addition, the conclusion of an academic paper publicised in the British Medical Journal summarised "Transition medication errors persist despite standard medicines reconciliation, and an interoperable prescription information system has the potential to substantially reduce transition medication error prevalence, associated harm and healthcare costs. Additional potential benefits include healthcare professional time saved, improved patient experience and care quality, quicker discharge and enhanced cross-organisational medicines optimisation."

To support the implementation of ePMA across Wales, an NHS procurement framework, with 3 selected suppliers, was developed. As part of the framework agreement, DHCW were identified as the framework operator with each individual health board being responsible for its own call off agreement with its chosen supplier, based on its own business requirements. The framework sets out that contract terms were 5 years operational service plus 2 years extension and determined the set of terms and conditions ePMA would be bound to.

The Health Boards ePMA Programme has been working to timelines which directly correlate to Welsh Government funding via its Digital Priorities Investment (DPIF) funding stream, reporting against funding milestones which is overseen by DHCW. Welsh Government have committed to funding the pre implementation and implementation phases for the programme as detailed below, subject to the approval of a business case submitted by individual Health Boards detailing the resource requirements and associated implementation costs.

Asesiad / Assessment

The Programme is now able to finalise and progress the full business case for approval, and therefore is seeking a decision from the board on its position to



proceed based on the indicative investment set out below. The following options are available at this time:

Option 1 - Do Nothing

This option presents that the Health Board opts to not proceed with the ePMA business case any further.

Benefits:

No benefits will be realised.

Risks:

The manual recording of prescriptions and medications administered will without doubt continue, presenting the following risks for services and the organisation:

- Further incidents occurring due to errors being made through illegible records
- Further incidents occurring due to errors being made through incorrect records
- Continued inefficiencies due to manual ways of working
- Continued isolated records across Secondary Care
- Increased digital immaturity
- Reputational damage if The Health Board do not deliver against the National ambition for ePMA
- Increased Welsh Risk Pool insurance premiums if the Health Board are the only Health Board in Wales not to pursue the implementation of ePMA

The only mitigation to these risks would be for the Health Board to stand up a non-digital programme of work to address and improve the manual recording of medicines being prescribed and administered.

Option 2 – Proceed to full business case

This option presents that the Health Board opt for the programme to proceed with the full business case for Health Board and Welsh Government approval, with the intention of awarding a contract with the Health Boards chosen supplier.

Benefits*:

Quality and Patient Safety Benefits:

- 100% of patients with a completed and documented allergy assessment
- 50% reduction in medicine administration errors
- 95% reduction in the number of blank boxes on an administration record
- 75% reduction in the number of missed doses due to medication not being available
- Reduction in Secondary Care Dalteparin spend by 15% (£149,283 cash releasing)



- 40% reduction in the number of prescribing errors and subsequent 37.5% reduction in the categories being recorded
- Increase in the volume of medicine reconciliations completed to 70%
- Achieve 90% for Venous thromboembolism (VTE) prophylaxis prescribed and 90% completion rate for VTE prophylaxis risk assessment
- 15% reduction in prescriptions longer than 7 days and improved review of IV prescriptions at 72 hours
- 50% improvement in the administration of time critical medicines

Operational, governance and decarbonisation benefits:

- Reduction in medic's time, to zero, spent rewriting medication charts (£60,058 non-cash releasing)
- Reduction in Pharmacy time, to zero, spent rewriting medication charts (93,693 non-cash releasing)
- Reduction in annual medication spend by a predicted 1% (£277,301 cash-releasing)
- Reduction in time taken to complete the nurse's morning medicines administration round by 2% (£36,292 non-cash releasing) – releasing 4 hours 55 minutes per day across nurses, resulting in time released for other activities, based on an average of 8.34 minutes per patient
- Reduction in time spent transcribing discharge medicines (£532,554 non-cash releasing)
- Reduction in the reliance on paper-based sources, reducing the current amount spent on paper medication charts by 95% (39,660 cash releasing)
- Reduction in time spent scanning core medicines charts (£7,441 non-cash releasing)
- Time saved accessing paper charts (£34,059 non-cash releasing)
- 95% decrease in paper (paper will still be required for business continuity purposes)

Additional benefits which will emerge during implementation and will be measured during and following implementation include:

- More accurate patient medical records on admission = improved patient safety
- Improved Therapeutic Drug Monitoring (TDM) = less blood monitoring
- Reduced number of hospital acquired infections = reduced number of in-patient C Difficile cases
- Improvements in prescribing practices in Homecare = better shared documentation
- Remote prescribing = reduction of out of hours travel expenses to community sites
- More timely medication reviews = dashboard can be used to highlight patients with the greatest needs
- Improvements in discharge planning = beds freed up more efficiently & improved patient flow
- Improved working practices =
 - improved staff recruitment and retention levels



- improved staff satisfaction levels
- improved staff sickness following medication errors
- Improved monitoring of prescriptions = reduction in prescription fraud
- Improvements in availability of digital equipment (laptops and carts) in clinical areas which will benefit future digital transformation initiatives
- Improvements in Wi-Fi provision across our sites will directly benefit planned programmes of work such as our Clinical Communications Platform.

The ePMA solution will also interact with the national shared medicines record which will allow Health Board clinicians to see medicines information for patients who may have been treated and prescribed medication in other Health Boards in Wales and will also link up to Primary Care electronic prescriptions, so clinicians and GPs have a full view of a patient's medication record. There are also future developments planned for the NHS Wales App to enable patients to see their prescriptions, select a preferred pharmacy and to contribute to the shared medicines record by recording over the counter medications they may be taking.

Without ePMA Aneurin Bevan Health Board patients who attend neighbouring Health Boards that have implemented ePMA will not have a complete medicine record resulting in clinicians seeing only a partial view of the clinical record.

The total predicted cash and non-cash releasing savings are shown below:

Cash Releasing	Per Annum (£)
Reduction in secondary care Dalteparin spend	149,283
Reduction in annual medication spend	277,301
Reduction in the reliance on paper-based sources	39,660
TOTAL Cash Releasing savings	466,244

Non-Cash releasing	Per Annum (£)
Reduction in Medics time spent rewriting medication charts	60,058
Reduction in Pharmacy time spent rewriting medication charts	93,693
Reduction in the time take to complete morning medicines administration round	36,292
Reduction in time spent transcribing discharge medicines	532,554
Reduction in time spent scanning core medicines charts	7,441
Time saved accessing charts	34,059
TOTAL Non-Cash Releasing savings	764,097

*See Appendix 1 for full benefits plan

Risks:

The business case and future of ePMA is dependent on the provision of Welsh Government Funding and local investment. Known risks are:



- Welsh Government have indicated that funding will only be available for financial years 24/25 and 25/26 and therefore the opportunity of securing circa £5m investment towards Health Board implementation will be lost if the Health Board did not proceed with this business case
- The Health Boards current financial position presents a limited ability to invest as required
- Upfront cost implications for wi-fi improvements work will be required to mitigate risks to successful delivery due to inadequate wi-fi coverage across the estate
- There will be additional costs for the Health Board that will need to be included in future hardware refresh budgets, to maintain the ePMA solution / devices circa £280k p/a
- Availability of skilled resource required to implement and maintain the service

Financial Position:

The table below sets out the current anticipated investment required for the implementation phase of the ePMA system:

Cost Summary	2024/2025	2025/2026	2026/2027	2027/2028
Health Board Funding (Revenue)	179,467	0	1,937,032	2,029,999
Health Board Funding (Capital)	0	0	568,076	79,503

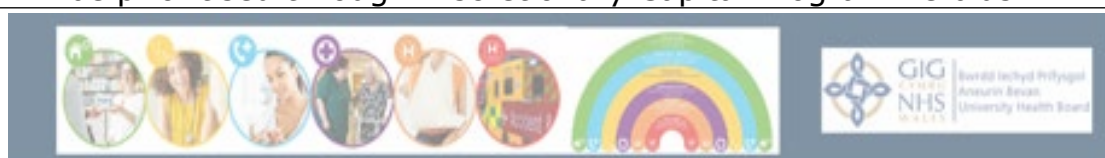
The following funding will be provided by the Welsh Government's Digital Priorities Investment Fund to support the implementation phase:

Cost Summary	2024/2025	2025/2026	2026/2027	2027/2028
Welsh Government (Revenue)	754,414	2,141,367		
Welsh Government (Capital)	320,554	1,622,400	0	0

Following implementation, the annual running costs of the ePMA solution is set out below:

Cost Summary	2028/2029 (9 months)	2029/2030	2030/2031
System Running Costs	1,186,764	1,033,736	1,057,923
Cash Releasing Benefits	466,244	466,244	466,244
Total Cost per annum	720,520	567,492	591,679
Non-Cash Releasing Benefits	764,097	764,097	764,097
Net Benefit	-43,577	-196,605	-172,418

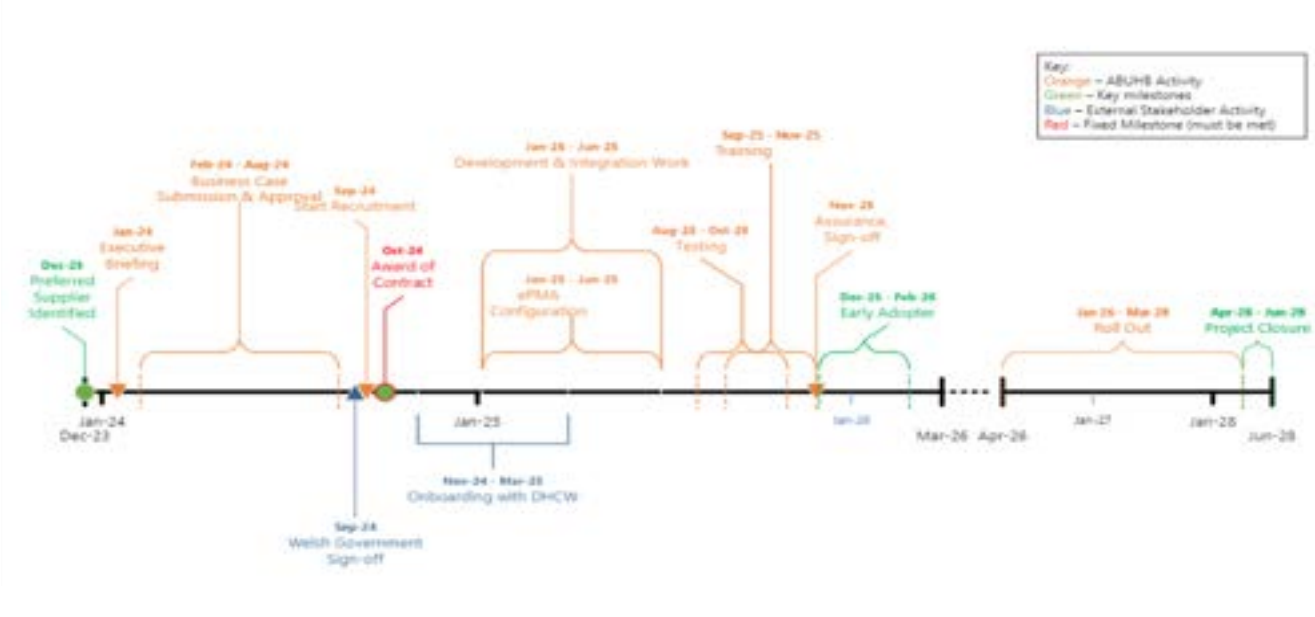
In addition, capital funding will be required to support replacement of equipment which will be prioritised through Discretionary Capital Programme bids:



Cost Summary	2028/2029 (9 months)	2029/2030	2030/2031
Capital Costs	277,271	277,271	277,271

High level implementation plan

It is anticipated that the ePMA Programme will be operational for a period of 4 years. From year five it is expected that the ePMA service will become business as usual, at which time normal service delivery will resume and further optimisation of the system and supporting process can be fulfilled.



Argymhelliad / Recommendation

The Board is asked to APPROVE the investment in the ePMA solution set out in this paper and the full business case.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 3.1 Safe and Clinically Effective Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well



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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Estimating the impact on patient safety of enabling the digital transfer of patients' prescription information in the English NHS BMJ Quality & Safety Digital prescriptions – good for patients, good for prescribers and good for dispensers (who.int)
Rhestr Termau: Glossary of Terms:	ABUHB – Aneurin Bevan University Health Board AWMSG - All-Wales Medicines Strategy Group DHCW – Digital Health and Care Wales DPIF – Digital priorities investment fund DTM - Therapeutic Drug Monitoring EPMA - Electronic prescribing & medicines administration VTE - Venous thromboembolism WG – Welsh Government WHO – World Health Organisation
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper No does not meet requirements
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.



	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives



FULL BUSINESS CASE

This template should be used to document NEW investment cases greater than £50k, as per the Scheme of Delegation. Please refer to separate

\Title of Business Case:	Secondary Care Electronic Prescribing and Medicines Administration

Unique ref No.:	To be completed by Corporate Support

guidance on the content required for each section.

Directorate/Division:	Digital, Data and Technology

Divisional Director:	Paul Solloway

Project Lead(s):	Amy Smith, ePMA Programme Manager

Drafting and Approvals Status Record

Version No.	Date Issued	Amendment History	Accountable Manager
0.1	16-01-2024	Initial Draft	ePMA Programme Manager
0.1	19-01-2024	Peggy Edwards (CNIO) amendments incorporated	
0.1	19-01-2024	Kelly Griffiths (Digital Portfolio Benefits Manager) amendments	
0.1	19-01-2024	Rob Ludman (Head of Service Management) amendments	
0.1	19-01-2024	Sharif Biharie (Head of ICT) amendments	
0.1	25-01-2024	Hayley Saunders (ePMA Lead Nurse) amendments	
0.1	25-01-2024	Melanie Poole (ePMA Lead Consultant) amendments	
0.2	13-02-2024	David Hanks (Head of Service Planning) amendments	
0.2	13-02-2024	Wendy Davies (Enterprise Architect)	
0.2	13-02-2024	Ruth Madine (Deputy Head of HR) amendments	
0.2	13-02-2024	Victoria Richards-Green (ePMA Pharmacy Lead) amendments	
0.2	13-02-2024	Inclusion of ERSG (national assurance body) amendments	
0.3	15-02-2024	Zoe Thomas (Portfolio Manager) amendments	
0.3	16-02-2024	Nicola Quiller (Business Change Manager) amendments	
0.4	27-02-2024	Final Draft	
0.5	14-03-2024	Approved Draft	
0.6	04-04-2024	PIP suggestions and proposals added	
0.7	17-06-2024	Finances and timeline update to reflect June 24 position	
0.8	18-07-2024	Updated finances (Change in inflation rates, addition of depreciation/vacancy values)	
0.9	15-08-2024	Updated finances (following WG funding position and changes to Programmes positions in SD)	
1.0	11-09-2024	For Presentation to Executive Board	

Integrated Divisional/Corporate team members involved in developing Business Case	
Finance Business Partner (Name)	Andrew George
HR Business Partner (Name)	Ruth Madine
Capital Planning (if applicable) (Name)	N/A
Approval by Divisional Manager / DMT	Janice Jenkins

1. Executive Summary

Subject/Purpose

The primary aim of Electronic Prescribing and Medicines Administration (ePMA) is to remove paper-based processes from prescribing and medicines administration and significantly improve patient safety and quality of care. In addition, an electronic system will improve medicines management processes and enhance medicines optimisation. This will enable greater control over what is prescribed, how it is prescribed and how it is administered.

In 2020, Welsh Government commissioned a Strategic Review into e-Prescribing ¹. The review, resulted in recommendations being made on how a fully digital, multi-sectoral e-Prescribing platform for Wales could be delivered as a major transformational programme. The recommendations of this review were endorsed by Welsh Government with the Minister for Health and Social Services of Wales setting an expectation that this programme of transformation will be delivered by September 2026, making funding available for this period to support the transformation. Each Health Board and Trust in Wales has been asked to endorse this opportunity and deliver an ePMA solution within this timeframe.

This Full Business Case sets out the case for change and the investment required to implement an ePMA solution across Aneurin Bevan University Health Board's (ABUHB) Secondary Care provision. It seeks approval for the capital and revenue investment required to implement the chosen solution and for the funding associated with its ongoing optimisation and management.

In addition to seeking approval for the capital investment and revenue budgets, the Business Case seeks authorisation to proceed with the ePMA implementation in ABUHB. This includes:

1. Committing to the specified revenue and capital investments
2. Awarding a contract to the preferred supplier
3. Initiating recruitment for the implementation team, with immediate effect
4. Proceed to the implementation phase of the project, closing pre-implementation
5. Establishing a new digital product delivery model for long-term optimisation and support for the ePMA solution.

ABUHB's ePMA Programme, as part of the National Secondary Care ePMA Programme has recently undertaken a detailed phase of work to understand the complex processes and requirements for an ePMA system along with a comprehensive tender process to determine the best ePMA solution for ABUHB. The outcome of which is a recommendation that ABUHB award a contract with their preferred ePMA supplier.

This Business Case details the requirements for ABUHB to sign up to a contract with the chosen ePMA supplier, to enable an implementation programme to be established for the development, configuration, deployment and support for the delivery of an integrated electronic prescribing and medicines administration system across Secondary Care Services including but not limited to; Emergency and Assessment Units, Inpatient Wards, Mental Health and Outpatient Services. The

¹ dhw.nhs.wales/files/eprescribing/welsh-government-eprescribing-review/

Business Case also sets out the long-term requirements for the acceptance and ongoing delivery and management of the new digital service.

Scope

The scope for implementation of ePMA will include a full product delivery inclusive of supporting infrastructure, software, hardware, configuration, testing, training, programme support and the establishment of a new digital service. The solution will be available for use by all services within secondary care where medicines are prescribed, administered and dispensed. Within the scope of this programme ePMA will be made available in all secondary care inpatient wards and outpatient departments, inclusive of the various assessment units, theatres, recovery and emergency departments. Implementation of ePMA will be across all acute and community hospital sites of the Health Board.

Out of scope for this programme includes:

Primary care e-prescribing: This is being managed as part of the Primary Care Electronic Prescription Service (EPS) Programme, which aims to introduce electronic transfer of prescriptions between GP Practices and community pharmacies or dispensing contractors. EPS will not provide the system that creates electronic prescriptions.

Community Teams: Teams working within the community such as Community Resource Teams and District Nurse are not in currently scope for this ePMA Programme.

The ePMA Programme will work closely with EPS and other digital programmes such as the Shared Medicine Record (SMR) Programme to ensure joined up thinking and approaches are achieved.

Stakeholders

To date, there has been engagement with a number of services across ABUHB along with external stakeholders including DHCW, ePMA suppliers and existing ePMA users. Clinical engagement has been undertaken to establish, review and endorse the benefits set out in this business case, determining the requirements for ePMA in ABUHB and for the evaluation of the different ePMA systems to ensure the needs of services are met. Engagement with Technical Subject Matter Experts has been undertaken to determine the technical requirements for ePMA, for supplier evaluation and contribution to the case for change.

Several key stakeholders have been involved in the development and review of this business case. A full stakeholder list can be found in Appendix 1.

Proposal – Preferred Option

Following the tender exercise, the preferred option is to award a contract to the successful supplier and implement ePMA across all in scope secondary care services within ABUHB. The reasons for this option being the preferred are twofold:

National context: the ePMA Programme was identified as a much-needed major transformational change. The introduction of ePMA supports a number of key policies and reviews for Wales:

- Well-being of Future Generations (Wales) Act 2015

- A Healthier Wales: our Plan for Health and Social Care 2018
- All Wales Medicines Strategy Group Five Year Strategy “Supporting prudent prescribing to obtain the best outcomes from medicines for patients in Wales” 2018-2023
- Tackling antimicrobial resistance 2019–2024 The UK’s five-year national action plan 2019
- Pharmacy: Delivering a Healthier Wales 2019
- Putting Value at the Centre of Health and Care in Wales - A Three-Year Action Plan 2019
- Health and Social Care (Quality and Engagement) (Wales) Act (2020)
- The Wales Audit Office Report “Managing Medicines in Primary and Secondary Care” 2016
- The Parliamentary Review of Health and Social Care 2018
- Transforming Access to Medicines Review 2018
- Healthcare Safety Investigation I2018/018. Healthcare Safety Investigation Branch. 2019

Local context: the current outdated approach is exposing ABUHB to significant risks, which without action will not only continue, but will become more of an issue as time passes. As the pressures and challenges become significantly bigger for frontline services, we increasingly need new, more effective and more efficient ways of working to ensure we can not only address the issues that are impacting the level of patient care, but also allow ABUHB to modernise services through the utilisation of new digital ways of working that enable improved ways of working and increases patient safety. An ePMA will enable ABUHB to meet changing legal requirements such as for remote prescribing and will:

- Improve Patient Safety
- Improve Clinical effectiveness
- Improve Quality and Clinical Governance
- Improve Operational Productivity

An ePMA solution will support a number of the Health Board’s key objectives, including;

- Health and Care Quality Standards (2023) aiming to ensure that all tasks associated with medicines are:
 - Safe
 - Timely
 - Effective
 - Efficient
 - Equitable
 - Person-centred.
- IMTP priorities:
 - Adults in Gwent live healthily and age well
- Strategic Equality Objectives, to:
 - 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.

Resource Implications

The Nuffield Report (2016) - Delivering the benefits of digital healthcare, cites seven lessons that all health care organisations embarking on a digital strategy should consider. The Business Case

acknowledges these elements as key components to successful implementation of ePMA in ABUHB and factored the structuring and resources requirements accordingly:

- Transformation first
- Culture change is crucial
- User-centred design
- Invest in analytics
- Multiple iterations and continuous learning
- Support interoperability
- Strong information governance

An assessment of the estimated funding requirements, inclusive of the capital and revenue costs, associated with the implementation and ongoing delivery of an ePMA system in ABUHB has been completed and is summarised in the table below. This assessment includes:

- System purchasing costs
- System licence costs
- Estimated staffing costs for implementation of ePMA
- Estimated wi-fi network improvement costs, on which ePMA will be fully reliant
- Estimated hardware costs for rolling out ePMA
- Estimated staff costs for the ongoing delivery of ePMA
- Estimated annual hardware refresh costs.

The detailed financial statements, for both the implementation and delivery of ePMA, is set out in appendix 2. Appendix 2c sets out a full financial statement for the investment required for implementing an ePMA solution in ABUHB, a summary is below:

Financial Summary Implementation	2024/25	2025/26	2026/27	2027/28	2028/29	Totals
	£'s	£'s	£'s	£'s	£'s	£'s
Total Revenue Required	933,880	2,141,367	1,937,032	2,029,999	440,324	7,482,603
WG Revenue Funding Requested	754,414	2,141,367	0	0	0	2,895,781
ABUHB Revenue Funding Required	179,467	0	1,937,032	2,029,999	440,324	4,586,822
Total Capital Required	320,554	1,622,400	568,076	79,503	0	2,590,533
WG Capital Funding Requested	320,554	1,622,400	0	0	0	1,942,954
ABUHB Capital Funding Required	0	0	568,076	79,503	0	647,579
Total Investment Required	1,254,434	3,763,767	2,505,108	2,109,502	440,324	10,073,136

In addition to the investment required for the implementation of an ePMA system, an annual net change to budgets will apply, post implementation, with effect from 28/29 for ongoing delivery of the product. An estimation of this change is set out below (**N.B.** year 1, 28/29, *revenue* costs will differ. This is due to the programme period spanning the 28/29 financial year. Year 1 net change to budgets

will be £746,440 Revenue). A full statement of the product delivery costs applicable from 28/29 can be found at appendix 2d.

Financial Summary Product Delivery	
Estimated 29/30 Annual Revenue Total	1,033,736**
Estimated 29/30 Annual Capital Total	277,271
Total Estimated Annual Investment	1,311,007*

*Subject to inflation

**Expected annual supplier fees applicable for duration of contract (currently expected to run for maximum of 7 years from 'contract award')

Contingency

Due to the very nature of a new digital implementation of this scale there is some ambiguity. Taking into consideration lessons learnt from other similar programmes of work there are often additional costs that arise throughout delivery; therefore, a financial contingency has been calculated. This amount has not been included in the financial model due to it being unknown. It is however being noted so that all investors can consider the implication. If any unplanned costs for the implementation of ePMA materialise, the programme will submit a change request to DPIF to request the required amounts. The estimated contingency is set in relation to integration works and/or any external costs that may arise, and is estimated at:

CONTINGENCY	2024/25	2025/26
Estimated unplanned expenses e.g. 3 rd Party Systems/Suppliers for integration	£50,000	£50,000
Total Estimated Contingency	£50,000	£50,000

Depreciation

It is also noted that due to the volume of hardware required to ensure a successful and safe delivery of ePMA, there will be an element of depreciation. These figures have not been included in the financial statements and are provided for information purposes only. The estimated depreciation value for the maximum term of the product contract is as below:

	24/25	25/26	26/27	27/28	28/29	29/30	30/31	TOTAL
Purchases	£320,554	£1,222,400	£568,076	£79,503	£277,271	£277,271	£277,271	£3,022,346
Depreciation								
2024/25	£32,055							£32,055

2025/26	£64,111	£244,480						£308,591
2026/27	£64,111	£244,480	£113,615					£422,206
2027/28	£64,111	£244,480	£113,615	£15,901				£438,107
2028/29	£64,111	£244,480	£113,615	£15,901	£55,454			£493,561
2029/30	£32,055	£244,480	£113,615	£15,901	£55,454	£55,454		£516,960
2030/31			£113,615	£15,901	£55,454	£55,454	£55,454	£295,878
2031/32				£15,901	£55,454	£55,454	£55,454	£182,263
2032/33					£55,454	£55,454	£55,454	£166,363
2033/34						£55,454	£55,454	£110,908
2034/35							£55,454	£55,454
TOTAL	£320,554	£1,222,400	£568,076	£79,503	£277,271	£277,271	£277,271	£3,022,346
Notes: Assumes kit purchased on 1 st October 2024 then 1st April going forward								

Vacancy Value

Additionally, it is anticipated that there will be an element of staff turnover during the implementation and delivery of ePMA and as such a vacancy factor of 5% has been set. These figures have not been included in the financial statements and are provided for information purposes only. Estimated vacancy values have been calculated, for the maximum term of the product contract, as below:

Vacancy Value							
2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total
£'s	£'s	£'s	£'s	£'s	£'s	£'s	£'s
10,958	50,872	90,039	93,312	48,713	40,312	41,521	375,728

To date, Welsh Government's (WG) Digital Priorities Investment Fund (DPIF) has supported the pre-implementation phase of work through funding of all associated costs. WG have confirmed their commitment to supporting local implementation projects by an offering of further DPIF funding to cover the resource costs which make up the temporary organisation formed to prepare the organisation for ePMA, and to complete the implementation itself. The level of DPIF commitment is not yet known and will be subject to approval of this business case and the associated requests for capital and revenue funding. It is however the expectation of WG and the Minister for Health and Social Services in Wales that all implementations will be completed no later than September 2026 and is therefore reasonable to assume that the availability of WG funding will not be available beyond this date. ABUHB will not be able to deliver a programme of this size by September 2026, a 4-year programme is required to implement an ePMA safely at pace within ABUHB, the finances have therefore been calculated on the basis that WG funding will not be available beyond September 2026, but the programme will take 4 years to deliver.

Welsh Government will not fund resources deemed necessary for the ongoing operation of ePMA. All costs associated with the ongoing delivery of ePMA, beyond the implementation period will fall solely to ABUHB.

Benefits and Risks of Preferred Option

Benefits

The introduction of ePMA in ABUHB will initiate seamless digital communication and sharing of prescription information between prescribing and dispensing systems within ABUHB. It will connect primary and secondary health care and will iron out historical gaps in information and data systems, covering all bases inclusive of inpatient wards, outpatient departments, emergency, and assessment units within ABUHB.

Staff will be empowered to share crucial information across professions and with our primary care partners. This programme of change is more than the implementation of a new system, ePMA will become the key player for a new way of working, underpinning:

- Person-centred care
- Integration across health & social care
- Quality & Safety
- Effectiveness
- New service models & legislation
- Efficiency through mobile working.

The introduction of ePMA will see the realisation of both nationally agreed and locally identified benefits. Appendix 3 sets out the full detail of the expected benefits, including an estimated £466,243 recurrent (flat rate) efficient cash-releasing saving, along with numerous efficient non-cash releasing, timely, effective and person-centred benefits, in summary these are:

- Reduction in expenditure, through savings on medication spend and prescription charts
- Increased safety around prescribing - improved documentation of allergies etc
- Improved efficiencies for clinical services – less time spent locating documents and rewriting charts
- Improved prescribing practices in line with guidelines
- Improved patient experience.

Risks

The prioritisation level for the preferred option in this business case is: **Medium Priority** for the organisation. (Appendix 4)

Along with the resource funding, this option will require ABUHB to commit to embedding a new system and transforming the way in which medicines are prescribed and administered at pace. The programme will not be able to deliver the programme in this way without sufficient and significant resource funding for its duration. The introduction of a new system will on its own require time for development and deployment, but the level of transformational opportunities will require organisational wide business change.

To achieve such change at pace the required level of dedicated resource is high. The programme will be dependent on Software Development and ICT resource to develop the system to national standards

with a digital infrastructure that ensures clinical services are equipped and ready to start using ePMA without issue. Clinical teams will need to be on board and committed to establishing and adopting the new ways of working required with an ePMA. Without this commitment ePMA will not succeed.

The critical risks that will impact the success of this approach include:

- Current financial position in ABUHB and NHS Wales resulting in insufficient funding and risking programme delivery
- Software development and integration resource which is already limited and working at full capacity with existing Health Board priorities
- Working outside of nationally set timelines, risking reputational damage
- Unable to recruit to key ePMA positions, present risk of insufficient resourcing for implementation (consideration has been given sharing resources with other Health Boards, however this cannot be confirmed at this time)
- Lack of buy in from clinical service areas, due to existing pressures
- The safe delivery of ePMA requires pace, but other organisational and external factors could affect delivery e.g., winter pressures, staff shortages
- Other organisational changes, requiring time, resource and commitment from the clinical teams and wider organisation
- Potential costs arising from stakeholders e.g., costs arising from works required by DHCW
- Dependency on DHCW, a critical stakeholder without contract, to deliver the capabilities for integration with the national architecture, including the shared medicines record and open APIs.

A full list of the risks that could impact the preferred option set out in this business case and the delivery of ePMA in ABUHB are set out in appendix 5.

Dependencies

The implementation and delivery of a new ePMA system in ABUHB is dependent on several internal and external factors and will need to be managed throughout.

Internal dependencies include development works within ABUHB's Clinical Workstation to ensure the system works effectively with ePMA and the availability of other supporting services which will be fundamental to ePMA being implemented on time.

External dependencies include DHCWs delivery of the shared medicines record and the electronic prescribing service both of which will impact the way in which ePMA will be developed. There will be dependencies on both DHCW and the supplier for delivery of a fully integrated system.

A list of dependencies can be found in appendix 6.

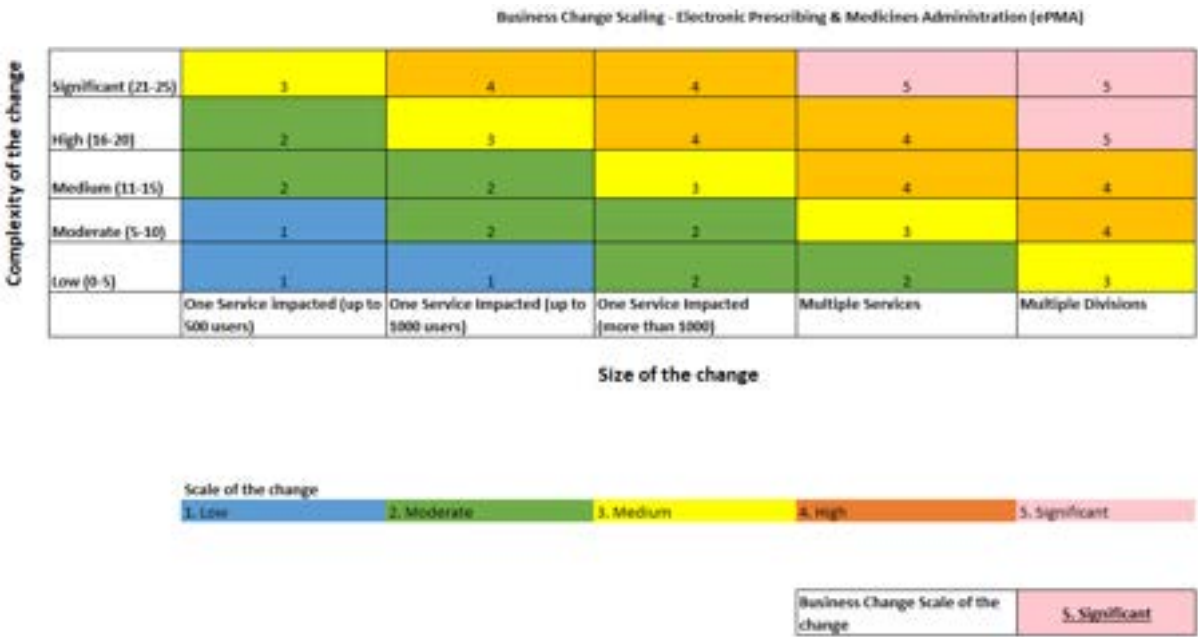
Business Change Scaling

The implementation of ePMA will require a significant transformational change programme and therefore Health Board wide support and commitment from all divisions will be imperative as it will impact multiple frontline services. Support from services will be fundamental in delivering a successful and lasting service.

In preparation for ePMA a business change scaling assessment has been conducted identifying that the complexity of the ePMA programme will require **significant** level of change for ABUHB (total complexity score 24) as it will affect multiple frontline services. This score has been determined based on the following complexity scoring factors:

- The change would impact over 80% of staff in the service (score 5)
- Stakeholder engagement is required with a large number of services (score 4)
- The change will affect a number of processes that are done frequently and will be significantly different from current processes used (score 4)
- There is adequate time available to implement the change (Score 2)
- ABUHB has a track record of implementing similar change before, but not the same (score 4)
- The work involves quite significant organisational and cultural change (score 4)
- Clinical leads and/or other managers have adequate control or influence to deliver the required business change (score 1)

When combined, the scale and complexity of the change required has been deemed in the highest change category; **significant**, as detailed in the matrix below.



Conclusion & Recommendation

As with many complex national initiatives, there remain unknowns and risks that need clarity and control in the early stages of initiation. At present ABUHB have a good understanding of these issues and are in active dialogue with the national team and other stakeholders to establish a clear path for implementation to reduce the associated risks.

Business change and the appointment of the required resources for this are crucial in providing the service definitions for change, as well as exposing, defining, managing and realising the benefits.

Time constraint is a critical factor with both the funding provision and the safety aspects of implementing an ePMA system, both of which require delivery at pace. The funding commitment is available from 1st April 2024 and the plan being put forward will see ePMA being executed to a position of roll out ready within 18 months. To achieve an autumn 2025 roll out, a contract needs to be awarded with the supplier and a dedicated ePMA implementation team and funding needs to be in place from April 2024.

The Executive Board are asked to support the awarding of the contract with the preferred supplier and the associated implementation costs of the ePMA programme, in particular support commencement of resource recruitment and the proposed Governance arrangements.

2. Context/Background

The contents of this business case provide the detail for why and how ABUHB can fully digitalise the prescribing and administration of medication across its secondary care settings. This change presents an opportunity for ABUHB to radically transform the way in which it works through modernising its prescribing and administration of medication. It brings opportunity to increase efficiency and patient safety practices, aligning with the Welsh Government's vision outlined in the 2021 Strategic Review on The Future of Electronic Prescribing in Wales ².

While Electronic Prescribing and Medicines Administration (ePMA) systems have become standard internationally, ABUHB and wider NHS Wales are somewhat behind the curve of this and will need to invest to bring operations up to date.

Throughout hospitals in ABUHB and the wider NHS Wales landscape, the system of manual paper prescribing and recording of medicines administration (drug charts) is used. This is an out-dated best practice but still inherently and consistently proven flawed process, which continues to be mainstream because of convenience, custom and practice. Whilst the Health Board strives to ensure the paper processes are as robust as possible, the high prevalence of medication errors and high expenditure associated with medicines usage highlights that changes to this way of working are needed to reduce the errors. One of the key principals of the Well-being of Future Generations (Wales) Act 2015, is to “take action to try and stop problems getting worse or even stop them happening in the first place” ³. The mandate to do something is clear.

Swansea Bay University Health Board (SBUHB) is the only UHB in Wales to have introduced an ePMA, a journey they commenced in 2018 and continue to roll out to the remaining services. The implementation of ePMA at SBUHB has been successful in improving patient safety and efficiency. Medication errors were reduced, and the timeliness of medication administration improved. A reduction in nursing time on medication related tasks allowed Nurses to focus on other patient care activities. The lessons learned by SBUHB have been captured and incorporated. Engagement with

² dhw.nhs.wales/files/eprescribing/welsh-government-eprescribing-review/

³ [Well-being of Future Generations \(Wales\) Act 2015 \(legislation.gov.uk\)](https://legislation.gov.uk)

SBUHB and other organisations with ePMA, has been fundamental in shaping this business case and its supplementary plans. A list of the lessons captured can be found in appendix 7.

The business case emphasises the fundamental role of medication management in clinical care and the pressing need to address the widespread issue of prescribing errors. Adopting ePMA will eradicate the current flawed paper-based processes, significantly reducing medication errors, improving patient safety, and optimizing medicine management processes. This shift aligns with national interoperability⁴ standards, leveraging open architecture to seamlessly integrate with existing NHS Wales infrastructure.

Beyond the immediate benefits to patient care and safety, a whole-system approach to ePMA implementation promises organisational advantages such as enhanced accountability, process efficiencies, and opportunities for modernisation. The proposal is in line with recommendations from the Senedd's Health and Social Care Committee who published a report into medicines management in Wales and emphasised the need for rolling out electronic prescribing capabilities throughout hospitals in Wales⁵ and later, an independent Strategic Review into e-Prescribing which set out a plan for the delivery of a comprehensive ePrescribing programme for Wales.

The said reports and subsequent recommendations led to the establishment of an All-Wales Programme, to deliver the plan and an All-Wales commercial framework for Health Boards to purchase an 'approved' e-prescribing solution.

DHCW were appointed to lead the programme with the support of local teams in each Health Board/Trust and DHCW's Digital Medicines Transformation Portfolio established four succinct programmes to deliver this plan and the key capabilities, inclusive of the Secondary Care electronic Prescribing and Medicines Administration (ePMA) programme.

The project has, to date, received support from the Welsh Government's Digital Priorities Investment Fund (DPIF), enabling ABUHB to undertake pre-implementation work and align with the all-Wales approach. The next steps involve securing approval and funding to move forward with awarding a contract and implementing the ePMA system, marking a vital phase in ABUHB's commitment to transforming healthcare practices.

3. Case for Change

Whilst the key motivation for introducing an electronic prescribing and medicines administration system is to improve the safety of medicines use, the introduction of ePMA will provide the Health Board and Wider NHS with an opportunity to completely transform the way in which medicines are prescribed, dispensed, and administered. EPMA will improve medicines management processes,

⁴ For this project, interoperability is defined as a feature of digital systems and products that allows the seamless exchange of information between systems through the use of accepted standards.

⁵ [cr-ld11478-e.pdf \(senedd.wales\)](#)

enhance medicines optimisation and will bring much greater control over what is prescribed, how prescribing is undertaken and how medications are administered, all of which will contribute to better quality care and greater patient safety.

EPMA will also improve the way in which medicines information is stored and shared with those who need it and will provide the Health Board with better data to improve reporting and bring greater knowledge to support decision making.

The case for change and the justification for the subsequent investment is based upon both the opportunities and the issues that the current way of working in ABUHB provides. The case concentrates on the key inter-related aspects, that the programme aims to deliver through the implementation of ePMA, and which will in turn provide benefits to ABUHB, patients and wider NHS Wales:

- **Improved Patient Safety:** reduced medication errors, missed doses, drug interactions, adverse reactions and serious incidents associated with prescribing and patient information due to more secure and more accurate information along with greater sharing of patient information between primary and secondary care services
- **Improved Clinical Effectiveness:** no more incomplete, illegal or ambiguous prescribing, a single and comprehensive view of patients current and historic drug record, providing real-time decision support through system alerts and warnings (e.g., allergies). ePMA will improve formulary guidance, thus improving appropriate and accurate prescribing and audit-trails of medicines administration
- **Improved Operational Productivity:** improved communication of real-time information between prescribers, pharmacy and other clinical teams; streamlined operational and clinical processes; more effective control and management of drug expenditure. ePMA is reported to reduce the time it takes to prescribe, check, supply and administer inpatient drugs
- **Improved Quality and Clinical Governance:** ability to monitor and evaluate key performance indicators, total visibility of clinical decisions and outcomes. It is anticipated that ePMA will positively contribute to achieving a range of national and local targets, including Never Events, NICE guidance and Antimicrobial Stewardship monitoring amongst others.

The Scale

Prescribing and medicines administration are two of the most significant activities within the delivery of hospital-based healthcare. The complexity and frequency of prescribing is high and increasing with over 3,000 medicines available for prescribers to choose from and with over 95% of patients receiving medicines during their hospital stay. Between 2014-2015 and 2022-2023 the number of prescription items dispensed in Wales increased by almost 8% from 78.5 million to 84.5 million and this figure continues to rise. Wales dispensed the highest number of prescription items per head of population – 25.4 compared to 20.1 in England at a cost of almost £594 million ⁶. In 2022/23, according to Pharmacy

⁶ [Prescriptions in Wales, 2019-20 \(gov.wales\)](https://gov.wales/prescriptions-in-wales-2019-20)

Financial Data, ABUHB dispensed approximately 1,379,866 drug containers which cost circa £55 million.

The provision of safe and effective prescribing is challenging, and it is reported that 2 of the 3 main sources of harm from medicines occur due to Adverse Drug Reactions (ADRs) and prescribing errors. ADRs are linked to harm caused to patients, increased length of stay in hospital and mortality, all resulting in financial consequences for the Health Board. Audit Wales, Managing Medicines in Primary and Secondary care, reports that ADRs are associated with around 6% of hospital admissions and prescribing errors, which although vary greatly, are associated with up to 50% of hospital admissions in Wales ⁷.

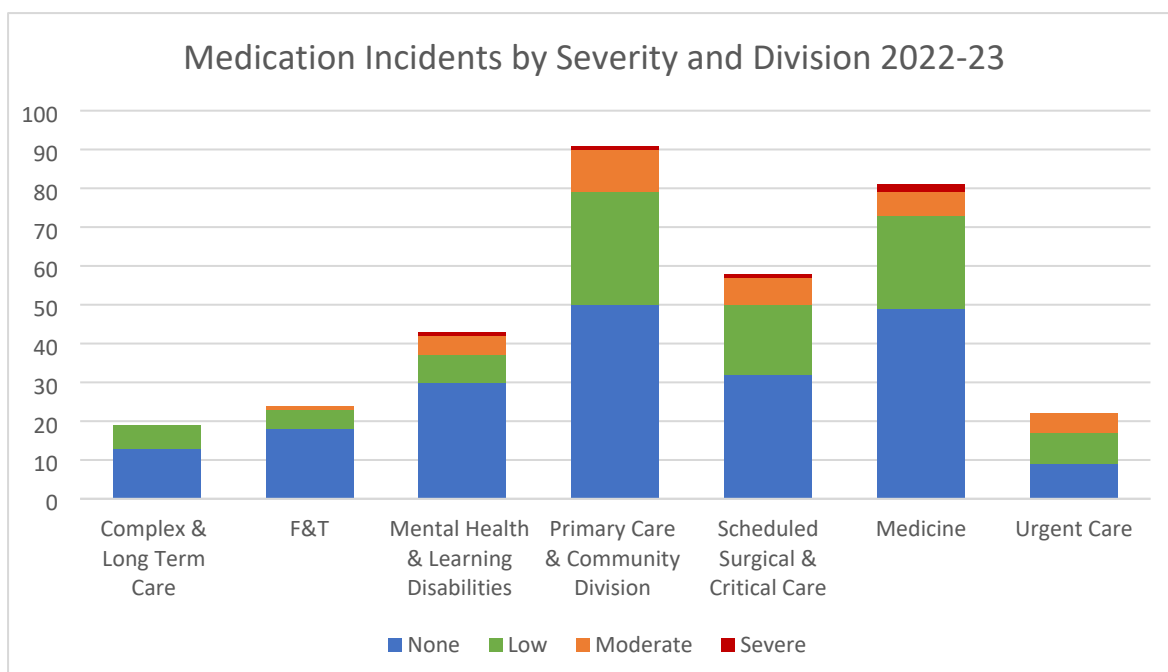
According to Health Education and Improvement Wales (HEIW) ADRs are estimated to cost NHS Wales £466m and occur in 6.7% of hospitalised adult patients of which, 0.15% of these have fatal consequences for patients in Wales. The risk to patient safety is evidently high and putting in place controls for prescribing errors is a substantial challenge for the healthcare system.

Incident reporting through Datix provides the opportunity to gain a view on the number of errors that can occur in prescribing and administration of medicines. During the Financial Year (FY) 2022-23 there were 1,430 medication incidents reported through Datix for ABUHB. With the top 5 categories being:

- Administration errors – 577
- Medication supply errors - 362
- Medication prescribing errors – 215
- Medication storage, security & disposal - 122
- Medication documentation errors – 108

Of the 1,430 reported incidents, 1 incident was catastrophic, 19 were severe and 133 were moderate, the remaining (1,277) incidents fell within the low categories.

⁷ [Adverse Drug Reactions | CPD for General Practitioners \(heiw.wales\)](https://www.heiw.wales)



Current Service Provision

This business case details not only the change required to move away from manual paper prescribing and recording of medicines administered to electronic records, but also details the changes to the supporting infrastructure required to ensure ePMA is delivered and used in the best possible way that serves a new modern way of working.

Current Position

In our hospitals, the system of manual paper prescribing and recording of medicines administration is used. This system which involves handwritten prescriptions and medicine administration records being documented on paper drug charts is one that results in numerous issues and involves considerable waste. This section delves into those issues and the opportunities that currently present.

The majority of prescribing is undertaken by doctors, those normally in very junior positions. Prescribers write the medication onto a paper chart, which also serves as the administration record by those who administer medicines. This chart is further used by other healthcare professionals, in particular by pharmacists who verify and supply the medicines required.

There are several issues that arise from the current paper system that contribute to incidents arising. Most patients attending hospital will have one or more medicines prescribed, supplied and administered. With many different members of staff being involved in the prescribing and administration processes; the sheer scale means that medication errors are inevitable. This can be further complicated by the changing nature and new drug options being made available. An error in drug choice or dosage gives the potential to be very serious, even critical.

Factors that contribute to errors being made include: the work environment including workload and pressures due to shortages in staffing, breakdown in communication, lack of knowledge or training. The Trusted to Care (Andrews) Report highlighted the issue of poor procedures and

record-keeping around the administration of medicines ⁸.

The following summarises some of the regular and persistent issues that present in ABUHB:

Access to Records

A considerable amount of time is used searching for patient medication charts. Charts are used by multidisciplinary teams and are often taken away from the patient's bedside to be updated elsewhere, which can at times result in charts going 'missing' for some time if someone forgets to put the chart back or gets pulled elsewhere and forget they are holding the chart. Many staff have reported numerous occasions of time being 'lost' or 'wasted' due to them being unable to locate patients' medication records.

The 'loss' of records is a regular issue that is extremely time consuming for staff, including healthcare workers who are often asked to help search for charts. The time spent retrieving records directly impacts patient care, often resulting in delays to care being given, delays to time critical medications being administered and delays in starting/stopping medications or in actioning changes to patients' medication.

Issues often arise when a record is required by two services at the same time. A single paper record for each patient can mean that a patient requiring medication may be delayed in receiving it if the chart is unavailable. At times, Pharmacy will take the chart off the ward to review and action the chart alongside other pharmacy systems that are not available on wards. It is common that Pharmacy staff need to re-visit wards as they are unable to locate patient charts when undertaking ward rounds e.g. if a patient's chart has moved with the patient who has gone to theatre. This not only results in time being lost, but also causes delays to medications being given or prescriptions being updated. This presents significantly higher risks for those patients receiving time critical medications. This way of working is hugely inefficient where at times, hours can be lost due to being unable to locate a medication chart. This issue is having direct impact to the effectiveness of, and the level of direct patient care being provided.

The sharing of records is particularly inefficient as it requires physical movement of paper, which is not only time consuming, but also presents as an Information Governance (security) risk.

Lost Charts

In instances where medication charts are lost there is no form of back up, instead a new prescription must be written from scratch. This task is often ineffective, as the doctor will have to re-write the chart without any history or notes to aid them, this can result in lost or missing information such as any medications that have been stopped, started or changed whilst the patient is under the care of the hospital. This issue directly impacts patient safety, with risks for potential harm to patients due to no record being available to identify what medications the patient is taking or when they received their last dose.

⁸ [Microsoft Word - Trusted to Care - 20140506 - FINAL_eng \(gov.wales\)](#)

The paper inpatient medication administration record is often the only source of information with details of the patient's medications during their admission. Patient's medical notes rarely detail medication information particularly where dose changes have been required or changes to medication times etc. thus resulting in future medications being provided based on patient or staff memory.

A lost chart also means that the patient cannot be given any medication until the chart is either found, or re-prescribed. Where time critical medications are required, serious consequences for the patient could occur.

Transcribing Errors

The need to re-write patient medication charts is also problematic with the current system. Transcribing errors is another, well-documented issue with the current paper-based method, as all charts that remain active for a particular period expire and will require a new chart to be re-written (a standard chart expires after 14 days / long-stay chart after 28 days). This task is in-efficient and extremely time consuming and can result in delays to medicines administration due to the time waiting for doctors to complete re-writes.

Re-writing of charts commonly results in:

- Medication omissions e.g. missed route, dose, start date, medicine name, medicines reconciliation information, patient information, frequency, allergy information
- Transcription of the wrong patient's chart
- Medication being continued in error
- Duplication of medicine
- Incorrect medicines
- Wrong spelling of medication
- Prolonged use of unrequired medications i.e. antibiotics

All these transcription errors can lead to errors in either prescribing or to the administration of medication.

Below are examples of errors that occurred in ABUHB due to transcribing errors.

Example 1

Illegible Charts

Due to the scale and reliance on the physical writing of paper records currently, there is high risk of errors associated with handwriting. The first most common issue is illegible handwriting, which subsequently can lead to misinterpretation of what has been prescribed. Many medication names sound and even look similar to that of another drug. Without clear legible writing, the person reading the prescription could reasonably assume something else is required, which could have harmful consequences for the patient.

Additionally, there have been instances where the administration route or doses have been unclear. Decimal points have been missing or unclear during the recording of doses.

Incomplete Records

Incomplete or charts with missing information is particularly problematic for Health Records. Staff working in Health Records are responsible for copying the paper record into a digital format, through scanning of the paper record. This involves splitting out the pages and scanning each page onto the correct patients record. Very often the charts are incomplete and key information is missing from each subsequent page. This presents significant risk for incorrect records being copied to the wrong patients record. Very often the Health Records staff are unable to scan documents, until patient identifiable information is confirmed, causing delays to the upkeep of records due to incomplete paper files being maintained by clinical teams.

Medication Errors

The World Health Organisation has identified that medication errors are a leading cause of injury and avoidable harm in the healthcare system across the world⁹. Such errors are often a consequence of handwritten paper charts, a process which has remained broadly unchanged in ABUHB for many years. Human errors are an inherent risk in any system and with the addition of limited resource and systems to check and prevent such errors, they continue.

Below are examples of where medication errors have occurred in ABUHB, subsequently requiring corrective actions being made, investigations being carried out and additional training being put in place to mitigate the chance of these errors being repeated.

Example 1:

DATE	PRESCRIBER (signature)	INDICATION	DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS	STARTED	CONTINUED	DOSE CHANGED
16/12	[Signature]	Cap pain	10-20mg SC	SC	10-20mg SC				
Dose too high - please re-prescribe 13/12/21									

Here, the patient was prescribed an incorrect dose of Midazolam for this indication which had to be discontinued and re-prescribed by another prescriber, at 2.5 mg 2 hourly, as required. Had the patient received the maximum dose prescribed in one administration, they would have been given 8 times the correct dose. Also, no frequency was documented, leaving potential for the patient to receive

⁹ [Medication Without Harm \(who.int\)](https://www.who.int/news-room/fact-sheets/detail/medication-safety)

Example 2:

DATE →		ROUTE →		SPECIFY TIME IF REQUIRED ↓		DOSE ↓		SIGNATURE		MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST	
12/12		PO								Alendronic acid		Once a week (Today)					
												Medication Reconciliation (only)				SUPPLY	
												Stomach (circled)		Blank box		5	
Morning		20mg		(U)		X	X	X	X	X	X						
Midday																	
Evening																	
Bedtime																	
↳ weekly!																	

In addition, the writing of the dose in this example is unclear. Whilst 70mg is the standard weekly dose, there is also a 10mg dose available which can be administered daily. The writing in this example could be read as 20mg and not 70mg as intended, this could have led to a potential administration error. These errors are not picked up with the paper records, as nurses do not record the dose given, they only record that they have administered what was prescribed.

The current paper records take up a significant amount of space. The medication charts are manually scanned into the electronic record along with copies of discharge prescriptions. This requires the physical splitting up of the 12-page paper chart and scanning against the correct patients' record and requires considerable time and resource to undertake. As highlighted above, this task can be unnecessarily prolonged if charts are incomplete or omitting required patient information. EPMA will remove the need for this, thus saving admin time for the Health Records Service.

Medication History

Storing, sharing and retrieval of paper records is currently a resource heavy task, the paper system requires very manual and time-consuming work to enable the sharing, storing and retrieval of information. All of these tasks present opportunities for paper to get misplaced, damaged or lost which adds risks to patient safety and to the level of patient care provided. Failing to maintain accurate records with all relevant medication history risks future patient care being affected.

Additionally, there are many different charts across ABUHB which are used and recorded for specialist medications e.g. Charts used specifically for warfarin treatment or insulins. These are recorded in addition to patient medication administration records and add further issues for patient records not being wholly up to date with the full medication history.

EPMA will fully digitalise all inpatient medication administration charts and specialist medication charts, providing a single view of the patients' medication history.

Quality and Clinical Governance

Aside from the patient care aspect, the current manual and paper provision presents challenges for data collections. Audits and reporting have been a challenge for many areas as the data available for them is not easily available. The current ways of working present a manual, time-consuming only option for gathering data, often reliant on extensive time being spent trawling through paperwork and files. This issue means that as an organisation we often have to spend a lot of time gathering information, which again is ineffective and not efficient. At a time when the need for data intelligence is heightened and more important than ever, this is an issue that requires improvements and resolutions.

EPMA will improve the organisation's ability to monitor and evaluate medication data, providing better reporting functions with real time information. It will also improve visibility of clinical decisions and outcomes.

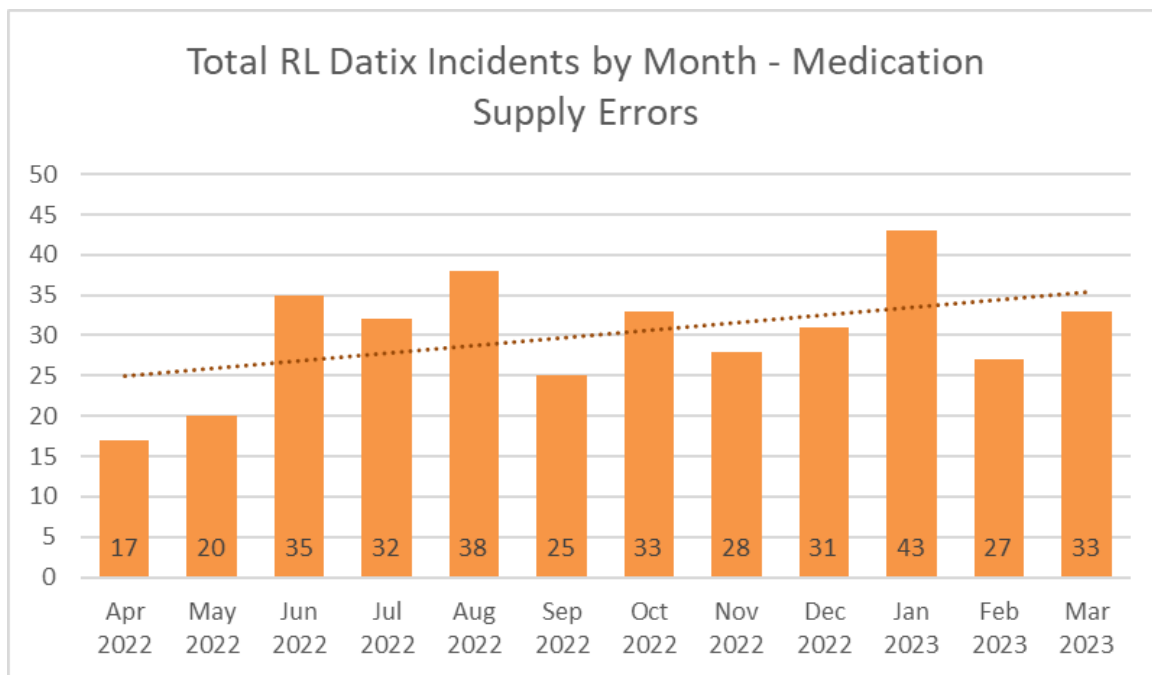
EPMA will reduce the time spent responding to subject access requests and investigating incidents as information will be more easily available.

Reporting Issues

The reporting of Datix currently relies on self-reporting of incidents, and it is acknowledged that staff do not always have the time or access to suitable ICT devices to do this. Eluned Morgan MS, Minister for Health and Social Services recognises this, stating in her March 2023 Explanatory Memorandum that 'there may be some elements of underreporting in the new Datix system' ¹⁰. Subsequent research in preparation for ePMA has concluded that in ABUHB Datix incidents are under-reported and are therefore not a true representation of actual activity although, ABUHB reported numbers are comparable with other Welsh Health Boards.

Medication supply errors reported through Datix show an upward trajectory for year 1st April 2022 to 31st March 2023 (as shown in the graph below) averaging 30 per month.

¹⁰ [explanatory-memorandum-duty-of-candour.pdf \(gov.wales\)](#)



The reported prescribing errors for inpatients on Datix do not show a correlation between the time of day or a particular day when prescribing errors occur; what they do show however are the types of errors reported. Some specific examples of the prescribing errors involving the incorrect patient investigated and reported by the ABUHB Putting Things Right Team (Dec-21 - Jul-23) were due to:

- Incorrect patient drug history used to re-write patient chart – Serious Incident which contributed to patient death.
- 50ml of NaCl (Sodium Chloride) with K (Potassium) given to a patient who didn't require it – prescribed for incorrect patient.
- 2 different patient names on the same chart.
- Prescription chart in another patient folder – administration error as patient details not checked.
- 1 dose of apixaban prescribed and given to incorrect patient – Doctor had picked up the file of another patient.
- Fentanyl patch prescribed and administered to a patient that didn't require it – error picked up by Pharmacy – unable to establish if fentanyl had been intended for a different patient.

It is anticipated that ePMA will provide intervention in prescribing as it will reduce the risk of prescribing errors, improving accuracy and reducing workflow of medical staff, providing an audit trail of activities and guidance for prescribing; for example, through prefilled prescription sentences and common dose levels, thus reducing preventable errors.

If there was an ePMA system in ABUHB most of these incidents would not have been able to occur due to the removal of paper-based systems and files and the need to no longer manually transcribe patient information, providing clinical effectiveness and patient safety measures.

Financial

As well as the indirect costs associated with the issues highlighted above, there is a substantial amount of financial resource tied up with management of the existing paper-based prescribing and medication records that could otherwise be used to support and improve direct patient care.

It is highly anticipated that the introduction of ePMA will provide a number of efficiencies for the Health Board, including for those costs associated with; the manual transfer of paper to electronic records, scanning, physical space for storing of archived paper records, courier service involved in the physical movement of paper between services and sites, the costs of purchasing the specialist paper for the paper prescriptions and medication charts.

Digital

The current paper practice relies upon many different manual processes and systems to record and store patient medication records all of which rely upon time-consuming labour-intensive activities. To achieve a paperless system that releases the manual resource and free's up the time of many, a digital solution that removes the need for paper is needed.

The Health Board have, to date, invested to support the move from paper to digital however ePMA will help accelerate this and the benefits that can be realised.

Existing Hardware Position

There has been a significant investment in new technology and hardware over the last decade, however there is an ongoing need to modernise and refresh hardware to enable services to continue to use and adopt new digital services.

Research in preparation for ePMA has been undertaken, to understand and evaluate the current situation regarding the hardware that is available on inpatient wards and secondary care services across ABUHB;

- Surveys have been undertaken to determine what works well/not so well and to identify areas where existing hardware is being underutilised and why
- Lessons learned by existing ePMA users across the UK have been shared and considered to determine how hardware impacts the success of ePMA
- Lessons learned by other digital programmes/projects in ABUHB have been gathered to help inform the hardware request for ePMA

Research found that there are some services that continue to have limited access to equipment to work digitally, and some areas have equipment which is underutilised. The underutilisation of digital equipment is for various reasons, including; insufficient charging, missing kit, too bulky for the ward/service area and due to impracticalities of using at the patient's bedside. It has been found that equipment often gets lost or misplaced due to movement and sharing of individual aspects of the ICT kit.

Whilst the sharing and reusing of equipment by multiple teams for multiple use can at times offer effective use of equipment, we know that it can also become problematic and preset periods of time where equipment is unavailable. Staff have shared of instances where they have had to spend their time 'hunting for devices' instead of caring for patients.

Hosting Arrangements

The expectation and funding commitment for ePMA is that all Health Boards in Wales will consider cloud hosted solutions as a preferred hosting solution. Any consideration or choice of an alternative provision will only be supported if reasonable or exceptional rationale is demonstrated.

The majority of ABUHB systems are currently hosted on premise, which means that records and information are stored on an in-house server or servers, where the organisation acquires the server or servers and installs the software on-premises.

There are however an increasing number of new systems coming into circulation across the NHS with cloud hosted provisions. Cloud based hosting comes with two options for Health Boards to consider:

1. Supplier provided cloud-based hosting solution, where a 3rd party hosts the solution, including servers and data, in their own cloud environment. The 3rd party are responsible for the management and security of this data. Access to this is normally via a Web browser session.
2. Organisation owned cloud-based hosting – In this solution ABUHB would host the solution, including servers and data, in their own cloud environment. ABUHB would, as a result, be responsible for the management and security of the data. Access to this is normally via a web session to our cloud landing page.

At present ABUHB's ICT Services agree that Option 1, a supplier provided cloud-based solution is to be pursued. Option 2, an ABUHB owned cloud-based hosting solution will not be available in time for this programme. Whilst there are plans to develop ABUHB's own cloud-based hosting environment in the future, the concept is subject to significant investment, and it is not currently anticipated to be available within the next 5 years.

This business case is therefore based upon ABUHB purchasing a cloud hosted solution with its preferred supplier.

Wi-Fi Connectivity

It is a much-known fact amongst users and suppliers of ePMA, that even with the very best ePMA solution, it will only be as good as Wi-Fi coverage allows. Existing ePMA users have reported that poor Wi-Fi coverage is one of the greatest risks to a successful move to electronic prescribing and medicines administration.

EPMA will be rolled out to approximately 160 wards/units across ABUHB, consisting of inpatient wards, theatres, assessment units, ED and outpatient departments across 16 sites.

To enable the level of risk associated with Wi-Fi and the successful delivery of ePMA, to be understood, a high-level assessment of the Wi-Fi coverage has been undertaken. The assessment involved a review and analysis of the wards/units in ABUHB, from which ePMA will be accessed. It determined the current level of coverage and the potential investment required to bring these wards/units up to ABUHB's expected standard and thus mitigate the risk to successful implementation.

Of the 16 sites assessed, just one site was deemed as having excellent Wi-Fi, with over 90% coverage. 7 sites were deemed as having 'fair' or 'less than fair' Wi-Fi and are operating with 50% or less than 50% coverage. The remaining 8 sites have been assessed as having 'good' coverage where 80% Wi-Fi coverage is in place.

The assessment has presented the associated risk being scored as significant, risking failure to the implementation and use of ePMA. This risk will therefore need to be treated to ensure the realisation of this risk is mitigated. An investment to improve the Wi-Fi infrastructure has been deemed as necessary.

Whilst an investment to improve Wi-Fi has been identified to mitigate the related risks for ePMA, it should be noted that any uplift and improvement to the Health Board's Wi-Fi, will have wider positive impact on other existing and upcoming digital systems and solutions in our hospitals.

Architectural Design (Interoperability)

The successful delivery of ePMA is heavily reliant on the new ePMA system being fully interoperable with existing (and evolving) local and national systems and resources to ensure seamless access to the right information at the right time and to ensure a shared medicine record can be achieved.

A design that allows for the ePMA system to fit perfectly with the strategic imperatives and design principles both locally and nationally to implement secure, open, standards-based access to patient data is essential.

Service Demand Analysis

There is an ever increasing, justified demand for all medications prescribed and administered to be recorded in a digital record to enable a more effective and more efficient way of working. A move from manual paper records to electronic will provide much improved outcomes including:

- Improved patient safety
- Improved clinical effectiveness
- Improved operational productivity
- Improved quality and clinical governance.

Several factors drive this increasing demand, including expectations on Health Boards to have greater control and management of its drug expenditure, increasing requests on Health Boards to report on prescribing and medication and advances in digital platforms but the greatest demand is that Health Boards put things in place reduce the level of preventable harm caused which in turn reduces the number of patient safety incidents caused in health care settings and the financial burden on the NHS as a result of incidents occurring.

National Direction and Reasons why

In NHS Wales, most medicines used in hospitals are prescribed and their administration to the patient is recorded using a traditional paper-based chart system. The general acceptance is that many medication errors are a preventable source of harm in healthcare and thus supports the view that digitisation of both the prescribing and administration process should be advocated as a method of reducing these errors. This has resulted in widespread recommendations for the introduction of ePMA systems in the UK. To date around 65% of hospitals in England have introduced such systems to a number of service areas; the number is growing rapidly and is expected to reach 75% when the latest round of funding is distributed. In Scotland, three health boards have implemented e-prescribing, and one board is in the process of implementation. In Wales, only one Health Board has implemented an ePMA system to date.

It is therefore the national direction that electronic prescribing and medicines administration is introduced to improve the safety of medicines use and to reduce the current levels of preventable adverse drug events. It is important for NHS Wales that the introduction of ePMA is done in collaboration with the Secondary Care Electronic Prescribing and Medicines Administration programme to ensure this new functionality fully complements and integrates with the existing NHS Wales infrastructure.

The main National policy and strategic drivers include:

- Welsh Government e prescribing review*
- Written Statement: Statement on the ePrescribing Programme (2021)
- NHS Wales Leadership Board Paper: ePrescribing in Wales (2021)
- A Healthier Wales: Long term plan for health and social care (2018)
- Informed Health and Care (2015)

- AWMSG Five-year Strategy (2018-2023)

Local Direction and Reasons why

For ABUHB, the current paper system is one that is outdated and poses many flaws, which subsequently presents inefficient processes and leaves the organisation open to unnecessary, preventable cases of patient harm and high levels of financial risk because of these incidents. The current way of working is one which impacts a multitude of teams from the front-line clinical workforce to the central Health Records and Quality and Patient Safety teams who have to deal with the time-consuming work involved when incidents occur, and investigations required. Whilst the greatest ambition is to improve patient safety and reduce those preventable cases of harm, there are a plenitude of outcomes that can be achieved as a result of introducing an ePMA system in ABUHB from more efficient operations to more effective clinical governance.

Furthermore, the implementation of ePMA will provide the Health Board with greater control over its stock order management, reducing duplicated orders and thus reducing wastage.

Service Capacity Analysis

Workforce Capacity and Demand Analysis/Challenges

The introduction of new ways of working brought by the implementation of an ePMA system, will see significant change to all Health Board Clinical Professions. This change needs to be clinically supported to ensure the safe implementation of the new processes. High profile cases have highlighted how the poor introduction of digital systems can lead to serious harm and the death of patients¹¹. The support to Health Care Clinical Professionals needs to be made available by respected peers who are experienced in medication related processes and can respond to on-the-spot clinical scenarios which non-clinical staff would not understand. Suitable and effective training will also be essential.

Whilst the requirements for support are clear, ABUHB, as with other NHS organisations are experiencing unprecedented challenges at a time where extensive change is being introduced. Some of these challenges are set out below and have been carefully considered when determining the preferred model of delivery.

Pharmacy Context and Capacity

Whilst the Pharmacy service in ABUHB is well versed in the use of automation (e.g. dispensing robots, Omnicell's) it is limited in its ability to fully maximise the digital platforms available and is inadequately resourced for utilising new innovations.

ABUHB Pharmacy Service has been in a significant period of service escalation over the past 18 months due to inadequate staffing levels across multiple acute hospital sites, resulting in reduced ability to cover basic clinical pharmacy and specialised pharmacy services. Resulting strategies to deal with these service pressures have included the need to redefine the roles of Pharmacy Technicians and Pharmacy Assistants, expanding their traditional remit to support the provision of clinical pharmacy services, and reduce the workload of Pharmacists, where the vacancy rate has been highest.

¹¹ [Patient died and 30 harmed after new IT system launch | News | Health Service Journal \(hsj.co.uk\)](https://www.hsj.co.uk/news/patient-died-and-30-harmed-after-new-it-system-launch/1-1311177)

Pharmacists specifically are in short supply, leading to the profession being on the Home Office shortage occupation list. ABUHB pharmacy service currently operates with approximately 20% vacancy rate (above the national average from the 2023 NHS Benchmarking Programme of 13%). In addition, ABUHB has lower than average pharmacy staffing within its establishment when compared with other Health Board's within Wales, ABUHB is below average in terms of both total pharmacy WTE staffing per 100 beds (16.1 vs 17.2) and total Pharmacist WTE staffing per 100 beds (5.72 vs 6.2). However, Pharmacy Technician staffing (WTE per 100 beds) is comparable (6.63 versus 6.59). Therefore, there is insufficient capacity to support neither the implementation nor business as usual (BAU) phases of ePMA within the current pharmacy establishment. Additionally, there is currently a lack of digital readiness within the existing pharmacy staffing groups and therefore a workstream involving the upskilling of all staff to enable utilisation of the ePMA system efficiently and effectively will be required.

Despite this, there is wide recognition that pharmacy is an essential stakeholder for ePMA, both from a clinical and a technical perspective. Pharmacy is essential to the clinical and technical elements of the system both in the implementation and service delivery phases. Failure to properly implement e-prescribing systems can also result in new types of errors that reduce workflow efficiency, increase medication cost, and threaten patient safety.

It is therefore essential that a lead post is developed to support pharmacy to work alongside existing digital leads of other professions within the Health Board. A robust team to support the Lead Pharmacist both from a clinical pharmacist and a pharmacy technician resource will allow integration with current pharmacy systems and the ability to ensure benefits are realised. Pharmacy are often responsible for the reporting of information in relation to drug spends, errors and incidents and therefore it is essential that sufficient resource is built into the programme to allow this. Without adequate resource the ePMA system and its benefits including integration with other systems and overall proficiency of informatics enhancement will not be realised, leading to missed opportunity from financial and patient safety perspectives.

At present the secondary care annual drug spend is circa £56M. There would be an enhanced ability for pharmacy teams to interrogate prescribing practices within Secondary Care, Homecare, clinics etc. providing speciality and clinician prescribing data in a proactive manner to enhance prescribing efficiencies at the point of prescribing. To enable this benefit to be realised the team would need to be appropriately resourced across all pharmacy sites.

Nursing Context and Capacity

In September 2022, the Royal College of Nursing (RCN) in Wales published its annual report on the state of the nursing workforce in Wales, reporting that there were, at that time 2,900 nurse vacancies in NHS Wales, and was increasing. The report highlighted how these “vacancy numbers are deeply troubling” and “patients are paying the price”. The workforce in ABUHB is not immune to this pressure and have experienced these challenges across nursing for some time.

The nursing workforce are also one of the biggest clinical groups which have been subjected to the highest level of change to their working practices, with the introduction of new digital ways of working being at the forefront of those changes. Our nursing workforce are subsequently becoming more familiar with using digital systems and tools to carry out their work, but still require adequate support to ensure they can keep up with the vast pace of change. But more importantly, they need to be at the forefront of those changes. To ensure the nursing workforce can keep up with this vast change, but also to ensure new systems will be used by this group of staff, they need to be involved and leading the changes. The RCN found that “programmes and systems are being designed without nursing input” which are leading to failing systems and money being spent “on the wrong things” which could be “avoided if nursing staff were involved in decision-making”. The eHealth lead at the RCN, says: “Involving nursing staff in the design and implementation of programmes and systems to improve patient care is not an optional add-on – it is absolutely vital.” The implementation of WNCr is evidence of this concept, where the development of WNCr system was led primarily by a nursing workforce and has subsequently been well received by the wider nursing workforce through implementation and delivery of the system.

This demonstrates the increasing need for digital nursing roles, something which is recognised in ABUHB, but are roles that are not currently employed to as routine positions, instead digital nursing roles are being considered on an ad hoc basis. Aside from the Chief Nursing Informatics Officer position, recruitment to digital nurse roles in ABUHB are considered as and when business needs require e.g. through Digital Projects such as WNCr and as identified to meet corporate needs such as for the undertaking of audits.

Learning from other projects and other NHS bodies who have deployed ePMA have been captured and considered. Experiences and lessons learned from the implementation and the ongoing continued support required for WNCr have also been incorporated for ePMA.

Medical Context and Capacity

Having the involvement of medical staff in the implementation of an ePMA system is crucial for ensuring the system's effectiveness, safety, and seamless integration into healthcare workflows. Medical expertise will be essential to the development of the system that will need to be delivered in a way that supports and meets the needs of each service and the respective challenges and requirements of the service.

Within ABUHB, nearly 600 dedicated doctors in training work alongside a large cohort of SAS doctors and over 250 Consultants. However, the medical workforce faces daunting challenges. Across Wales, there is a stark reality of a shortage of medical professionals. According to the Royal College of Physicians (RCP), only 36% of consultant physician positions in Wales were filled in 2021. The situation is no less challenging for junior doctors, with the RCP Wales reporting 25% of ST3 medical registrar

posts remaining unfilled nationally, with 70% of medical registrars experiencing frequent rota gaps. The Wales Royal College of Emergency Medicine echoes these concerns, reporting widespread vacancies and weekly rota shortfalls. Within ABUHB, these challenges are evident, and recently published NHS staff vacancy data reveals a 13.1% vacancy rate for medical and dental staff.

The implementation of an ePMA solution will provide significant benefits for the medical workforce. ePMA promises transformative benefits, particularly for our junior doctor workforce who undertake the majority of prescribing and chart rewriting. However, its adoption is not without challenges. As highlighted in the Global Digital Health Partnership's 2019 White Paper on Clinical Engagement in Digital Health, implementation requires more than just technical prowess—it demands clinical engagement from the outset, with clinicians having a sense of local ownership and influence. The paper emphasises that incentivising clinicians with opportunities to directly impact patient care is paramount.

Moreover, the successful implementation of ePMA hinges on the presence of "hands-on" clinical champions and that “engagement does not stop at implementation; there needs to be a mechanism for ongoing refinement aligned with the evolution of clinical processes and practices”.

4. Option Appraisal

i. Option 1 - “Do Nothing”

Benefits: No benefits will be realised

Pay & Non-Pay Costs: No costs will apply

Risks including consequence, likelihood and mitigating action/s:

The manual recording of prescriptions and medications administered will without doubt continue, presenting the following risks for services and organisation:

- Further incidents occurring due to errors being made through illegible records
- Further incidents occurring due to errors being made through incorrect records
- Continued inefficiencies as a result of manual ways of working
- Continued isolated records across Secondary Care
- Increased digital immaturity
- Reputational damage if ABUHB do not deliver against the national ambition for ePMA
- Ongoing financial risk due to further incidents and errors

The only mitigation to these risks would be for ABUHB to continue with and stand up non-digital programmes of work to address and improve the manual recording of medicines being prescribed and administered.

By doing nothing, the organisations offering of new transformational opportunities will be limited. Without new digital ways of working, the organisation will be limited in how much change it can consider and adopt.

ii. Option 2 – award a contract with the preferred ePMA Supplier and progress with implementation of system and new ways of working

Benefits:

- Patient safety improvements
- Increased clinical effectiveness
- Improved working practices and operational delivery
- Improved Quality and Clinical Governance
- Delivery at pace with control
- Minimised disruption to daily working practices
- Time allocation for issue resolution

Pay and Non-Pay Costs:

- Implementation costs will be applicable at a sum of £10,073,136.

Risks including consequence, likelihood and mitigating action/s:

- Inadequate Wi-Fi infrastructure causing unsuccessful adoption of ePMA – a Wi-Fi assessment identified varied levels of coverage and has been deemed as a risk that is almost certain to occur without any mitigation action. Mitigation of this risk will require investment for improvements to Wi-Fi coverage
- Insufficient hardware preventing use of ePMA – an assessment of hardware and a recommended model ward has been produced to establish to level of hardware required in ABUHB to mitigate this risk. The outcome of this assessment is that without an investment in additional hardware this risk is almost certain to occur.
- Unsuccessful recruitment to required roles – this is a likely risk and will require close monitoring. Alternative arrangements will need to be considered if recruitment is unsuccessful.
- Lack of buy in and support from clinical services – there is a likely risk that clinical pressures and other change initiatives could prevent or delay delivery of ePMA. An extensive change and engagement plan will be followed to ensure engagement and involvement of services.
- Operating with dual processes could cause, confusion, additional work for extended periods and discrepancies in patient records. Detailed planning and support will be critical to ensure minimal impact.

ii. Option 3 – award a contract with the preferred ePMA Supplier and progress with an accelerated implementation of system and new ways of working

Benefits:

- Patient safety improvements
- Increased clinical effectiveness
- Improved working practices and operational delivery
- Improved Quality and Clinical Governance
- Less financial investment required

Pay and Non-Pay Costs:

- Costs will be applicable at a sum of £ 9,437,017 (N.B cost as of Jan 2024).

Risks including consequence, likelihood and mitigating action/s:

- Inadequate Wi-Fi infrastructure causing unsuccessful adoption of ePMA – a Wi-Fi assessment identified varied levels of coverage and has been deemed as a risk that is almost certain to occur without any mitigation action. Mitigation of this risk will require investment for improvements to Wi-Fi coverage
- Insufficient hardware preventing use of ePMA – an assessment of hardware and a recommended model ward has been produced to establish to level of hardware required in ABUHB to mitigate this risk. The outcome of this assessment is that without an investment in additional hardware this risk is almost certain to occur.
- Unsuccessful recruitment to required roles – this is a likely risk and will require close monitoring. Alternative arrangements will need to be considered if recruitment is unsuccessful.
- Lack of buy in and support from clinical services – there is a likely risk that clinical pressures and other change initiatives could prevent or delay delivery of ePMA. An extensive change and engagement plan will be followed to ensure engagement and involvement of services.
- There is risk of staff fatigue due to pace of roll out and change amongst ePMA team
- Poor adoption of ePMA if services are insufficiently supported during and following ‘go-live’
- No time allocation to support services that experience issues, risking successful adoption and buy in for ePMA
- A focus on pace presents high risks in terms of programme failure and services being left without ePMA if time allocation is insufficient.

Preferred Option

Option 2 is preferred; to award a contract with the preferred ePMA Supplier and progress with implementation of system and new ways of working.

This option is preferred as it best supports both local and national context and requirements. This option allows ABUHB to deliver this complex transformational change programme in a way that aligns ABUHB with other Health Boards in Wales who are also adopting ePMA solutions. It will allow for vast benefits realisation and the model of delivery set out in this business case will enable ABUHB to deliver this change in a controlled environment and in a time frame that ensures that true transformational change takes place and is embedded for the long term and not just for the purpose of implementing another new digital system. From discussions with the preferred supplier, this is their recommended option based on learning and experiences of rolling ePMA systems with other Health organisations of a similar size and set up.

The resourcing of this option ensures that ABUHB build and grow the right level of experience and knowledge to deliver future iterations of change for ePMA and other digital opportunities that arise as a result of implementing an ePMA.

The associated capital investment will ensure a robust digital infrastructure is delivered to support the successful implementation and service delivery of ePMA for the long term.

5. Aspiration of Preferred Option

Clinical Provision

The objective of the programme is to create a clinical system containing a full record of all medicine activities, including prescribing and administration, pertaining to a patient's activity, and where medicines information could be accessed 24/7 from any location.

It is the aim that all prescription and medicine administration documents, which are currently handwritten and recorded on paper will be digitalised, enabling access to the resulting record to be available by any relevant person, from anywhere at any time.

To achieve this aspiration, there will need to be substantial changes to the way in which clinical activity is undertaken across all clinical staffing groups. Changes will include:

- Staff to adopt a new digital system for prescribing and recording of medicines they administer
- Changes to standard operating procedures to ensure staff record information in the new way
- Adopt new standard operating procedures to ensure staff understand and adhere to the new ways of working as required with ePMA
- Services to take responsibility for new technology and supporting hardware
- Changes to and creation of new local policies to reflect new digital ways of working
- System development in other existing ABUHB systems to support the new ways of working with ePMA.

The introduction of ePMA is seen as a welcomed opportunity to transform many medicines related activities. There is ambition within ABUHB to utilise the implementation of ePMA to make way for further, supplementary changes that can be considered following or alongside the introduction of an ePMA system. As part of the business requirements setting ABUHB included several requirements that arrived from the ambition to change, including:

- The introduction of new processes to help enhance working practices that interact with ePMA e.g. Patient group directions (PGD's) and new formulary medicines
- The introduction of new medicine administration processes such as the introduction of patient wristband scanning to support and prepare the organisation for a future opportunity to progress closed loop medicines administration.

Whilst ABUHB acknowledge these opportunities, the depth and practicalities will be considered throughout implementation, when business needs and system capabilities are better known.

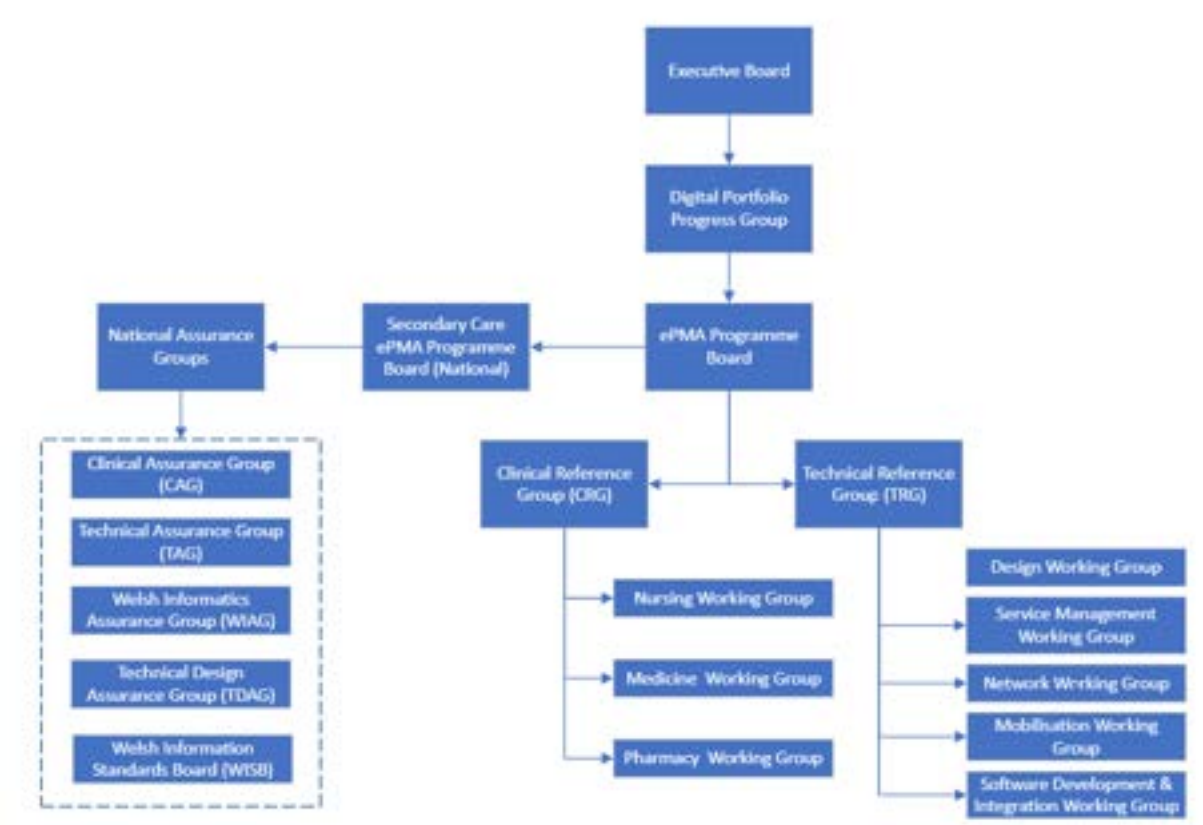
This change process needs to be clinically supported to ensure the safe implementation of the new processes. High profile cases, such as the recent HSJ article¹², have highlighted how the poor introduction of digital systems can lead to serious harm and the death of patients.

¹² <https://www.hsj.co.uk/patient-safety/patient-died-and-30-harmed-after-new-it-system-launch/7035723.article>

Governance and Reporting

The local ePMA Programme will be managed by a Programme Manager, overseen by the Digital, Data and Technology Directorate and the Digital Portfolio Progress Group. The programme will operate with Clinical and Technical Reference Groups, which will each be responsible for the delivery of a number of workstreams within the timescales set out in section 10.

The ePMA Programme will be delivered in alignment to the Digital, Data and Technology Project Management Framework and the following structure diagram provides the reporting and governance arrangements, inclusive of both internal and external reporting. To ensure appropriate reporting of risks and issues, ABUHB’s Programme Manager will represent local programme through attendance at the National Secondary Care ePMA Board and representations from the National Programme will be invited to attend the local Programme Board.



To ensure ABUHB are aligned to the national approach and to enable collaborative working on national standards and policy, members of ABUHB’s reference groups will attend National Assurance Group meetings and will invite national representatives to local meetings as required.

EPMA Resource

The delivery of ePMA will require both temporary and permanent positions which will be filled on a rolling basis in line with the proposed implementation timeline and required activities. Fixed positions will be utilised during the roll out of the solution when implementation activities are at peak and a full dedicated team will be required to support staff and business activity. Fixed term positions will be for

a maximum of two years to enable maximum support during peak activity and limit any potential impact that often occurs with longer term positions. Recruitment to fixed term positions will be available to staff currently at risk of redundancy and as development opportunities for existing staff.

Permanent positions will be required during the implementation of the ePMA system and for the ongoing management and optimisation of ePMA to ensure ABUHB are able to fully utilise the system it purchases and the processes that support the new ways of working.

The proposed resource model has been determined by research into other NHS Organisations where an ePMA has been implemented and through reviewing of lessons learned by other ABUHB change programmes where lessons around resourcing have been learned. In addition, the programme has analysed the impact on services who will be responsible for undertaking the required activity during implementation and delivery of ePMA in ABUHB. The production of the resource model has been determined jointly between the programme and the services that will be required to deliver ePMA.

The ePMA resource utilises existing positions and roles where available. A number of programme roles already in post and working on ePMA currently will continue to support ePMA on approval of this business case. The experience those positions have gained to date will enable a seamless transition to implementation, minimising loss of knowledge and learning.

Implementation Resource

A dedicated Implementation Team will manage and deliver the implementation of the new ePMA system in ABUHB. The team will be multidisciplinary, consisting of digital programme roles, clinical, technical and support roles. Appendix 2c provides a full list of the roles required to support and enable the implementation of ePMA.

Pharmacy Resource

A Lead pharmacist position will lead the pharmacy roles and ensure that the ePMA system is developed and configured to ensure medicines safety. There is a vast amount of configuration work required to set: medication order sets, prescribing protocols, clinical decision support, medicines safety parameters, role-based access and ensure dm+d is correctly applied. Pharmacy roles will ensure integration with current pharmacy systems in addition to the ability to ensure benefits of ePMA are realised.

Engagement with all clinical specialties will be essential for ensuring configuration meets the different needs and clinical protocols. This teams system knowledge and expertise will be essential for troubleshooting, training and support to clinical colleagues when rolling out the system. Engagement with national colleagues to enable learning and best practice to be shared will also be key to the implementation of ePMA in ABUHB. The proposed resourcing model provides for an ability to demonstrate, through analysis of data, the granular nature of the financial drug spend e.g. consultant level medication expenditure. Included in the model is dedicated time for site-based Pharmacists to contribute to and represent their sites specific ways of working to ensure staff are prepared and to undertake available readiness activity.

The proposed pharmacy resource models for both the implementation and product delivery of ePMA takes into account the current staffing capacity and context as set out in section 3 of this business case. The resource model has been developed with the constraints in mind, which continue to present ongoing staff vacancies, and provides a realistic assumption of the resource requirements within the staffing groups where it is believed recruitment will be achievable, it also utilises existing pockets of expertise and knowledge to further reduce the potential for recruitment difficulties.

The model is based upon benchmarking resource data provided by other NHS organisations, where ePMA has been implemented and continues to be delivered as a business-as-usual system and is also based upon learning and experiences gained from undertaking pharmacy recruitment activities in ABUHB. The model provides a feasible staffing structure moving forward for both the implementation of the new system and for the Pharmacy Department to appropriately manage the work that materialises from ePMA.

Whilst the proposed resource model has been produced with mitigations in mind to provide the best opportunity for successful recruitment, the current position and resourcing requirements will present a risk for the programme and the Pharmacy department due to the very nature that the availability of resources to fulfil these roles are limited. This risk has been included on the programme risk register (appendix 6). The mitigation for this risk will be to commence early recruitment of these positions and if unsuccessful recruitment materialises, the programme and Pharmacy Department will review the posts remaining and consider alternative staffing arrangements to find alternative solutions.

Nursing Resource

The current nursing position and context set out in section 3 will play an important factor to how the service supports the roll out and delivery of ePMA and has been taken into consideration when determining the required nursing resource for rolling out ePMA and for its long-term delivery, to ensure sustainability, stability and scalability.

A Lead Digital Nurse is required to oversee the development of ePMA and ensure that the nursing processes are subjected to appropriate changes. This role will work alongside other new and existing digital leads from other professions within the Health Board and other NHS organisations. The Lead Digital Nurse will be supported by a team consisting of both clinical and technical resource, to ensure effective medicines management processes are in place that are safe and technically viable. They will be responsible for ensuring patient safety risks and issues are managed within ePMA and that benefits are realised and will be fundamental for ensuring the nursing workforce are prepared and supported during roll out. The Lead Nurse and Nursing support will identify and establish nursing champions for ePMA and will ensure training is effective for existing and new nursing staff. Without adequate nursing resource, effective use of the ePMA system and its benefits will not be realised, leading to missed opportunity from financial and patient safety perspectives.

In addition to the dedicated full time Nursing Resource, the Programme will fund dedicated sessions for Ward and Specialist Nurses to participate and contribute to the development and implementation of ePMA. These sessions will be available to ensure the coordination of ward staff for training and attendance and ward specific readiness activities and for ensuring service specific policies are adhered to.

Medical Resource

The ePMA programme plan to recruit and utilise clinical fellows as part of the implementation team. Having clinical fellow posts with dedicated sessions to the ePMA programme should make these posts attractive and enhance recruitment, bringing benefit to the health board and the ePMA programme. Clinical fellows will become ePMA champions who can publicise and positively influence their peers prior to go live, assist in training the medical workforce, and be part of the onsite support team at go live. They will provide valuable insight into regulatory requirements related to prescribing and medication administration, ensuring that the ePMA system complies with the relevant local and national policies and guidelines. have a critical part to play in ensuring user acceptance, addressing usability concerns, resolving issues and subsequently increase the likelihood of successful adoption. They will also have a critical part to play in ensuring user acceptance, addressing usability concerns during implementation, resolving issues and subsequently increase the likelihood of successful adoption. To fulfil this, the programme is looking to utilise four Clinical Fellows, each working 0.5 WTE on the ePMA Programme. This will enable all shifts to be supported with the right peer support and will enable the Clinical Fellows to continue to work clinically to maintain their clinical practice.

Given the recognised shortages across junior doctor rotas, the support of clinical fellows will ensure that ePMA roll out specific tasks do not create a significant extra work burden to ward staff. This is particularly important for drug chart transcribing in admission areas and wards with high turnover and high acuity patients. Ensuring clinical care isn't compromised and patient safety is maintained during the implementation and roll out is essential, and the clinical fellows are a fundamental part of our strategy to ensure this.

In addition to Clinical Fellows, the Programme will fund dedicated sessions for medical workforce to participate and contribute to the development and implementation of ePMA. The sessions will be made available to ensure Specialist Consultants can contribute and shape ePMA and will be essential for ensuring safety and accuracy and that the programme is compliant with service specific regulations.

Longer term, Clinical input will be essential in ensuring the ePMA system is regularly updated to accommodate new and changing practices. Healthcare is dynamic, with new medications, treatment protocols, and best practices emerging regularly, therefore Clinical input will be important for the continuous improvement and optimisation of the system and working practices.

Clinical Safety

The support and input of ABUHB's Clinical Safety Officer will be required to ensure the necessary clinical safety processes are in place and any clinical safety risks are understood and mitigation actions are in place. The ePMA Programme will utilise ABUHBs existing Clinical Safety Officer who will lead on clinical safety activity such as completion of the clinical safety hazard log. This role will also be a key position on the Clinical Reference Group.

Programme Resource

A Programme Manager will have responsibility for management and delivery of the ePMA Programme and will manage the Project and supporting resource necessary for delivery of a programme of this scale. This role will be the key link with the national Secondary Care ePMA Board, ensuring issues and

risks are escalated as required. This role will be responsible for the budget management and have oversight of the programme plan to ensure the proposed timeline is achieved.

A number of programme positions including, the Programme Manager, Programme Support Officer, Business Change Manager and Business Analyst are already in post and have been working on ePMA pre-implementation activities to date. On approval of this business case, these positions will continue to work on ePMA and will transition to the implementation team. Whilst these positions will need to be funded, the transition from pre-implementation to implementation will reduce the recruitment requirements. There will be no need to backfill these positions.

Technical Resource

A mix of ICT resource will be required to ensure ePMA is deployed with the necessary supporting infrastructure. An existing Applications Architect has been fundamental in supporting ePMA activities to date and will continue to support implementation activities on approval of this business case. The Applications Architect will be responsible for ensuring ABUHB design an ePMA solution based on open architecture that allows for a seamless integration with other local and national systems. Networks resource will be crucial for ensuring the cloud solution is appropriately set up and supported and that the Wi-Fi network is sufficient and reliable for ePMA.

A Mobile Engineer will be critical in ensuring fit for use hardware is procured and deployed to the end users. Service desk and Clinical Applications Support roles will be required as additional resource to existing teams to ensure end users are sufficiently supported.

Due to current capacity issue for developers, integration specialists and testers in ABUHB external resource will be utilised to manage the integration work required for ePMA, and to lead testing, quality assurance and service acceptance activities.

All of these roles will work closely with the Product Specialist, Business Change, Clinical Teams, and Service Management positions to form a multi-disciplinary team consisting of a wealth of, subject matter experts to ensure a solution is deployed that brings a plethora of change and improvements.

Training

As noted in the 2016 by Robert M Watcher government report 'successful implementation of health IT requires the initial and sustained engagement of front-line users of the technology, whether it is healthcare professionals or patients. It also means that healthcare settings need a robust, well trained, and well supported cadre of experts (CCIOs and others) who understand clinical practice, technology, and change management. These individuals are crucial in promoting the adaptive changes that are needed when an organisation switches from one way of doing work to another'¹³. This will be key to the training approach adopted by ABUHB and the Programme acknowledge that preparation of high-quality, relevant, and engaging training will be key for success; the importance of which cannot be underestimated as highlighted later in section 9 (training considerations) of this Business Case with the case of Royal Surrey Foundation Trust.

¹³ <https://www.hsj.co.uk/patient-safety/patient-died-and-30-harmed-after-new-it-system-launch/7035723.article>

The ePMA Programme Team will be responsible for planning and developing the training approach utilising a variety of methods to engage the workforce and ensure a variety of methods are utilised to cater for a range of learning styles.

It is recognised that people are creatures of habits so asking them to embrace new technology when they are comfortable with existing methods requires careful and mindful planning. To raise awareness and to begin to prepare staff a range of engagement sessions will be planned, such as 'pop up' stands at each of the hospital sites throughout the health board, here staff will be presented with opportunities to engage, try out equipment, watch demonstrations, view the system, register for digital confidence training, or nominate themselves for champion roles.

Training will be offered to staff through a variety of mediums, in a format that will seek to minimise impact to daily routines, it will feature specific in-person training, at ward(s) prior to go live, delivered by a team of dedicated trainers, supplemented by ePMA clinical specialists. This will be complimented by user role specific e-training packages developed in collaboration with our ePMA system supplier tracking of staff completion with these models will be the responsibility of lead clinicians, ward managers and pharmacy leads, ensuring staff engagement within the agreed timeframe prior to go live and/or highlighting staff for whom further development is required. The Programme Team will also develop a range of resources such as quick reference guides, online, easy access bitesize videos and Frequently Asked Questions (FAQs) all of which will be made available via the ePMA SharePoint site and via Pulse.

The Health Board is engaged with its agency providers, enjoying positive working relationships, this will be maintained and nurtured with the implementation of ePMA. An online training approach will be adopted for agency workers; and no worker will be able to register for shifts with ABUHB without having undertaken the required mandatory training modules to ensure a safe and healthy workplace for staff, patients and agency workers. The ePMA programme team will adopt an integrated workforce approach, working in partnership with the Workforce and Organisational Development Team, in particular the Resource Bank Management team to put in place guidance and structure early to ensure the agencies utilised are aware and have time to prepare for the changes and how this will affect them prior to go live of the solution.

Learning from the experience of Oxford University NHS Trust who noted the importance of floor walkers during ePMA implementation, the ABUHB training model sees the value of including these in go live plans. In addition, the Programme Team will seek to recruit champions (super users) and buddying up wards to act as mentors and build on momentum so that teams feel equipped, in-control, know how to seek technical help and guidance and are confident to operate once the Programme moves on to the next ward or area.

Clinical Communication and Engagement

A sustained engagement plan will be essential for the successful delivery of ePMA. Early and ongoing, continuous engagement with all key staffing groups (medical, nursing and pharmacy staff) will be critical and will therefore need to be carefully planned and managed.

The ePMA programme team will prioritise being visible and available to staff, where they work to answer any questions, alleviate any concerns and develop strong working relationships with end users. To date this way of working has proven hugely beneficial to the programme, which has benefited the collection of benefit baseline data, provided the programme team with insightful knowledge about current ways of working but has also allowed the programme to start building relationships with staff who are keen to be involved in the implementation of ePMA. Work to date has also incorporated agency and student staff which has provided the programme with areas of consideration for the programme to be aware of. Having the ePMA Programme Team on site will be vital for the duration of the programme.

To support ongoing engagement the programme will seek to recruit champions for nursing, pharmacy and medical; these champions will be key knowledge holders but will also act as point of contact, engaging with and keeping clinical teams informed throughout the rollout of ePMA. The team will seek to communicate frequently through a variety of methods, including utilising clinical engagement days and symposium events to provide clinicians with opportunities to ask questions and address concerns raised. The impact of good engagement with clinical will be paramount to success and will be a priority as the programme team acknowledges the influence clinicians have when it comes to implementing operational changes, such as that of ePMA.

Lessons Learned

A series of lessons learned have been captured to date, from other internal programmes of change, other Health organisations where ePMA systems have been rolled out and are being used. Site visits to ePMA sites and literature shared through NHS Digital have been considered and taken on board to help shape how the implementation of ePMA in ABUHB will be delivered.

This work will continue to be built on as the programme transitions to implementation and throughout the delivery lifecycle. Lessons learned registers will capture any new and emerging information and workshops will be held where shared lessons are discussed and considered.

Product Delivery

Once the implementation of ePMA is complete, the programme will transition to a Product Delivery team for management of the day-to-day delivery and for the ongoing continuous improvement and optimisation of the ePMA system. Successful transition from project implementation to product delivery requires a collaborative effort from multidisciplinary teams to ensure the product continues to meet user expectations and evolves to meet changing healthcare industry standards.

The product delivery model will include dedicated product delivery roles, inclusive of clinicians, product management and product support to manage, enhance and optimise the product to ensure ABUHB realises the benefits identified and sees a return on its investment. The product delivery resource will work together to:

- Identify and prioritise features based on user needs, regulatory requirements, and user/service demands
- Implement rigorous testing processes to ensure the product's reliability, security, and compliance with healthcare standards

- Stay informed about updates and changes in regulatory requirements and make necessary adjustments to the product, ensuring compliance with relevant healthcare regulations and standards
- Ongoing development of training and support materials such as documentation, to address user queries and issues
- Assess and optimise the solution's scalability to accommodate a growing user base and increased data volume
- Continuously monitor and improve system performance to ensure a seamless user experience
- Conduct regular security audits and updates to address potential vulnerabilities to protect patient data and ensure compliance with data privacy regulations
- Establish procedures for handling software updates and patches
- Establish a feedback mechanism to collect input from users and stakeholders to address any issues with the product and prioritise future enhancements
- Develop comprehensive documentation for end-users and administrators e.g. user manuals, system architecture documentation, and release notes
- Develop a marketing strategy to promote ePMA and ensure effective use of the product
- Establish a process for continuous improvement based on user feedback, technological advancements, and best practice
- Plan regular updates and releases to enhance the product's capabilities.

It is anticipated that the project will transition to product delivery by January 2028. The current expected roles are set out in appendix 2d.

Data Intelligence

The introduction of ePMA systems provide significant improvements to Health Board reporting. It is however a common finding that, with the implementation of ePMA Health Boards can expect to see an initial rise in reported patient safety incidents related to medicines. This is due to improved data availability and interrogation through automation and the interoperability of data capture processes.

It is anticipated that ePMA will quickly start to provide ABUHB with greater intelligence. Through increased data and quality around the medicines prescribed and administered in ABUHB, it is expected that the Health Board and Services will be able to use the information to make informed decisions about the medicines prescribed and administered and apply changes to clinical practice. It is also anticipated that the new improved data provisions will allow for targeted interventions based on learning and knowledge. With new improved reporting capability and increased levels and quality of data, it is the aspiration that ABUHB, will have better insight into and in thus will be able to reduce patient safety incidents.

New Modern Hardware

The success of ePMA is highly dependent on accessibility and useability of digital hardware. If hardware is unavailable at a time when a member of staff needs to prescribe, administer, or review a medication, they will be unable to carry out the task, which will in turn present a barrier for staff to using ePMA but also adds risks for patient safety.

We have learnt that there are a number of services with kit that is not being used. It is therefore the plan that the ePMA Programme will repurpose existing digital hardware that is currently not being used, reuse any underused hardware and where additional kit is necessary, a flexible, fit for use stock is deployed to ensure staff can effectively adopt the use of ePMA without accessibility issues to kit when they need it. An assessment of hardware carried out has determined that services kit on their wards/across departments which is not being used but are in full working order. On approval of this business case the ePMA Programme will work with each individual service to fully understand specific needs, to retract unused kit and repurpose kit from areas who have determined kit as unfit for use e.g. bulky kit in busy areas e.g. ED, for use by those who have more space.

In addition, funding from WG's DPIF will be sought to ensure all services who will be using the ePMA system have sufficient and fit for purpose hardware. The investment required to enable this have been determined by a proposed model ward for ePMA, produced by the ePMA Programme. The model ward has been developed based on research and learning from existing ePMA users, other digital projects in ABUHB e.g. WNCR and from surveying work which looked at individual/service specific requirements for hardware, location and lived experiences. The hardware requirements have considered nurses, medical staff and pharmacy staff separately as the use cases confirm that each of the working groups will have different models of use for ePMA e.g. Pharmacy will require more handheld/mobile devices due to working across multiple locations and requiring kit at the same time as other clinicians, whilst medical staff will benefit from ward based devices at or near the patients bed side.

The ePMA hardware ask includes a mixture of fixed devices on carts with lockable medication cabinets and hand-held mobile devices. Include in the hardware ask is the capability for scanning of barcodes and thus enable ABUHB to consider and prepare for closed loop medicines administration and bring additional safety measures for ePMA.

Also, within the hardware ask there are standalone printers which will be essential for business continuity purposes, during times when the ePMA system is unavailable and paper records will need to be maintained.

Hosting Arrangements

Welsh Governments Digital Strategy for Health and Social Care Wales set out that the introduction of new digital solutions should consider Cloud solutions as the first choice. Cloud solutions offer better flexibility, greater opportunities for scalability and collaboration.

The ePMA programme has considered a supplier hosted Cloud solution as its preferred option to meet both local and national requirements. The resource and associated costs set out in this business case are relative to the purchasing and implementation of a supplier hosted cloud solution.

Improved Wi-Fi Connectivity

To ensure the most effective implementation with minimal disruption, ABUHB's wi-fi networks will require investment.

Out of the 16 hospital sites in ABUHB, 7 have been assessed as having 'fair' or 'less than fair' wi-fi coverage. There is just one hospital in ABUHB that has been assessed as working to excellent standard, with 90% wi-fi coverage.

Poor wi-fi presents a significant risk for ePMA due to the scale and time sensitive nature associated with the recording of medicines prescribed and administered. To put ABUHB in a more reliable position which provides for greater stability for ePMA, and thus improve the likelihood of a successful implementation, the wi-fi infrastructure in ABUHB will need investment and a programme of improvement prior to the services, working in those areas, go live.

Architecture

The proposed design for the ePMA system fits perfectly with the strategic imperatives and design principles both locally and nationally to implement secure, open, standards-based access to patient data.

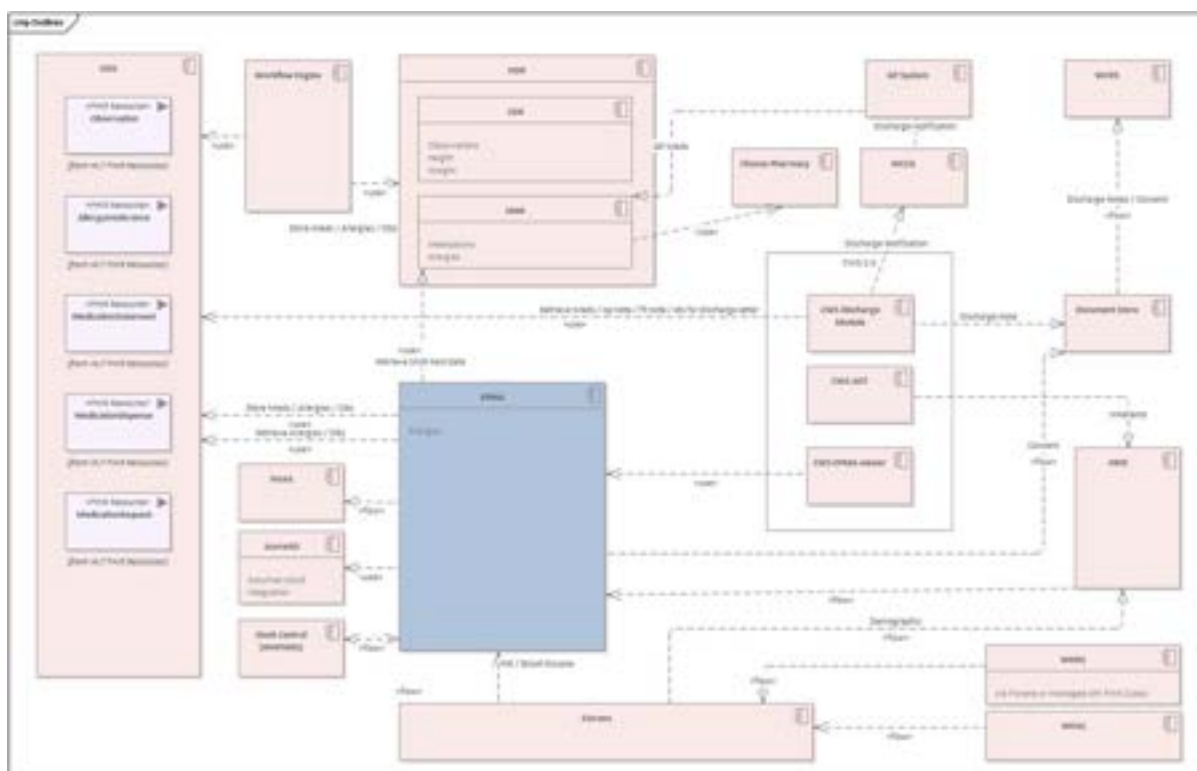
Our aspiration is to enable integration across the components shown in the diagram below, enabling the holistic view of a patient in all settings, using each system (both local and national) and store to its best advantage. The closer we get to this aspiration; the safer patient care will be.

The following interfaces have been identified:

Integration	Description	Who	Status / Notes
NIIAS	Audit of access and update information sent to central service	DHCW / Supplier	
Azure AD	Secure Access	DHCW / Supplier	
Stock Control ordering	WHPSMS	DHCW	
Stock Control - storage	Omniceil	ABUHB / Supplier	To be included in solution design on discussion with supplier
WPAS Demographics	Changes to patient information from WPAS.	DHCW	
CWS ADT	Admission / Transfer / Discharge information from CWS	ABUHB / Supplier	
SMR to ePMA Medications	Medications to be retrieved by ePMA on admission from SMR. TBC – valid Status to update. Includes GP recorded	DHCW / Supplier	
SMR to ePMA Allergies	ePMA to retrieve Allergies from the SMR on admission. Includes GP recorded	DHCW / Supplier	
CDR to ePMA Observations	ePMA to retrieve observations as required. Includes GP recorded	DHCW / Supplier	

ePMA to ODS Medications	ePMA to store Medications in the ODS periodically, and specifically on discharge	Supplier / ABUHB	
ePMA to ODS Allergies	ePMA to store Allergies in the ODS periodically, and specifically on discharge	Supplier / ABUHB	
ePMA to ODS Observations	ePMA to store Observations in the ODS periodically, and specifically on discharge	Supplier / ABUHB	
ODS to SMR Medications	Medications updated in ODS (LDR) sent to Central SMR	ABUHB / DHCW	
ODS to CDR Observations	Observations updated in ODS (LDR) sent to Central CDR	DHCW / ABUHB	Not critical for Go live – observations can be manually entered into the ePMA for meds use
WRRS Results to ePMA	Small subset of patient pathology results of particular importance to the ePMA (e.g. INR / Blood Glucose)	DHCW / Supplier	This is shown on the diagram as established method via Fiorano, but could be replaced by the Managed API currently being developed by DHCW
SMR to Choose Pharmacy	Transfer discharge medicines to Choose Pharmacy to enable Discharge medicines review.	DHCW / Choose Pharmacy	
ODS to CWS Discharge Data	Use of ODS Resources to generate Discharge Summary in CWS	ABUHB	Has dependencies on the ePMA to ODS interfaces
CWS View on ePMA	Read Only view of patient ePMA record	ABUHB / Supplier	
Discharge Summary Store	PDF of final Discharge Summary to local and national store	ABUHB / DHCW	API in Production – Requires DHCW Assurance of the discharge summary as a document source.
Discharge Summary Send to GP	Send via WCCG or alternative	DHCW / ABUHB	Query whether the method is changing
CDR to ODS Observations	Event based pull into ODS from CDR (curated by a clinician)	ABUHB / DHCW	Query if this is required currently. I.e. to synch obs / allergies / meds on demand

The following diagram indicates our ambition to utilise a standards-based approach to data sharing designed to be both utilitarian and robust in terms of resilience.



6. Outcomes and Benefits Realisation Plan - Value

Objectives

The desired objectives of implementing an ePMA system include:

- Improved clinical screening of patients when presenting at ED through more accurate/thorough patient records, including known allergies
- Elimination of blank/incomplete records through the digital sharing of information and mandatory completion of information
- Clinical efficiency through digitisation of processes
- Reduced costs in relation to paper resources, high-cost drugs and streamlined pharmacy order processes
- Increased patient safety through digital record keeping (i.e., one source of the truth) and clinical decision support when prescribing
- Reduction in scanning costs and storage of paper-based records
- Improved reporting and use of data to inform learning and promote best practice.

In addition, several cash-releasing and non-cash releasing benefits have been identified with the implementation of ePMA within ABUHB.

Benefits

The introduction of ePMA will see the realisation of many benefits. Appendix 3 contains a full list of the benefits that have been identified as achievable benefits, including those identified at a national

level (of which there are 8). The benefits, identified at both a local and national level, will be realised as follows:

Efficient Cash-Releasing

- Achieve a reduction in Secondary Care Dalteparin spend by 15%
- Reduce the current amount spent on paper medication charts by 95% charts (NB*)
- Achieve a 1.0% reduction in annual Secondary Care drug expenditure (*Of influenceable Drugs - E.G. Excluding known NICE approved Drugs (manually identified by ABUHB Pharmacy staff within the Pharmacy stock management system, in the absence of an approved NICE list))

Efficient Non-Cash Releasing

- Achieve 90% recording of VTE Prophylaxis prescribed (NB*)
- Achieve a 90% completion rate for patients requiring a VTE Prophylaxis risk assessment (NB*)
- 95% medicines administrations status completed will aid ABUHB in reducing the number of blank boxes (reason code: No Code Documented = Blank Box) (NB*)
- Reduce the number of prescribing errors by 40% in relations to drug, dosage and frequency and reduce the categories being recorded by 37.5%. It is anticipated that the following categories are eradicated or reduced and no longer reported as incidents. (NB*)
 - Contraindication – Allergy (reduced)
 - Contraindication – Drug Interactions (Reduced)
 - Duplication of Medication (**Not Ingredients) (eradicated)
 - Illegal Prescription (eradicated)
 - Medication prescribed without a dose (eradicated)
 - Prescription written without a valid medication name (eradicated)
- 100% of ABUHB patients will have ePMA records with an allergy assessment undertaken and information documented (prior to prescribing taking place) (NB*)
- 60% reduction in the time spent looking for mis-placed paper drug charts, reading illegible handwriting and waiting for charts to be re-written (NB: not 100% reduction as following implementation staff may potentially spend time looking for ICT equipment to access digital charts)
- Reduce the time taken by 2% to complete the MORNING drug round, providing a 4 Hour 55 Minute daily saving across ABUHB
- Achieve a 75% reduction in 2 or more consecutive omissions in medicines administration due to 'Medication Unavailable' ('5's') documented on the medication administration record
- Through implementation of ePMA zero hours will be spent by Junior Doctors re-writing patient drug charts
- Through implementation of ePMA zero hours will be spent by Pharmacy reviewing & checking re-written patient drug charts
- Zero hours spent by Band 2 Health Record staff scanning patient medication charts
- A 50% reduction in medicines related adverse patient events reported through Datix
- Through implementation of ePMA ABUHB discharge processes will be streamlined to report a 75% reduction in the time spent transcribing and checking TTH prescriptions.
- Achieve a 95% reduction in the volume of paper medication charts ordered by the Health Board.

Timely and Safely

- Increase the volume of medicine reconciliations completed within 72 hours of patient admission to 70%
- Achieve a 50% improvement in the administration of time critical medicines

Effective

- Staff report that they have improved access to patient medication records and more accurate patient medicines data
- Staff report more economic use of time due to a reduction in the duration of patient assessment
- Staff report improved information sharing between Primary and Secondary care services
- Staff report that better prescribing habits have been adopted by prescribers in ABUHB

Person-Centred

- An improvement in the number of critical time medications being administered on time, resulting in patients reporting that they feel safer during an in-patient hospital stay, in relation to their critical time medicine management
- Patients report that they less frequently have to remind/chase staff to administer medication during in-hospital stays.

**NB = National benefit that has been adopted locally by ABUHB*

The realisation of benefits, as a result of implementing ePMA will be managed through a benefits realisation register. This document will specify who will benefit from the benefits, who will own the benefits and be responsible for the monitoring and reporting of the realisation of the benefits identified. It must be noted that given the significant transformational change delivered by ePMA some of the identified benefits will not be realised until the programme has transitioned to Business as Usual (BAU), and it is expected (as detailed in Appendix 3) that full benefits may take 1 – 3 years post-implementation of the ePMA programme across ABUHB. The ABUHB Business Change Manager for ePMA will oversee benefits realisation even after program closure.

For the purpose of cash saving benefits, it is acknowledged that those identified will be defined as:

- Recurrent – Returning a financial saving for items or services, such as stationary costs, travel expenses or drug costs currently incurred by the Health Board (Caveat – This is based on current prices and does not include inflation costs)
- Flat Rate – A charge, saving or level that does not vary (i.e. a single fixed fee/amount).

It is anticipated that by implementing ePMA the Health Board will reduce its use of paper in line with Welsh Government public sector decarbonisation ambitions for Wales to be net zero by 2030, which will also provide cost savings. Some of these savings will be realised through no longer having to purchase paper resources. Data provided by ABUHB Finance and Procurement Services demonstrate that costs for purchasing Medicine Administration Records (MAR) and WP10 prescription pads would return £39,659 estimated recurrent (flat rate) savings based on 22-23 FY spending. It is also expected

that a 1% reduction in expenditure of influenceable drugs would offer a recurrent (flat rate) of £277,301 as a direct result of supported clinical decision being offered through the ePMA system. Additionally, it is estimated that the Health Board will experience a 15% reduction in Dalteparin spend, returning a £149,283 recurrent (flat value) saving realised in year one.

The implementation of ePMA will also enable efficiency (non-cash releasing) savings, through enabling staff to undertake other clinical duties including direct patient care, in particular Nurses, Pharmacists and Junior Doctors. It is predicted that ePMA will release Junior Doctors from spending (on average) 43 hours per week re-writing lost, missing or full medication charts at a cost of £60,058 per annum to the Health Board and Pharmacy efficiency (non-cash releasing) savings of £93,692 no longer having to check these same re-writes, enabling the staff to undertake other clinical duties, such as patient medication reviews. In addition, Pharmacy staff currently provide a service supporting transcribing patient discharge (TTH) medication, based on average number of prescriptions transcribed by pharmacy over a given period this will provide further efficiency savings of £6,973 as a direct result of implemented ePMA.

There are also some additional benefits (not included in Appendix 3) which will likely emerge as the project commences and those that are not currently measurable which will be achieved through the implementation of ePMA, these include (but are not limited to):

- Improved antimicrobial stewardship (Inappropriate oral & IV antibiotic prescriptions).
- More accurate patient medical records on admission will improve patient safety due to digitised recording.
- Improved Therapeutic Drug Monitoring (TDM) through:
 - A reduction in the number of blood monitoring.
 - Less blood monitoring required.
- Reduced number of in-patient C Difficile cases due to reduced antibiotic use over 5 days.

The implementation of ePMA would also help in delivering much needed improvements in prescribing practices in Homecare, aiding the reduction of patients missing doses of required medication due to prescribing errors and delays which are frequently reported, in addition to incorrect brands of medication and delivery formulations being prescribed. Similarly, it will aid the reduction of out of hours travel expenses, in particular to our community sites by equipping medics with the resources and patient information at their fingertips to empower them to be able to confidently and safely prescribe for patients in their care without the need to travel, often long distances.

As well as the benefits, identified as achievable and set out above, there are many other opportunities that may emerge, and which could benefit the Health Board once ePMA is implemented, including: Time efficiency savings, improved bed management, and improved patient flow. With the absence of data to baseline and evidence the levels of these opportunities, the business change team and benefit owners will undertake regular reviews to review the benefits identified and establish whether any new benefits can be realised. Reviews will consider the value of any new and emerging benefits for the organisation.

As highlighted above, ePMA will free clinical staff from the current cumbersome paper processes, providing staff with more time to undertake other duties, including but not limited to an increase in more meaningful interactions with patients, more timely medication reviews and education to patients to support self-management of medication. Quicker discharge process could materialise due to streamlined and more timely discharge process, freeing up beds quicker and improving patient experiences.

It should be noted that where staff releasing time has been identified, staff numbers will not be reduced, instead, staff time will be released to undertake more timely and more effective activities. In addition to this, it is expected that staff satisfaction levels will increase, which will in turn improve staff recruitment and retention levels, making the health board a more attractive place to work through streamlined digital processes.

7. Clinical Evidence

Patient Safety

Electronic Prescribing and Medicines Administration has revolutionised the healthcare landscape, bringing about numerous benefits, particularly in the realm of patient safety. This technological advancement in medication management offers multifaceted advantages that contribute to safer and more efficient healthcare practices.

1. **Accuracy and Legibility:** One of the primary benefits of ePMA is the elimination of handwritten prescriptions, which are susceptible to misinterpretation due to poor handwriting. EPMA ensures accuracy and legibility, minimising the risk of medication errors caused by misreading prescriptions.
2. **Real-time Access to Patient Records:** ePMA systems provide healthcare professionals with real-time access to patients' medication histories, allowing for comprehensive reviews of current and past prescriptions. This immediate access aids in preventing adverse drug interactions, allergic reactions, omitted medicines and duplication of medications.
3. **Decision Support Tools:** Integrated decision support tools in ePMA systems assist healthcare providers in making informed decisions about medication choices. These tools can alert prescribers to potential drug interactions, allergies, or dosage issues, enhancing the overall safety of the prescribing process.
4. **Streamlined Communication:** ePMA enhances communication between healthcare providers and pharmacists. Instantaneous transmission of prescriptions reduces the chances of misunderstandings or delays in medication dispensing, ultimately benefiting patient safety.
5. **Allergy and Sensitivity Alerts:** ePMA systems include features that highlight patient allergies and sensitivities. These alerts prompt prescribers to reconsider certain medications or doses, preventing adverse reactions that could compromise patient safety.

6. **Comprehensive Medication Reconciliation:** ePMA facilitates more efficient medication reconciliation during transitions of care. Whether a patient is moving between healthcare settings or undergoing a change in treatment, an ePMA will help ensure a seamless and accurate transition, minimising the risk of medication-related issues.
7. **Enhanced Monitoring and Reporting:** ePMA systems enable better monitoring and reporting of prescription patterns and outcomes. This data can be analysed to identify trends, potential issues, and areas for improvement, contributing to ongoing efforts to enhance patient safety.

In conclusion, the adoption of ePMA represents a significant stride toward ensuring patient safety in healthcare. The integration of technology not only reduces the likelihood of errors but also provides healthcare professionals with valuable tools to make more informed decisions, ultimately promoting a safer and more effective medication management process.

User Stories

There are many use cases for ePMA, explaining from a user perspective what they require from an ePMA system. The top three use cases for ABUHB are set out below:

Use Case 1 – for electronic prescription generation: A qualified prescriber can create electronic prescription for patients, which includes all legal requirements, decision support, ADR checks, drug interactions and any additional instructions.

Use Case 2 - for medication order supply: A pharmacist can receive alerts and notifications of electronic prescriptions, verify them, and dispense medications accurately. The system can check for allergies and drug interactions.

Use Case 3 – for electronic medication administration: A registered nurse, or other healthcare professional trained to administer medicine can record medication administration electronically, ensuring accurate documentation of when and how medications are administered to patients in accordance with 5R's.

Each of the above use cases are supported by a series of user stories, setting out what functionality and capability the users of an ePMA would require. These use case and supporting user stories are set out in appendix 8.

8. Application of Prudent Healthcare Principles

Prudent Healthcare Which principles apply to your proposal?	Yes/No – give a brief description
Do only what is needed – no more, no less and do no harm	Yes – This principle applies with the introduction of ePMA.

	EPMA is an electronic system which improves access to vital information for health professionals. It will promote patient safety by: 1. Reducing unnecessary and inappropriate prescriptions and ensure that health care professionals have access to vital patient information to make appropriate and informed decisions about the medication patients receive 2. EPMA will be based upon strong integration enabling greater access to shared patient information 3. EPMA will enable greater insight into medicine prescribed and administered, helping us know if we are doing things right and what can be done better 4. EPMA will help ensure appropriate prescribing via decision support, as well as triggering medication reviews at defined points, supporting best practice to stop medications such as antibiotics after the minimum duration required. This should help reduce the harm from unnecessary antibiotic treatment such as c difficile 5. Allergy information will be available within the ePMA system and thus will prevent the prescribing of inappropriate medicines.
Reduce inappropriate variation using evidence-based practices consistently and transparently	Yes - This principle applies with the introduction of ePMA. EPMA will have decision support which will be directly linked to relevant, up to date local and national guidelines so ensuring that everyone utilises the same evidence-based advice and guidance. EPMA is a widely used system across the NHS England and Scotland with various ePMA systems being utilised. Health Boards in Wales are currently planning implementations for ePMA. The introduction of ePMA in ABUHB will ensure there is no variation in care for patients compared to other Health Boards.
Care for those with the greatest health need first, making most effective use of all skills and resources	Yes - This principle applies with the introduction of ePMA. EPMA will allow staff to prioritise patients based on time sensitive needs, e.g. nurses will be prompted to see the patient with time critical medications med first. Medics will be able to see which patients need to be seen with a prioritised view, so enabling patients with the greatest need to be seen as a priority and by the most appropriate member of staff. EPMA will reduce inefficiencies by ensuring only the patients that require clinical intervention are seen. (with the current paper system, patient records need to be reviewed and assessed to determine whether a patient requires attention, however ePMA will provide an

	electronic automation of this and thus removes the need for physical, time-consuming reviews).
Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production	Yes - This principle applies with the introduction of ePMA. The introduction of ePMA will see many efficiencies for medical staff to be better utilised elsewhere. Time released through efficiencies will provide new and additional opportunities for health care professionals to ensure service users are fully empowered in all aspects of their medicines.

9. Impact Assessment, Resource Implications and Affordability of Preferred Option

Workforce Implications

The prescribing and administration of medicines is undertaken by three core workforce groups: Medical, Nursing and Pharmacy. In ABUHB, there are approximately 6,500 members of staff across these three groups who will require access to ePMA to undertake their role. A new ePMA system will be made available and accessed by the vast majority of these staff 24 hours per day. It is anticipated that approximately 750 members of staff will access the system at any one time.

In addition to Nursing, Pharmacy and Medical staff, the system will also be accessed by and will therefore impact a multitude of other staff at varying degrees across the Health Board, including Allied Health Professionals, Healthcare Scientists, Clinical Support Services, Administration and many more. Full impact assessments will be completed once the full business case has been approved and the approval to proceed to implementation has been received. Full impact assessments will form part of the implementation.

The nursing workforce form the biggest workforce group, administering medications throughout the day, every day with medical staff forming the second biggest group of staff. Whilst the number of Pharmacy staff is lower, they are at the forefront of prescribing and checking medication records and are responsible for the safe supply of medicines in ABUHB. All the above working groups undertake comprehensive tasks each day to ensure that patients receive the required medication to manage their symptom or condition, in a safe and effective way.

The current departmental context and capacity assessments, inclusive of the recruitment and day to day operational challenges, have been taken into consideration when determining the resource required for the implementation of ePMA.

Where possible, existing roles and resource will be utilised to support the programme and the resource plan is reflective of the current available positions.

Benchmarking with other ePMA users has been carried out to determine the skills required and ensure ABUHB learn from their experiences. Lessons learned from other transformational programmes of this

scale and from other ePMA users (as set out in appendix 7) have been considered and incorporated in ABUHB's resource plan for both implementation and product delivery.

The full resource model, for the implementation of ePMA is detailed in appendix 2c. The resource model also incorporates the current expected Product Delivery resource that will be required for the long-term delivery of ePMA.

The resource plan is inclusive of:

- Clinical resource
- Clinical Safety
- Digital Programmes resource
- Product Delivery resource
- Training
- Development and Integration resource
- ICT and Infrastructure resource
- Data Analytical resource
- Commercial resource

The resource plan is reflective of and will enable the successful delivery of ePMA in ABUHB as set out in the planned implementation timeline (see section 10).

Benchmarking confirms that ABUHB's resource plans are comparable with other Health Boards in Wales' for ePMA. Whilst there are some differences, the key positions and considerations are comparable. The greatest difference is the period ABUHBs resource covers. The key reasons for this difference are 1. the current capacity challenges experienced by clinical services in ABUHB and 2. the significant recruitment risk to the expansion of resource beyond the presented plan.

Potential Service Impacts

The introduction of a new ePMA system across secondary care services in ABUHB will have varying levels of impact on different groups and services. To date stakeholders from various groups have contributed to, and shared how ePMA will impact them. On approval of this business case, a more detailed assessment will be undertaken which will require active engagement with each of these groups.

A list of the stakeholders engaged with to date can be found in Appendix 1. A brief overview of how each of the following groups or services may be affected is set out below:

Patients, Carers, or the Public:

Pros:

- Improved patient safety through electronic tracking and verification of prescribed medications
- Enhanced communication and coordination among healthcare providers, leading to better-informed care decisions
- Potential for reduced medication errors and improved medication adherence

- Increased accessibility to personal health records and medication history for patients and their caregivers

Cons:

- Patient concerns around the use of their personal data and how it is stored electronically.

Clinical Support Services:

Pros:

- Streamlined medication management processes, leading to increased efficiency
- Enhanced ability to track and manage medication inventories
- Integration with other clinical systems for a more comprehensive patient care approach
- Digitally enhanced services providing a potential capability for adoption of other digital solutions

Cons:

- Initial training and period of adaptation will be required
- Potential disruptions during the implementation period.

Non-clinical Support Services and Facilities Management:

Pros:

- Improved coordination and communication between clinical and non-clinical staff
- Streamlined processes for ordering and managing medicines
- Potential for increased efficiency in facilities management due to less storage and movement of paper

Cons:

- Potential training and adjustments to working practices.

Patient Transport:

Pros:

- Improved coordination with clinical services for transportation needs
- Better visibility of patient medication requirements during transportation

Cons:

- Potential for disruptions during the implementation.

Works and Estates:

Pros:

- Enhanced tracking and management of medication-related equipment
- Less storage space required for storing of paper records

Cons:

- Potential need for adjustments to facilities to accommodate the new system and equipment.

Equipment and ICT:

Pros:

- Improved integration with other clinical systems
- Increased interoperability between different healthcare IT systems
- Improved Wi-Fi provision which will potentially mean there could be a reduction of issues reported due to poor Wi-Fi

Cons:

- Financial investment for purchasing new equipment and improving supporting infrastructure
- Potential challenges in the implementation of new technology.

Primary and Community Services:

Pros:

- Improved coordination with secondary care for a more seamless patient experience
- Enhanced access to patient medication history for primary care providers

Cons:

- Potential need for training and adjustment in working practices.

Local Authority Services:

It is anticipated that there will be no impact for local authority services and further work will be undertaken once the ePMA operating model is confirmed.

Third Sector Agencies:

It is anticipated that there will be no impact for third sector partners, but further work will be undertaken once the ePMA operating model is confirmed. There is however potential for improved data sharing and collaboration which could involve changes in protocols. Third Sector Agencies may need to adjust their working practices to support the new system and ensure effective communication and coordination with healthcare providers.

External Commissioning:

It is anticipated that there will be very little impact for external commissioning partners, but further engagement will be undertaken once the ePMA operating model is confirmed.

- External bodies responsible for overseeing healthcare services may need to revisit existing arrangements to ensure they incorporate the new ways of working as required with ePMA. EPMA will offer new opportunities for real-time data tracking and reporting. External bodies could benefit from new enhanced capabilities to monitor performance.
- The implementation of ePMA will require external funding and investment. Welsh Government, as the funding body, will need to consider budgetary implications and allocate resources accordingly to support the implementation of ePMA.

In summary, while there will be potential challenges during the initial implementation phase, along with upfront investment, the introduction of an electronic prescribing and medicines administration system has the potential to significantly improve patient care, coordination among healthcare providers, and overall efficiency in healthcare delivery. Proper training, communication, and support during the transition will be essential to mitigate potential drawbacks.

Training Considerations

Factoring in adequate and robust training opportunities during rollout will be paramount to success. A recent report about implementation of the Surrey Safe Care electronic patient record (EPR) at the

Royal Surrey Foundation Trust and Ashford and St Peter's Hospital Foundation Trust found a lack of training and understanding was to blame for several patient safety incidents. The Health Board saw a spike in patient safety incidents being filed, including one in which a patient died, and a further 30 that led to patients suffering some degree of harm. In addition, Ashford and St Peter's reported a total of 269 Datix reports as a result of the Surrey Safe Care implementation.

The catastrophic harm that led to a patient's death was not "directly linked to technical problems" but "human factors" were involved, including inexperience or unfamiliarity with the electronic prescribing system. The programme team have paid particular attention to this report to enable learning and draw on the serious lessons learned around staff training and confidence in system use and have factored this into rollout and training plans.

The impact to daily routines and working practices has been carefully considered and as such the programme will be offering training through a variety of platforms, in a way to minimise impact to operations.

To ensure ABUHB staff are sufficiently trained and supported in readiness and during the roll out of ePMA, it is proposed that, an experienced and dedicated training team is utilised. The programme will also establish ePMA 'Super Users', enrolling them in 'train-the-trainer' sessions so that they can effectively and confidently support staff during implementation and ongoing through service delivery.

Additionally, research has shown that dedicated clinical resource is vital for ensuring each of the ePMA user groups are supported effectively through training and support by those with the appropriate levels of clinical leadership and experience. The ePMA programme has carefully considered this and reflected this requirement within its implementation resource plan (see appendix 2c).

Financial Implications

A detailed breakdown of the financial investment required for the implementation of ePMA is attached in appendix 2. A summary of which is set out below:

A total investment of £10,073,136 is required. This investment is required for the period of implementation, spanning 5 financial years from 1st April 2024 to 30th June 2028.

A recurring financial implication will also apply from year 5, post implementation, and is estimated at £1,311,007 per annum which is inclusive of staffing costs, hardware and annual system licence costs. Actual costs and requirements will be subject to a further business case, setting out the proposed service delivery model and requirements for the longevity of ePMA, inclusive of contract end with ABUHB's current proposed supplier.

Revenue

The total revenue investment required over the period of implementation equates to £7,482,603. £2,895,781 of this total revenue investment will be requested from Welsh Government. ABUHB will be required to fund £4,586,822 of the overall implementation revenue costs.

A recurring revenue implication will apply from year 5, post implementation. The recurring revenue investment is estimated at £1,033,736 per annum (excluding inflation), which is inclusive of staffing and annual system licence costs.

Annual staff costs will be applicable indefinitely.

Annual system licence costs will be applicable for the duration of the ePMA contract, which is currently set to run for a minimum of 5 year, up to 7 years.

Capital

The total capital investment required over the period of implementation equates to £2,590,533. £1,942,954 of the total capital investment will be requested from Welsh Government's DPIF. ABUHB will be required to fund £647,579 of the overall implementation capital costs.

A recurring capital implication will apply from year 5, post implementation. The recurring capital investment is estimated at £277,271 per annum to cover for hardware refresh costs.

Proposed Funding Source

Welsh Government (WG) have agreed to fund resources which make up the temporary organisation formed to prepare the organisation for ePMA, and to complete the implementation itself up until September 2026. WG will not fund resources deemed necessary for the ongoing optimisation and support of the ePMA solution, except during the readiness period, for example, for upskilling of resources that will become part of the established product delivery team. Once the ePMA is operationally live within the Health Board/Trust, any operational resource must be funded by the Health Board/Trust.

Welsh Governments Digital Priorities Investment Fund (DPIF) funding can be used for project support periods to support ward preparation and readiness, and for a short-period post go-live before a ward is handed over to the operational product delivery team.

In line with WG's expected completion date and without any formal confirmation, it is the expectation of the local programme that the capital funding will only be available for years 2024/25 and 2025/26. It is also expected that WG will fund the initial purchasing of the system.

The committed funding period is yet to be confirmed by WG, beyond the guidance that "funding proposals can cover multiple financial years". It is however clear that WG encourage an accelerated deployment and initially set out an expected completion date of September 2026. It is also the current position, that DPIF will end as of September 2026 and it is therefore highly unlikely that commitment for funding beyond this date will be received. The timescales and funding requirements set out by ABUHB are focused on ensuring a safe deployment. EPMA focuses on improving patient safety risks and ABUHB's deployment will follow this mantra also. However, this funding position presents risk to ABUHB and its proposed funding model. There is risk that ABUHB's 4-year implementation plan is insufficiently supported by external funding.

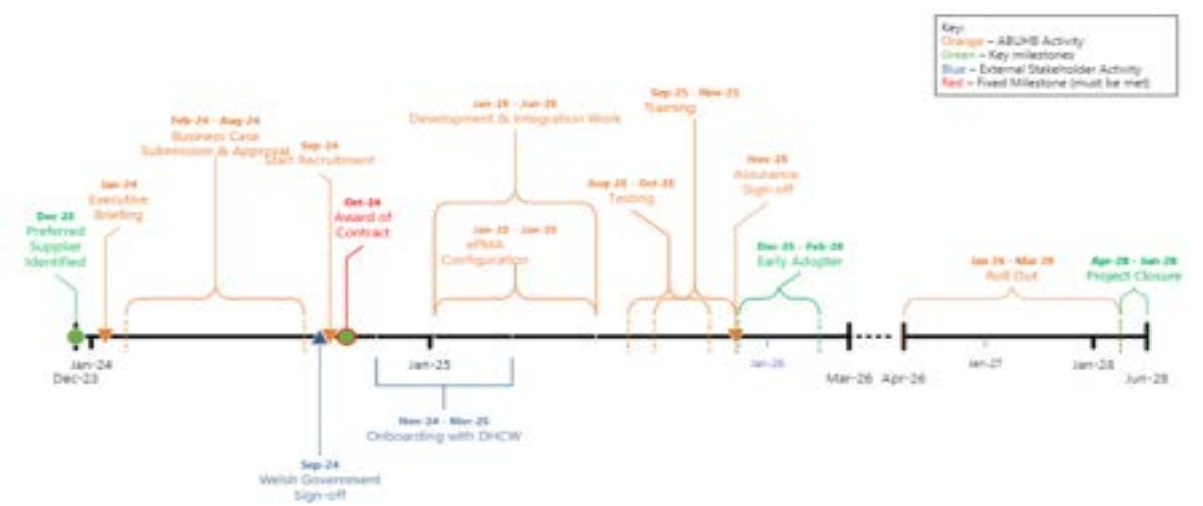
To consider ABUHB’s request for funding, WG required the local Programme undertake a series of assurance tasks. On 29th January 2024 ABUHB submitted its draft, full business case, inclusive of a funding proposal to the ePMA Resource Sponsor Group, made up of WG’s Policy Lead and DHCW’s Secondary Care ePMA Programme representatives, for assurance and review. The recommendations of which have since been incorporated in this business case to provide clarity for both organisations. Following the National ePMA Programmes endorsement, ABUHB require internal approval of its Full Business Case before formal submission to WG for consideration and approval.

If, following the receipt of funding the programme identifies additional costs, WG and ABUHB change management processes will apply. The programme will manage all aspects of the budget and will follow the relative escalation processes if issues arise that require additional investment to treat a risk or issue.

A contingency budget has been set to cover anticipated third-party costs which are deemed as likely to occur by the programme. As these costs are not yet known or confirmed the programme have determined this contingency by known costs charged by other existing systems and suppliers in ABUHB.

10. Implementation Plan and Measurement of Success

The following timeline sets out ABUHB’s proposed plan for the implementation of ePMA:



ID	Task Description	Named Lead	Estimated start date (ESD)	Estimated finish date (EFD)	Dependent on any preceding task/s	Status

1	Milestone 1 Initiation	ePMA Programme Manager	June 2024	Sept 2024	Business Case and Funding Approval	
2	Milestone 2 Readiness	ePMA Programme Manager	Sep 2024	Jan 2025	MS1 Recruitment	
3	Milestone 3 Product Delivery	ePMA Programme Manager	Jan 2025	June 2025	MS2 Acceptance of Work Packages	
4	Milestone 4 Go Live	ePMA Programme Manager	July 2025	December 2025	MS3 Testing, Training, New service acceptance	
5	Milestone 5 Project Closure	ePMA Programme Manager	Sept 2027	June 2028	Service acceptance and transition to product delivery.	

The timescales set out in this case are deemed as the most achievable for ABUHB. The timeframes set for programme activities and achievement of milestones have been determined by lessons learned by other ABUHB programmes which have delivered business change initiatives and by the ways of working in ABUHB e.g. time required to undertake design and development activities. Additional factors which have been taken into account include:

1. Benchmarking against other organisations where ePMA systems have been implemented
2. Lessons learned by other ePMA sites including Swansea Bay UHB
3. ABUHB's current resourcing position to deliver ePMA
4. Implementation planning discussions with ABUHB's preferred supplier
5. Competing programmes of work / priorities.

11. Conclusion and Recommendation

The introduction of new digital ways of working has a significant part to play not only in enabling this transformational change with improvements to; patient safety, efficiencies, reducing duplication and making available information that is sharable and accessible at the point of care but also increasing the availability of data and knowledge.

The chosen model for ePMA is to provide a fully interoperable solution where each individual Health Board needs are at the forefront of system choice. The model allows for multiple solutions to be purchased based on local requirements and configuration, but with an open

architecture to enable a joined-up approach for sharing of information regardless of system or location.

This system will replace the current paper-based systems used by the Health Board with electronic prescriptions and medication records. It will offer a single source of truth and will allow for patients to be prioritised according to medication needs during medicines administration activities.

The introduction of ePMA will enable significant transformation to the way in which ABUHB prescribes and administers medications and will in turn realise a multitude of benefits for the organisation. Patient safety is at the forefront of those benefits but the efficiencies and benefits as a result of new improved data will be sizeable. Additionally, ePMA will lead way for ABUHB and other digital opportunities such as electronic patient record.

The Executive Board is asked to:

- Approve the preferred option presented in this Full Business Case and agree the programme progresses to project initiation
- Approve the programme to submit a request to WG DPIF for funding
- Approve the required investment from ABUHB.

12. Appendix

APPENDIX 1: Stakeholder List

Name	Role	Role in the ePMA Programme	Business Case Reviewed
Zoe Thomas	Digital Portfolio Manager	Portfolio Manager	Jan-24
Kelly Griffiths	Digital Portfolio Benefits Manager	Digital Portfolio Benefits Manager	Jan-24
Nicola Quiller	Business Change Manager	Business Change Manager	Jan-24
Sharif Biharie	Head of ICT	Lead / SME on ICT	Jan-24
Rob Ludman	Head of Informatics Service Management	Lead/ SME on Informatics Service Management	Jan-24
Chris Williams	Operations Manager	Lead/ SME on ICT Operations	Jan-24
Phil Wrintmore	ICT Technical Services Manager	Lead/ SME on ICT Technical Services Manager	Jan-24
Lynne Wilde	Interim Assistant Director of Information Services	Lead/ SME on Information Services	Mar-24
Andy Warburton	Head of Enterprise Architecture	Technical Lead / SME of Enterprise Architecture	Jan-24
Wendy Davies	Application Architect	Technical Lead / SME of Application Architecture	Jan-24
Cynthia Henderson	Head of Health Records/Referral and Booking	Lead / SME on Health Records	Mar-24
Anne McDonnell	Deputy Head of Health Records - DHR	Lead/ SME on Health Records	Mar-24
Lyn Pope	Senior Decision Support Analyst	Lead/ SME on Finance	Jan-24
Andrew George	Business Partner Accountant	Business Partner Accountant	Jan-24
Ruth Madine	Deputy Head of HR	HR Advisor	Jan -24
Tanya Mullins	HR Advisor	HR Advisor	Jan -24
David Hanks	Head of Service Planning	PIP Advisor	Jan- 24
Victoria Richards-Green	Clinical Informatics and Prescribing Support Lead Pharmacist	Clinical Lead for Pharmacy	Jan-24
Hayley Saunders	Senior Nurse Professional Practice	Clinical Lead for Nursing	Jan-24
Melanie Poole	Consultant Anaesthetist	Clinical Lead for Medical	Jan-24
Robin Rice	Consultant Orthopaedic Surgeon & CCIO	CCIO	Jan-24
Peggy Edwards	Chief Nursing Information Officer	CNIO	Jan-24
Ann Slee	DHCW - ePMA Advisor	ePMA Advisor	Jan - 24
Laurence James	DHCW Programme Lead	ePMA Programme Lead	Jan -24
Rhian Rice	DHCW Assistant Chief Architect	EPMA Architect Lead	Jan -24
Leighton Davies	Welsh Government	DPIF Policy Lead	Jan -24

Linda Jones	Head of Nursing Education, Development, Corporate Services	Head of Nursing Education, Development, Corporate Services	Feb -24
Linda Alexander	Associate Director of Clinical Operations	Associate Director of Clinical Operations	Feb - 24
Lisa Forey	Head of Pharmacy – Operational Services	Head of Pharmacy – Operational Services	Apr- 24
Bethan Jones	Principal Pharmacist Procurement, Logistics, Informatics, Homecare and Clinical Pharmacy	Principal Pharmacist Procurement, Logistics, Informatics, Homecare and Clinical Pharmacy	Apr -24

APPENDIX 2: Financial Schedule

Appendix 2a – Total Implementation Cost Summary

Cost summary	2024/25	2025/26	2026/27	2027/28	2028/29	Totals
	£'s	£'s	£'s	£'s	£'s	£'s
Revenue						
Staff	398,630	2,000,117	1,800,782	1,866,249	387,199	6,452,978
Non-Staff	35,000	10,000	5,000	5,000	1,250	56,250
Licence Costs	0	100,000	118,750	146,250	48,750	413,750
Supplier Service Costs	31,250	31,250	12,500	12,500	3,125	90,625
System Costs	469,000	0	0	0	0	469,000
Sub Total	933,880	2,141,367	1,937,032	2,029,999	440,324	7,482,603
Capital						
Hardware	108,654	1,265,700	568,076	79,503	0	2,021,933
Wi-Fi Improvements	211,900	356,700	0	0	0	568,600
Sub Total	320,554	1,622,400	568,076	79,503	0	2,590,533
Total	1,254,434	3,763,767	2,505,108	2,109,502	440,324	10,073,136

Appendix 2b – Implementation Investment Breakdown

Cost summary	2024/25	2025/26	2026/27	2027/28	2028/29	TOTALS
	£'s	£'s	£'s	£'s	£'s	£'s
Total ABUHB Revenue Funding Required	179,467	0	1,937,032	2,029,999	440,324	4,586,822
Total WG Revenue Funding Requested	754,414	2,141,367	0	0	0	2,895,781
Total ABUHB Capital Funding Required	0	0	568,076	79,503	0	647,579
Total WG Capital Funding Requested	320,554	1,622,400	0	0	0	1,942,954
Total	1,254,434	3,763,767	2,505,108	2,109,502	440,324	10,073,136

Appendix 2c – Implementation Resource

Revenue

Ref	Role	WTE	Period	Band	Costs (£000s)					Total
					Yr1 24/25	Yr2 25/26	Yr3 26/27	Yr4 27/28	Yr 5 28/29	
Director of Digital	Executive Lead	N/A	Fixed Term from Apr 24	N/A	0	N/A	N/A	N/A	N/A	N/A
Clinical	Senior Responsible Officer	0.4	Fixed Term from Nov 24	TBC	27,916	69,009	71,079	73,212	18,852	260,069
Pharmacy Team	Lead Digital Pharmacist	1	Permanent from Jan 25	8b	49,219	93,619	96,428	99,321	25,575	364,161
Pharmacy Team	Senior Digital Pharmacist	1	Fixed Term from Jun 25	8a		65,112	80,478	82,892	0	228,482
Pharmacy Team	EPMA Senior Pharmacy Technician	1	Permanent from Apr 25	7		68,028	70,069	72,171	18,584	228,851
Pharmacy Team	EPMA Pharmacy Technician	1	Permanent from Jun 25	5		38,820	47,981	49,421	12,726	148,947
Pharmacy Team	EPMA Pharmacy Technician	2	Fixed Term from Aug 25	5		62,112	93,167	95,962	0	251,241
Pharmacy Team	Site Lead	0.1	Fixed Term from April 25	7		19,237	19,814	20,409	5,255	64,715

Nursing Team	Senior Digital Nurse	1	Permanent from Jan 25	8a	28,541	78,134	80,478	82,892	21,345	291,390
Nursing Team	Digital Nurse Support	1	Permanent from April 25	6		57,721	59,452	61,236	15,768	194,177
Nursing Team	Digital Nurse Support	3	Fixed Term from Jun 25	6		144,302	178,357	183,708	0	506,366
Nursing Team	Specialist Nurse	0.1	Fixed Term from Jan 25	7	4,809	19,237	19,814	20,409	5,255	69,524
Clinical	Clinical Lead	0.1	Fixed term for pre-implementation	Medical	20,672					20,672
Clinical	Clinical Fellows	2	Fixed Term from Jun 25	TBC		98,764	126,813	135,690	34,940	396,208
Clinical	Specialist Consultant Lead (SPA Time)	0.4	Fixed Term from Jan 25	TBC	22,069	88,276	90,924	93,652	24,115	319,037
Clinical	Junior Doctor Relief/Agency (for transcribing)	0.4	Fixed Term from Oct 25	TBC		23,703	50,724	54,275	13,976	142,678
Clinical	Band 7 Relief/Agency (for transcribing)	0.4	Fixed Term from Oct 25	7		27,444	58,731	62,842	16,182	165,200
Clinical	Band 6 Relief/Agency (for transcribing)	0.4	Fixed Term from Oct 25	6		23,286	49,833	53,321	13,730	140,170
Clinical	Clinical Safety Officer	N/A	As required by Programme	8c	0	0	0	0	0	0

Clinical	Clinical Support Services	0.4	Fixed Term from April 25	8a	0	29,460	30,344	31,254	8,048	99,106
D,D&T	Portfolio Manager	1	Permanent from Nov 2024	8b	37,872	93,619	96,428	99,321	25,575	352,814
D,D&T	ePMA Programme Manager	1	Permanent from April 2024	8a	0	0	0	0	0	0
D,D&T	Senior Project Manager	1	Permanent from Oct 2024	7	33,023	68,028	70,069	72,171	18,584	261,874
D,D&T	Programme Support	1	Permanent from April 2024	5	0	0	0	0	0	0
D,D&T	Project Implementation Manager	1	Fixed Term from Apr 25	6		57,721	59,452	61,236	15,768	194,177
D,D&T	Product Specialist	1	Permanent from Jan 25	5	11,307	46,584	47,981	49,421	12,726	168,018
D,D&T	Business Change Manager	1	Permanent from April 2024	7	0	0	0	0	0	0
D,D&T	Digital Service Manager	1	Permanent from Dec 2024	6	18,680	57,721	59,452	61,236	15,768	212,857
D,D&T	Applications Architect	1	Permanent from April 2024	8A	67,238	69,255	0	0	0	136,493
D,D&T	Business Analyst	1	Permanent from April 2024	7	0	0	0	0	0	0

External	Consultancy Resource - testing & development	N/A	Fixed Term 25/26	N/A		355,680				355,680
D,D&T	Lead Trainer	1	Fixed Term	5	0	0	0	0	0	0
D,D&T	Trainers	4	Fixed Term	4	0	0	0	0	0	0
D,D&T	CAIST	1	Fixed term from Aug 25	4	0	24,604	38,013	39,154	10,082	111,853
D,D&T	Service Desk	1	Permanent from Aug 25	4	0	24,604	38,013	39,154	10,082	111,853
D,D&T	Senior Network Wi-Fi Analyst	1	Permanent from Dec 24	6	18,680	57,721	59,452	61,236	15,768	212,857
D,D&T	Senior Mobile Engineer	1	Permanent from Dec 24	6	18,680	57,721	59,452	61,236	15,768	212,857
D,D&T	Data Analyst	1	Permanent from April 25	5	0	46,584	47,981	49,421	12,726	156,711
D,D&T	Commercial Lead	0.5	Fixed Term from Apr 24	7	39,925	34,014				113,864
Subtotal					398,630	2,000,117	1,800,782	1,866,249	387,199	6,452,978
Non-Staff	Promotional /Marketing	N/A	N/A	N/A	20,000	0				20,000
Non-Staff	Expenses - Travel/Site Visits Expenses	N/A	N/A	N/A	5,000	10,000	5,000	5,000	1,250	26,250
Non-Staff	Training Resources	N/A	N/A	N/A	10,000					10,000

Other	License Costs*	N/A	N/A	N/A	0	100,000	118,750	146,250	48,750	413,750
Other	Supplier Service Costs**	N/A	N/A	N/A	31,250	31,250	12,500	12,500	3,125	90,625
Other	System Costs	N/A	N/A	N/A	469,000		0	0	0	469,000
Total					933,880	2,141,367	1,937,032	2,029,999	440,324	7,482,603

*Estimated expected licence/annual supplier costs

Capital

Ref	Description	Source of Investment	Cost (£000s)					Totals
			Yr1 24/25	Yr2 25/26	Yr3 26/27	Yr4 27/28	Yr5 28/29	
			£'s	£'s	£'s	£'s	£'s	£'s
Hardware	Hardware items necessary for the implementation of ePMA	Combination of ABUHB and WG Capital Funding	108,654	1,265,700	568,076	79,503	0	2,021,933
Wi-Fi	W-Fi related items, necessary for the implementation of ePMA	Combination of ABUHB and WG Capital Funding	211,900	356,700	0	0	0	568,600
Sub total			320,554	1,622,400	568,076	79,503	0	2,590,533
Total			1,254,434	3,763,767	2,505,108	2,109,502	440,324	10,073,136

Appendix 2d – Product Delivery Team Resource

Revenue

Ref	Role	WTE	Period	Band	Costs			Sub Total	Requires Recruiting
					Yr5 28/29	Yr6 29/30	Yr7 30/31		
Pharmacy Team	Lead Digital Pharmacist	1	Permanent from Sept 24	8b	76,725	105,369	108,530	290,624	Y
Pharmacy Team	EPMA Senior Pharmacy Technician	1	Permanent from Sept 24	7	55,752	76,566	78,863	211,180	Y
Pharmacy Team	EPMA Pharmacy Technician	1	Permanent from April 25	5	38,177	52,430	54,003	144,611	Y
Nursing Team	Senior Digital Nurse	1	Permanent from July 24	8a	64,034	87,941	90,579	242,554	Y
Nursing Team	Digital Nurse Support	1	Permanent from Oct 24	6	47,305	64,965	66,914	179,184	Y
Medical	Lead ePMA Medic	0.4	Permanent	TBC	56,556	77,670	80,000	214,227	Y
DDaT	Digital Service Manager	1	Permanent from Jul 2024	6	47,305	64,965	66,914	179,184	Y
DDaT	Product Specialist	1	Permanent from April 25	5	38,177	52,430	54,003	144,611	Y

DDaT	Service Desk	1	Permanent from April 25	4	30,246	41,538	42,784	114,568	Y
DDaT	Data Analyst	1	Permanent from April 25	5	38,177	52,430	54,003	144,611	Y
DDaT	Senior Network Wi-Fi Analyst	1	Permanent from April 26	6	47,305	64,965	66,914	179,184	Y
DDaT	Senior Mobile Engineer	1	Permanent from April 27	6	47,305	64,965	66,914	179,184	Y
Sub total					587,065	806,236	830,423	2,223,723	
Non-Staff	Expenses - Travel/Site Visits Expenses	N/A	N/A	N/A	3,750	20,000	20,000	43,750	N/A
Non-Staff	Supplier fees	N/A	N/A	N/A	9,375	12,500	12,500	34,375	N/A
Non-Staff	License fees	N/A	N/A	N/A	146,250	195,000	195,000	536,250	N/A
Sub total					159,375	227,500	227,500	614,375	
Total					746,440	1,033,736	1,057,923	2,838,098	

Capital

Ref	Description	Source of Investment	Yr5 28/29	Yr6 29/30	Yr7 30/31	Sub Total	Requires Recruiting
Hardware Refresh	Refresh costs for deployed items e.g. end of life/broken items	ABUHB Capital Funding	277,271	277,271	277,271	831,813	N/A
Sub total			277,271	277,271	277,271	831,813	
Total			1,023,711	1,311,007	1,335,194	3,669,911	

APPENDIX 3: Detailed Benefits Realisation Plan based on Value Team definitions

Desired Objectives	Benefit	Current State (Baseline)	Target Future State	Timescale	Category
Improved mandatory thromboprophylaxis screening <i>National Benefit</i>	By including mandatory assessment, prescribing and monitoring functionality for venous thromboembolic prophylaxis (VTE) screening and treatment. Improving compliance with prescribing standards and policies at the point of prescribing to improve patient outcomes. (Recording the documentation of VTE Risk assessment on medication charts).	During a Jan-Dec-22 study 76% of ABUHB patients have a VTE Risk Assessment completed	Achieve a 90% completion rate for patients requiring a VTE Risk Assessment	1 Year post ePMA rollout across all ABUHB in-patient sites	Efficient – non-cash releasing
Improved mandatory thromboprophylaxis treatment	By including mandatory assessment, prescribing and monitoring functionality for venous thromboembolic prophylaxis (VTE) screening and treatment. Improving compliance with prescribing standards and policies at the point of prescribing to improve patient outcomes. (Recording Prescribing of VTE prophylaxis when clinically necessary to do so and assess if matches VTE risk assessment).	- During a Jan-Dec-22 study 11.4% of ABUHB patients had prescribed VTE treatment recorded (Based on snapshot audit carried out with 149 patients) - Current ABUHB Secondary Care Dalteparin spend for the FY Apr-22 - Mar-23 = £995,218	- Achieve a 90% recording of VTE Prophylaxis prescribed - Achieve a reduction in Secondary Care Dalteparin Spend by 15% (Providing a £149,283 recurrent saving (Caveat – This is based on current prices	1 Year post ePMA rollout across all ABUHB in-patient sites	- Efficient – non-cash releasing - Efficient - Cash Releasing

1.National Benefit 2.ABUHB Benefit			and does not include inflation costs))		
Eliminate blank administration record	Improved recording of a medicines administration status documentation when medicines have been administered or not, ensuring drug charts are complete. (Reduction in blank boxes).	During the study period Jan-Dec-22 for every 1000 patients sampled, an average of 81 patients missed medication doses (in the previous 24 hours) according to the reason, 'no code documented (blank boxes)'	95% Medicines Administration Status Completed will aid ABUHB in reducing the number of blank boxes (reason code: No Code Documented = Blank Box)	2 Years post ePMA rollout across all ABUHB in-patient sites	Efficient – non-cash releasing
National Benefit					
Reduction in Prescribing Errors	EPMA provides a reduction in prescribing errors (including transcription error) in a number of ways: immediate access to clinical decision support resources, prescribing medication with pre-determined doses and frequencies, real-time interaction checking and an electronic drug history.	In the FY Apr-22 – Mar-23 215 prescribing errors were recorded over the 16 Datix categories, this averages at 17.91 errors per month	Reduce the number of prescribing errors by 40% and reduce the number of categories being reported by 37.5%. It is anticipated that the following categories will be reduced or eradicated and no longer reported as incidents: Contraindication – Allergy (reduced) Contraindication - Drug Interactions (reduced) Duplication of Medication (*not ingredients) (eradicated) Illegal Prescription (eradicated) Medication prescribed without a dose (eradicated) Prescription written without a valid medication name (eradicated)	2 Years post ePMA rollout across all ABUHB in-patient sites	Efficient – non-cash releasing
National Benefit					
Improved allergy recording and status checking to 100%	Improved allergy recording and status documentation. ePMA systems include functionality to document allergy status and to make this mandatory and remind users to complete the status. This will improve patient safety by ensuring that prescribers have the most up to date information or are clearly aware when an allergy status is not known to make clinical decisions appropriately	During the study period Jan-Dec 22 99% of 149 patient drug charts sampled had documented patient allergies	100% of ABUHB patients will have ePMA records with an allergy assessment undertaken and relevant information documented (Prior to prescribing taking place)	1 Years post ePMA rollout across all ABUHB in-patient sites	Efficient – non-cash releasing
National Benefit					

Time saved Accessing Secondary Care Prescription Charts	Digital access to create, view and amend secondary care medicines prescribing and administration information in real-time, means that time no longer needed to "find" or be in the same place as a single physical paper drug chart.	A ward study concluded that on average staff spend 1,386 hours per year looking for misplaced drug charts. A ward study concluded that on average staff spend 342 hours per year reading illegible handwriting. A ward study concluded that on average staff spend 947 hours waiting for drug charts to be re-written.	There will be a 60% reduction in the time spent looking for misplaced paper drug charts, reading illegible handwriting and waiting for charts to be re-written (Overall)	1 Years post ePMA rollout across all ABUHB in-patient sites	Efficient – Non-Cash Releasing
<i>National Benefit</i>					
Reduced need to purchase and file paper prescriptions charts	The introduction of EPMA will reduce the need for ordering of paper medication charts. (Will still be required for business continuity purposes)	In the FY Apr-22 - Mar-23 paper based resources cost ABUHB £41,746.95	Reduce the current amount spent on paper medication charts per year by 95% (95% reduction delivers a recurrent saving of £39,659.60 saving) (Caveat – This is based on current prices and does not include inflation costs)	1 Years post ePMA rollout across all ABUHB in-patient sites NB: Dependent upon EPS being implemented in Community Pharmacy Services	Efficient – Cash Releasing
<i>National Benefit</i>					
Improved medication reconciliation for patients at the point of admission	By patient information being stored electronically there will be improved access to shared clinical records through the ePMA system. Clinicians will have accurate patient medication history. This in turn is more clinically effective and will optimise quality and efficiency across the entire care pathway.	During the study period Jan-Dec-22, 57% of 109 ABUHB patients sampled had a medicines reconciliation undertaken within 24 hours of admission.	Increase the volume of medicines reconciliations completed within 72 hours of patient admission to 70%.	1 Years post ePMA rollout across all ABUHB in-patient sites	Effective (not cash releasing)
<i>Local Benefit</i>					
Enhanced accuracy in patient medical records upon admission, facilitated by digitised recording, will enhance patient safety. This, in turn, boosts staff confidence	The electronic storage of patient information will lead to enhanced access to shared clinical records via the ePMA system. Clinicians will benefit from having precise patient medication histories, resulting in increased clinical effectiveness. Consequently, this optimization will enhance quality and efficiency throughout the entire care pathway.	Baseline – Post ePMA rollout	Staff report an improvement in accessing patient medication records and noted a higher accuracy in patient medicines data. Staff report more efficient use of time attributed to reduced patient assessment duration resulting from the implementation of ePMA.	1 Years post ePMA rollout across all ABUHB in-patient sites	Effective

in diagnosing and prescribing.			Staff report improved information sharing between Primary and Secondary care services.		
<i>Local Benefit</i>			Staff report that better prescribing habits have been adopted across the ABUHB by prescribers.		
2% Decrease in nursing drug round time as a result of 'task lists' being produced from ePMA based on Morning Drug round only (NB: Minimum expected saving across multiple drug rounds per day)	Staff report an increase in nursing time allowing more meaningful interactions and/or time to deliver direct patient care due to reduction in drug round time.	Currently ABUHB nurses take an average 8.45 minutes per patient when completing the morning drug round. NB: This is calculated using the total MORNING drug round time – Based on 1,686 patient beds (as at 19/12/23) = 237 Hours and 26 Minutes	Reduce the time taken by 2% to complete the morning drug round, providing a 4 Hour & 55 minute daily saving. This will enable ABUHB to make a recurrent (flat value) annual efficiency saving of £36,291.95 (Based on the morning drug round) NB: 2% efficiency delivers 4 Hours 55 Minutes saved – Morning Drug Round across 1,686 beds (Nov/Dec-22 Time & Motion Study) NB: In line with Benefits Methodology, it is expected only 50% of this efficiency gain will be redeployed to value-adding activities, therefore the true value of the efficiency gain will be £18,145.98.	2 Years post ePMA rollout across all ABUHB in-patient sites NB: Provided full integration with Omnicell	Efficient – non-cash Releasing
<i>Local Benefit</i>					
Pharmacy order management and clinical verification processes will be streamlined because of ePMA therefore saving time; allowing staff to deliver direct	The implementation of ePMA will lead to more efficient processes in pharmacy management, as it allows for improved visibility of stock and orders. This will result in fewer recorded incidents of Medication Unavailable (5's).	During the study period Jan-Dec-22, 95 ABUHB of 109 patients sampled had recorded missed medication doses in the previous 24 hours according to the reason, code 5 - Medicine Unavailable	Achieve a 75% reduction in 2 or more consecutive omissions in medicines administration due to 'Medication Unavailable' ('5's') on Medicines Administrations Charts.	1 Years post ePMA across all ABUHB in-patient sites	Efficient – non-cash Releasing

patient care for example: conducting patient medication reviews and/or medication safety checks. <i>Local Benefit</i> Doctor and/or Pharmacist time saved not reviewing, re-writing lost, missing or full medication charts therefore enabling time for direct patient care, releasing pressure on staff.	Storing patient information electronically eliminates the risk of medication charts needing to be re-written due to issues such as loss, being full or going missing.	1. Currently ABUHB Medics take an average 10-minutes to re-write individual patient drug charts, equating to 43.08 Hours/Week 2. Currently ABUHB Pharmacists take an average 15-minutes to review & check re-written patient charts, equating to 64 Hours/Week <i>**Based on the current average 258.5 re-writes per week</i>	1. Through implementation of ePMA zero hours will be spent by Jnr Drs re-writing patient drug charts, therefore improving job satisfaction and providing efficiency savings of £60,058.44 (recurrent - flat rate) NB: In line with Benefits Methodology, it is expected only 50% of this efficiency gain will be redeployed to value adding activities, therefore the true value of the efficiency gain will be £30,029.22 (recurrent flat rate) 2. Through implementation of ePMA zero hours will be spent by Pharmacy reviewing & checking re-written patient drug charts, therefore improving job satisfaction and providing efficiency	1 Years post ePMA across all ABUHB in-patient sites	Efficient – non-cash Releasing

Local Benefit			savings of £93,692.56 (recurrent - flat rate) NB: In line with Benefits Methodology, it is expected only 50% of this efficiency gain will be redeployed to value adding activities, therefore the true value of the efficiency gain will be £46,846.28 (recurrent flat rate)		
Reduction in the annual Secondary Care drug expenditure by 1.0% will provide a financial (CR) saving to the Health Board.	The enhanced accessibility of patient information will support clinicians to make more informed decisions, leading to the selection of more appropriate medication routes and a reduction in the use of high-cost (influenceable) drugs. With access to more accurate and detailed patient history, clinicians will be empowered to make more precise clinical decisions in collaboration with their patients. Through improved reporting of medication and patient data, ABUHB will benefit from enhanced data quality, supporting decision-making processes, service improvement initiatives, and cost reduction efforts. Standardised level of care.	In the FY Apr-22 – Mar-23 ABUHB spent £27,730,082 on secondary care drugs (excluding NICE approved drugs)	Achieve a 1.0% reduction in annual Secondary Care drug expenditure (*Excluding NICE approved Drugs), providing £277,301 recurrent savings for Drugs Issued <i>(Caveat – This is based on current prices and does not include inflation costs)</i>	1 Years post ePMA across all ABUHB in-patient sites	Efficient – Cash Releasing
Local Benefit					
Reduction in time spent scanning Core Drug (MAR) Charts will enable staff to prepare and scan other documentation.	The implementation of ePMA renders manual scanning of Medicine Reconciliation Charts by Health Records unnecessary, as this task is now automated through digitisation. Consequently, Health Record employees will be released to concentrate on other duties, such as organising and scanning additional documentation. This enhancement optimises their time management and enhances overall workflow efficiency.	Currently Band 2 Health Record employees at ABUHB spend 10 hours per week scanning patient medication charts.	Band 2 Health Record staff will no longer need to dedicate time to scanning patient medication charts. This change will result in efficiency gains of 10 hours per week for each employee, allowing them to focus on additional tasks and responsibilities. NB: In line with Benefits Methodology, it is expected only 50% of this efficiency	1 Years post ePMA across all ABUHB in-patient sites	Efficient – non-cash Releasing

Local Benefit		£14.31 X 10 Hours = £143.10 per week (1 B2). Annual cost efficiency £1,717.20 per Band 2 staff member Average Gross Cost Per Hour for x1 B2 Staff Member £14.31	gain will be redeployed to value-adding activities, therefore the true value of the efficiency gain will be 5 hours per week.		
Improved reporting of prescribing and administration errors will enable the Health Board to measure the cost of bed days saved from reduced adverse events, therefore improving clinical safety. Local Benefit	The introduction of ePMA in ABUHB will establish safer systems that effectively capture patient safety incidents. This capability will enable the reporting of more meaningful data, facilitating a deeper understanding of safety trends and contribute to reduction of adverse patient events.	In the FY Apr-22 - Mar-23 Datix recorded 577 incidents in the Medication Administration error and 215 incidents in the medication Prescribing errors category.	A 50% reduction of adverse patient events reported through Datix. NB: We will expect to see an increase in incidents (due to better reporting) followed by a decrease	3 Years post ePMA across all ABUHB in-patient sites	Efficient – non-cash Releasing
Time saved not having to transcribe discharge medications Local Benefit	The implementation of ePMA ABUHB will lead to improved processes, such as the electronic production of DAL to GP. This enhancement in efficiency will release medical staff from administrative tasks, allowing them to allocate more time for patient focussed duties.	In the FY Apr-22 – Mar-23 ABUHB Junior Doctors spent an average 20 minutes per 10 item (average) TTH prescription. NB: Based on: Total in-patient discharges (excluding deaths) 59,991 (1,146 per week) 1,146 x 20 min average = 22,920 mins (382 hours) Junior Doctor Salary Average Gross Cost Per Hour £26.81 382 hours x £26.81 = £10,214.42 per week	Through implementation of ePMA ABUHB discharge processes will be streamlined to report a 75% reduction in the time spent transcribing TTH prescriptions. Providing a recurrent (flat value) efficiency saving of £532,554 NB: In line with Benefits Methodology, it is expected only 50% of this efficiency gain will be redeployed to value-adding activities, therefore the true value of the efficiency gain will be £266,276.92 per annum.	1 Years post ePMA across all ABUHB in-patient sites	Efficient – non-cash Releasing

The implementation of ePMA Will aid the Health Board in delivering digital transformation and achieving its decarbonisation plan Local Benefit	The introduction of ePMA will significantly reduce the reliance on paper-based sources (patient medicines reconciliation record) by digitising medicine prescribing and management processes.	In the FY Apr-22 – Mar-22 ABUHB purchased 664,100 paper-based MAR Charts	Achieve a 95% reduction in the volume of paper medication charts (630,895 less charts)	1 Years post ePMA across all ABUHB in-patient sites	Efficient – non-cash Releasing
Patients in receipt of time critical medications (e.g., Diabetes / Parkinson's) will experience an improved service due to the implementation of task lists Local Benefit	The implementation of ePMA will increase nurses' awareness of patients requiring time-critical medications outside of regular drug rounds, targeting a 50% improvement in drugs being administered on time.	During the study period Jan-Dec-22, an average of 2 in every 1000 sampled patients missed doses in the previous 24 hours that were critical time medicines	Achieve a 50% improvement in the administration of time critical medicines	3 Years Post ePMA rollout across all ABUHB in-patient sites	Timely & safely
Improved in-patient experience will be realised through the implementation of ePMA and in-system alert functions for patients in receipt of time critical medications. Local Benefit	As a consequence of ePMA, patients in receipt of time critical medication will experience enhancements in: ◦ Self-Administration capabilities ◦ Timeliness in medication administration ◦ Safer medication management practices	Currently there are only manual processes in use throughout ABUHB hospital wards that rely on staff using personal alarms or reminders and/or patients prompting staff to alert them that time critical medication are due.	An improvement in the number of critical time medications being administered on time, resulting in patients reporting that they feel safer during an in-patient hospital stay, in relation to their critical time medicine management Patients report that they less frequently have to remind/chase staff to administer medication during in-hospital stays.	1 Years Post ePMA rollout across all ABUHB in-patient sites	Person-Centred

It must be noted, as identified within the Business Case that baselining within ABUHB has been impacted by the confidence in data reported through Datix and therefore it is expected that due to the implementation of the system, reporting will be significantly improved and therefore more timely and accurate data will be available.

A number of national benefit measures have been baselined utilising data from the Medicines Safety Thermometer, which was a snapshot audit carried out Jan-Dec 2022 (utilising a monthly average of 109 patients) and therefore not a true proportionate reflection. This study concluded in Dec-22 due to funding implications thus ceasing data collation.

In addition, it must be highlighted that all benefit assumptions remain assumptions until proven in implementation. The role of the Business Change Manager is critical in the identification and realisation plan against each benefit. The benefits within the business case are varying levels of maturity but clearly demonstrate the potential for not only delivering against clinical futures but also in driving efficiencies through releasing time to care.

There are also some interdependencies that will affect the ability of the programme team in realising benefits, for example it is anticipated that nurses will enjoy a 2% reduction in the time taken to complete daily drug rounds, however, this is dependent upon the ePMA supplier appointed and their ability to action a planned upgrade to their system to enable integration with Omnicell. Likewise, the ability to reduce the purchase and/or printing of FP10/WP10 patient prescriptions will be dependent upon the implementation of Electronic Prescribing Services (EPS) being implemented in Community Pharmacy Services.

Furthermore, many of the benefits have been identified due to their ability to improve efficiency of the tasks undertaken by our staff, and the potential to increase job satisfaction. They are designed to release pressure on our workforce, enabling them to increase meaningful interactions with the patients in their care. This in turn will improve staff retention and therefore make the health board a more attractive place to work as a result of the digital environment and what this means for our staff.

DHCW have been tasked by Welsh Government with overseeing and leading All-Wales national benefits realisation work, ABUHB ePMA Programme Team will ensure full engagement with them to support this work and in providing data necessary to report and track these.

APPENDIX 4: Risk Based Prioritisation of the Preferred Option *This is a 2-part matrix to assess the scale of your project, i.e. complexity, risk, capacity, support required, and its priority status against operational and strategic objectives.*

Score for Complexity and Resource Consumption Criteria (Part 1)						
Criteria	1	2	3	4	5	Score
Scope	One main deliverable		Multiple deliverables		Complex and vague. Dynamic dependencies.	3
Costs	Resource neutral.	May involve some costs within departmental Scheme of Delegation i.e. <£50k.	Investment required <£100k. Executive approval.	Investment required £100-£250k	Investment required >£250k	5
Workforce Dependencies	No changes to workforce.	Workforce impact involves changing practice and procedures. Provision of short training programmes provided through in house. May require recruitment but no current skills shortages and no risk of the use of agency or high-cost variable pay.	Workforce changes effect small number of staff and involve changes to base or rotas only (potential short-term protection), which may require formal consultation under OCP or Requires provision of in house or external training or Will require recruitment but no current skills shortages identified and low risk that failure to recruit will require agency or high-cost variable pay.	Workforce changes impact staff and involve reduction of staff in post &/or changes to roles by 2 thirds &/or changes to bases &/or rotas (Potential long term and short-term protection through formal OCP or Requires provision of external training and backfill of posts). Will require recruitment of skills already in short supply, & Likely risk of failure to recruit which will require agency usage or high-cost variable pay.	Significant workforce changes effecting a whole service, function or ward and involving reduction of staff in post &/or changes to roles by 2 thirds &/or changes to bases &/or rotas (potential long term and short-term protection through formal OCP) or Requires external training and backfill of posts. Will require recruitment of skills where there are already significant vacancies and skills on occupational shortage lists and and will require agency usage or high cost pay to provide the level of resource requirements/or internal recruitment creates vacancies and high-cost variable pay or other parts of the service.	5
Indicative Capital Requirements*	No capital requirements	Small scheme <£100k	£100k to £500k	£500k - £1m	>£1m	5

* It is recognised that capital requirements may not be clear at the scoping stage		ABHB CEO / Dep. CEO approval required.	ABHB Executive Team approval required.	ABHB Board level approval required	External capital funding and approval required.	
Stakeholder Involvement & Consultation	Needs only internal staff (or 'free' resources) to do the work and consuming very low effort Informal internal discussion with staff only.	Involves working across 2 or more service areas. Informal discussions with stakeholders such as CHC, patients and staff required. HR and Trade Union support may be required.	Involves working across 2 or more service areas, and external partners or bodies. Some corporate support may be needed. Informal discussions with Trade Unions, HR, CHC and patients. Formal workforce consultation required.	Formal discussions with Trade Unions, HR, CHC and patients advised. Executive or Board level approvals required. Needs close working with other Divisions and/or corporate support to do the work. Requires some dedicated staff to do the work.	Requires dedicated staff resources and its own budget to deliver. Formal public consultation required. Potential political interest. Likely stakeholder opposition.	5
Project Duration	Very short-term – <3 months	Short- term – 3-8 months	Medium 9-<12 months	Med-Long term 12-18 months	Long term >18 months	5
Score for Complexity and Resource Consumption Criteria (Max score 30)					Total Score	28

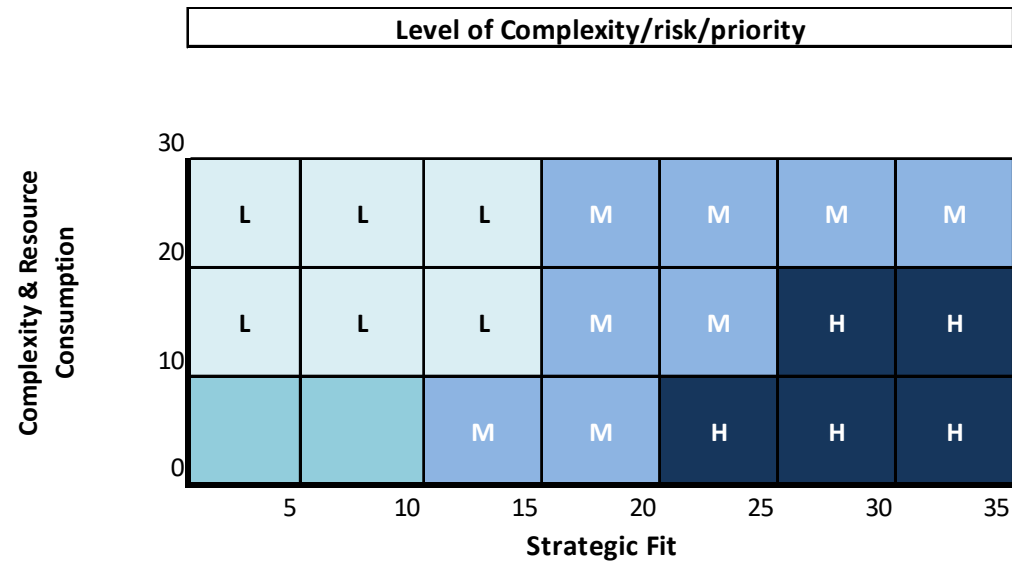
Score for Strategic Fit (Part 2)						
Criteria	1	2	3	4	5	Score
IMTP Strategic Priority:	Local priority e.g. improves efficiency, resolves local difficulty.	Key to delivery of Divisional objectives, e.g. financial or annual plans.	Key to delivery of ABUHB corporate objectives, e.g.	Key to delivery of a national priority e.g. target or strategy.	Delivers more than one national or regional or legislative directives	4

Degree of Alignment			financial balance, Clinical Futures			
IMTP Strategic Priority: Health Inequalities	No/neutral impact on health inequalities.	Some small evidence that narrows gap in life or healthy life expectancy for small % of target Pop.	Some evidence of positive impact on moderate % of target Pop.	Good evidence of positive impact on significant % of target Pop.	Robust and convincing evidence on large % target Pop.	4
Organisational Risk Profile	Very low risk, if any. Failure not mission critical.	Low risk, modest changes, failure a local difficulty	Moderate risk profile (Amber). Major changes. Failure would have significant impact on business or operations.	Major changes. Failure would have major impact on strategic objectives and/or reputation.	High risk profile or mandatory compliance issue Red-rated risk on ABUHB Corporate Risk Register. Failure potentially catastrophic.	3
Evidence of Effectiveness	No evidence will have intended impact.	Limited amount of evidence predominantly from descriptive case studies, surveys or expert opinion.	Some evidence from non-comparative cross-sectional, or before and after studies, e.g. case control and cohort studies.	Moderate evidence from randomised and non-randomised comparative studies.	Strong evidence of effectiveness (well-conducted systematic reviews/meta-analyses).	4
Benefits/Value: Financial	Small financial benefit.		Makes a moderate contribution to the division's /organisation's savings target.		Makes a significant contribution to the division's/ organisation's savings target.	1
Benefits/Value Non-financial (inc QPS & EQIA)	Outcomes – capture of PROMS	Outcomes – capture of PROMS and clinical outcomes	Outcomes & Costing – transforming element of a pathway	Outcomes & Costing - transforming and capturing over a complete pathway	Full Integrated Practice Unit	4
Sustainability	Does not support Well Being Future Gens' – Long term way of working or other ABUHB sustainability objectives, e.g. Clinical Futures.		Partially supports achievement		Fully supports achievement including impact on other services and the overall health and social care system.	5
Score for Organisational Priority (Max score 35)					Total Score	25

The prioritisation level for the Preferred Option in this business case is: Medium

Score for Complexity and Resource Consumption Criteria	Outcome
< = 10	Low level consumption
11 – 20	Moderate level consumption
>20	High level consumption

Score for Strategic Fit	Outcome
< = 10	Low Priority for Organisation
11 - 20	Moderate Priority for Organisation
>20	High Priority for Organisation



H	High priority for the Organisation
M	Medium priority for the Organisation
L	Low priority for the Organisation
	Low priority for the Organisation but High priority for Division

APPENDIX 5: Implementation Programme Risk Assessment

Level of Risk	Risk Detail	Mitigation
High	Insufficient external funding for the period of the programme - Welsh Government have indicated that funding will only be available for financial years 24/25 and 25/26, with a Ministerial expectation that implementation will be completed by September 2026 resulting in a greater financial investment for ABUHB	ABUHB to determine the feasibility of unfunded period, and how the organisation will fund the programme if preferred option is approved.
High	ABUHB's current financial position presents limited opportunity to invest as required	To date the programme have profiled the costs to provide the minimum investment required to implement an ePMA solution over 4 years. If preferred option is approved the organisation will need to identify how it will fund the programme
High	Longer time using dual processes (digital and paper processes) – which could lead to confusion, additional work for prolonged periods and potential discrepancies in patient records such as missed or double doses, over ordering of medications	Planning and support will be critical in ensuring minimal impact associated with running dual processes for an extended period.
High	Insufficient hardware causing low adoption of ePMA	An ePMA model ward has been produced and an assessment undertaken to determine the required level of hardware to enable ePMA – the required investment is incorporated in the costs
High	Insufficient Wi-Fi preventing use of ePMA	A wi-fi assessment at each ePMA site has been carried out to determine the level of investment required to ensure a reliable wi-fi network is in place. The estimated costs have been incorporated in the costs
High	ABUHBs software development and integration resource is limited and currently working to capacity, delivering existing Health Board priorities, risking the delivery of ePMA tasks on time	

High	Unable to recruit to key ePMA positions which could impact the delivery and implementation of ePMA	Closely monitor responses and availability of clinical posts, and investigate alternative options and arrangements if roles are not being filled such as amending job descriptions, job-sharing, full time / part time contracts, reviewing clinical time-balance, as well as sharing resource with other Health Boards
High	Due to the current staffing levels in pharmacy, which currently presents ABUHB in a position of service escalation, there is a risk that the programme will be unable to recruit to the required pharmacy positions.	The pharmacy staffing model for both implementation and product delivery has been determined by both roles required to implement ePMA (as baselined against other ePMA users), but also with local experiences in mind re: recruitment success. Monitoring of recruitment will be undertaken, and alternative options will be explored if unsuccessful.
High	The safe delivery of ePMA requires pace, but other organisational and external factors could affect delivery e.g., winter pressures, staffing shortages	Ensuring robust support at the time of implementation and ongoing support in the service delivery processes are essential. This support needs to be made available by respected peers who are experienced in the administration processes and can respond to on-the-spot clinical scenarios which non-clinical staff would not understand. Suitable and effective training will also be essential
High	Dependency on DHCW to deliver the technical infrastructure	Work closely with the DHCW team to ensure clear understanding across parties. Joint planning will be needed to determine the requirements and work packages for all parties to ensure the readiness and sign-off of the required technical infrastructure is completed
High	Dependency on the supplier to deliver a system which matches the requirements set out in the procurement	Regular communication and clear, open planning and testing between ABUHB and the supplier to ensure the product being delivered adheres to the requirements set out in the procurement.
Moderate	Increased incident/Datix reports, due to prolonged periods of dual running processes	Robust planning and rotation of support. Interim ways of working and robust SOPs will be necessary for services working with dual processes.
Moderate	Recruitment to the levels of resource required to implement and maintain the service	Alternative arrangements will be further explored such as shared resource with other Health Boards – discussions have taken place and will continue

Moderate	Delays to the programme schedule due to the length of time it will take to have funding approved and to recruit key roles before the programme can commence at pace	ABUHB to consider recruitment at risk before the full business case is approved, for key positions, with no formal offers being made until funding is approved
Moderate	Delayed period of time for full realisation of benefits	Consider and adopt a product-based delivery which would provide the capability for benefits and value to be delivered sooner
Moderate	Unrealistic expectations for implementation timelines set from a national perspective	Reviewing resource availability, different approaches of delivery and discussing commitment from various stakeholders to support the implementation which may lead to a reduced timeline to align closer to the current national implementation timeline. ABUHB will continue to discuss shared resources and learning with other Health Boards. ABUHB will factor in lessons learned from other national programmes and other similar scale projects and will sign-up to plan which ensures safe delivery of ePMA
Moderate	Lack of buy in from clinical service areas, due to existing pressures could delay or prevent ePMA being adopted	A clear engagement and business change plan will be followed to ensure strong interactions with the services to manage the existing pressures and prepare services for the incoming changes and challenges
Moderate	Other organisational changes, requiring time, resource and commitment from the clinical teams and wider organisation could affect delivery and adoption of ePMA	Regularly liaise with other programmes and directorates to ensure there is knowledge of ongoing and emerging work. Have direction and support on priorities from senior and directorate level to ensure there is awareness and understanding of the level of work, commitment and resource required
Moderate	Unknown costs arising from stakeholders e.g., DHCW	Regular liaison with external stakeholders to enable early identification of costs. Contingency set for unexpected costs
Low	Digital literacy and digital confidence of staff	Engage with staff ahead of implementation and ensure there is sufficient training, support and guidance available to empower staff and increase confidence and digital skills

APPENDIX 6: Dependencies

Level of Dependency	Who is responsible?	Dependency description	Management of dependency
High	DHCW & ABUHB	ABUHB infrastructure which links up with the National infrastructure (interoperability)	Ensure close management of work and testing is carried out, alongside regular communication between ABUHB and DHCW technical teams. Review of resource and options to recruit third-party contractors / consultancy to ensure the work required is completed to the required timeline.
High	DHCW	Shared Medicine Record (SMR) must be delivered for ePMA to be successfully implemented as this will feed ePMA and vice versa. This is part of the DMTP portfolio, and it is reliant on DHCW to complete this work	National programme to ensure clear communication and updates on progress to all Health Boards in Wales via the DMTP, and through local subject matter experts.
High	DHCW	National Data Repository (NDR) - DHCW need to ensure that the ePMA system will be accepted as a trusted source	National programme to ensure clear communication and updates on progress to all Health Boards in Wales via the DMTP, and through local subject matter experts.
High	DHCW	Electronic Prescription Service (Primary Care). This is part of the DMTP portfolio, and it is reliant on DHCW to complete this work. A benefit of the programme is dependent upon EPS being implemented in community pharmacy services	National programme to ensure clear communication and updates on progress to all Health Boards in Wales via the DMTP, and through local subject matter experts.

High	Supplier	Supplier to deliver the system with the required capabilities and functionality outlined in the contract and procurement process. Some areas of the benefits will be reliant on the supplier's ability to action planned up-grades e.g. integration with Omnicell cabinets	Through the use of the contract and ITT documentation, the supplier will be held accountable to deliver the functionality agreed. Regular contract management meetings will be scheduled to manage this.
High	ABUHB	CWS internal development to ensure that the ePMA solution works and does not create difficult work arounds for staff. It is key that this CWS development work on Admissions, Transfers and Discharges is completed ahead of ePMA implementation	Review internal processes and identify the priority of work required in CWS for ePMA. Conduct a review of resource and CWS development roadmap and consider options to recruit third-party contractors / consultancy to ensure the work required is completed to the required timeline. Timeline to go live will incorporate time to develop CWS
High	ABUHB	As is - To be Processes e.g. ED, Discharge process, MAR charts, medical record and drug charts in ePMA, Wet signature change of process, short term leave on and areas wards, etc.	ePMA Implementation Team to identify current processes and 'To-be' processes through a prioritised list. Areas of high complexity and commonality first to be implemented to be focused on initially.
High	ABUHB	Correct hardware availability to support and enable a successful implementation for ePMA	An ePMA model ward assessment and evaluation has taken place to determine the required level of hardware to enable ePMA. The required investment has been incorporated in the costs and a contingency amount has been set. Further evaluation work will take place during implementation phase of the programme.
High	ABUHB	Strong wi-fi strength/ connectivity across ABUHB which is able to support the capacity of additional users when ePMA is implemented	A wi-fi assessment at each ePMA site has been carried out to determine the level of upgrade and investment required to ensure reliable wi-fi networks are in place. An estimated cost has been incorporated in the costs and a contingency amount has been calculated.
High	ABUHB	Recruitment to key roles within the ePMA implementation team which if not in post could delay the programme due to the lack of knowledge and experience required for this programme	Once business case has been approved, recruitment to key roles will begin with immediately effect to ensure roles are secured at earliest opportunity. The recruitment to key roles will be closely monitored and alternative options will be investigated if challenges arise such as review of job descriptions and sharing resource with other Health Boards.

APPENDIX 7: Lessons Learned

Theme	Key Lessons Learned
Implementation	Promoted ePMA as a 'process improvement' rather than an ICT project. When clinicians are presented with opportunities to get involved, they are more likely to feel it isn't 'being done to them' When they went live in ED they had a lead for the area and the lead was chosen/nominated by their colleagues LUH learnt site to site from the 1st go live - Speciality sites/areas – Vital to ensure you have these people on site at go live for decision making purposes. Rollout included staff from whole hospital not just Pharmacy and the Deputy Head of Operations was on the Project Team, and they regularly briefed staff and kept people (including the project team) updated.
Governance	Dedicated e-Hospital Board, which is led by the Chief Medical Officer and volunteer clinicians from medical and pharmacy on board
Governance / Support	Beneficial that they have numerous 'techy' clinicians, registrars and junior doctors
Drug Files	Not all drugs administered are able to be done via ePMA: IV administration through bag infusion isn't always recorded on system (NC) and is sometimes recorded on paper.
Implementation: Transcribing	Transcribing was key. it was useful to keep a chart regarding the number of transcribed drug charts as a tally/to keep check. Medics Transcribed. Pharmacists checked. They set a target of a minimum of 5 patients per hour transcribed during the rollout phase. Started transcribing 8am with a 3pm finish

Training	Had floor walking teams which consisted of the Project Team, ICT Facilitators (8 in the team, predominantly nurses) plus ICT staff who knew the system and champions (who were trained prior to go live). All staff are trained via video prior to go live as difficult to release them for scheduled classroom training, particularly during a pandemic! The videos were purposely kept short to allow the ePMA to easily update them when upgrades are made. The short videos of 'specific functions' works well and are done in modules. These videos have been uploaded to the training database and there is no testing applied. They do monitor to ensure compliance. All videos are available via the hospital intranet for refresher training. Module devices allow users to scan a QR code that can be found on posters throughout the hospital. Specific Teams did the training videos to ensure they were relevant to their specialities, e.g. Palliative Care, Diabetes Nurse etc. They are currently updating videos to take account of upgrades applied. The team stressed that the backbone of training is the videos, and they went out to staff to ask what they would prefer training-wise.
Implementation: Support	A helpline ran during go live days and overnight support was supported into the start (1st Hour or so) of nightshift for 1 week, but it was not really required. They had a dedicated overnight on call, but there were minimal calls. Because they use NC for everything it is centrally maintained by ICT for login support etc.
Implementation: Access	Bank - Access to ePMA is role based as per their ESR logins – Access is set up at induction. They tend to use Bank more than agency and shifts are offered out as OT to LUH employees first. They have 17,000 employees, 8,000 of whom are clinical. Agency – Generally use the same agencies and the same staff pick up the shifts available. They must complete training prior to picking up shifts. Last minute cover is infrequent but does happen – for this they have 'vanilla' accounts e.g., Locum1 – the nurse on shift records the doctors name and GMC no and this is recorded against the account. They have had no issues relating to this.
Concurrent Users	They have 5,000 concurrent user licences because NCis used for more than just ePMA.
Testing	They worked in partnership with NCto develop their testing/ UAT testing

System	Pharmacy stock control is via JAC, WellSky & CareFlow and LUH have no plans to move away from this. They are awaiting V8.1 which will allow the move away from paper. Pharmacy have set up smart lists, e.g., ward reports which detail patients meds not started and outstanding TTO's. – they are happy to share smart lists with us for examples. Parkinson's team have smart lists to identify patterns, mis-administration etc.. Front end reporting does have a limit of 10,000, e.g., antibiotic use over 1 year would be a data warehouse report. Having interoperability is key
Business Continuity	They have 2 resources in place. 1. System down / network up – online chart which can be printed off (this is refreshed every 3 minutes). 2. Network down (Never event) – in this case there are x 3 disaster recovery laptops. The laptop is plugged directly into a printer directly and charts are printed for the whole hospital. They used to have a dedicated PC on every ward, but found these were being switched off, cables were removed etc. They have spoken to some hospitals have 10 PC's locked in a dedicated room with 3-4 printers – but LUH feel this is unfeasible. Clinical facilitators check disaster recovery laptops weekly and do regularly find cables missing or switched off etc. These are disaster recovery Laptops dedicated to ePMA. NC have an App on disaster recovery.
Benefits/ Reporting	Team size has been the main barrier to them measuring and realising benefits. They do not have any surveys post go live and have not been good at benefits realisation, so have no information to share. They are just starting to measure this (1year + after Go LIVE). They do know that in relation to antibiotics Pharmacy have saved 80+ hours a year using smart lists to identify patients on antibiotics. They can also run 'family of drugs' specific drug delayed or missed drugs reports. Patients on clinical meds who haven't been seen by pharmacist reports. They have developed a Pharmacist dashboard for 'Patients need to be seen' with Nervecentre. They are using Nervecentre more to ensure high risk patients.

Key Points Summary	Governance: Included front line engagement with nurses, pharmacists and doctors. Executive sign-up. Use of service managers and senior nuses with frontline experience in deployment planning Preparation: 2 years to plan and implement - user expectations managed - forums to keep stakeholders engaged and aware Risk Management: Agile methodology and incremental improvement to design the approach. Ensure patient does not have TWO active prescriptions. Risk Logs. Iterative. Good Relations - Tech/Clinical/Vendor Team. Learnt from first roll-out of paper to ePMA. Transition Process - Paper checklists Shared progress using a shared spreadsheet
Training	All staff training was 1.5hours. There were short videos (specific to the differences between systems - highlights the bespoke nature of training) Use of training environment. Champions in each clinical area
Implementation: Resource	Implementation team: have specific implementation (transitioning) staff and floor walkers, need high availability. 3/4 charts / per transcriber/ verifier / per hour Oversight team Staff rebalanced depending on demand Floor walkers - over 2,000 hours of floor walkers were needed for support when Go LIVE took place at the 3 different hospitals (LGH, LRI, GH). Specialist ePMA Pharmacy Techs and Pharmacists available and with the ability to manage the change process and adjust drug sentences IT support throughout to ensure no issues with devices and providing laptops to the team

Implementation: Transition Process	Emergency admissions areas first followed by medical base wards and then surgical wards. All new admissions (including elective surgery) to start on the new system from 07:00. All patients going to theatres to have prescribing done on the new application thus avoiding dual paper/EPMA application use in the theatre department. Once all verifying was complete, then paper chart no longer used. The average duration of transcribing and verifying for a ward is 1 hour. (DEPENDS ON THE NUMBER OF FACILITATORS) All the patients drug records are made on the EPMA application quickly, minimising the risk of going back to using drug chart. (Remove chart) Posters placed above the patient's bed effectively alert the ward staff that patient is on ePMA system. Avoid transitioning a ward over the lunchtime drug round or removing paper drug charts during a drug round. i.e. don't remove paper over lunchtime! Transcribing completed before 5pm to prevent delays to patient flow out of hours Specialities analysed for the average number of drugs per patient. The team tested the duration of time it took to transcribe from Medchart to Nervecentre on a single laptop. During the pilot, the team monitored the time for chart transition. Result = 3/4 Drug charts per hour. Ensure you factor in... - Experience and speed of transcribing/verifying workforce. - Unexpected drug configuration issues. - Empty beds. - Volume of day-case patients. - Number of new admissions on the day (which would not need transcribing).
Drug Files	Undertaken months Prior to roll-out Clinical Engagement (on risk log) Specialities - Lead Doctors, Pharmacists, Nurses – consulted Drug Order sets - Aiming towards Standardised Prescribing Deemed Essential Local clinical teams released to help with local system configuration.

Implementation	Pilot site was Medical Wards over 3 months Cornwall undertook a phased roll out followed by Big Bang on Surgical Wards. Need to go at pace to limit confusion between paper and ePMA Community was done via a phased roll out. Main ISSUES: Heavy reliance on bank staff during rollout. Transferring between paper – ePMA – paper was problematic VTE is non-mandatory in A&E Transfer of patients between Mental Health Units and A&E can be problematic Faster rollout is better. ePMA to non-ePMA wards is easy. Non-ePMA to ePMA is problematic due to the need to transcribe charts From experience better to roll out in admission wards and work forward. Pilot in a self-contained area e.g., COE unit with longer stay patients. Went live in one day in surgical which was hard but best way to roll out in complex department. Different staff groups will approach it differently. Undertake a thorough pilot and then go as fast as possible with rollout as easier to manage once you remove paper options. Staff do not want to revert to paper. Get buy in from nurses, pain team etc as these staff will be key in supporting doctors Start running reports immediately to showcase what the system can do and use as a means inform Doctors about what data is available. Pharmacists transcribed charts. Technicians acted as second check. Completed transcribing after morning drug round. Transcribed the wards the day before go live – with updates morning of go live. Provided on the ground support for 1 week. Ensured we covered both shifts, therefore providing cover up to 10pm. Checked ward rosters to ensure all staff were supported. Did not cover weekends or overnight in person – but did provide telephone support. Big Bang is highly dependent on Pharmacy support. People like face-to-face support. Metrics > included training numbers that we needed Junior Doctors and nurses were easy to train Consultants and Surgeons who use the system less frequently are generally the one who struggled due to infrequent use

Scope	Home visit teams are mainly on ePMA but there are issues with WIFI connection issues in people's homes and staff often need to hotspot from own phones Scope Includes: 1. Live in community and mental health 2020 (Clozapine is on ePMA) 2. Live in neonates and Paed's 3. Chemotherapy inpatient ward is on ePMA, except for the prescribing of chemotherapy 4. Most outpatient wards are on ePMA – but there is a mix Scope Excludes: 1. Critical Care 2. Chemotherapy 3. Theatre (Still paper based) 4. Fluid / Infusion 5. Insulin and warfarin
Training	Training took place face to face initially, now all training is completed via e-learning (YouTube) and only those who fail (5 attempts) are given one to one tuition. Agency staff must complete training before they are able to book shifts. EPMA - Introduction (cornwall.nhs.uk) Training must take place as close to go live as possible. Initial training was groups of 1-7 to 1 trainer.
Communication	Communicated via: Newsletters - Governance Groups - Trust Facebook page - Training reminders as pop ups on PC - Site Visits - Nursing Groups
Configuration	Can re-name drugs to make it easier to search Have had to build drug database themselves which has been linked to dm+d via a mapping tool. Have an 'either' 'or' function for the prescribing of tablets or liquid. Red allergy banner pops up when you login to the system. They have set the alert level to 4 to avoid unnecessary pop ups. There have been issues with this that impacted some patients. Query over whether this will be lowered.

Devices	They predominantly use laptops due to space rather than COW's Tablet and handheld devices are not used anymore Currently testing the Surface Go. Have trialled other devices but keep returning to laptops as users need to access various apps/sites etc. which these aids. Laptops are generally the cheaper option, although they do have to be replaced often due to breakages etc. Need a thorough plan to manage replacement of equipment.
Implementation: Resource	1 Pharmacist, 1 Technician 2 Nurses 2 Data Analysts – very important roles to have your team IT Project Manager Testing Support

Implementation: Resource	Pre-implementation: Project paused multiple times due to lack of pharmacy availability - created a bottle neck - This needs to be resourced! Configuration was completed by 1 pharmacist doing 1 full-day per week for a year hybrid role for pharmacy combined with ePMA 2 Week implementation in palliative care (own 12 bed unit at Morriston Hospital), then moved on to Medicine as less complex than Surgery - plan was to roll out to 1 ward per week due to limited resource, which consisted of: 8B Pharmacist Clinical/Strategic Lead – who oversaw final check of transcribing X3 B6 Pharmacy Technicians X1 B6 Nurse X2 Facilitators X1 Project Manager X1 Principal Project Manager For rollout overtime shifts were offered to the ICT team. The Digital Team were utilised for the training of nurses only. Go live week they worked: 7am – 5pm, 1 – 11pm and Digital 5-11pm. There was a minimum of 2 people on each shift. They went live on each ward on a Tuesday lunchtime. SB had a team of 6; ideally, they required 9. Took approximately 15 hours per ward to transcribe and clinically check charts. They picked up on call shifts and worked, sometimes over 15-hour days, evenings and weekends. Transcribing was done by the B6 staff on the HEPMA Team, most of this work was undertaken by the team, all of whom underwent transcribing training. Monday was used to check all charts before go-live Tuesday. Pharmacy team refused to support the rollout at Morriston Hospital, so all transcribing was undertaken by clinical staff in the HEPMA Team (6 people). After go-live any new admissions were the responsibility of the wards to transcribe onto go-live. There were no breaks during implementations – this was exhausting. SBUHB had a robust support plan for go-live with a 24/7 support phoneline, the HEPMA Team continue to support this in BAU. SBUHB HEMPA Team did all the roles e.g., amending and creating drug files, however any complex configurations they would refer on to the supplier, System-C. Challenge: Recruitment to positions

Implementation: Timeline	The HEPMA Team initially worked to the Welsh Government target of all medicine wards live within 3 months, but it took 6 months. This was influenced by Business Continuity at Morriston Hospital (11 wards) and Gorseinon Hospital (40 bed unit) and additionally because Pharmacy caused multiple stops during roll out. Going to ED first would have been better in hindsight. Key you understand your flow from front door through the hospital. Need to understand SOPS, Process mapping, lengths of stays, map out ward areas, configuration, ADT etc.
Scope	Cardigan Renal presented numerous issues as other pathways needed access to the EPMA system. A lesson learned here was to ensure patient journeys were fully scoped. A&E was not in scope, but there are now plans to roll out. Wards went live first, followed by the assessment units and currently SBUHB are rolling out ePMA to surgery. Stephanie recommends going last in A&E as a 24-hour implementation model is essential. Paediatrics are in scope in SBUHB, but drug files must be configured differently (100+ drug files) – Configuration complexity is an issue. Learning Disabilities, Mental Health and Maternity are all in scope and will be going live.

Devices	The hardware initially purchased for ePMA was unsuitable and breakages were a regular occurrence. Following engagement and discussions with key stakeholders the following hardware from Kinetic-ID was purchased: Non powered Laptop Carts were changed to a single cubicle cart which held a touch-screen device. This prevented breakages of the laptops previously used. The new single cubicle cart could also have an external USB keyboard, an available writing platform and option to add on Imprivata card reader. The single cubicle carts are lighter in weight and can be more easily moved around the ward. Large laptop carts were changed to a powered clinical cart. The new carts were smaller, more light weight and assisted nurses with their medication rounds. There were new lockable medication drawers which enabled safe transportation of medication. Battery usage indicator available to monitor battery levels of the carts. Availability for additional features to be added to the carts such as Imprivata card reader. DELL laptops were changed by mounting an arm to support a device and keyboard to the anaesthetic stack. When the laptops changed to be on a mounted arm to anaesthetic stock it improved infection control. This gave those in theatres a larger screen to work from, with touch-screen features and housed unit the device was in prevented breakages. The new carts also provided space for an external USB keyboard and a Imprivata card reader. In SBUHB, they have six ePMA carts per four bedded bay and three individual rooms. The device's camera is still viewable and usable within the housing unit on the cart. There are charging points in each bay for the devices. The plugs and cables used mean that if someone pulls a cart away while it is plugged in, the charge cable disconnects from the wall safely preventing any damage to the walls, sockets, and devices. Each device is tracked so they can identify where each device is on site. They have an additional stock of 10 devices for replacements. Engage with Clinicians and key stakeholders - picking the correct device is important - do not underestimate this. Host hardware demo days to ensure kit chosen is appropriate and suitable Work with suppliers who listen to users and provide bespoke hardware to your health board/trust
Testing	Testing took about 8 weeks and in this time testing of local procedures, work arounds and config were carried out. For local config, get your CRG to sign-off.

Training	Training did e-learning pre-emptively to get staff involved and engaged. Then did face-to-face training just before go live.
Implementation: Timeline	Implementing HEPMA been approximately a 5-year process to date. There was a two-year procurement, pre-implementation and build period with extensive implementation planning. Once implementation commenced, it took 18 months to complete. GGC rolled out 6-9 wards at a time as safety and speed was crucial as they wanted to reduce the need to print when following a patient pathway/patients transferring from an ePMA enabled ward to a non-ePMA ward. We choose to pilot on a challenging area to learn all the lessons. It also needed to be a challenging area. The pilot was in a respiratory ward due to the complexity of the medication. This gave the implementation team confidence. "If we can do it there, we can go anywhere?" was the feeling from staff. This approach of challenging first was how the programme continued through rollout.
Implementation: Resource	We worked with our university colleagues and managed to enable 21 Pharmacy final year students to do the transcribing in to the digital chart just prior to go-live. They would transcribe on the Sunday prior to the go-live on the Monday on all 8 wards. They could usually do about 90 beds in this time (Transcribing was not prescribing). They were paid HCSW bank shift salaries and often worked from 9-13:00 on the Sunday. (The emphasis was on transcription/ Copying not prescribing). We had a team of 24 facilitators, these individuals where a mixture of contractors and IT type education staff. This was where a considerable investment of the budget went. This was key to the success of the rollout. It was pivotal that these staff were not nurses, doctors, or pharmacists they were just experts in the software. The vendor company trained all of these. These were dedicated to GGC not Scotland wide. They worked backward from an 18 months' time scale for an implementation to ensure patient flow could be followed. The Facilitators covered all the drug rounds and all shifts 1-2 on each ward. They also considered wearing t-shirts that made them stand out in case a staff member had a question with the logo: "HEPMA try it, its not as bad as you think." The lead nurse for the site managed the rollout meetings and ensured everyone was ready to go. They also had to

	agree the plan and there were tweaks made, from a safety perspective. After about day 3 on a ward the staff were asking us to leave as they got the system and were just getting on with it. We then went back 4 weeks later to see how they were doing. The only limiting factor for rollout is how many staff you can afford to support.
Governance	We had a 30 minute every week with executives and then we had a project board monthly (PM and finance were always there) and a Clinical Reference Group (CRG) with all the staff from the wards that were about to go-live. Once they had gone live, they would drop out and the new ward teams would join. This was chaired by the lead pharmacist. There was an informatics nurse and Chief Nursing Information Officer (CNIO), pharmacy technicians and medical colleagues and Non-Medical Prescribing (NMP) lead for the area in this group and the group made all the decisions about the system.
Training	All wards had to have 65% of staff trained or we would not go-live. The training was about 30 minutes and the addition of bite-size videos which were 2-3 minutes long were also very helpful. You must log the staff training to get to the 65%. Not only were clinical staff trained on the system but ward clerks had read only access (training) as they would be printing from the system when patients moved from HEPMA to non HEPMA wards.
Agency/Bank Staff	This was a large piece of work and is still ongoing. Many of our agency workers with us for a long while it is just the random agency that we still struggle with. It is a positive for Scotland that there is only 1 system in Scotland, so if staff have worked elsewhere they can be signed off quickly. We do have 4 generic logins we want to move away from this, but it was the only way to manage agency staff.
Alert Fatigue	The pop ups are irritating especially when you have worked on shift for a few shifts as you must click on them all even if you know them, so people do get click happy and not read them. The limit of certain drugs in a time is not a function in the software so for example you can exceed how many paracetamols is given if you do not check retrospective administration.
Devices	We spent far too long thinking about this, we laboured over carts and trolleys and iPads etc... turned out we did not really need all this thinking. Laptops work and trolleys were too big for many areas. The staff liked it when the device could be attached to the drug trolley.

Business Continuity	We had around 130 laptops and this is not really working that well for us, we now check on these devices weekly as you never know when you need them. We try to ask the ward managers to think about the HEPMA kit like they do their crash trolleys so if they break, we can replace or fix early. This was a culture shift.
Scope	Out of Scope: Mental health initially, Peads' have a very vanilla version, Midwifery has badger's net, Neonatal Intensive Care Unit (NICU), Intensive Therapy Units (ITU) has care flow, Theatres and anaesthetics, and Emergency Departments (ED)
Implementation: Resource	<u>Pre- implementation/system analysis:</u> Project manager, Digital Pharmacist, Business analyst, Digital Nurse, Digital Pharmacy Technician, Admin support/PSO, Test lead. <u>Implementation/just before prep;</u> (based on roll out at 1 ward per week will need greater for big bang but shorter period): Project manager, Digital Pharmacist, Digital Nurse, Digital Technician, Admin support, Test lead, Trainers/role out support x 4/5. Basically all the above listed in pre-implementation but with addition of: Ward based support and training, Ensuring a senior team member on each shift for direction and overall team management for each day, on call etc. More agile response to issues and ongoing roll out problems across the team. <u>Post-implementation/BAU:</u> EPMA system manager (8a), EPMA nurse (6), EPMA Technician (6), Admin support (4) A dedicated BAU team consisting of 3 people have received long term funding for ePMA BAU. This team carry out changes and configurations as needed and ensure system updates are carried out without any impact on the services. They also manage all aspects of business continuity. The BAU team also offer dedicated trouble-shooting support across all hospitals. This should be factored into the business case. <u>Detail role descriptions:</u> https://nhs.wales365.sharepoint.com/:w:/r/sites/ABB_Informatics_Programmes/ePMA/012%20Research/Resource%20(Other%20HBs)/Resource_WyeValley%20Team%20-

	%20Pre%20%26%20Post%20Implementation_2310.docx?d=w582de05c029d4a2c97b70f83626a066f&csf=1&web=1&e=UPF9v4
Devices	Nursing staff certainly preferred and arm and cradle to be attached to their drug trolleys as opposed to having to pull around a separate laptop on wheels as well as the drug trolley. The laptops themselves just needed to be large enough to display everyone properly, good battery life, and importantly needed to come with the appropriate software and licensing build to enable full use of the system. A lesson learned here was that the devices needed to be able to open and print MS word format documents for the discharge summaries as this is what they are in for us. Easy one to overlook! Always conduct testing using the actual devices users will be using for real and not project team devices! Work done around mapping out charging points on each ward, where the trolleys and laptops could go and how good the wifi signal was in each area Nurses generally use laptops that sat in cradles on a metal arm attached to the drug trolley. In theatres and ICU though it was just a laptop on wheels. Doctors used existing multi-screen workstations on wheels. Pharmacy we found benefitted from kit that had a laptop on wheels with a little table on which they could write, go through a patient's meds and balance any remaining paperwork. Nurses liked the 'laptop on an arm. Doctors complained that they wanted an iPad at the end of each bed which wouldn't have worked as you need to be able to type stuff and the system does not display well on a tablet. Plus, they would have needed to log in separately for each patient so it wouldn't have been the best solution I don't think. Doctors did find it hard to adapt to needing a computer with them for the ward round to review meds and we got a lot of stick about it in the early stages until it just became part of working life. Pharmacy initially just had laptops on wheels, but they needed something with a little table on it to support their work. It was generally fine at first, but we've found kit very often gets broken and often ended up being the project team's problem to solve when we still have some budget / devices left to deal with it at least. This is an important point. Clarify right from the start who is responsible for the kit once it is handed over to the ward. If management and maintenance responsibility for kit (and most important the budget to pay for it) sits more centrally with IM+T / estates etc then this will probably be ok. If however, this sits with the ward / department / service to whom the kit has been handed over then be prepared for a few arguments when things rather inevitably get broken. Try and get this very clearly and formally agreed because it will be challenged.

	As it goes out project did indeed get this agreed that once kit is handed over to the ward, they then take ownership of it but this was very quickly forgotten once laptops started getting smashed!! Also, think about kit for escalation areas. Try to have provision for this and store some escalation kit in an area the site team can access 24/7 to kit our areas opened during bed pressures so they don't have to 'borrow' kit from other wards that realistically they will never see again. I think Justin got an out of hours phone call asking him to come in and magic up some kit for an escalation area out of thin air. Try to avoid that situation if you can. A charging station was installed in each ward with a capacity for 10 ePMA specific laptops. Vehicles for holding the tablets were created by utilising existing kit to manage the costs and there is an ePMA bay in every ward.
Scope	In Inpatients and maternity (worked well and implementation went well here), but not currently in Outpatients, neonates. If a patient is admitted from ED then they are added to the ePMA system, but not currently live in ED.
Training	Challenging training agency and bank staff Champion user work was challenging and difficult to get engagement. WVT developed 15-minute eLearning videos for agency staff which are held on their intranet site. After completing online training, a short assessment needs to be passed to allow IT to grant access to a user account to access the system. The pass expires after 90 days.
Implementation	Pilot site was not done for long enough. 2 weeks on 2 different wards (Stroke and Paediatrics) - this wasn't enough, need to give yourself more time here to work out the issues. Roll out was then 1 ward a week. Did a big bang approach for two areas: 1. Theaters, and then 2. Community sites. The community roll-out was from March-April and this was done within 6 months of the pilot areas. Benefit of rolling out fast is there is a limited mixed economy of paper vs ePMA From contract signing in January 2020, to the first pilot area in September 2020. Configuration began in March 2020. Prescription errors changed but not dropped. Promote order sets to users to help them move away from moderate harm reports on datix.
Business Continuity	This has been a struggle to get right. Keep this in mind when planning, need plans for planned and un-planned down-times. PDF drug charts, are they stored to C Drives, and hardwired to printers, users need to be aware of the processes. Very little downtime, but each time has been for a different reason. Important to remember that Windows updates

	can impact the system. Ownership of business continuity is important to get right. Need to embed this early on and potentially look to include this in the training as it puts the knowledge and ownership back onto the ward. Managed by BAU Team. The supplier conducts a 90-minute meeting with WVT on a monthly basis to support development and improvement. A user group is well established bringing other Trusts together so that any changes needed are for everyone, and therefore shouldn't incur extra cost.
Benefits	It is an easy sell to Nurses, more difficult to sell to Consultants and FY1 are also impacted as well. Surprisingly Pharmacy was the hardest to see the system to. Good to push: 1. Don't have to transcribe charts (at discharge) and 2. Order sets (these will need to be configured locally)
WNCR - Implementation	<u>Report from the National team (DHCW) regarding the lessons learned from the WNCR Implementation:</u> https://nhs.uk/sharing/007%20WNCR%20Learning/WNCR%20Implementation-Lessons%20Learnt.pdf?csf=1&web=1&e=I8fxVV
WNCR - Devices	From initial assessment staff preferred laptops on trolleys over iPads, however there is a mix out there. Need to bear in mind the storage of kit both prior deployment and also space for storage of kit out on the wards as there is limited space. Asset management and keeping track of kit is difficult. Need to be clear on accountability of the kit. - Need to make Ward Managers accountable for the devices, it is useful to get the General manager on board with this and in agreement. Staff have taken devices which are not assigned to them and this has caused issues. Collect the cost codes for every area.

WNCR: Training	Had 8 staff in the training team, now down to 5/6. Found it challenging to book training rooms. Used RPA to set up temporary accounts. Use day rooms on the wards or the little pods or offices on wards to train in 1-2-1 or in groups of 2. Try to stay on the ward if possible. Training lasted about 10-30minutes, length of sessions depended on number being trained and also on the staff members digital skills. MAU at RGH are bad at releasing staff for training, so this area may need additional support. Training matrix set up for the different groups/ roles/ cohorts/ level. Liaise with the bank to set up sessions for staff prior to their shifts to ensure they are trained. Agency staff is a big cohort and this will require a longer input. Different cohorts of staff could take longer to train so might be different in each area/ division. Aim to get 80% of available staff trained prior to go live (this excluded staff on sick leave, maternity leave, annual leave etc.). After the week of training, a go/no go decision call was made and a go live date confirmed - training and go live is a 2 week approach per ward. Prep 1 area, then during the 2nd week start prepping the next ward area for go live. Ideally the go live date would be before Wednesday - preferably on the Tuesday UAT environment was available but only Peggy Edwards and Lucy Flatman reviewed and used it. Clinical FAQ's were set up and staff could access them via a QR code on the device/trolley. QR codes were also printed and put in lifts for staff to access training and the national sharepoint site with training resources. Need to factor in Twilight shifts and be available up to 2am. Did this from RGH onwards. Do twilight shifts for a two week period. Weekend shifts can vary in impact, as they tend to do other work over the weekends such as risk assessments so need to check what processes/ tasks they do solely on the weekend to see how that would impact training and support for the weekends. It is difficult to get into introductory meetings/ sessions and get a large cohort of staff trained in one go, but this would be a good opportunity if you can get in! Generally 11am was a good time to start training Nurses as washes and drug rounds had finished - although this could vary ward-by-ward and even site-by-site. Staff got hold of the WNCR team for clinical queries by using Vocera and they also showed staff how to log technical queries via Halo. Train the Trainer took place for at least 2 weeks.

WNCR: Implementation	Staff log in to WNCR is their NADEX but lots of staff do not know what this is and it has caused some issues. All agency staff should also have nadex accounts. Get the ward manager to provide all nadex accounts before training commences so if any are not set up, it gives you time to get this created. Roll-out went from Wards towards MAU (Inside out) There was some staff anxiety therefore try to eliminate this - benefit stories are always good
Implementation	COVID-19 impacted timelines. Pilot Ward was COTE. Piloted ePMA across surgical directorate for 2 months (big bang approach across adopted). The focussed on haematology and elderly wards. 1 day to deploy and then support on ward for 1 week. Prior to a go live, circa 1-2 days to transcribe patient meds onto system and to validate Yeovil Hospital (300 beds) - deployed across whole hospital within 8 weeks
Implementation: Resource	Have never really transitioned to a BAU model. Support model: (1) First line is a Digital clinical team on call (pharmacists and application support. 11 people on rota, 2 people covering bleeps. 10 individuals, including pharmacists and pharmacy techs and trainers, nurse facilitators and IT support WhatsApp used to field queries from wards. Direct bleep Monday-Friday. Completed a survey with users who didn't feel a 24/7 support model was required; on call model was deemed sufficient. Support model: (1) First line is a Digital clinical team on call (pharmacists and application support. 11 people on rota, 2 people covering bleeps. WhatsApp used to field queries from wards. Direct bleep Monday-Friday ePMA team is under digital including CPIO role. 2 pharmacists and pharmacy technicians
Business Continuity	Dedicated business continuity terminals circa 1 per 60 beds (business continuity machine). Print out charts if outage occurs. Individual business continuity PCs are connected to standalone printers which are connected to uninterrupted power supply. Regular checks are made by team on the business continuity PC. IT receives a notification is a business continuity PC goes off line. Access restricted to admin staff. Every 15 minutes, a snap shot of every patients' drug chart and two days space to record medicines administration is taken as a PDF and sent to business continuity terminals. Medicines prescribed or administered are re-entered into the system, if an outage has occurred. A "grandfather" computer sits centrally within the digital team which takes all copies from the business continuity terminals

Training	2 phases. Level 1 is the basics in order to undertake role and level 2 is the more complex aspects that will help undertake their role. They provide bronze, silver and gold awards to incentivise getting staff trained up to more complex tasks. Recommended clinical people undertaking face-face training if at all used, rather than trainers. Agency staff have to be trained in order to take on a shift.
Devices	Mini PCs used with large screens on carts, COWs, Devices attached to medicines trolleys. Accountability forms signed by ward managers so that it is clear where responsibilities lie for replacing broken equipment.
Scope	Insulin is still on paper, and day-case prescribing is still out of scope at present
Training Resource	Failure to effectively deploy the digital strategy led to nearly 1,000 safety reports recorded, including one where a patient died and 30 others where they suffered harm. This was due to human factors and not directly linked to technical problems. RSFT identified issues regarding insufficient training and users lacking confidence in using the new system which led to additional training and guidance being introduced.

Implementation	Build on pre-existing information/ learning already gathered from other projects, which is relevant. ePMA was new to the Trust, therefore it is important to get the right buy in at the right levels in the Trust, supported by the Executive. Ensure there is a group of doctors/nurses and other stakeholders, dedicated to supporting the project from start to finish. Ensure there is a team of Pharmacists and/or Pharmacy Technicians in line with the size of the project, to support ePMA as an ongoing project. It is important to start to develop a strong and open working relationship between suppliers and the Trust at the outset of the project and to agree key early dates to ensure activities are in place to move the project forward and bring clarity as quickly as possible. Look at go live dates early on as part of planning and avoid key dates when critical staffing is unavailable e.g. holidays. Involve key leads from the beginning e.g. from project start up. Put together a workshop with the suppliers and the project team to build a detailed joint project plan which is then monitored and updated together throughout the project. Develop a good relationship with the supplier project managers and encourage team members to do the same with their supplier colleagues.
Implementation: Resource	Project Managers from Berkshire Healthcare NHS Foundation Trust, Servelec Healthcare Ltd and Emis Health Trust Project Management Office (PMO) Work stream leads and team members with expertise in system configuration and testing, transformation, training, IT and pharmacy Business and technical expertise from Servelec Healthcare Ltd and Emis Health Trust Chief Pharmacist Trust Head of Procurement for CCN development Oversight provided from Trust Chief Information Officer ePMA Project Board signed off the initial project plan and received regular updates

Communication	It is important to start stakeholder communication and engagement at an early stage. The team did this, and it worked well at gaining buy in. Understanding the product and its limitations are essential to set user expectations and give time to the team to explore workarounds and options. Limitations were not fully known beforehand. Ensure that all processes that are involved or have an impact on medication, are considered when completing to-be process mapping and engagements with stakeholders. Due to the functionality of the ePMA system, workarounds had to be developed to ensure that processes could be completed in an efficient and safe manner. Audit and reporting requirements should be discussed early on and included in as-is and to-be process mapping, to ensure that the functionality is available. Early supplier engagement is very important, so that staff setting up the system and building the templates know what to do and how to do it. Ensure that the suppliers can demonstrate the end to end processes before moving forward. Many of the admission and discharge processes are still disjointed.
Communication	Engage Users early and continuously. We achieved this by creating the EPR Trust Approval Group, which met on a weekly basis, and by attending ward/clinics/dept own meetings. Develop detail end to end workflows. These can be then be used to create the test scripts and user guides. Include all possible stakeholders in workflow creation workshops. If possible, hold design and workflow workshops away from where staff work normally to allow them to focus on the workshops.

Implementation	The transcribing process is a valuable learning tool but must be used in conjunction with the needs of the service (e.g., not all areas have non-medical prescribers) A proper handover to IM&T Services is essential for the project team to be able to provide full support to subsequent phases. Where a phased roll-out is employed, there will always be a risk of patients moving from an area that is still on paper to an area where ePMA has been deployed (or vice versa). For patients moving from paper to electronic during the roll-out phase, this should be treated as additional transcribing learning. For patients moving from electronic to paper areas, we found this to be a good real-world test of our downtime drug chart solution. This involves a real-time print-off of a patient's electronic chart, with spaces for 5 days' worth of administrations, for use in planned downtime or when discharging patients to community hospitals
WNCR - ICT Kit & Digital Skills	Kit wise, the laptops went down well, bar the stands they were on, the keyboard connectors to the ipad were not difficult to break, so if they were broken it made the iPad not fit for purpose for WNCR as there is a lot of writing. Regarding digital Skills a lot of staff either didn't have a nadex or we had to get their passwords reset due to not using them which in turn showed they were not using other AD authenticated systems. They seem to have taken to WNCR well mind, with the majority of the PIR data I've got from GUH stating it was easy to use and easy to navigate - From Adam Rooke BCM, WNCR
WNCR - Training/Support Staff	WNCR - we rely on volunteers for afternoon shift cover, we are losing all support from the digital trainers so only me a Lucy. We need to make sure we make shifts part of a any contracts - From Peggy Edwards

APPENDIX 8: Use Case/User Story profiles

UC ID	Use Case	US ID	User Story
UC01	Electronic Prescription Generation		
	A qualified prescriber can create electronic prescription for patients, which includes all legal requirements, decision support, ADR checks, drug interactions and any additional instructions.	UC01-US01	As a qualified prescriber, I want to create electronic prescriptions for my patients, including medication name, dosage, formulation, device (where appropriate), frequency, route and duration to streamline the prescription process and reduce errors.
		UC01-US02	As a qualified prescriber, I want to access patient's electronics administration records to verify the patient's details.
		UC01-US03	As a qualified prescriber, I want to access patient's electronics health records to understand the patient's medical history.
		UC01-US04	As a qualified prescriber, I want to access patient's shared medicines record to understand and pull through the patients' medications history.
		UC01-US05	As a qualified prescriber, I want to access BNF/HB/HP (National and Local Health board guidelines and healthcare policies) tools or systems to ensure the medication policies and guidelines are adhered.
		UC01-US06	As a qualified prescriber, I want to select appropriate medication in line with BNF/HB/HP policies and guidelines to ensure accuracy in the treatment.
		UC01-US07	As a qualified prescriber, I want the system to alert me if prescribed medication conflicts with a patient's known allergies or interacts with their current medications.
		UC01-US08	As a qualified prescriber, I want the system to be able to generate an advanced electronic signature which meets the legal requirements.
		UC01-US09	As a patient, I want to receive electronic prescription (WEPS) service to get medicine from community pharmacy of my choice.
		UC01-US10	As a qualified prescriber, I want the system to allow me to modify patients' medication or dosage or frequency or route electronically based on their response to the treatment.
		UC01-US11	As a pharmacy staff, I want to get digital alert or notifications as soon as the prescription is created or altered in order to prioritise my workload and ensure timely medicine order supply.
		UC01-US12	As a healthcare professional, I want the system to generate built-in or customised reports and dashboards on ad hoc or periodic basis for patient treatment data analysis.
		UC01-US13	As a healthcare professional, I want the system to allow me to view built-in or customised reports and dashboards on ad hoc or periodic basis to analyse and improve patient care.

UC02	Medication Order Supply		
	A pharmacist can receive alerts and notifications of electronic prescriptions, verify them, and dispense medications accurately. The system can check for allergies and drug interactions.	UC02-US01	As a pharmacy staff member, I want to view the medicine orders electronically to ensure efficient and timely supply.
		UC02-US02	As a pharmacist, I want the system to allow me to review and verify electronic prescriptions for accuracy and appropriateness before dispensing medications to patients.
		UC02-US03	As a pharmacist, I want the medication order supply request to be linked to the patient's electronic prescription record to ensure the order is dispensed to the right patient.
		UC02-US04	As a pharmacist, I want to access a patient's electronic prescription record to identify potential allergies and drug reactions to ensure the patient's safety.
		UC02-US05	As a pharmacist, I want the system to allow me to update the availability status of a patient's drugs with them to ensure the accuracy of the dispensing order.
		UC02-US06	As a pharmacist, I want the system to alert me if a prescribed medication conflicts with a patient's known allergies or drug reactions with their current medications.
		UC02-US07	As a pharmacy staff member, I want the system to allow me to generate medicine supply requests to dispense them accurately.
		UC02-US08	As a pharmacist, I want the system to allow me to update the status of medication orders for the supply workflow tracking.
		UC02-US09	As a pharmacist, I want the system to allow me to generate built-in or customised reports and dashboards on an ad-hoc or periodic basis for audit and compliance data analysis.
		UC02-US10	As a pharmacist, I want the system to allow me to view built-in or customised reports and dashboards on an ad-hoc or periodic basis for medication supply data analysis.
UC03	Electronic Medication Administration		
	A nursing staff can record medication administration electronically, ensuring accurate documentation of when and	UC03-UC01	As a nurse, I want to access a patient's electronic details rapidly to verify the patient's identity.
		UC03-UC02	As a nurse, I want the system to allow me to access electronic medication prescriptions either by swipe-through or single sign-on to administer them accurately.

how medications are administered to patients in accordance with 5R's.

UC03-UC03	As a nurse, I want the system to allow me to access a patient's electronic prescriptions to check at the point of admission the medicines' availability status with the patient and at Omnicell to mobilise the medicines.
UC03-UC04	As a nurse, I want the system to allow me to electronically order medicine supplies to ensure the right medications at the right time.
UC03-UC05	As a nurse, I want to access a patient's electronic medication history to identify potential allergies and drug reactions to ensure the patient's safety.
UC03-UC06	As a nurse, I want the system to display detailed information about the medication, including name, dosage, route, frequency, timing schedule and any special instructions.
UC03-UC07	As a nurse, I want the system to allow me to document the administration of each medication and record any new allergies and adverse reactions to ensure the patient's safety.
UC03-UC08	As a nurse, I want the system to send real-time alerts and notifications of the medication schedules to me to ensure that I administer them at the right time.
UC03-UC09	As a nurse, I want to receive real-time alerts for over-due doses or schedule changes to ensure patients' safety.
UC03-UC10	As a nurse, I want the system to display a list of scheduled medications for a selected patient or group of patients to ensure timely patient care.
UC03-UC11	As a nurse, I want the system to alert me when the time critical medicine is due to ensure timely administration.
UC03-UC12	As a nurse, I want the system to allow me to administer the medication using a closed loop process to ensure patient safety.
UC03-UC13	As a nurse, I want the system to allow me to document medication administration or non-administration electronically to ensure the accurate documentation of patient care.
UC03-UC14	As a nurse, I want the system to allow me to manage the medication administration or non-administration electronically to ensure the accurate documentation of patient care.
UC03-UC15	As a nurse, I want the system to record all modifications to medication administration or non-administration electronically to ensure a complete audit trail.
UC03-UC16	As a nurse, I want the system to allow me to view the inventory of Omnicell to ensure sufficient stock.

UC03-UC17	As a nurse, I want the system to allow me to generate built-in or customised reports and dashboards rapidly on an ad-hoc or periodic basis for audit and compliance purposes or data analysis.
UC03-UC18	As a nurse, I want the system to allow me to view built-in or customised reports and dashboards rapidly on an ad-hoc or periodic basis for medication supply data analysis or audit and compliance purposes.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Welsh Language Annual Report 2023-2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sarah Simmonds, Executive Director of Workforce and Organisational Development
SWYDDOG ADRODD: REPORTING OFFICER:	Geraint Scott – Head of Welsh Language Unit

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

Er Sicrwydd/For Assurance

This report addresses the statutory duty of the Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards, under the Welsh Language (Wales) Measure 2011. The report has been prepared in accordance with Welsh Language Standard 120. The Health Board's Welsh Language Standards Annual Report, which requires Board approval, and will need to be published, bilingually, by the end of September 2024.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Welsh Language Standards Annual Report (**Appendix 1**) addresses the statutory duty of the Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011. The report has been prepared in accordance with Welsh Language Standard 120 and highlights the improvements and progress made by the Health Board during this reporting period.

The Welsh Language Annual Report 2023-2024 was considered and approved at the Executive Committee meeting on Thursday 12 September 2024.

The Board is asked to note the improvements and progress made in the last year, to support the next steps highlighted in this paper and approve the Welsh Language Standards Annual Report attached ahead of publishing by the end of September.

Cefndir / Background

On 20 March 2018, Assembly Members voted in favor of the Welsh Language Standards [No7.] Regulations 2018 (the 'Regulations'). The two key principles that underpin the Regulations are:

- In Wales, the Welsh Language should be treated no less favorably than the English Language; and
- Persons in Wales should be able to live their lives through the medium of Welsh Language if they choose to do so.

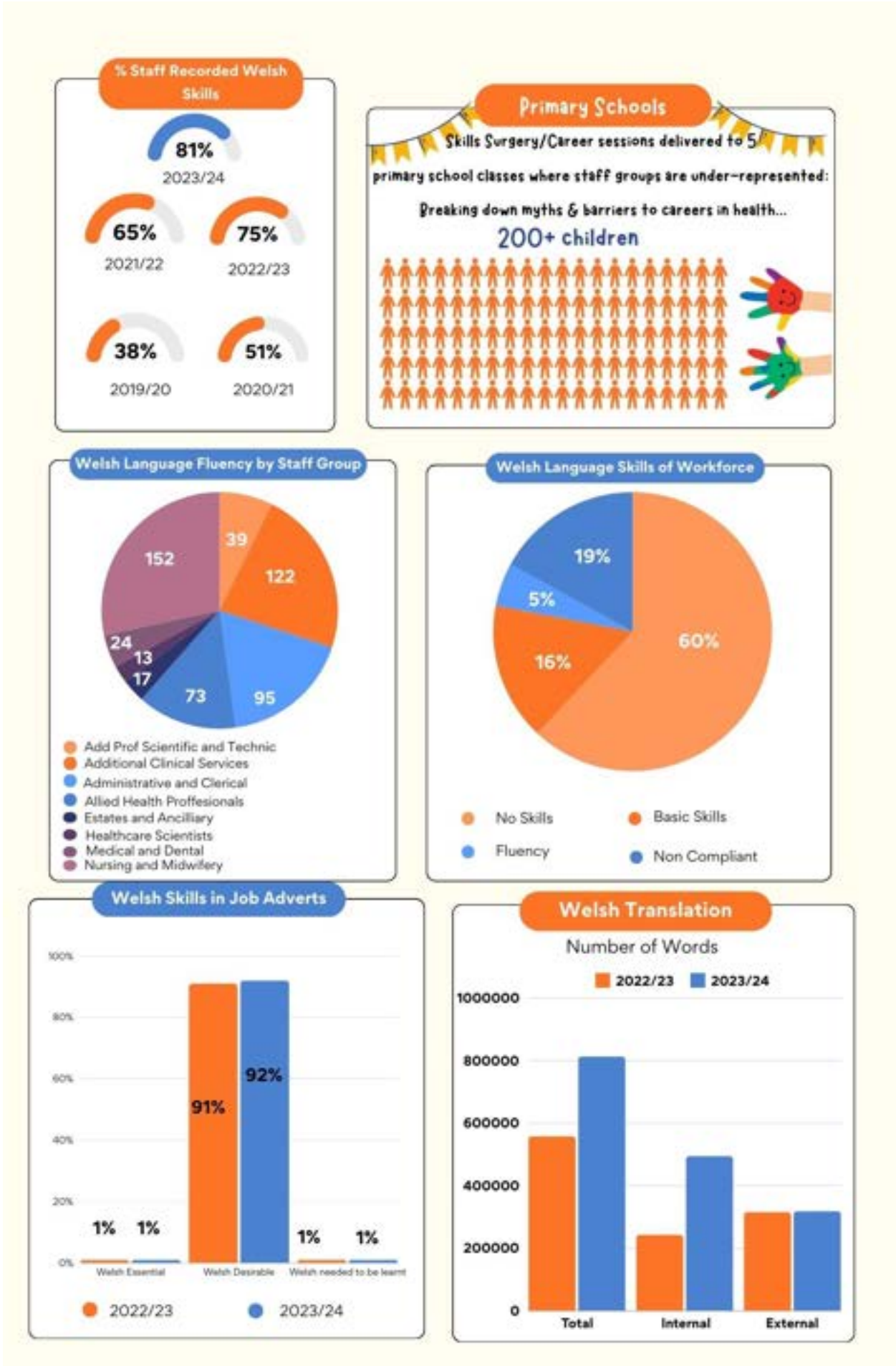
The Standards have provided the Health Board with the impetus to ensure the delivery of quality, equitable bilingual public services. Addressing the challenge of mainstreaming the Welsh Language and increasing the use of Welsh and bilingualism, in the provision of services and within our administrative functions has been the key focus for the reporting period.

Asesiad / Assessment

The Welsh Language Annual Report 2023-2024 (Appendix 1) outlines the work undertaken between the period of 1st April 2023 and the 31st March 2024. Some key success to draw your attention to:

- Implementation of new translation system increasing both governance and value of the translation service offered to our divisions.
- Increased compliance against self-declaration of Welsh Language abilities passing 80% for the first time since the implementation of the standards.
- Increase in the training opportunities offered to staff at all levels of abilities. These include, for the first time, a dedicated Welsh Language tutor to support those with Welsh Language skills but who lack confidence in using those skills in their work as well as an immersive residential Welsh Language course in Nant Gwrtheyrn.
- We have expanded our work to schools and colleges to include non-Welsh medium secondaries and our 'Syrjeri Sgiliau' programme for primary school aged children.
- We've worked closely with our Digital, Data and Technology colleagues as well as those in the Booking Centre and Switchboard to greatly improve our compliance in relation to our written forms of communication with service users.

The data dashboard below gives an overview of the key performance indicators that we report on.



Over this period, we received our first investigation from the Welsh Language Commissioner's Office within the reporting period of this report. The investigation was based around our compliance with Standards 9 and 10. These standards relate to telephony services.

Standards 9 is in relation to advising service users that they are able to access a Welsh Language service, with standard 10 relating to staff available to deal with those calls in Welsh.

We were able to identify a solution to ensure compliance with standard 9 but despite several targeted attempts to recruit Welsh speakers into specific roles, we were unable to secure the requisite Welsh Language skills. As such we not able to assure full compliance with standard 10.

However, through working positively both with the Commissioner's office and the relevant teams within the Health Board we were able to bring that investigation to a conclusion. The ability to recruit staff with the requisite Welsh Language skills into roles where we have identified a clear need is going to continue to be a key challenge for the Health Board. We hope that the continued work undertaken by the Welsh Language Unit to firmly place the Health Board as the employer of choice to Welsh speakers will support us in this area.

Over the next year some of our key pieces of work include the following:

- Development and publication of our next five-year plan to increase the offer of clinical consultations through the medium of Welsh.
- With an increase in the number of digital platforms being utilised throughout the Health Board we will continue to work closely with our Digital, Data and Technology colleagues to ensure that any new platforms/technologies developed conform to the Welsh Language Standards and meet the needs of our Welsh speaking service users.
- We will develop a resource with our Welsh speaking service users which explains the importance of service delivery through the medium of Welsh. This resource will allow us to further develop our induction programme to our staff.
- We will build on the success of our work with schools and colleges including the 'Skills Surgery' project to firmly embed the Health Board as the employer of choice for the next generation.

Argymhelliad / Recommendation

The Board is asked to note the progress made and support the future work identified throughout the report and within this paper and approve for the report to be published on our website by the end of September 2024.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	CRR0021 Current score 12
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 4. Dignified Care 6. Individual care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Welsh Language Strategic Group More Than Just Words Forum All Wales Welsh Language Managers Group Local Stakeholders in the Welsh Language Community

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

• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	The Welsh Language is a cross-cutting issue and is relevant to all objectives of the Well-being of Future Generations Act. Theme 7: A Wales of vibrant culture and thriving Welsh Language is particularly relevant.

WELSH LANGUAGE STANDARDS ANNUAL REPORT 2023 / 2024



FOREWORD



I have great pleasure in endorsing the publication of Aneurin Bevan University Health Board's 2023-24 Welsh Language Standards Annual Report.

We as a Health Board strongly believe that the Welsh language should not be a stand-alone target, but rather something that is embedded in all aspects of our work and believe that this report shows that ambition.

I hope you enjoy reading about our progress to date as well as our vision for the future.

Diolch

NICOLA PRYGODZICZ
CHIEF EXECUTIVE

FOREWORD

I am proud to present Aneurin Bevan University Health Boards annual report for 2023-24.

We remain fully committed to ensuring that we deliver the highest quality Welsh language services to our communities here in the Gwent region.

We hope you see the strong work we continue to do across all aspects of our services. We believe the report shows that our work is guided not only to ensure compliance with the Welsh language standards but to uphold that the needs of our population.

We work with our staff as well as our stakeholders and partners to deliver the priorities of Welsh Governments' 'More than Just Words' plan and are thankful for this opportunity to share this with you.

SARAH SIMMONDS,
DIRECTOR OF WORKFORCE & ORGANISATIONAL
DEVELOPMENT

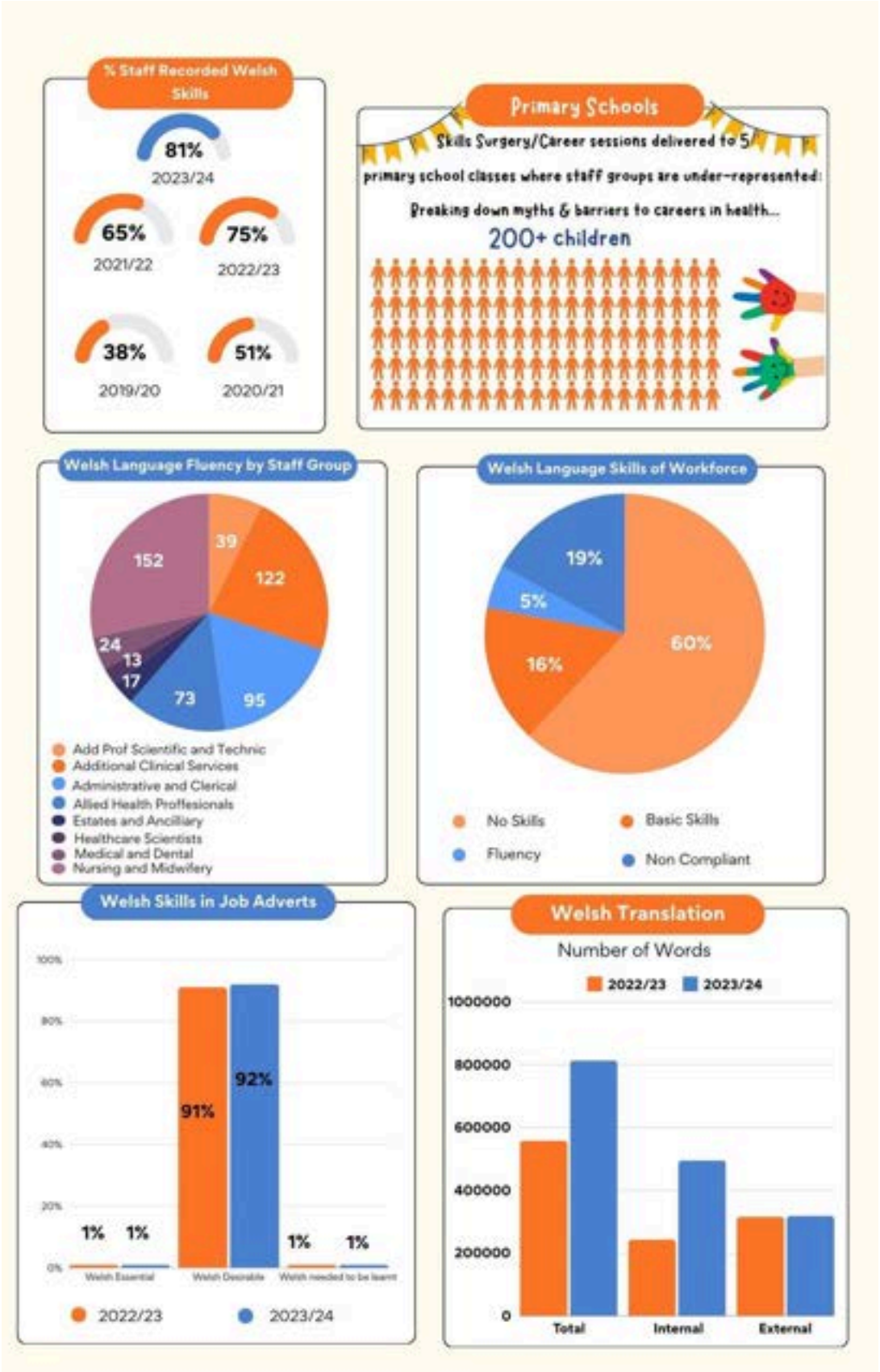




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DATA DASHBOARD



INTRODUCTION

This report outlines the work undertaken to support the delivery of Welsh language services to our patients and service users in the area covered by Aneurin Bevan University Health Board (ABUHB).

The report addresses the statutory duty of the Health Board to provide an annual account to the Welsh Language Commissioner on compliance with the Welsh Language Standards in accordance with the Welsh Language (Wales) Measure 2011. The report has been prepared with the requirements of Welsh Language Standard 120. The reporting period is April 1st 2023 to March 31st 2024.

Our targets in relation to Welsh language are monitored within our People Plan, as well as being reported to Welsh Government in accordance with the 'More than Just Words' actions.

The 'More Than Just Words' plan is Welsh Governments strategy document for delivery of Welsh language service in Health and Social Care. The current plan as well as the detailed actions associated can be found [here](#).

We continue to experience challenges when looking to advance our Welsh language service provision, but have made positive steps to understand the Welsh language skills of our workforce and are taking clear action to ensure that the Health Board builds a reputation in becoming the employer of choice for Welsh speakers in the region.

We are also pleased to include progress made on areas described in previous annual reports, reflecting the improvements and progress made during this reporting period.

Our continued progress in auditing and mapping the linguistic skills of our staff has ensured a greater understanding of our capability to deliver care through the medium of Welsh in our services and where we need to either recruit new Welsh speakers or further develop the skills of those in post. This helps to inform and develop recruitment campaigns that will directly support the 'Active Offer' principle being embedded across our services. The "Active Offer" refers to the ability to provide services on behalf of the Health Board in the medium of Welsh without it having to be specifically requested.

We have developed a number of systems to improve our delivery of written correspondence both in letter and SMS form (text messages), this is now fully bilingual following procurement of digital systems which have enabled a more streamlined service.

In line with Standard 120, this report also describes specific information in a number of key areas. This data includes:

- The Welsh language competency levels of our staff,
- The training we offer through the medium of Welsh,
- The number of complaints we have received in relation to the Welsh language,
- The level of Welsh competencies we require on any vacant and new posts advertised during the reporting period.

MANAGEMENT, ADMINISTRATION OF AND COMPLIANCE WITH THE WELSH LANGUAGE STANDARDS

Accountability, Governance and Assurance

The Executive Director of Workforce and Organisational Development is responsible for the Welsh Language portfolio within the Health Board. The Health Board has ultimate responsibility for the implementation of the 121 standards as outlined in our compliance notice from the Welsh Language Commissioner's office. Through training and awareness campaigns we ensure that all staff understand that it is everyone's responsibility to enhance the offer that we can make to meet the needs of our Welsh speaking population.

Welsh Language Unit (hereon referred to as the WLU)

The Welsh Language Unit (WLU) includes staff working at a strategic, managerial and practical level in the areas of language policy, training and development. The WLU resides within the Workforce and Organisational Development Division. The function supports staff in the delivery of services in accordance with the duties placed upon the Health Board. The role of the WLU is to provide leadership, advice, guidance and support regarding Welsh language matters to the organisation.

The WLU provides regular updates on progress, issues and good practice to the Welsh Language Strategic Group, which is the internal cross-organisation steering and governance group and approves the WLU's work plan.

Welsh Language Strategic Group (WLSG)

The purpose of the WLSG is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to Welsh language service provision for service users.

The reporting mechanism for this group is through the Health Board's People and Culture Committee which is accountable to the Board. The WLSG has a key role with regards to workforce related legislation and the legislative frameworks provided by the Equality Act 2010 and the Welsh Language (Wales) Measure 2011.



The Strategic Group provides assurance and advice to the Health Board in relation to the appropriateness of the arrangements for workforce planning, workforce development and engagement which are in line with the Health Board's Annual Plan, Priority Programmes and arrangements to meet organisational Welsh language strategic objectives.

In addition to assurance provided to the People and Culture Committee, the WLSG presents an Annual Monitoring Assurance Report to the Executive Team confirming the Group has met its terms of reference and key duties.

The WLSG is chaired by the Executive Director of Workforce and Organisational Development and meets quarterly. The clinical, operational and corporate membership of the group is designed to ensure that the information discussed within the Strategic Group is disseminated throughout the Health Board. Its membership is also designed to ensure the divisions and departments within the Health Board are given an opportunity to raise concerns, issues or initiatives they may experience in relation to Welsh language delivery.

The meeting is administered by the Workforce and Organisational Development Division through the WLU.

The Welsh Language Standards are a standing item on the agenda of the WLSG. A comprehensive implementation plan is monitored by the WLSG and any gaps in capacity, or issues of compliance, are escalated to the People and Culture Committee, Executive Team and Board as appropriate.

Risk Management

The Health Board identifies active and integrated risk management as a key element of all aspects of our functions and responsibilities. Risks in relation to the Welsh language, are recorded in the Workforce and OD risk log.

Current potential risks include meeting the requirements of the Welsh Language Standards, delivering the Bilingual Skills Strategy and implementing the 'Active Offer' principle of providing a service in Welsh without someone having to ask for it. Having Welsh language recorded as a risk ensures that the actions and controls are regularly reported to and reviewed by our People and Culture Committee.

ANNUAL SUMMARY



The Standards, which have been applied to the Health Board under section 44 of the Welsh Language (Wales) Measure 2011, are contained in the Compliance Notice which can be found on our website.

Following our work in mapping the Welsh language abilities of our workforce (data can be seen in this report), we are now in a better position to map the areas where there are skills gaps and look to put plans in place to either fill those gaps or develop measures to support those departments that are lacking in Welsh language skills.

With the recognition that we need to further develop our future workforce we look to develop imaginative and creative ways of engaging with our prospective workforce and reinforcing at an early stage, the importance the Health Board places on their ability to use the Welsh language when communicating with patients, service users and their families. We have further developed our toolkit of resources in this area and now include learning opportunities and targeted workshops around specific areas that are often overlooked when considering a role in the Health Board. If we are to meet the challenge of ensuring full Welsh language services, we also need to engage those who have learnt Welsh as a second language. Further details around our education work can be found later in the report.

With the development in digital tools to support our service users and staff, we have worked closely with our colleagues in our digital, data, and technology division to ensure any

platforms or online tools our service users interact with are compliant with the standards providing a fully bilingual offering to our Welsh speaking population.

We have developed materials to support our staff who have little to no Welsh language skills to understand the importance of the language and to use incidental Welsh. These focus on the vocabulary that will be useful to them in their role as well as general Welsh terms.

We have further developed our training offer to ensure that there is a training offer available for all language levels, abilities, and teaching methods. From our staff engagement events, that we have a number of staff who were educated to high level in Welsh, but lack the confidence in using those skills, a partnership has begun through the Ganolfan Dysgu Cymraeg to provide a tutor to work specifically with this cohort. This is in the early stages but the initial pilot cohort (33 staff) have found the programme very helpful. We are currently communicating with this cohort to explore what is the best way to continue to support them when their period with the tutor ends to maintain their newly found confidence. Further individuals have been identified for the next two cohorts.

BILINGUAL ONLINE SERVICES

Corporate Website

Our corporate website, as one of the most significant information platforms for our local population, has evolved once again this year. We are pleased to report that, overall, compliance remains positive in this area. The allocation of internal and external translation resources remains in place for the communications team to meet the continually increasing demands for Welsh language content, which is now a well-established process. Engagement with the Welsh medium corporate website has increased over the past year, with almost 4000 views across this period, compared to just over 2,000 last year. Some of the site's most popular pages this year included our hospital sites and information on Pharmacies and GPs.

The Health Board's commitment to maintaining access to the Recite Me website accessibility tool has also continued for both the English and Welsh medium corporate websites this year. With its features including screen reader compatibility, translation into more than 100 languages, and an integrated dictionary, this has yet again proven a useful tool for Welsh learners of all abilities. We are always seeking to improving our compliance in this area and to ensuring that this site is kept as up-to-date as possible.



Recite me

SOCIAL MEDIA PRESENCE

We are, once again, pleased to report that throughout this period, all communications assets produced by the Communications and Engagement Team have remained fully bilingual. Although the following numbers of our Welsh and English Social Media accounts remain unparalleled with each other, our Welsh-medium Social Media following has grown gradually during this period and we've seen a slight increase in engagement across these accounts.

Channel	Medium	Number of Followers 2022/23	Number of Followers 2023/24
	Welsh	276	327
	English	108,112	109,238
	Welsh	237	252
	English	26,050	26,456
	Welsh	114	155
	English	12,575	13,349

We were fortunate to be able to showcase the efforts of some of our Welsh-speaking staff members and volunteers on our social media accounts throughout the year. As part of Diwrnod Shwmae, we shared a video of a fantastic Welsh learner who has developed a bilingual card game for patients of all ages and Welsh language abilities. On Dydd Gwyl Dewi, we were able to share the amazing story of one of our Welsh-speaking volunteers, who identified that a patient she was visiting may be a Welsh speaker, and used her Welsh language skills to converse with the patient and put her at ease whilst in hospital. This was a real testament to how 'little things' make a big difference when learning and using Welsh. On Diwrnod Hyrwyddo Hawliau'r Gymraeg, we partnered with some of our colleagues across health and social care in Gwent to collectively show why using Welsh is #MoreThanJustWords to us.

WORKING WITH CAREERS WALES, SCHOOLS AND COLLEGES

We understand that the key to delivering Welsh language services to our service users is a workforce with sufficient Welsh language skills. In order to future proof our workforce the children currently studying in our local schools and colleges need to understand the importance of the skill of being able to communicate in Welsh. With this in mind we have set up a suite of resources to empower and educate students of all ages and deliver these throughout the area covered by the Health Board.



Research shows that preconceptions around job roles are learnt much earlier than first thought. For this reason, we have created a programme under the name 'Syrjeri Sgiliau – Skills Surgery' to educate and raise awareness with Primary School children of the roles within the Health Board.



The project was produced in collaboration with our Equality, Diversity and Inclusion team following a successful grant application to Health Education Improvement Wales. A series of sessions were delivered to children in a school setting. Each of the sessions would function to challenge ideas that the children had around different roles in health and to educate them on all of the opportunities that would be open to them in the future as part of our workforce. Sessions covered areas such as; Urgent Care, Primary Care, Children's Services as well as looking at the non-clinical roles that are essential to the day to day running of the Health Board.

Skills ambassadors from different fields were also used, to share lived experience of the roles we were discussing. We were also able to show real life experience of both service users and staff when trying to use their Welsh language skills in the Health Board. This functioned to reinforce to them the importance that the Health Board places on growing those bilingual skills. Each student also received a certificate as well as a goody bag.

Here are some of the quotes received from children:

During an activity where the children needed to draw both a Doctor and a Nurse and list characteristics, one child asked:

“Does a nurse have to be a lady and a doctor have to be a man”

While showing one of the animations another student from a different school said:

“I thought it was only doctors, nurses and paramedics who worked for the NHS, I didn’t know about all of these other jobs.”

Within our resources we have focused on schools in population areas which are underrepresented within our current workforce.

Although we are proud of our diverse workforce, we are also aware that some communities within our population are not fully represented within our current staff. The data shows that the proportion of Welsh speakers in our community is higher than the proportion of Welsh speakers in our workforce. Therefore it was key for us to engage with pupils in Welsh medium schools.

To ensure wider reach and sustainability of the programme of work, one of the legacies of the project will be the development of an on-line toolkit. This toolkit will be available to all teachers, and will allow them to deliver the sessions themselves to their students.

Through working with teachers we will ensure that the lessons and resources in this toolkit will be fit for purpose and align with the new curriculum for Wales. Those teachers who have already been involved in the project have given only positive feedback, commented on how much benefit the children have got from the activities and noted their desire to be part of the project again in future years.



Welsh Medium Secondaries

We continue to work hard with our Welsh medium secondary schools throughout the region and have run a varied series of events around general careers information, as well as focussing on specific fields of interest.

One new offering was a day focused around Health Sciences to year 7 pupils in Gwent Is Coed school. This day of activities gave the students real practical experience of different areas within Health Sciences and helped to shine a light on a sometimes overlooked area of work within the Health Board. These included practical sessions around haematology and sample collecting and analysis.

Our other activities in this area include workshops with students across the age range and larger open careers events. In our discussion we have spoken with a large number of students who have clearly experienced our services themselves and have often discussed their desire to 'give something back'. Within the discussions we also ensure that they fully understand the importance and value of using their Welsh language skills in a career in Healthcare.

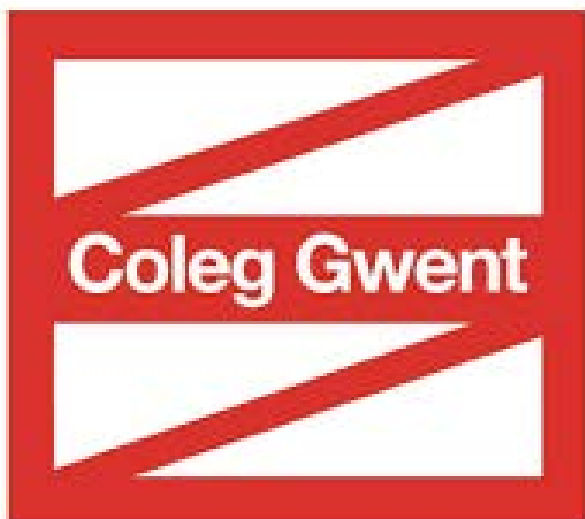
Non-Welsh Medium Secondaries

All students in Wales study Welsh language up to the age of sixteen. As such it is important to understand that all young people in Gwent have abilities in Welsh that could prove invaluable to the Health Board. With this in mind we have undertaken careers sessions with our non-Welsh medium secondary schools. We are further developing this in the next year to align with the Gwent integrated Schools Programme for Health and Social Care. This will ensure that all schools in the region will get the same message in relation to Welsh language importance and the 'More than Just Words' plan.



Colleges

We work closely with both Coleg Gwent and Coleg y Cymoedd to provide awareness sessions on 'More than Just Words' and the Welsh language standards to all students that are studying Health and Social Care courses within the colleges. Our clear aim is to generate a workforce that is well informed around the importance of the Welsh language to our Welsh speaking service users before they begin working for us.



Work Experience

With an awareness that work experience for many is their first experience of work within the Health Board we have looked to map the opportunities for Welsh speaking students to undertake their work experience placement either partially or fully through the medium of Welsh. The ambition is to show the students the normalisation of Welsh language within the Health Board. Using the networks we have within the Welsh medium secondaries as well as within the Welsh speaking community, we will share these details with those individuals who would benefit from this.



Gyrfa Cymru
Careers Wales

STAFF ENGAGEMENT

A key element of our work is to ensure that the exceptionally hard-working staff throughout the Health Board understand the importance of the Welsh language within their work, are aware of our duties and responsibilities and know where to seek support and learning opportunities.

Tailored Welsh language awareness is provided to these groups of individuals within the Health Board within our ongoing development programmes such as:

- Nursing & Midwifery Academy & Alumni – these are our senior nursing colleagues working across all disciplines across the Health Board. Here we deliver a workshop on Inclusive Leadership in Nursing & Midwifery Practice.
- Leadership Development Programme – these are new or aspiring leaders from all aspects of the Health Boards work and include both clinical and non-clinical staff.
- HCSW Clinical pathway – The Health Care Support Workers who work across our sites are vital and tend to have a huge effect on the care of our service users. They tend to be the staff our service users have most contact with and as such it is key that they have an understanding and appreciation of the need for delivery of services through the medium of Welsh to our service users.



STAFF RESOURCES AND TRAINING

We continue to generate materials to support all of our staff to use basic Welsh language skills with our service users. These are often tailored to the environment and include materials designed for certain roles such as our telephony staff.



We'd like to thank Betsi Cadwalader University Health Board for allowing us to adapt their original resources.



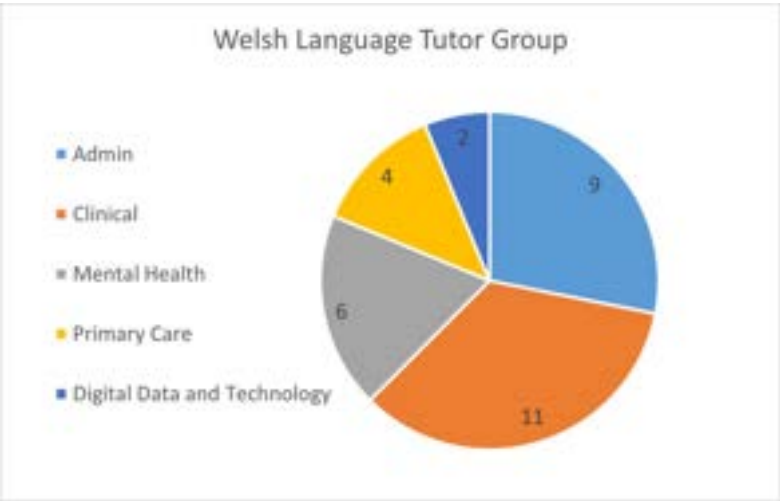
We continue to provide a wide variety of learning opportunities for our staff. Our data notes that we have staff at all stages of their learning journey and therefore our offer needs to match those needs. For those that have no Welsh language skills we can offer basic courtesy level Welsh, this also includes our international staff where English is not their first language. For those looking to further their Welsh language skills we ensure they are fully supported to do so and are offered the correct learning to match their needs. These courses can be offered on-line or in a classroom setting and include basic, intermediate and fluency courses.



An exciting development in this area is our first members of staff to participate in the immersive Welsh courses at Nant Gwrtheyrn. Some of the staff in question were past fluent speakers who have lost confidence in their abilities while others were individuals who had learnt the Welsh language but had a desire to reach full fluency.

Although a wonderful opportunity, due to operational constraints, there are many staff that would not be able to take up this opportunity. We therefore looked to provide another mechanism for staff who had higher level Welsh language skills but lacked the confidence to use them. With this in mind we are thrilled to note that we have a new collaboration through the centre for learning Welsh. The project involves qualified tutors from Coleg Gwent working with those individuals who have Welsh language skills but lack the confidence to use them in the work setting. The tutors work in small groups or on a one-to-one basis so that the sessions can be tailored to properly meet the needs of the learner.

The below graph shows the roles undertaken by the staff who made up the first cohort with the new confidence building tutor.



We will engage with all staff who undertake Welsh language training to ensure that they amend their Welsh language abilities to reflect their new skills. With those who undertake Welsh learning such as that noted in the case study above, we will engage with them six months after the completion of the course to understand the impact of the new found skills on their delivery to patients.



Case Study Jayne Hamer

I left my Welsh comprehensive school and started working in the NHS over 25 years ago. During that time, I was only able to use my Welsh skills occasionally in Welsh primary schools whilst working out in the community. I had lost most of my confidence in speaking Welsh and using my Welsh skills when I started my current role. This course sounded like a perfect way for me to improve my confidence with other Welsh speakers and learners.

The Using Your Welsh with Confidence course held at Nant Gwrthorn is for NHS staff in Wales who have Welsh language skills but would like to practice with the support of specialist tutors. It is a 5-day immersive course in North Wales. The location itself is breath-taking, the course I attended included a programme of activities through the medium of Welsh, workshops held by specialist tutors including Yoga and Mindfulness and musical entertainment. We visited Plas Glyn Weddw Gallery, Wales's oldest art gallery and also a local brewery called Cwrw Llyn where we were able to practise using our Welsh skills with the local community. There was also plenty of opportunities for us to meet and chat with other students attending other Welsh courses at Nant Gwrthorn.

I thoroughly enjoyed my week at Nant Gwrthorn, the tutors were excellent, the course content was perfect and well run. I met a lot of people who like myself were there to improve their confidence and Welsh language skills. It was lovely to be able to chat with everyone in the Welsh language. Having this opportunity has proven very valuable to me, I feel my confidence has improved greatly since attending the course and I would highly recommend it.



PATIENT COMMUNICATION SYSTEMS

We have procured a new system for the delivery of messages and letters to our service users. Our previous service was not fully compliant with the Welsh Language Standards the Welsh Language Unit has been a part of the planning of the new provider from the outset. We have actively engaged with the Digital, Data and Technology team and have been able to test the system at varying stages of its development. We also regularly audit the written correspondence sent to our service users enabling us to identify issues early and put in restorative measures where problems arise.

Through our closer links to the teams developing new software and systems for the Health Board we are able to ensure that new technologies and platforms are functional for those wishing to use the platforms in Welsh.

In a wider context, we are currently looking to improve the way we map the linguistic skills of our service users. We currently provide communication bilingually, however, we aim to map the language skills of our service users and to identify those who are looking for services through the medium of Welsh to proactively put mechanisms in place to provide these services to them in support of the Active Offer.



COLLABORATIVE WORKING

Recognising that we can learn a lot from other organisations both within health and in the larger community in Wales we seek to work with partners to collaborate and share best practice. We launched a joint video with Coleg Gwent and a number of our partners in Local Government over our social media platforms to coincide with Welsh language rights day, the video shone a light on the importance of delivery of services through the medium of Welsh.

[‘Mae Gen I Hawl’ Video](#)

The ‘More than Just Words’ forum is made up of the organisations from health and social care working towards the goals of the ‘More than Just Words’ plan. The group meets quarterly and looks to develop resources that can be useful across the organisations.

As Welsh language leads across Wales we have established a Welsh language managers network which looks to develop all Wales solutions, where applicable, to the challenges we face. One example of this is the development of a central information hub that will lead to more effective sharing of good practice at a national level.



EQUALITY IMPACT ASSESSMENTS AND SITE VISITS

Equality Impact Assessment (EQIA)

The Health Board has further developed its Equality Impact Assessment process. Although this process had already begun prior to the result of the tribunal upholding the Welsh Language Commissioner's ruling against Neath Port Talbot Borough Council ([Tribunal upholds Welsh Language Commissioner's ruling](#)), it supported the need for this development.

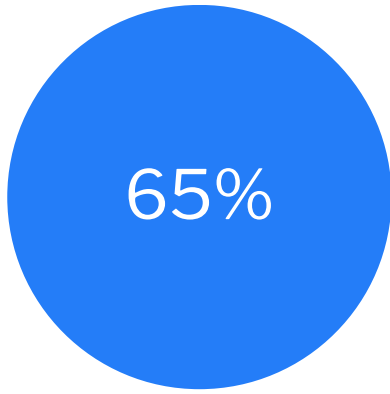
Within the EQIA we aim to ensure that conscientious consideration is given to Welsh language implications of both decisions and new policies. The Head of the Welsh language unit is a standing member of the EQIA panel, and as such is part of ensuring the Welsh language has been fully considered before any EQIA is signed off.

Site Visits

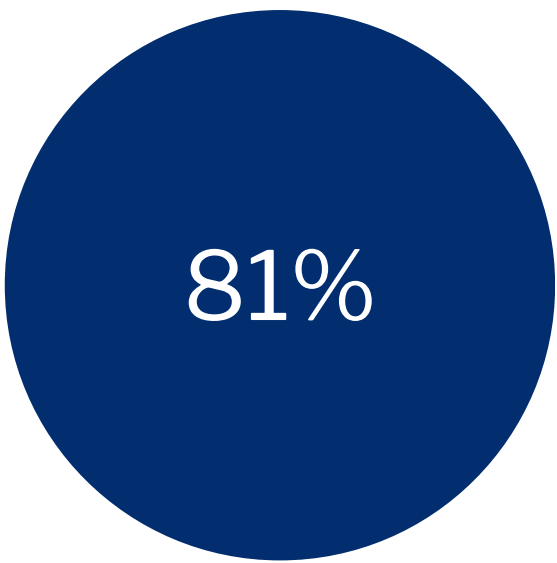
We regularly undertake audits of our Healthcare settings to identify any instances of both good practice and non-compliance. Following each visit the sites are provided with any actions that need to be undertaken. A follow up visit is scheduled at an appropriate time to ensure these actions have been undertaken. Examples of good practice are shared with other colleagues through the WLSG to ensure they are cascaded across all locations. The audit includes a walkaround of sites both communal areas and wards. We monitor signage, letters and forms, as well as ensuring that our staff are wearing Welsh language visual markers and that 'Active Offer' posters are clearly displayed to ensure our service users are aware that they can seek support in Welsh. In our visits this year we have noted an improvement in overall compliance, but continue to see issues in relation to temporary signage being produced and displayed in English only. This matter will be addressed through communication in the next year.

THE FIGURES

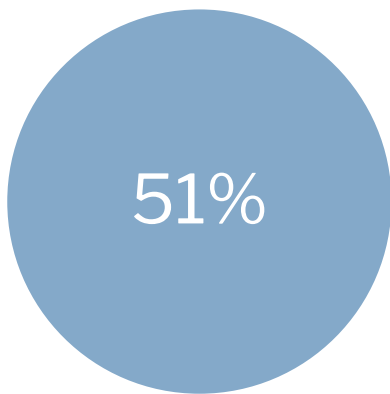
% OF STAFF WHO HAVE
RECORDED THEIR WELSH LANGAUGE
SKILLS VIA ESR



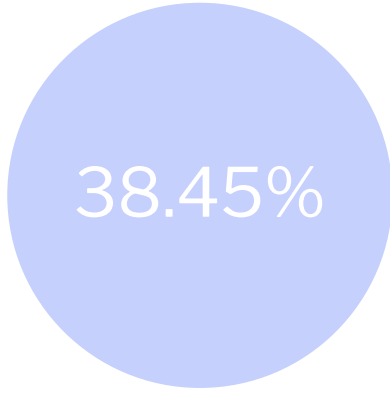
2021/22



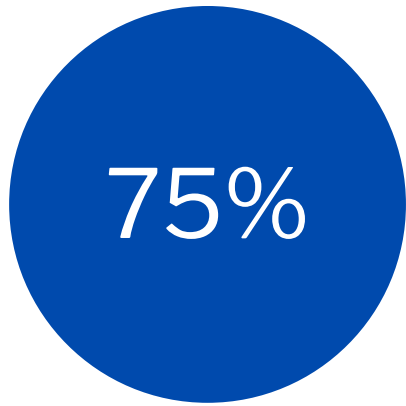
2023/24



2020/21



2019/20



2022/23

PERFORMANCE INDICATOR DATA

‘More than Just Words’ Awareness Training

The mandatory training module developed at an all-Wales level has been well received and gives staff a good general understanding of the principles of ‘More than Just Words’. In the first year of the training, we have in 12 months reached 74% compliance.

Employee skills

The percentage Staff who have recorded their Welsh language skills on ESR has reached 81% a rise of 6% from last year and a rise of 43% since 31st of March 2020.

Recruitment Skills Data

Although the number of roles advertised with Welsh as being essential, desirable or needed to be learnt shows a small decrease, this correlates with a general decrease in the number of overall jobs advertised. As a proportion of the number of vacancies the trend continues to show an increase in the number of roles advertised as Welsh essential, desirable or needed to be learnt.

Over the next year we will be reviewing new recruitment tools implemented by Digital Health Care Wales and Powys Teaching Local Health Board which support a more accurate matching of Welsh language skill requirements and the needs of the service. The new mechanism removes the subjective element of this assessment. The recruiting manager is required to input information around current language skills within the department as well as information in relation to the level of interaction with patients. Based on this data an assessment is made and the recruiting manager is advised as to whether the role should be advertised as Welsh skills being essential, desirable, or not required.

WELSH COMPETENCY LEVELS OF OUR STAFF

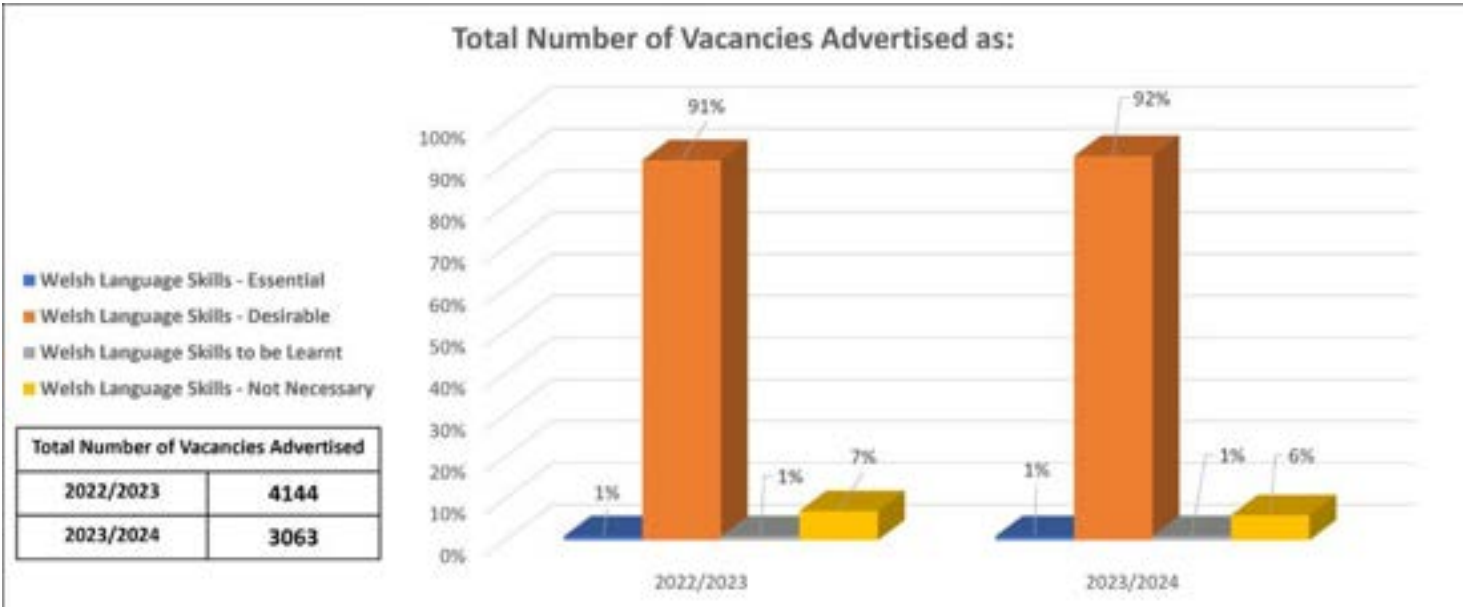
Listening and Speaking	2020/21	2021/22	2022/23	2023/24
Level 0	3790	7888	9063	9528
Level 1	676	1747	2045	2038
Level 2	136	355	434	415
Level 3	80	137	161	166
Level 4	82	135	151	139
Level 5	91	230	277	249
Non-compliant	9809	5300 -46% from previous year	4146 -22% from previous year	2882 -30% from previous year

Reading	2020/21	2021/22	2022/23	2023/24
Level 0	3753	7998	9412	9731
Level 1	590	1530	1850	1799
Level 2	136	355	434	398
Level 3	80	137	146	147
Level 4	82	135	141	132
Level 5	91	230	291	267
Non-compliant	9809	5379 -46% from previous year	4003 -25% from previous year	2943 -26% from previous year

Writing	2020/21	2021/22	2022/23	2023/24
Level 0	3867	8259	9723	10102
Level 1	462	1254	1530	1467
Level 2	131	337	418	397
Level 3	58	100	131	131
Level 4	61	105	116	104
Level 5	78	219	268	247
Non-compliant	10007	5446 -45% from previous year	4091 -25% from previous year	2969 -27% from previous year

The above numbers are based on live assignments

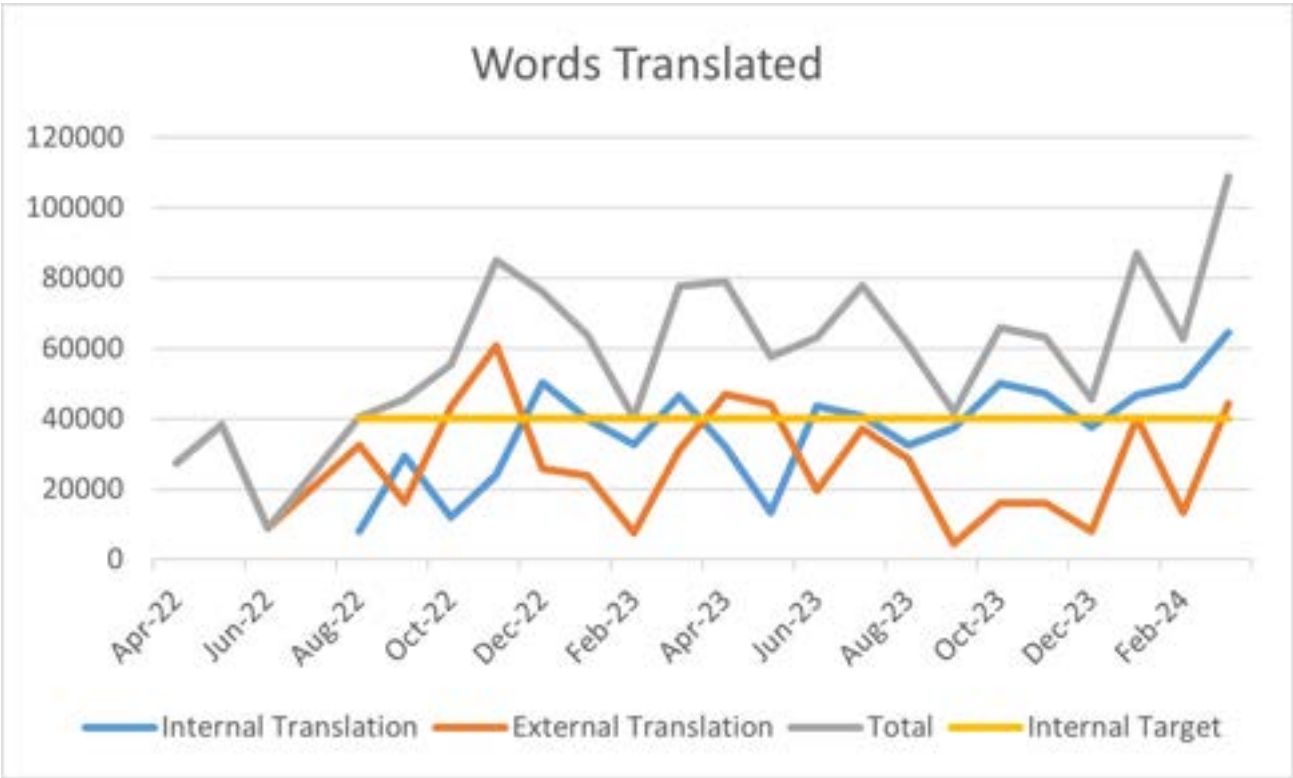
WORKFORCE PLANNING: RECRUITING TO VACANCIES 2022 - 2023



TRANSLATION

Over the past 12 months we have made considerable improvements in the internal processes used to identify, triage and translate. We have simplified the translation request process by all translation now centralised and managed by our internal translation manager. As a consequence, we are observing an increase in the understanding of the requirements in relation to translation within the Health Board and optimising the translation resources available.

We continue to see a general increase in the number of words translated and monitor new AI translation software options to ensure we are aware of the latest developments in this field such as Microsoft Co-Pilot.



FFRIND I MI

We recognise the invaluable service provided by the volunteers of the 'Ffrind i mi' service. As such we were thrilled to hear the story of Sylvia who is one of these volunteers. Sylvia, realising that one of the service users she visited was a Welsh speaker was able to talk with the patient in Welsh which was her first language. As the video linked below shows, the impact this had on the patient was immeasurable. The video is available by clicking [here](#).

Due to their hard work and continued support for our Welsh speaking service users we were thrilled that the Ffrind i Mi project were the recipients of the Health Boards Welsh language champion award within our wider Staff Recognition Awards.



COMPLAINTS

In the past year we have received 2 service user complaints that relate to Welsh language delivery. Both of these have been dealt with through the Health Boards Putting Things Right process.

We have also received one investigation by the Welsh Language Commissioners office. The investigation related to non-compliance with standards 9 and 10 which relate to our telephony service specifically **Standard 9:**

“When a person contacts you on your main telephone number (or numbers), or on any helpline numbers or call centre numbers, you must inform the person that a Welsh language service is available.”

and **Standard 10:**

“When a person contacts you on your main telephone number (or numbers), or on any helpline numbers or call centre numbers, you must deal with the call in Welsh if that is the person’s wish until such point as—

- (a) it is necessary to transfer the call to a member of staff who does not speak Welsh who can provide a service on a specific subject matter; and
- (b) no Welsh speaking member of staff is available to provide a service on that specific subject matter.”

The most practical way to ensure compliance with standard 9 is to include into your automated message a note to inform that a Welsh language service is available. The telephony system utilised by the Health Board at the time of the investigation did not allow for this amendment to be made to the messages. Working with colleagues in the Digital, Data and Technology team we were able to amend the phonelines, adjust the messages and ensure compliance with standard 9.

With regards standard 10 we have actively attempted on several occasions to recruit staff to the service in question who are able to deal with calls through the medium of Welsh. Although we continue to have limited success in recruiting staff with the requisite Welsh Language skills for these roles, we are pleased that the Commissioner’s office recognise the work undertaken in this area and have closed the investigation.

We will continue to utilise all available avenues to recruit Welsh language speakers to our telephony service.

CONCLUSION AND VISION FOR 2024- 2025

With a number of new digital platforms and mechanisms to support patients and staff, either already operational or in development we see this as a key area of work for us in the future. Where new systems are to be implemented to increase efficiency and develop new pathways to care, we will ensure that the Welsh language is fully embedded into that work.

We will connect further with our Welsh speaking service users to gain a greater understanding of their experiences in accessing Health provision in Welsh and the barriers they face. We aim to also understand why some service users who would prefer to access services in Welsh are not doing so. Our aim is to gain insights that will allow us to better tailor awareness sessions and training sessions delivered to our staff so that we are better equipped to both understand, and respond to the needs of our service users.

We will extend the Skills Surgery programme further inspiring and educating the Primary school pupils in the Welsh medium schools of the region about the opportunities there will be for future employment.

We will continue our routine work of site visits, mystery shopper and spot checks across our services and sites as an internal quality assurance measure.

A key priority for the year ahead is the development and publication of our new plan to increase the offer of clinical consultations through the medium of Welsh in line with standard 110 of the Welsh Language Standards. Our first 5-year strategy was looking at targets at a Health Board level, but it has become clear that in order to have a true impact there is a requirement to look at more targeted and bespoke plans within specific departments of the Health Board. Taking advice from the Welsh Language Commissioners office we will be commencing with a pilot in one service area with a view to understand how localised plans will be able to demonstrate a greater impact for patients and give an approach that can identify areas of development as well as examples of best practice that can be replicated across other areas.

We will develop our network and engagement activities throughout the Health Board focussing in the next year on the directorate manager level to ensure that the messages and information is reaching all staff at all levels throughout the Health Board.

We are pleased to have further developed our positive working relationship with the office of the Welsh Language Commissioner and look forward to the model of co-regulation that their office is looking to move towards.

We continue to drive for excellence in our Welsh Language Service Delivery and are grateful for the direction and guidance provided by the Welsh Language Standards as well as the 'More Than Just Words' plan. With the Health Boards new People Plan currently in development we will continue to embed the Welsh Language into all aspects of our work.





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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Quality Report 2023-24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Executive Medical Director Jennifer Winslade, Executive Director of Nursing Peter Carr, Executive Director of Therapies & Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents the Board with the first Annual Quality Report for 2023/24, aligned to the reporting requirements in the Health and Social Care (Quality and Engagement) (Wales) Act (2020), which emphasised quality, transparency, and engagement through the Duty of Quality, Duty of Candour, and Citizen’s Voice; Llais.

This report provides a narrative on our quality journey throughout the year and reviews past objectives and sets new priorities for improving patient and staff safety, outcomes, and experiences.

We implemented two strategies, the Quality Strategy and the Patient Experience and Involvement Strategy aimed at improving services, clinical effectiveness, safety, and experiences, involving patients, families, carers, staff, and the community. Our Quality Strategy prioritises patient safety and staff wellbeing, guiding our plans and decisions. We developed a number of workstreams that impact on patient safety and have driven improvement considering a whole system approach, with was a commitment and focus on developing our quality management system.

Heading into 2024/25, we will carry forward our achievements and focus on continuous quality improvement and recognise the significant and invaluable contributions of our teams, staff, volunteers, patients, partners, and stakeholders.

The Health and Care Quality Standards provide a clear framework to help the planning, delivery and monitoring of healthcare services in Aneurin Bevan University Health Board.

The outcomes and indicators reported here are a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover aspects of care, clinical outcomes, patient safety and patient experience.

Asesiad / Assessment

The Annual Quality Report provides information on our preparation programme to deliver the Duty of Quality and review our reporting and assurance framework. Key workstreams were identified as a priority for the first 12 months and key actions and initiatives can be found in the report to demonstrate the impact on patient safety.

The Health Board adopted a reporting structure which mapped progress on quality and patient safety against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

As part of our statutory reporting under the Duty of Quality the report aims to focus on a report that can be read by members of the public. Our first report reviews past achievements, identifies challenges, and outlines future priorities and monitoring methods. It showcases our efforts to embed quality across the Health Board, using continuous 'Always on' reporting throughout 2023/24.

As part of the Quality Strategy an Implementation Plan was produced for the Health Board to enhance the quality of healthcare throughout 2023. In order to deliver the Health and Care Quality Standards, the plan was mapped with quarterly objectives aligned to the six key quality domains. Highlights of the achievements for 2023/24 can be seen in the Appendix. This plan was built on existing achievements,

emphasising continuous improvement and embedding quality, safety, and learning in daily operations.

The report details the work on embedded learning and improvement which has developed over the year. Heading into 2024/25, we will carry forward our achievements and focus on continuous quality improvement. The Health Board is refining the workplan for year two and the quality enablers to support the delivery. As ongoing work, we will continue to strengthen our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

Key priorities for the next six months include automation and revision to the Quality Outcomes Framework, development of Integrated reporting with Finance, Workforce and Planning, strengthening of Quality Patient Safety structures within Divisions, refreshing the Quality Improvement Plan and strengthening assurance and reporting.

Argymhelliad / Recommendation

The Board is asked to NOTE the progress of work over the past 12 months as reflected and APPROVE the Annual Quality Report 2023/24.

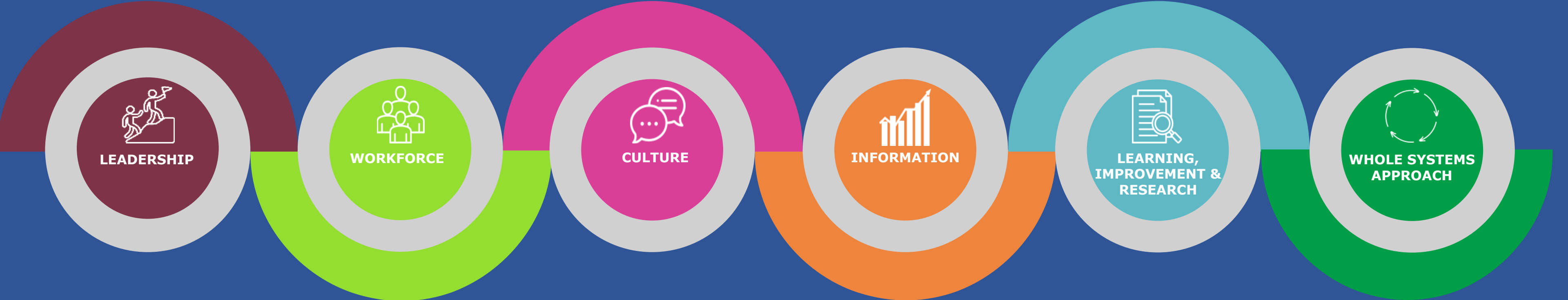
Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee Patient Quality, Safety & Outcomes Committee

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

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Quality Annual Report 2023/24



Executive Summary

Welcome to the Aneurin Bevan University Health Board's Quality report for 2023/24.

The Health Board presents the 2023/24 Annual Quality Report, reviewing past objectives and setting priorities for improving patient and staff safety, outcomes, and experiences. This report provides a narrative on our quality journey throughout the year.

This year was busy with many challenges, met by the hard work and commitment of our staff, leading to progress in our improvement priorities.

In 2023/24, Aneurin Bevan University Health Board focused on quality and safety, aiming to deliver high-quality healthcare. This focus was bolstered by the Health and Social Care (Quality and Engagement) (Wales) Act (2020), which emphasised quality, transparency, and engagement through the Duty of Quality, Duty of Candour, and the creation of the Citizen's Voice through Llais.

We have implemented two strategies aimed at improving the quality of our clinical services, the clinical effectiveness of care, improving safety and reducing avoidable harm and improving the experience patients, their families and their carers. These strategies have also increased the involvement of patients, families, carers, staff, and the community in planning delivering and assessing the quality of care.

Heading into 2024/25, we carry forward our achievements and focus on continuous quality improvement. Thank you to our team, staff, volunteers, patients, partners, and stakeholders for your invaluable contributions.



Jennifer Winslade
Executive Director of Nursing



Dr James Calvert
Executive Medical Director



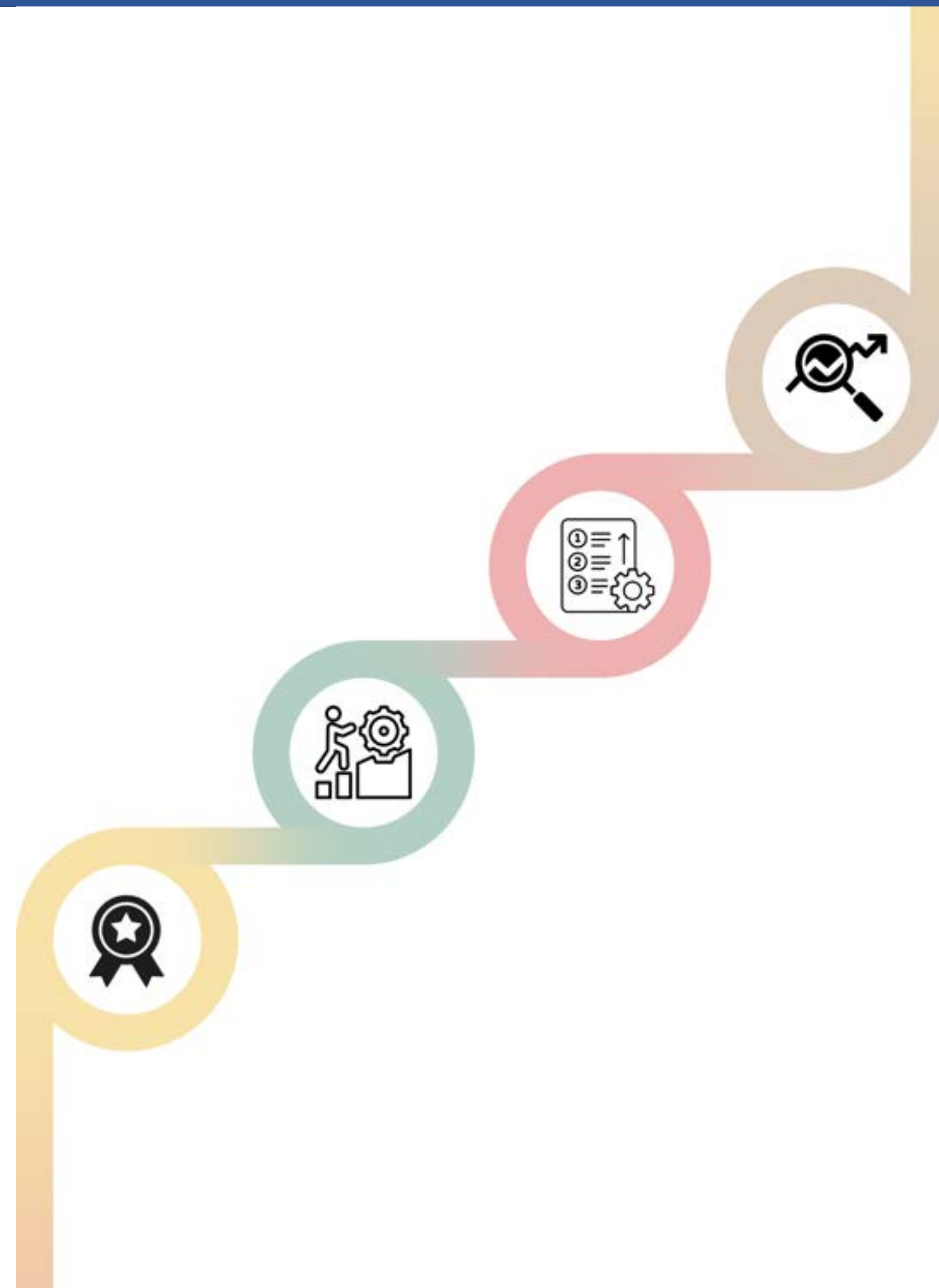
Peter Carr
Executive Director of Therapies
and Health Science

Introduction

NHS bodies must publish an annual quality report detailing steps taken to comply with the duty of quality. Our first report reviews past achievements, identifies challenges, and outlines future priorities and monitoring methods.

Quality standards are guided by the Health and Social Care (Quality and Engagement) (Wales) Act 2020, A Healthier Wales and Core Commissioning Requirements.

This report showcases our efforts to embed quality across the Health Board, using continuous 'Always on' reporting throughout 2023/24. This is reflected in our reporting to the [Patient Quality, Safety and Outcomes Committee \(PQSOC\)](#) and the forward work plan.



Preparation Programme

The Health Board initiated a comprehensive program to prepare for the Health and Engagement Act, including a readiness assessment to identify key leadership roles for quality and candour duties.

Workshops and sessions were conducted with stakeholders to develop a Quality Strategy with input from healthcare partners, patients, and staff, ensuring readiness for April 2023. The strategy was launched through engagement sessions, a Board developmental session, and updates to the intranet, along with public-facing videos and staff information provided by the NHS Executive. Information was also disseminated via memorandums and dedicated webpages with details and training resources.

The Health Board's Quality Strategy is underpinned by "A Healthier Wales," focusing on quality and safety through our 'pillars of quality' program. These pillars help review performance and reporting to the Board and PQSOC, ensuring high standards of care in:

- Patient and staff experience
- Incident reporting (falls, pressure ulcers, medicines management, mortality)
- Complaints, concerns, and compliments
- Health, safety, and security
- Infection control and prevention
- Safeguarding



Reporting and Assurance

The Health Board developed a Quality Outcomes Framework (QOF) as part of its Quality Management System in quarter two 2023/24. This framework tracks outcomes to systematically measure, monitor, and enhance healthcare quality.

The QOF aimed to enable continuous improvement with key goals to:

- Identify improvement areas and patient safety risks
- Establish benchmarks and quality indicators
- Promote evidence-based practices
- Enhance patient satisfaction and experience
- Ensure compliance with standards and regulations
- Enable data-driven decisions and resource allocation
- Foster a culture of accountability, transparency, and learning

The QOF has enhanced **reporting requirements** to the Board and Executive Committee, and providing assurance to PQSOC. Benefits of the QOF have included:

- Improved patient outcomes and safety
- Enhanced patient experience and satisfaction
- Increased adherence to evidence-based practices
- Efficient resource utilisation
- Regulatory compliance
- Improved staff engagement and professional development
- Accountability and transparency in care delivery

The Health Board has developed a Governance and Assurance Framework for Quality to support the Quality Management System (QMS) at all levels. This work will continue into 2024/25, reviewing reporting arrangements via Groups and Committees, aiming to implement a new oversight and reporting structure for transparency and performance monitoring. Objectives of the quality governance framework includes:

- Define and shape quality governance across the organisation
- Support the Board in achieving quality governance
- Clarify reporting lines
- Increase assurance, public trust, and confidence

A multi-professional Clinical Forum will be developed with Clinical Executives in 2024/25. This will form a Clinical Advisory Committee, which will support Quality and Professional Strategies, provide independent strategic advice and maintain a strategic overview.

Progress on 2023/24 Priorities

Our quality ambitions for the first three years focused on prioritising quality and safety, acknowledging that challenges evolve. Over the past year, our key commitments were:

- **Learning Organisation:** We strive to be a learning organisation where staff deliver high-quality clinical care daily.
- **System Understanding and Capability Building:** We aim to understand our care systems, build capability through an all-teach/all-learn philosophy, encourage innovation, and engage patients, relatives, carers, staff, and communities in improvement efforts while learning from mistakes.
- **Embedded Quality and Supportive Culture:** Quality is embedded throughout the Health Board, fostering a culture of openness and transparency where concerns can be raised.
- **Collaborating and Partnership:** Patients, relatives, carers, staff, and communities will partner with us to achieve our vision.

Our strategies have been shaped by the experiences of patients, relatives, carers, staff, and communities, focusing on improvement, planning, and assurance in alignment with the Duty of Quality and Duty of Candour.

Quality Strategy

This provided a:

- **Blueprint for Patient Safety and Quality:** Outlines patient safety and quality for the next three years.
- **Focus on Quality and Safety:** Prioritises quality and safety while addressing emerging challenges.
- **Improvement Objectives:** Sets improvement goals and a supporting framework for the next three years.
- **Commitment to Continuous Improvement:** Embeds a culture valuing quality and continuous improvement.



Patient Experience & Involvement Strategy

This provided a

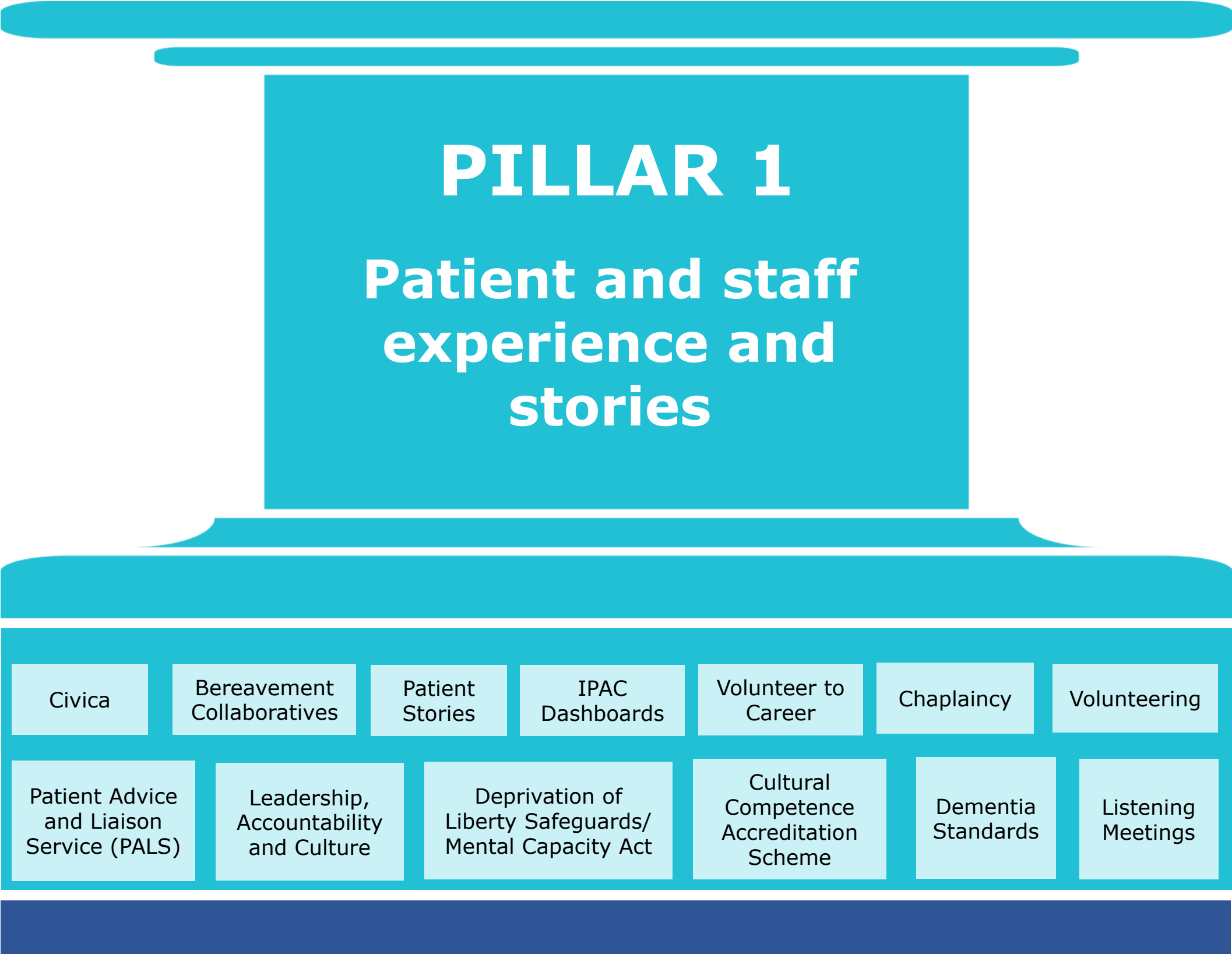
- **Feedback-Driven Culture:** Created & based on feedback from staff, patients, families, and carers, focusing on what matters to them.
- **Passion for Improvement:** Acknowledges staff's dedication to improving service experiences.
- **Learning from Experience:** Places learning from experiences at the Health Board's core.



These strategies ensure that quality, safety, and continuous improvement are central to all our activities, fostering a culture of excellence and collaboration.

Progress against 2023/24 Objectives

• Delivery of an approved strategy for Quality, Framework and Delivery Plan with a clear understanding of priorities.		Quality Strategy Implementation Plan developed and approved, supporting our reporting structure through a quality outcome framework.
• Through the launch of the new system for patient experience and the Health and Well-being survey, put in place mechanisms to learn from the insight gained.		Civica Platform Launch: Enhanced real-time patient experience feedback, enabling ongoing partnerships with patients, families, carers, staff, and communities.
• Establish a framework for learning and skills at all levels and the capacity and capability to grow and develop our skills and learning networks.		Listening and Learning Framework: Held meetings to engage and inform this nearly completed framework. Developing Best Practices: Through listening and learning, supporting staff to deliver excellent person-centred care.
• Deliver the Safe Care Partnership, Faculty workstreams and the outcomes as set by each team.		Quality Improvement Capability: Expanded through the Safe Care Partnership, building capacity, conditions, and connections for staff to use QI methodology to solve complex problems consistently. Just Culture: Continuously working to correct mistakes, encouraging experience sharing, and restoring confidence.
• Agree and implement the measures and reporting structures.		Reporting Structures: Huge progress on developing our reporting structure, reporting via a quality outcomes framework has enabled clear indicators reported aligned to the Health and Care Quality Standards. We have made this a priority to refine reporting for 2024/25.
• Review the capability of our data capture systems for resilience and suitability.		Quality Management System: working collaboratively with the Divisions of planning and digital, data and technology has enabled data capture to be developed through existing systems.
• Implement new systems to provide insight and support for delivery.		Quality Management System: developing the quality outcomes framework provided quantitative data that can be reported. We have enriched this data with narrative and included patient stories and staff feedback.
• Review our quality and safety structures and teams along with the reporting structures to ensure learning at every level and appropriate assurance and governance.		Reviewed Structures: Aligned resources within Quality and Patient Safety. A review of the reporting and assurance via current governance structures and Groups and Committees will continue through 2024/25.



Key Achievements

Patient Experience - Launch of the Citizen Feedback System:

- **Total Responses:** 1,343 (Person-Centred Care Survey: 1,137).
- **Satisfaction Score:** 86% for Person-Centred Care Survey.
- **Surveys:** 10 live surveys, including 3 national surveys (Emergency Department, Palliative Care, National Nosocomial Investigation).
- **Active Areas:** 190 areas.
- **Staff Training:** 229 Health Board staff trained.
- **Promotion:** Development of a promotional poster, improved uptake.
- **Engagement:** Enhanced engagement with Teams/Divisions and QPS Teams.
- **Collaboration:** Strong collaboration across Wales on patient experience.

Patient Advice and Liaison Service (PALS):

- **Launch:** November 2023.
- **Contacts:** 3,978 contacts, including enquiries and complaints.
- **Complaints:** 162 complaints received, 155 managed by PALS, 7 escalated to PTR (4.3%).
- **Compliments:** 49 received.
- **Champion Roles:** Developed roles in Equality, Diversity & Inclusion, Dementia, Bereavement, and CIVICA.
- **Recognition:** Nominations are being written in the Patient Experience category at the staff recognition awards for 2024.
- **Surveys:** Planned launch for PALS Patient and Relative Feedback survey will be launched in May 2024.
- **Engagement:** Met with families and clinical teams to avoid escalation to PTR; attended Caerphilly Deaf club following a formal complaint for positive actions.
- **Outreach:** Met with teams, directorates, and divisions to highlight PALS benefits.

Areas for Improvement

- Ensuring all 'live' areas are collecting feedback.
- Timely access to feedback by some areas.
- High volume of feedback from paper surveys, concerns about the method and cost.
- Delays with paper surveys might lead to missed or untimely feedback.
- Lack of SMS feedback usage possibly affecting response rates.
- Slower rollout due to training demands and limited staff (one dedicated member for CIVICA).

Priorities for 2024/25

- National progress; the Health Board is the only one in Wales not using CIVICA SMS.
- Limited resources, with only one Administrator affecting rollout speed.
- Need to demonstrate evidence of feedback collection and learning.
- Possible implementation of new Core Questions.
- Unable to offer bespoke PREM surveys due to resource constraints.
- Costs associated with implementing CIVICA SMS (currently piloting in the Emergency Department).

PALS Challenges for 2024/25:

- Achieving absolute early resolution is difficult due to complex enquiries.
- Developing a role for a Patient and Family Support Officer for end-of-life and bereavement support.
- Lack of dedicated PALS hubs across the Health Board; hubs would offer 'drop-in' opportunities.
- Current staffing limits capacity for face-to-face support, prioritising urgent cases.

PILLAR 2

Incident Reporting
Falls
Pressure Ulcers
Medicines Management
Mortality

Leadership, Accountability and Culture	Never Events	Deteriorating Patient	Patient Safety Incident process	QPSE Dashboards
Pressure Ulcers / Medicines Management	Staff Training	Datix (validation)	Falls Panel	Duty of Candour
Learning, Monitoring & Assurance	Just Culture/ Psychological Safety	Mortality	Risk Registers	Human Factors

Falls

Key Achievements

- Significant effort in tracking and analysing falls within the Health Board.
- Comprehensive data collection system through RLDatix.
- Notable reductions in falls incidents observed in February 2024, following a peak in January 2024.
- See falls improvement programme for additional information.

Priorities for 2024/25

- Managing a high volume of falls incidents, with 44 patients experiencing more than two falls within a short period.
- Continued improvement needed in falls prevention strategies, particularly among high-risk patients.

Pressure Ulcers

Key Achievements

- Establishment of the Pressure Ulcer Faculty in 2023.
- Implementation of educational initiatives and pilot projects, including a PDSA cycle.
- Downward trend in HAPU incidences from January to April 2024.

Priorities for 2024/25

- Meeting the Welsh Government standard of 0% avoidable HAPUs.
- Sustained efforts needed to maintain focus on prevention and address contributing factors.

Medicines Management

Key Achievements

- Enhanced monitoring and review processes, focusing on antibiotic prescribing and compliance.
- Utilization of whole genome sequencing (WGS) for Clostridioides difficile infection identification.
- Root cause analyses provided insights into sub-optimal antibiotic use, leading to targeted actions.

Priorities for 2024/25

- Addressing sub-optimal prescribing of antibiotics.
- Ensuring consistent compliance with hand hygiene and environmental cleanliness.

Mortality

Key Achievements

- Development of a governance process for mortality outliers.
- Implementation of the Risk Adjusted Mortality Index (RAMI) tool.
- Ongoing efforts to align mortality review processes with quality improvement frameworks.
- Development of a Learning from Deaths Reporting Framework

Priorities for 2024/25

- Need for a standardized framework to review and learn from mortality cases.
- Ensuring reliability and consistency of mortality data across reporting mechanisms.

Incidents Learning and Improvement

- A review of the Health Board's Patient Safety Incident Policy in November 2023 to align with the All-Wales Directive and to reflect patient and family feedback on the Safety Incident process. This Policy also more explicitly outlines expectations and procedures. A further update is planned to be approved by the Board in September following a further strengthening of the approach;
- Bespoke development of Chair, Investigating Officer and staff responsibilities for Patient Safety Incidents has been established;
- Bespoke rather than generalised training is being provided for Investigating Officers on a 1- 2-1 basis to guide them through the investigation process supported by a member of the Corporate Patient Safety Incident team;
- All moderate and above harm incidents are presented to the weekly Executive Huddle for an investigation level decision, identification of an appropriate Chair and allocation of Executive Sign off lead;
- There is now a focused review of open incidents with Divisional Quality and Patient Safety teams and escalation to Triumvirates (then Executives) where delays occur; and
- There has been an increase in the number of Executive Chairs to address delays in the initiation of investigation meetings.

Falls Improvement Programme

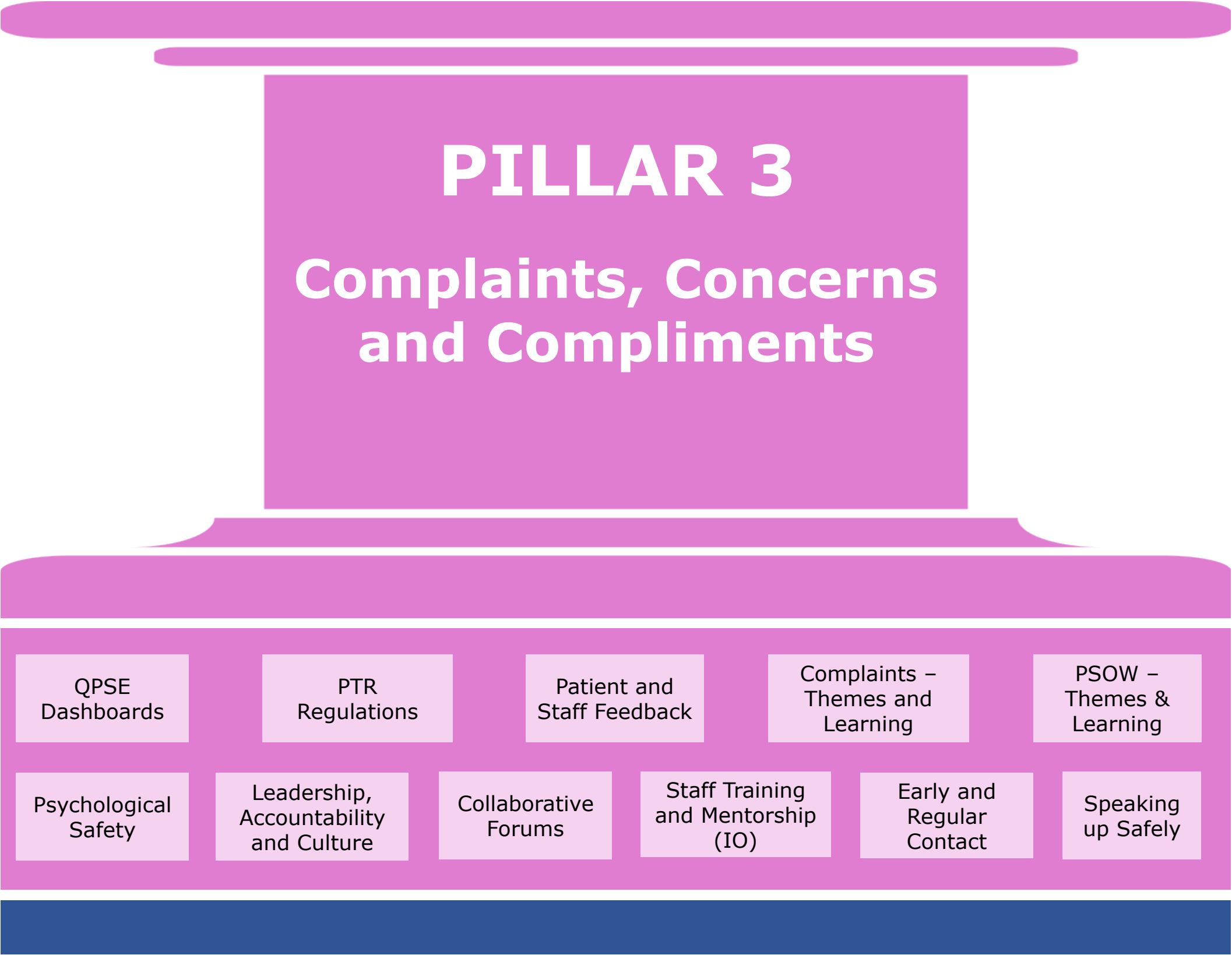
Key Achievements

- **Data Improvement:** Enhanced availability and analysis of falls data across the Health Board have informed key quality improvement initiatives, leading to better monitoring and reduction of falls.
- **SWARM Methodology Implementation:** Rolled out in April 2023 within the Medicine Division, this multi-disciplinary team (MDT) approach is being expanded across the wards.
- **Digital Integration:** Successful rollout of the Welsh Nursing Care Record Multi-Factorial Risk Assessment (MFRA) to wards, with completion anticipated in October 2024. Additionally, a modified MFRA has been developed for use in Emergency Departments.
- **National Contributions:** Contributed to the development of the Falls National Head Injuries pathway and the National Inpatient Falls Network's work on sensor use, setting a national standard.
- **Ward Accreditation:** Falls prevention and management have been incorporated into the ward accreditation initiative, further embedding these practices into daily routines.
- **Falls Awareness:** A highly successful Falls Awareness Week in 2023 saw significant patient and staff engagement across the Health Board.
- **RIDDOR Compliance:** Established a Standard Operating Procedure (SOP) and developed a compliance dashboard within the Datix system to improve reporting and monitoring.
- **Training:** Continued delivery of falls prevention and management training, adapted for the digital format of the Welsh Nursing Care Record.

Priorities for 2024/25

- **Consistency in Practice:** Ensuring consistent application of the SWARM methodology and MFRA across all wards and specialties remains a challenge.
- **Data Utilisation:** While data availability has improved, fully leveraging this data to drive sustained reductions in fall rates and severity of harm requires ongoing effort.
- **Staff Engagement:** Maintaining high levels of staff engagement in falls prevention initiatives, especially in the face of evolving clinical environments and pressures, is a continuing challenge.
- **Technological Integration:** The successful digital integration of falls management tools like MFRA needs continuous support to ensure all staff are proficient and the tools are used effectively.
- **Resource Allocation:** Ensuring that adequate resources, including appropriate flat lifting equipment and trained personnel, are available across all units to effectively manage falls.
- **RIDDOR Reporting:** Despite progress, achieving full compliance with RIDDOR reporting protocols across the Health Board requires ongoing monitoring and training efforts.

These achievements and challenges reflect the Health Board's commitment to reducing falls and improving patient safety across its facilities. The next steps focus on building upon these successes through enhanced training, data utilization, and multi-disciplinary collaboration.



Key Achievements

- **PTR Regulations:** Active engagement in the review and public consultation.
- **Early Resolution and Meaningful Engagement:** Implementation of PALS.
- **Planned Initiatives:** Introduction of an "Acknowledgement Team" and development of Communication Standards.
- **Groundhog Day 2:** an opportunity for cultural change? the Health Board's actions are complete
- **Collaborate & Learning:** Working closely with various oversight bodies and commitment to an open culture.

Common Complaint Themes

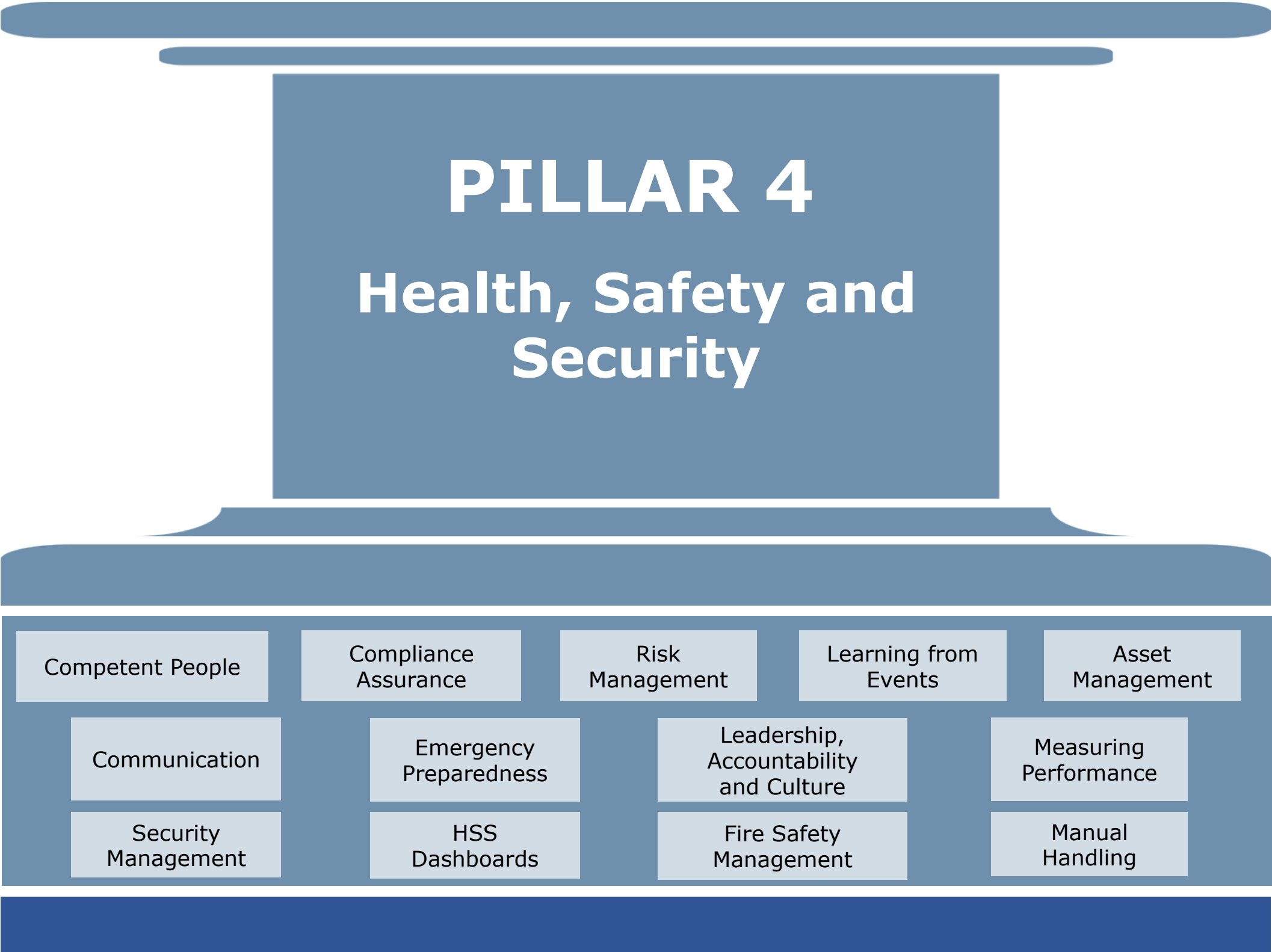
- Clinical treatment/ assessment
- Appointments
- Communication issues.
- Concerns about wait times and the impact of Covid on clinical treatment and assessment.

2023/24 Statistics

- **Formal Complaints:** 1,596 received.
- **Resolved via Early Resolution:** 1,555.
- **Compliance Target:** Striving to meet the Welsh Government's 75% compliance target for 30-working day response times.

Priorities for 2024/25

- Prioritise timely and appropriate management of concerns.
- Achieve compliance with the Welsh Government Targets
- Collaborate with colleagues, communities, and partners to ensure quality and safety.
- Working closely with various oversight bodies and commitment to an open culture.



Key Achievements

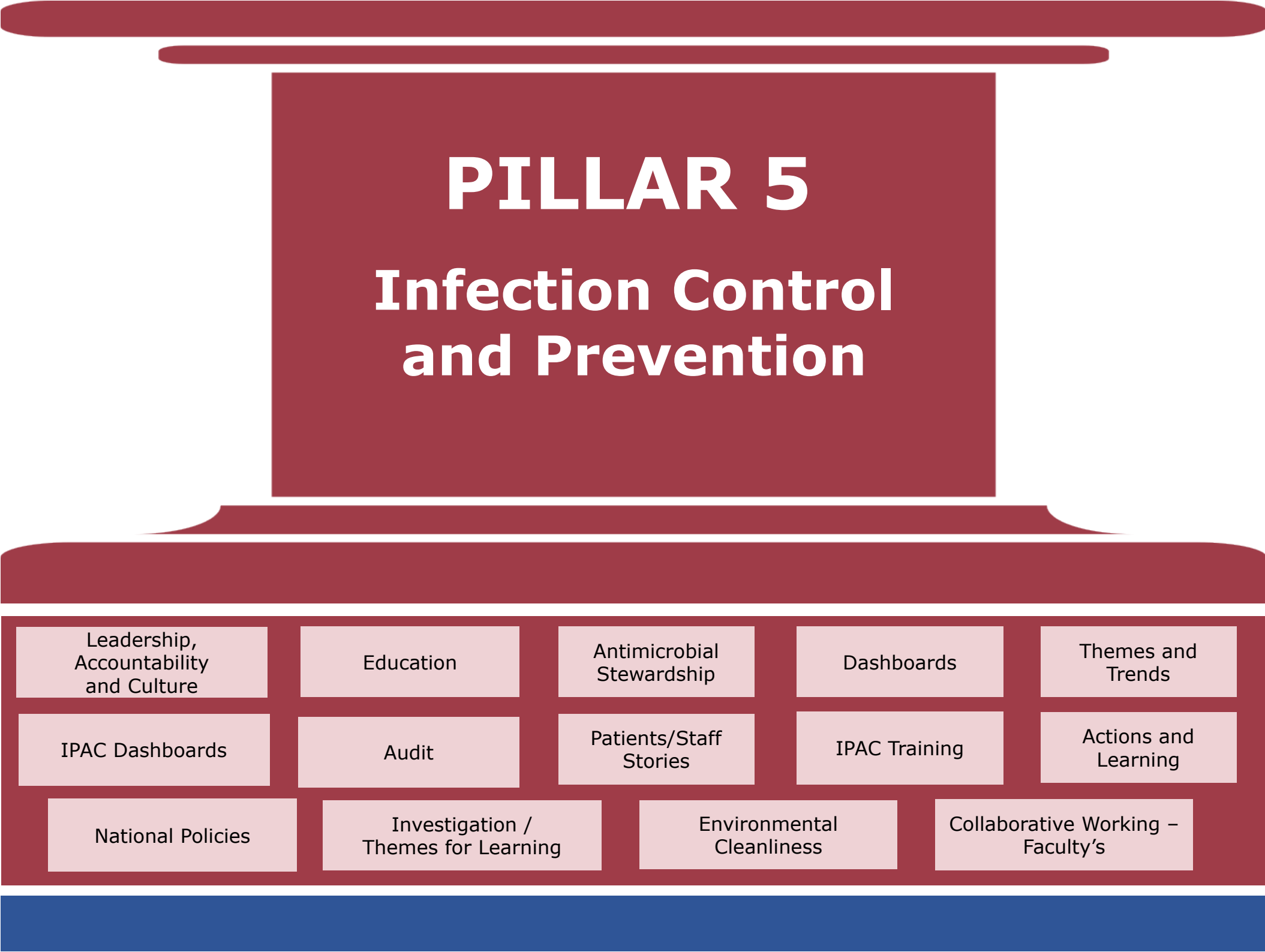
- **Health, Safety & Fire Improvement Plan:** Implemented a 30, 60, 90-day plan, resulting in improved compliance and risk reduction.
- **Health & Safety Monitoring:** Conducted 51 workplace inspections with an average compliance score of 88.2%.
- **RIDDOR Reporting:** Established a RIDDOR Compliance Dashboard and new awareness training sessions.
- **Training and Development:** Conducted various safety training sessions.
- **Safety Procedures and Protocols:** Introduced new or updated procedures.
- **Fire Risk Assessments:** Completed 96% of programmed assessments.
- **Support for New Developments:** Assisted with planning and opening of new facilities.
- **Fire Alarm System Projects:** Replaced outdated systems and planned further upgrades.

Areas for Improvement

- Ensuring timely action completion by local managers following inspections.
- Enhanced engagement in Health & Safety to reduce reliance on Corporate Health & Safety.

Priorities for 2024/25

- Continue to deliver the Health & Safety Improvement Plan
- Balancing resources to enhance current safety measures and implement new initiatives.
- Develop and embed a Health & Safety Management System
- Implement the Health & Safety Governance Framework
- Implement Health & Safety Checklists to enable local monitoring
- Implement a revised strategy for the delivery of inanimate load handling training



Key Achievements

- **Welsh Government Reduction Goals:** Reduction in infection rates.
- **C-Section Surgical Site Infections:** Reduced to pre-pandemic levels.
- **Audit & Education:** Conducted 1,538 audits and trained 1,294 staff.
- **Respiratory Infections:** Managed Covid-19, Influenza, and RSV rates effectively.
- **COVID Investigation:** Reviewed 2,883 nosocomial infection cases with no cases referred to Legal and Risk.

Key Strategies and Interventions

- Focus on Gram-Negative Bloodstream Infections through various initiatives.
- Enhanced cleaning strategy and prudent antimicrobial prescribing

Areas for Improvement

- Addressing increase in healthcare-associated infections, particularly Klebsiella bloodstream infections.

Priorities for 2024/25

- Developing a robust cleaning program to reduce healthcare-associated infections.
- Managing patient flow and infection prevention.
- Ensuring ongoing support for infection prevention best practices.

PILLAR 6
Safeguarding

Policy/SOP	Leadership, Accountability and Culture	Level 1, 2 and 3 Training	Safeguarding Supervision
Practitioner Concerns	Partnership Working	Domestic Abuse and Sexual Safety	Statutory Reviews

Key Achievements

- Improved Safeguarding Maturity Matrix outcomes.
- Delivered Level 3 Safeguarding Training.
- Expanded scope for safeguarding supervision.
- Achieved reasonable assurance in Safeguarding Audit.
- Sustained Independent Domestic Violence Advocate role in urgent care.
- Established a productive Safeguarding Committee.
- Actively supported MARAC process.
- Increased volume of Safeguarding Children and Adult referrals.

Areas for Improvement

- Addressing delays in quality assurance and service improvement due to increased operational activity.
- Mandating Level 3 Training for specific staff via ESR limitations.
- Securing funding for the IRIS program to support domestic abuse survivors.

Priorities for 2024/25

- Ensuring primary care staff receive necessary training and resources.
- Providing appropriate Safeguarding Adult Supervision.
- Developing and launching sexual safety documents.
- Revising delivery and monitoring model for Level 3 Safeguarding training.
- Launching the DATIX Safeguarding Module for better case management.
- Updating internal processes and achieving objectives despite operational demands.

Workstream Priorities

2023/24

Deteriorating Patients

Addressing Deteriorating Patients: 2023/24 Key Actions

Background

Deteriorating patients are a significant issue due to basic care and observation failures and presents a multifaceted problem across the Health Board. Oversight by the Executive Director for Nursing emphasised returning to fundamental nursing, therapy, and medical care practices. A thematic review of serious incidents highlighted issues such as incomplete observations and failures to escalate concerns, underscoring the need for comprehensive reviews.

Objectives

The Health Board aimed to address systemic issues and improve patient safety through the following strategies:

Actions and Steps

 THEMATIC REVIEWS	 EDUCATION AND TRAINING	 SYSTEMIC AND CULTURAL IMPROVEMENTS	 LEADERSHIP AND PSYCHOLOGICAL SAFETY	 SPEAK UP FOR SAFETY INITIATIVE
- Conducted thematic reviews to identify systemic issues and recurring themes - Engaged staff in reviews to promote understanding and shared learning across the Health Board.	- Developed and implemented regular education programs on managing deteriorating patients. - Replicated successful initiatives from the Safer Care Collaborative across other departments.	- Fostered a transparent and just culture, encouraging staff to report and discuss incidents without fear of blame. - Utilised safety culture surveys to gauge climate and identify improvement areas.	- Embedded psychological safety within the leadership culture. - Developed leadership competency to empower all staff, especially juniors, to voice concerns. - Incorporated psychological safety competency development into leadership training.	- Launched initiatives such as "Speak Up for Safety" to encourage staff to raise concerns. - Utilised patient safety walkarounds to proactively identify and address safety concerns.

Safer Care Collaborative

Overview:

A two-year national collaboration aiming to develop systems for safe, reliable, and effective care. It focused on strengthening leadership, supporting quality improvement, working across the system, and reducing patient health deterioration.

Achievements

Surgical Ward C0	Reduced cardiac arrests by 75%.
Monmouthshire Team	Improved patient experience during discharge through personalised care.
Older Adult Mental Health Services	Increased access to home-based memory services.
Acute Medical Unit	Introduced standardised observations every four hours.
Operating Theatres Team	Focused on reducing Never Events and building a safety culture.
Executive Safety Walkarounds	Facilitated direct communication between staff and executives to address concerns and support improvements.

Theatre Never Events

Definition of Never Events

- **Never Events:** Serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented.
- The national list of never events evolves, but all such events are avoidable adverse incidents.

Background

This programme, led by the theatre’s safety team with support from the Executive Medical Director and ABCi, addressed a series of never events that occurred in theatres. Despite prior efforts in quality assurance and system redesign, the lack of an overarching approach led to siloed learning and inefficiencies. This workstream emphasised the need for a more integrated system to enhance learning and improve outcomes.

Challenges included a lack of a universally understood process for preventing never events and contribution of multiple system, personal, and environmental factors to these events. There appeared to be an increased in reporting which indicated a transparent culture but also highlights recurring themes and systemic issues.

A thematic review of never events was undertaken in theatres and included:

- **Retained Foreign Bodies:** Such as retained swabs.
- **Wrong-Sided Nerve Blocks:** Involving teams like Anaesthetics, Radiology, OBS, Gynae, Trauma, and Orthopaedics.

Actions and Insights Over 2023/24

Existing Actions:

- Some teams adopted "stop before you block" protocols but faced implementation challenges.
- A test on wrong-site nerve blocks highlighted the need for systemic and multifactorial solutions.

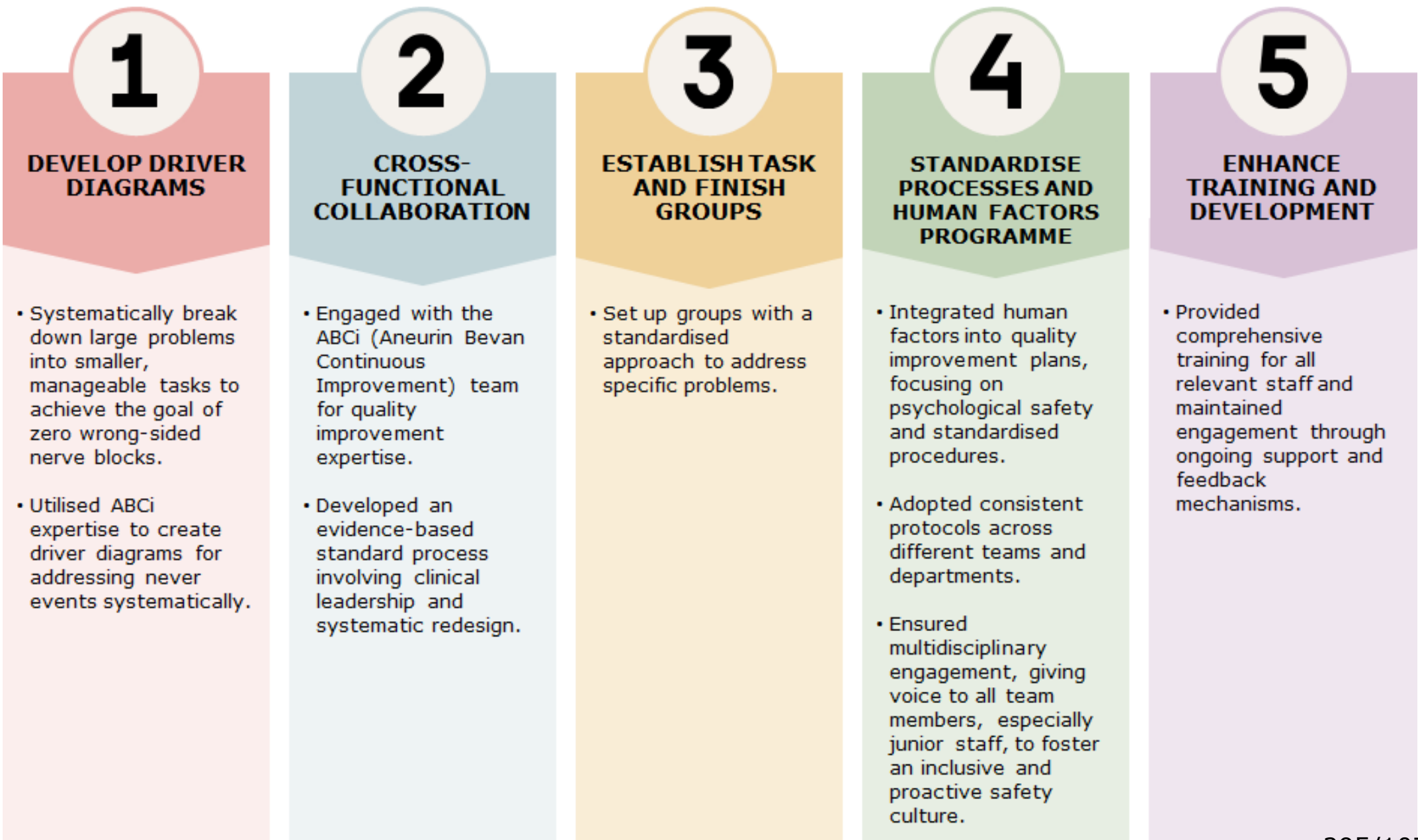
Human Factors Approach:

- **Simulation-Based Training:** Conducted fortnightly simulations in emergency theatres to test systems and generate actionable insights.
- **Team Training and Psychological Safety:** Focused on creating a just and safe culture, improving team dynamics, and fostering situational awareness.

Conclusion

The integration of these actions and strategies has led to a reduction in never events throughout 2023/24. This program has created a more cohesive, transparent, and safety-focused culture within the Health Board, significantly improving patient safety and care quality in theatres.

Key Steps Undertaken in 2023/24



Theatre Quality & Safety Programme

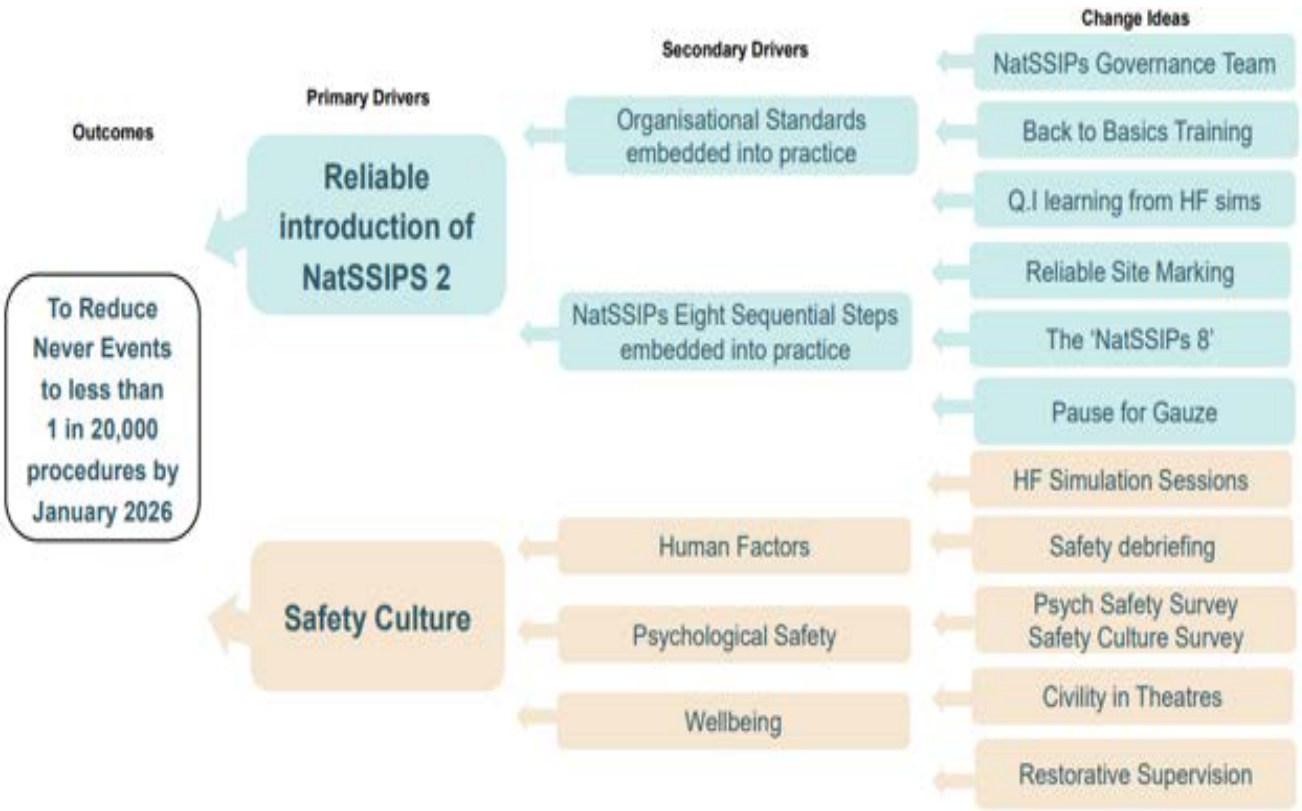
Aim

The aim of the Aneurin Bevan University Health Board Theatre Quality and Safety Programme was to reduce the number of Serious Incidents (SI), National Reportable Incidents, and Never Events across theatre sites. By integrating quality improvement practices into the daily routine of all theatre staff, the programme contributes to a stronger safety culture as a crucial component of the Health Board’s Quality Strategy.

Appointment of a Quality Improvement Advisor for Theatres (started January 2024) to support primary safety objectives in theatres, ensuring that lessons from never events and incidents contribute to a stronger safety culture.

Key Actions and Initiatives	
Introduction of National Safety Standards for Invasive Procedures (NatSSIPs) 2	• Work began to introduce NatSSIPs 2 across Theatres. • Current workstreams focus on updating the World Health Organisation Surgical Safety checklist, using Quality Improvement (QI) principles and co-design with staff to include the 'NatSSIPs 8' sequential steps. • The scope of work involves both organisational and sequential steps, with the wider teams exploring ideas for change, including patient engagement and creating a NatSSIPs network for the health board, linking all areas that undertake invasive procedures. • Theatre Safety and Compliance workstreams are being reviewed and realigned to the new Theatre Safety Agenda.
Building a Safety Culture Using Human Factors	• Regular protected space for the established human factors in theatres programme. • Use of simulation as a tool to test the system and identify improvement opportunities through 'listen to learn' debrief sessions. • Consideration of system, team, and individual factors at play. • Safety culture surveys for staff are used as a listening tool, facilitating debriefing sessions and identifying topics for future workshops to address potential safety concerns and share improvement ideas.
'Quiet for the Count' Project: Started in November 2023.	▪ Purpose: Develop a safety culture and understanding among all theatre team members about the importance of reducing distractions during surgical counts. ▪ Testing and Spread: Initially tested at Grange University Hospital (GUH) and eventually spread across all theatre sites.
Monthly 'Back to Basics' Training Sessions: Started January 2024	▪ Content: Safety education package focusing on different subjects each month to refresh key knowledge and provide updates on essential topics. ▪ Effectiveness: Pre- and post-training surveys demonstrated improvement in understanding and confidence across these areas.
Psychological Surveys: Regular Surveys	▪ Conducted across all theatre sites to capture qualitative data on potential future improvement projects and quantitative measures of psychological safety.

The Theatre Quality and Safety Programme scope of work is visually displayed in a driver diagram to support the reduction of never events in theatres. The diagram breaks down large goals into smaller, actionable tasks, aligning with the systematic approach suggested by the Aneurin Bevan Continuous Improvement (ABCi) team.



Summary

By implementing these comprehensive actions and initiatives, the Theatre Quality and Safety Programme aimed to create an integrated, safety-focused environment in the Health Board’s theatres. The programme has emphasised the importance of a strong safety culture, continuous learning, and systematic improvements to reduce never events and enhance patient care quality.

Radiological Serious Incidents

Background

A number of missed diagnostic findings and failures to follow up on radiological exams were identified as critical issues. These incidents dated back to 2019. Undertaking a thematic review of these incidents illustrated failures and found the root causes were identified as both human and system factors, with assumptions playing a significant role in that radiological results were received and acted upon. This work programme was led by the Executive Director of Therapies and Health Science.

Objectives

The Health Board aimed to mitigate these issues by standardising communication protocols, improving IT systems, and addressing human factors to enhance overall patient safety and care quality.

Key Themes and Issues

Systemic and Human Factors:	- Human assumptions are made that no incidental findings exist if none are expected and that someone else is following up on unexpected findings. - Failures in IT systems to capture or record results lead to missed follow-ups. Inconsistent communication methods within the Health Board exacerbate these failures.
Standardising Communication:	- Communication of findings has been inconsistent. - The development of the STOP protocol aims to standardise alert communication following significant findings, improving understanding and reducing errors. - The STOP protocol is nearing finalisation and will be shared across the Health Board.
IT System Improvements:	A new Picture Archiving and Communication System (PACS) provider has been selected, with implementation expected next year. This should enhance result communication clarity and accuracy, reducing errors.
Personal and Professional Responsibility:	- Emphasis on the responsibility and accountability of requesting clinicians (Referrer: IR(ME)R 2017) to act on results. - Complexities, especially in emergency departments (ED), where imaging may be requested in the name of a consultant who hasn't seen the patient.
Cross-Sector and IT Interface Issues:	- Assumptions are driven by the interface between primary and secondary care and differing IT systems. - Errors often occur due to dropdown lists and ambiguous messages in electronic discharge summaries. - Ensuring radiology reports are sent to the correct recipient is critical, requiring correct identification of the referrer, specialty, and location.

Actions Undertaken in 2023/24



Conclusion

By implementing these steps, the Health Board aims to reduce errors related to missed diagnostic findings and follow-up failures, thereby improving patient safety and care quality.

Health and Care Quality Standards

As part of the Quality Strategy an Implementation Plan was produced for the Health Board to enhance the quality of healthcare throughout 2023.

In order to deliver the Health and Care Quality Standards, the plan was mapped with quarterly objectives aligned to the six key quality domains. Highlights of the achievements for 2023/24 can be seen in the Appendix.

This plan was built on existing achievements, emphasising continuous improvement and embedding quality, safety, and learning in daily operations.



Duty of Candour

The Duty of Candour, effective from 1 April 2023, mandates all NHS bodies to openly and promptly report, manage, and investigate notifiable adverse patient safety events as stipulated by the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This includes compliance with the Concerns, Complaints, and Redress Arrangements (Wales) Regulations 2011.

Healthcare professionals who are subject to a professional Duty of Candour have to be open and honest with service users, colleagues, their employers and relevant organisations.

The statutory duty of candour and the professional Duty of Candour have the same aim: To be open and honest with people who receive care and treatment. The strong links between the statutory and professional duties of candour will empower staff to speak openly about concerns and will encourage learning to improve quality of care.

Operational since April 2023, through the Duty of Candour, the Health Board must be honest in informing patients and their families when things go wrong in providing care or our services fail to meet expectations or the standards that they should. There is an obligation to find out what went wrong; and, to make sure the same mistake does not happen again. A culture of openness, transparency and candour is widely associated with good quality care. It encourages learning and is achieved without apportion of blame. The Duty of Candour applies if the care the Health Board provides has or may have contributed to unexpected or unintended moderate or severe harm, or death. This duty builds on the Putting Things Right process for raising concerns or complaints.

The Health Board has provided information and guidance for all staff. It has shared the national programme of education and publicity to help ensure that colleagues across the Health Board were aware of the new Duty and the steps needed to comply with the Duty. The Duty of Candour integrates into incident reporting via Datix.

This included:

- Education materials are due to be available soon.
 - Staff awareness video
- Staff information leaflet (pdf) explaining what the new Duty means for all staff working in the NHS.
- A dedicated intranet page was also established
- New tools in DATIX that will help is have Candour conversations with patients and their family.
- Standardised templates and letters ensure consistent communication with patients.
- Meetings with Primary Care and community divisions support comprehensive reporting, and staff receive ongoing guidance on applying the Duty of Candour criteria consistently.

Duty of Candour

Achievements for 2023/24:	
Trigger:	Initiated when an adverse event review reveals unexpected or unintended harm (moderate, severe, or death) related to NHS-funded care.
Preparation:	The Health Board aligned incident management systems and processes to meet Duty of Candour requirements.
Training:	Duty of Candour training is available on the Health Board's electronic training platform (ESR), and staff are encouraged to complete it.
Implementation:	Centralised Quality, Patient Safety (QPS) teams and designated Duty of Candour leads ensure consistent training and compliance.
Reporting Tool:	A new Duty of Candour reporting tool supports continuous monitoring and data validation within incident and complaint systems.
Support:	The Patient Safety Incident team assists divisions in implementing the Duty.

Challenges and Improvements:	
Harm Categorisation:	Initial confusion in distinguishing between actual and healthcare-related harm in lower harm incidents led to additional education. Increased understanding is being achieved through education and support across multiple forums.



Learning and Improvement

Organisational Learning for Continuous Healthcare Improvement

In 2023/24, the Health Board placed a significant emphasis on organisational learning to drive continuous improvement in healthcare. By engaging staff and key stakeholders, we began to develop a comprehensive **Listening and Learning Framework**, demonstrating our commitment to embedding lessons learned to enhance patient care, safety, quality, and experience. This framework is set to be approved in April 2024.

Key Focus Areas for 2023/24:

- **Identifying Learning:** Actively seeking insights and lessons from various sources, including patient feedback, incident reports, and staff experiences.
- **Triangulating Learning:** Cross-referencing information from different sources to gain a holistic understanding of issues and ensure accuracy in learning.
- **Disseminating Learning:** Sharing insights and lessons learned across the organisation to ensure they are accessible to all staff and stakeholders.
- **Implementing Learning:** Applying the lessons learned to practical strategies and interventions to foster a culture of continuous improvement.
- **Just Culture:** Promoting a fair and open environment where staff feel safe to report incidents and share insights without fear of blame or retribution.
- **Triangulated Approach:** Integrating quality, patient safety, and experience data to create a comprehensive understanding and drive informed decision-making.

Initiatives and Developments for 2024/25:

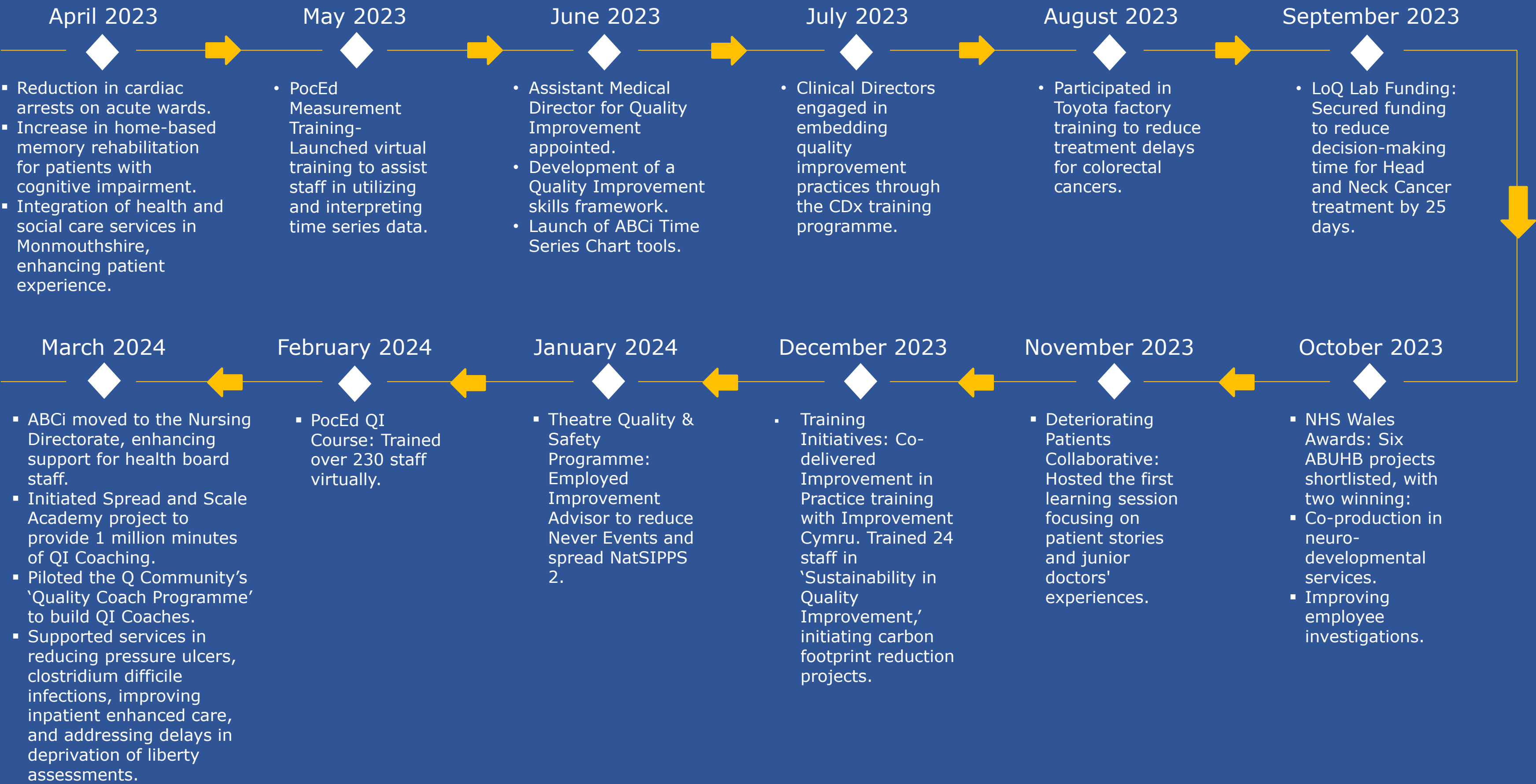
- **Bi-Monthly Learning and Improvement Forum:** Establishing a regular forum dedicated to learning and improvement, allowing staff to share knowledge, discuss insights, and drive change.
- **Learning Repository:** Creating a central repository to store and share knowledge, ensuring that valuable lessons and best practices are easily accessible.
- **Transformation of the Quality and Patient Safety Operational Group:** Evolving this group into a learning and improvement forum to reinforce a culture of continuous improvement.
- **Quality Improvement Strategy:** Developing a strategy over the next 6-9 months to provide a structured approach to quality improvement across the Health Board.

Commitment to Continuous Improvement:

The Health Board is committed to fostering a culture of continuous improvement, learning from every opportunity to enhance patient care, safety, quality, and experience. By embedding a Just culture and triangulated approach, we aim to create an environment where learning is a fundamental part of our operations, driving excellence in practice and improving outcomes for our patients.

ABCi (Aneurin Bevan Continuous Improvement) / Quality Improvement Timeline of Achievements	
In 2023/24, the Health Board made significant strides in quality improvement across various domains, with notable achievements in patient care, training, and operational enhancements. Despite the successes, challenges such as staff limitations, financial constraints, and the effective adoption of new tools remain. Moving forward, the Health Board is committed to addressing these challenges, fostering a culture of continuous improvement, and maintaining high standards of care for all patients.	
April 2023	- Continued support of All-Wales Safe Care Collaborative & local teams throughout 2023-24 to: - Reduce cardiac arrests on acute wards - Provide home based memory rehabilitation to a greater number of patients diagnosed with cognitive impairment to enable independence - Integrate health and social care services in Monmouthshire to re-able patients both before and after discharge leading to better patient experience
May 2023	New PocEd Measurement virtual training launched helping staff to use and interpret time series data
June 2023	- New role: Assistant Medical Director for Quality Improvement - Quality Improvement skills framework developed to train staff around QI methods - ABCi Time Series Chart tools launched
July 2023	Connecting with Clinical Directors around embedding quality improvement practice via 3 cohorts of CDx training programme
August 2023	ABCi team attended training at Toyota factory, and skills gained were used to reduce delays, particularly in making decision around treatment for colorectal cancers
September 2023	Q Lab funding obtained to support a project which has reduced the time to make decisions around treatment for Head and Neck Cancer patients by around 25 days
October 2023	- NHS Wales Awards – 6 projects from ABUHB of 24 across Wales were shortlisted, with two winners across eight categories. Winners were: - Co-production to support neuro-developmental services in Gwent (ABUHB) - Improving our Employee Investigations
November 2023	First ABUHB Deteriorating Patients Collaborative learning session took place focussing on listening to unheard voices including patient stories of bereavement and a junior doctor’s experience
December 2023	- ABCi team worked with Improvement Cymru to co-deliver Improvement in Practice training for ABUHB staff 24 staff successfully attended ‘Sustainability in Quality Improvement’ training, leading to several projects being initiated to reduce the carbon footprint
January 2024	Improvement Advisor employed to support Theatre Quality & Safety Programme aiming to reduce Never Events in Operating Theatres through building a culture of safety within theatres and spreading NatSIPPS 2
February 2024	PocEd QI, our bi-monthly QI fundamentals live virtual course, which is open to all staff in the organisation, has now over 230 staff successfully completing the training
March 2024	- The ABCi QI Unit continues to support quality improvement across clinical professions. ABCi has moved to sit within the Nursing Directorate which will free up additional support to work with staff across the health board - The ABCi team with support from colleagues in nursing, have initiated a Spread and Scale Academy project which aims to, ‘Unleash 1 million minutes of Quality Improvement Coaching to enable our staff to improve what matters to them and their patients’ - The ABCi team have led work in conjunction with Improvement Cymru colleagues to deliver a pilot of the Q Community, ‘Quality Coach Programme’ to build QI Coaches within clinical areas to support improvement work - ABCi continue to support services across different areas such as: - Reducing pressure ulcers - Reducing clostridium difficile infections - Improving enhanced care for inpatients - Improving effectiveness and patient experience around continence for patients living with dementia - Reducing delays around deprivation of liberty assessments
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Year in Review: Quality Improvement Milestones and Challenges in 2023/24



Quality Improvement

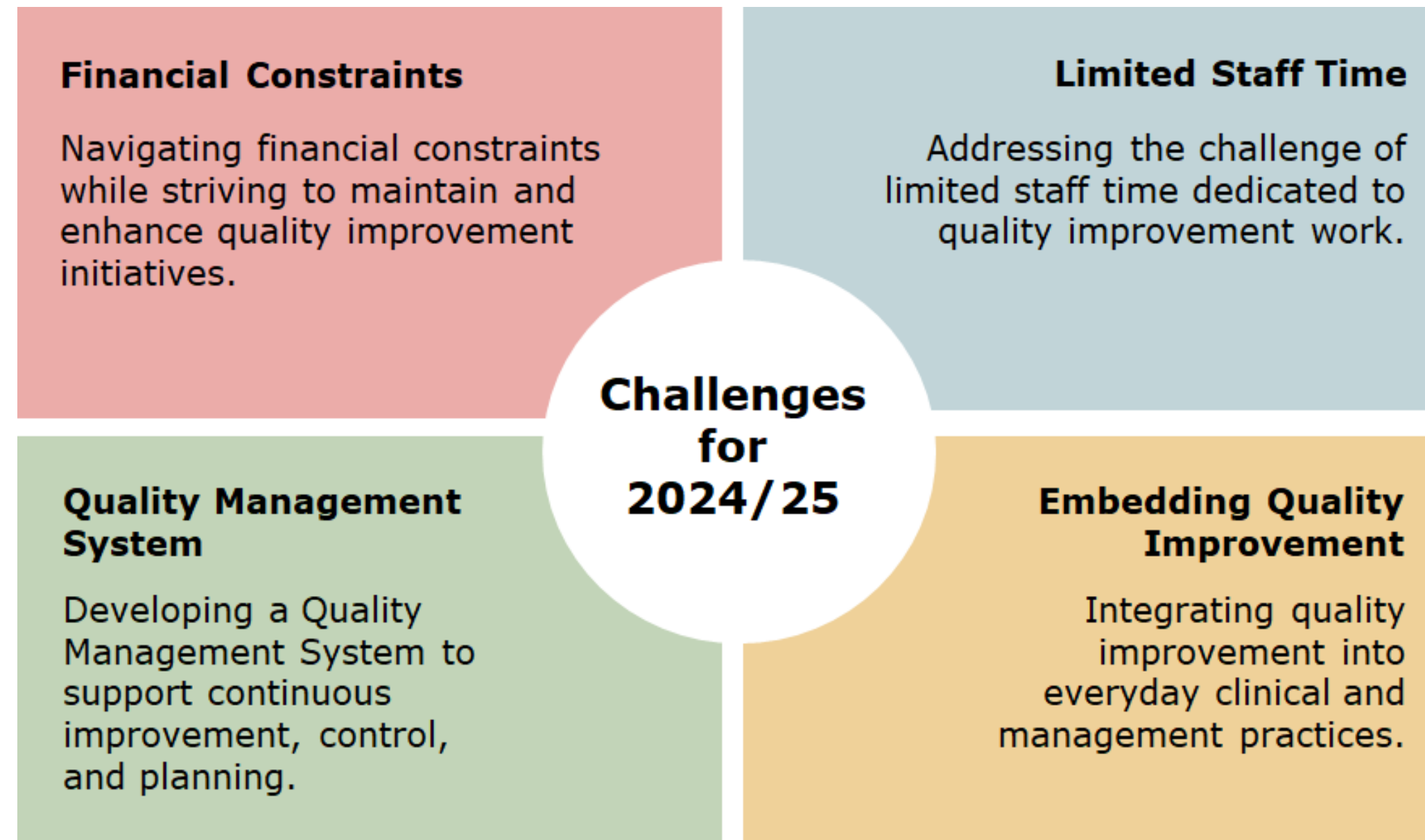
Areas for Improvement:

Team Withdrawals:

Three teams withdrew from the Safe Care Collaborative due to service pressures.

LifeQI Tool Adoption:

The adoption of the LifeQI tool was less effective than anticipated.



Learning from Deaths

The Health Board aimed to complete Mortality Reviews to learn and identify improvement. This has been aligned with the development of a learning from deaths framework (similar to NHS England) that will support an approach of systematic ward to Board reporting and monitoring of mortality, this will be launched in April 2024.

The objective is to ensure systematic ward-to-board mortality reporting and monitoring. Key indicators will include risk adjusted mortality. The Risk Adjusted Mortality Index (RAMI) adjusts for individual patient risk factors and co morbidities and therefore allows comparison between organisations. The accuracy of RAMI is dependent on the completion and accuracy of clinical coding. This has increased to 108 in December 2023 from 103 in 2021. The Health Board has also been reporting crude Mortality as part of the QOF. The mortality rate has remained flat and consistent, necessitating individual mortality reports for deep dives into high mortality specialties.

The role of the Medical Examiner (ME) Service is to provide independent death scrutiny, quality death certification, and reducing the stress of the bereaved. The service began in January 2021 and expanded to all sites in April 2023 (currently excluding maternity, paediatric, and neonatal). Approximately 25% of deaths are referred back to the Health Board for further action or learning. The learning from death framework will allow triangulation of accurate mortality data and Medical Examiner (ME) information for trend identification and condition-specific analysis.

There have been a number of achievements in 2023/24, this includes: Welsh Government mandated ME scrutiny of all deaths (excluding coronial cases) in April 2023, development of a mortality review screening panel to discuss the cases referred by the ME service and assess learning and improvement. The release of biannual newsletters highlighting ME referral themes and learning.

Future Goals for 2024/25 include: -

- Expansion of the ME service to include community deaths, increasing referrals.
- Continued communication of the biannual newsletters for shared learning.
- Sharing positive feedback and compliments from bereaved families with clinical areas.

Implement Robust Audit Processes and Plans

In 2023/24, the Health Board continued its Clinical Audit Strategy, presenting the strategy and new Audit Management and Tracking platform (AMaT) at Divisional meetings. AMaT training was provided, and all National Audits are now managed using this platform. The standardised reporting tool in AMaT facilitates the reporting of successes, concerns, risks, and assurance levels.

A SMART action plan is developed for each audit and monitored by the Quality and Patient Safety Clinical Audit team. Local audits are also being reported on AMaT. The platforms used in the Clinical Standards and Effectiveness Group (CSEG) to discuss each national report and ensure risks identified are acted upon accordingly. This process enables ensuring full participation in the Programme for [NCAORP 2023/2024](#). Continuous management of NCEPOD studies by the Audit team ensures full participation.

Despite resource issues delaying the Corporate Audit project and staff training, progress has been made. Challenges include obtaining engagement for multi-specialty audits and outdated information requests. For 2024-25, the focus will be on improving audit participation and data accuracy amidst busy clinical environments, while addressing resource constraints.

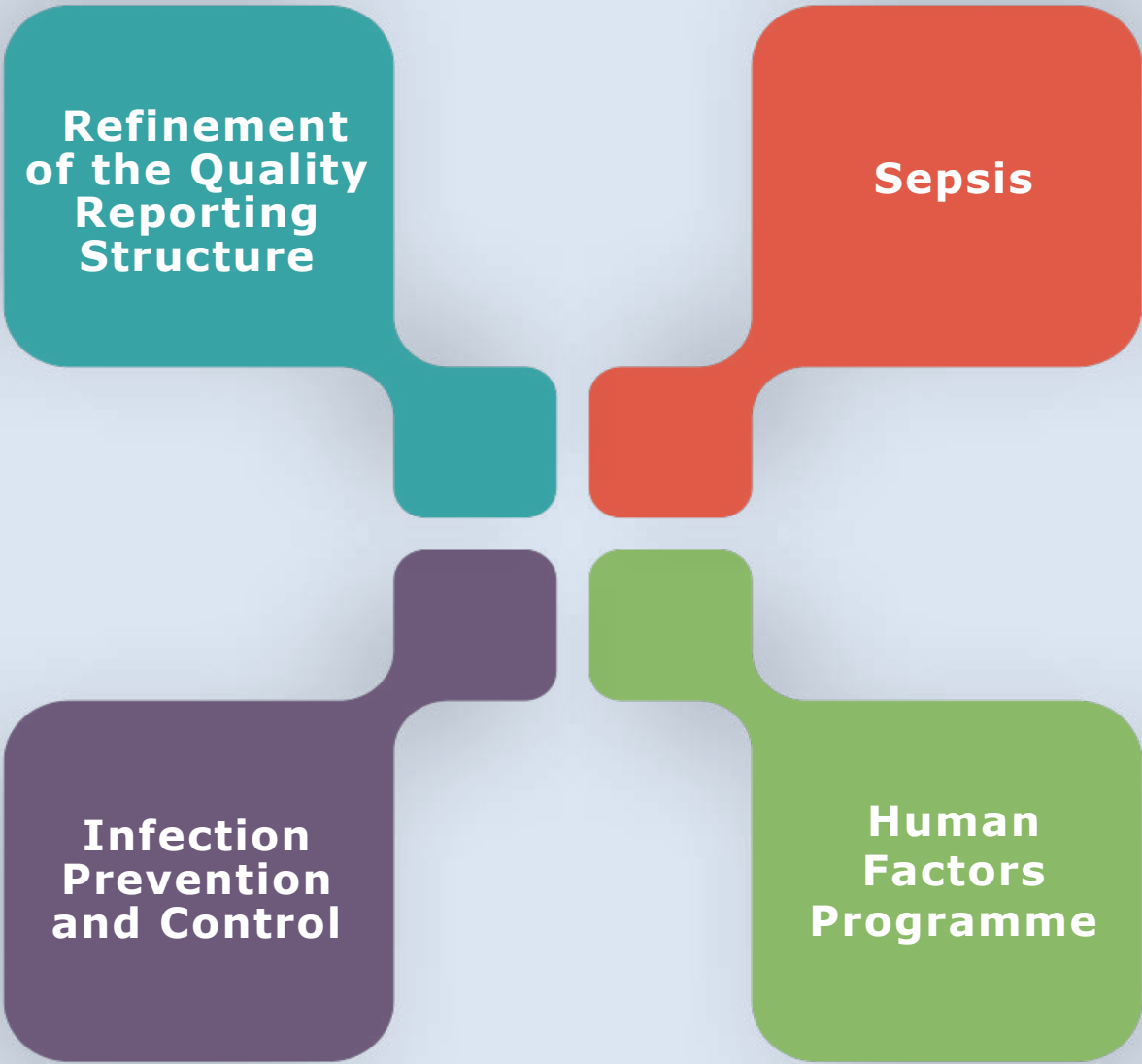
The Health Board [Clinical Audit Plan 2023/2024](#) has been published as well as the [Clinical Audit Activity Report 2023/2024](#) evidencing Health Successes and Concerns within each audit and detailing actions plans moving forward.

Key Workstreams for 2024/25

Commitment to Quality, Safety, and Patient Experience:

The Health Board remains steadfast in its commitment to quality, safety, and patient experience. By enhancing systems of care, promoting continuous learning, fostering innovation, and maintaining a culture of openness and transparency, we aim to create a healthcare environment that consistently delivers high-quality care and positive patient outcomes. Through the strategic initiatives outlined above, we are building a robust foundation for continuous improvement and excellence in healthcare delivery.

Key workstreams for 2024/25 include:



A workstream will be produced for each of these for 2024/25 with SMART action plans. A brief description is provided:

Infection Prevention and Control

With the routine reporting of infection rates, the Infection Prevention and Control pillar of our quality strategy will include a workstream to focus on improving antibiotic prescribing. Work going into 2024/25 already includes:

- **Enhanced Cleaning Programme:**
 - Need for a robust cleaning programme to reduce healthcare-associated infections.
 - Balancing the safety of patients with bed availability and ward reconfiguration.
 - Proposal submitted to Executives for a more focused approach.
- **Patient Flow and Infection Prevention:**
 - Daily challenge of protecting patients from infection while managing bed availability.
 - Attendance at Patient Flow Meetings to support patient placement.
- **Reporting and Root Cause Analysis:**
 - Use of Datix for reporting and analysing healthcare-associated infections.
 - Reinstated virtual root cause analysis meetings to identify themes and learning.
- **Supporting Divisions:**
 - Ongoing promotion of best practices in infection prevention.
 - Financial support from Regional Integration Funds (RIF), with potential risk to service provision if not funded in 2025.
- **Antimicrobial prescribing, stewardship and resistance:**
 - Work closely with Divisions to reinforce start smart and focus guidelines.

Refinement of the Reporting Structure

Ensure clear, evidence-based reporting across all committee and group levels to assure Health and Care Standards delivery. A workstream will include the following workplan:

- **Health Board Corporate Clinical Audit Plan:** Complete and refine the Clinical Audit Plan to ensure systematic evaluation and improvement of clinical practices.
- **Annual Health and Care Standards Reports:** Develop and regularly update these reports to track compliance with health and care standards, identifying areas for improvement.
- **Implementation of Standardisation Efforts:** Standardise processes and procedures across the Health Board to ensure consistency in care delivery.
- **Establishment of Corporate Support Roles:** Create roles dedicated to providing corporate support and integrating decision frameworks to streamline operations and improve decision-making.
- **Enhancement of Assurance Mechanisms:** Improve mechanisms for assurance to ensure that quality and safety standards are consistently met across all areas of care.
- **Utilise Existing Resources:** Leverage the Health Board's existing resources and support systems to effectively implement key initiatives. This includes using available tools, staff expertise, and technological solutions to drive improvements.
- **Alignment with Health Board Commitments:** Ensure all initiatives and actions are aligned with the Health Board's overarching commitment to quality, safety, and patient experience. This alignment ensures that every effort contributes to the broader goals of enhancing patient care and operational excellence.

Sepsis

The Health Board will focus on implementing the updated **National Institute for Health and Care Excellence (NICE) sepsis guideline (NG51)**. The updated guidance aligns with the [Academy of Medical Royal Colleges \(AoMRC\) statement](#) on the initial antimicrobial treatment of sepsis. This will build on improving patient safety by addressing systemic issues related to deteriorating patients. A workstream will be dedicated to sepsis recognition and early assessment from primary care to acute care. A full improvement plan will be developed and ensure the Health Board is delivering the Sepsis 6, focusing on the following:

- Initial treatment
- Including prescribing/admin of antibiotics
- Finding the source of infection
- Early monitoring
- Escalating care (Call for Concern / Martha's law)
- Information and support, - sepsis awareness and safety netting, patient information
- Training and education
- Audit strategy – develop an implementation plan for the Health Board on audit and assurance for sepsis organisation

We will look to work with the UK Sepsis Trust to embed best practice and to mirror any work undertaken nationally and UK wide to enable early recognition of sepsis and improve sepsis awareness.

Human Factors Programme

Implement Human Factors as a Health Board wide approach. Developed with medical, nursing, admin, and managerial staff, the programme at Grange University Hospital (GUH) promotes patient safety, team performance, and staff wellbeing. It embeds human factors by designing better systems and listening to staff. Stakeholders collaborate in protected spaces to identify solutions and actions.

Initially, the Health Board introduced human factors concepts through half-day workshops for multidisciplinary teams. The programme's core involves "safe listening spaces" and simulations to generate discussions for meaningful change. Originally focused on GUH Emergency theatres, it has expanded to other areas and includes a Human Factors training page on the Health Board's intranet.

With the success of the work on never events, this workstream aims to integrate human factors training and methodologies across the Health Board to improve patient safety and staff well-being. This involves implementing human factors training and establishing "safe listening spaces." The human factors programme currently uses existing training programs and resources to enhance overall patient safety and staff well-being.

Key Enablers for 2024/25

These will be mapped by quarterly goals as part of the year two objectives for the quality strategy. Improvement Plan for 2024/25: Aneurin Bevan University Health Board

1

A Learning Organisation

Foster a culture of continuous learning and improvement throughout the organisation.

- Q1: Embed our quality patient safety and quality improvement teams within our divisions
- Q2: Develop a learning repository for all our staff which will allow us to review how learning will be identified, stored, triangulated, shared, disseminated and implemented
- Q2: Develop a learning bulletin to share learning across the organisation
- Q2: Review mortality data and improve clinical outcomes by implementing a Learning from Death Framework and report
- Q2: Scope our Deteriorating Patients Collaborative
- Q3: Review quality and safety structures and reporting structures ensuring learning at every level.

2

Culture

Establish a supportive and proactive culture focused on quality improvement and patient safety.

- Q1: Engage to identify new quality improvers and support existing Quality Improvers
- Q1: Increase Quality Coaching capacity
- Q1: Develop our methodology to learn from incidents and establish a listening and learning framework, enabling us to deliver an learning forum
- Q3: Establish bespoke Patient Experience Collaboratives and use feedback for learning and improvement
- Q3: Formalise an approach to supporting staff involved in patient safety incidents
- Q4: Support a data informed experience (CIVICA) quality and patient safety agenda organisation wide
- Q4: Introduce an electronic patient feedback system to capture real time patient experience feedback

3

Quality Management System

Integrate quality management systems to ensure continuous improvement and compliance with health standards.

- Q1: Support the ward accreditation programme with quality and patient safety measures
- Q2: Utilise and triangulate patient experience data listening and learning from lived experience to provide qualitative data
- Q3: Improve the quality of incident reporting
- Q4: Identify specific areas within national clinical audits that require improvement

4

Quality Improvement

Use data-driven approaches to inform quality improvement initiatives and enhance patient safety.

- Q2: Produce an annual quality report outlining achievements and areas for strengthening
- Q2: Scope the theatre safety programme
- Q3: Strengthen the link between learning from direct and indirect feedback, investigations, and improvement work.
- Q3: Strengthen and embed 'Human Factors' to examine why incidents occur
- Q3: Utilise Clinical Audit expertise to provide the evidence-base and measurement function which drives quality improvement initiatives
- Q3: Initiate Leaders Skills Development Programme
- Q4: Data informed approach to learning from patient feedback and patient safety incidents

Conclusion

This report highlights the continued commitment of Aneurin Bevan University Health Board in providing high-quality care for everyone. Over the past year, we have made significant progress in enhancing patient safety, improving access to services, and ensuring that our care is compassionate, effective, and centered on the needs of those we serve.

The report presents a balanced picture of the Health Board's commitment to delivering the Health and Social Care (Quality and Engagement) (Wales) Act (2020) over the first 12 months. The Health Board has agreed the priorities clearly set out in the report and developed a robust methodology for improving clinical effectiveness, reducing harm, improving outcomes and embedding and measuring quality. We have collected a large amount of information on the quality of the services we provide aligned to the Health and Care Quality Standards, with a focus on patient safety, clinical effectiveness and patient experience.

We have deliberately focused on learning and connecting that learning into tangible improvements ensuring that we listen to our patients, their families and our communities drawing in a deep understanding of their experience to ensure that this becomes our moral compass for quality. Understanding the themes from the experience of our patients and their service users is critical to the quality management system delivery and therefore quality assurance but the value of individual stories is important to triangulate and understand whether improvements translate to real change. The experience of our staff is also of importance and how we listen to their experiences and understand how we can support them to continuously improve the quality of the care they provide, that safety concerns are responded to swiftly and decisively and that the experience of our patients and their families is improved.

We acknowledge the challenges faced by our healthcare system, including the ongoing pressures on our staff and resources. However, these challenges have only strengthened our resolve to innovate, collaborate, and adapt. Our dedicated teams have worked tirelessly to deliver services that meet the highest standards, and we are proud of the strides made in improving patient outcomes.

It was a year of challenge and change but, amidst this, we are proud that our culture for delivering high quality care and commitment to continuous improvement remains strong. This will be key to our ongoing work in 2024/25. As we look to the future, the Health Board remains focused on further improving the quality of care. We are committed to listening to our patients, supporting our staff, and working together with our partners to build a healthcare system that is resilient, responsive, and ready to meet the needs of our communities. Together, we will continue to work towards a healthier, more equitable future for all.



GIG
CYMRU
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WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Appendix 1

Progress on Implementation Plan for Quality Strategy Year One 2023/24



PERSON
CENTRED



SAFE



TIMELY



EFFECTIVE



EFFICIENT



EQUITABLE

Progress on our 2023/24 Priorities

As part of the implementation plan for the Quality Strategy the Health Board set a number of objectives aligned to the Health and Care Quality Standards. These were aligned to each of the domains of quality. There were a number of actions set throughout the first year as SMART objectives achieved by each quarter.

The implementation plan shows our commitments to the Health and Care Quality Standards. This report presents some of the highlights of the operational work programmes that have been delivered throughout 2023.24.

The implementation plan allowed us to achieve our deliverables for the first year:

1. Enabling staff to improve quality

The aim of the delivery plan was to enable staff to improve the services they for our patients and staff. This plan will ensure that we can answer the 'who', 'what', 'when', 'how', and 'why' we have focused on key projects and areas and how this will deliver our strategy. Improve patient and staff experience and embedding improvement into daily practice.

2. Implement the Duty of Quality

The duty required the Health Board to develop leadership and management systems with a view to securing improvement in the quality of services.

3. Meet the requirements of the Duty of Candour

This duty supports the Health Board when things go wrong in providing care or our services fail to meet expectations or the standards that they should. We are obligated to find out what went wrong; and, to make sure the same mistake does not happen again.

This Implementation Plan for the Quality Strategy aimed to be delivered over the next three years.

We have reviewed strategy and plan as part of our annual review. An for 2024/25 the implementation plan will be updated to focus on the new workstreams and priorities. It has been realised this is a ten-year ambition to evolve and sustain its development by our teams. Ultimately, it is about people, and the measure of its success will be determined by the experiences of our patients and staff.

Our Quality Strategy Commitment

- Aneurin Bevan University Health Board will be a learning organisation where staff members work towards delivering high quality clinical care every day.
- We will strive to better understand our systems of care, build capability through an all teach/all learn philosophy, encourage innovation and engage patients, relatives, carers, staff and communities in improvement endeavours, whilst learning from mistakes.
- We will ensure that quality is embedded throughout the organisation creating a culture of openness and transparency where people are supported to raise concerns
- Our patients, relatives, carers, staff and communities will partner with us to achieve this vision.

Priority 1: Person Centred Care



QUALITY PRIORITY 1: Deliver PERSON CENTRED care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.

Objective	Actions for each Quarter for 2023				Delivering (so what)	Indicators
	Q1	Q2	Q3	Q4		
Patient and Staff Experience						
Launch a system to capture Patient Experience across the Health Board (CIVICA)	• Launch the CIVICA system in Community Hospitals. • Divisional awareness campaign commences. • Training and user programme commences. • Define measures	• Generate and review first reports and insight	• Define and redesign the questions if required	• CIVICA available in all acute and community areas	• Opportunities to receive direct patient feedback to inform learning	• General experience rating of episode of care • Increase in number of responses in Civica
To respond and learn from complaints	• Review of resources and processes available to respond to complaints	• Recommendations finalised for approval, and implementation complete by the end of the quarter. • Reduction in complaints backlog	• Reduction in complaints backlog	• Backlog of complaints resolved	• Timely feedback and response to concerns • Opportunities to learn and focus improvement	• Compliments - themes identified for improvement • Reduction in the complaints backlog • Qualitative feedback use of the learning section in Datix • Increase in the number of actions plans completed

Our PERSON-CENTRED COMMITMENTS

QUALITY PRIORITY 1: Deliver **PERSON CENTRED** care to ensure that our patients, their families, and carers receive an experience that not only meets but exceeds their expectations. To improve patient experience in our hospitals and wherever they access healthcare. To increase patient, public and staff involvement.

What we said we would do:	What we did:
Launch a system to capture Patient Experience across the Health Board (CIVICA)	• The Health Board has written and implemented a Patient Experience and Involvement Strategy. • Aneurin Bevan University Health Board launched the CIVICA Citizen Experience platform in February 2023 to capture patient feedback via QR codes. • Feedback is anonymous, allowing analysis down to the ward/team/department level. • A Person-Centred Care Survey was introduced to support quality strategies, providing benchmarks for patient care. • Feedback is reported to the Quality and Patient Safety Operational Group quarterly. • A Patient Advice and Liaison Service (PALS) was introduced in November 2023, with data reported to the same group.
To respond and learn from complaints	In 2023/24, the Health Board made significant strides in managing patient concerns, receiving 1,596 formal complaints and resolving an additional 1,555 through early resolution. Efforts are ongoing to meet the Welsh Government’s target of 75% compliance with 30-day response timeframes, while ensuring the quality of investigations and responses. Key initiatives included: • Review and Engagement: Active participation in the review of the Putting Things Right (PTR) Regulations, currently under public consultation, to ensure preparedness for any new guidelines. • Patient-Centred Approach: Full implementation of the Patient Advice & Liaison Service (PALS) in November 2023, which focuses on early resolution of concerns through a single point of contact. • Planned Enhancements: Introduction of an “Acknowledgement Team” to ensure timely, meaningful engagement with those raising concerns, and the development of Communication Standards to maintain consistency across concerns teams. • Process Improvement: Weekly assurance meetings to address investigation bottlenecks and improve compliance with PTR regulations. The Health Board continues to work closely with external partners and remains committed to learning and improvement. Common complaint themes in 2023/24 included clinical treatment, assessment issues, appointment delays, and communication problems, particularly in relation to waiting times—a lingering effect of the COVID-19 pandemic.

Priority 2: Safe Care



QUALITY PRIORITY 2: Provide SAFE care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information

Objective	Actions for each Quarter for 2023				Delivering (so what)	Measure	
	Q1	Q2	Q3	Q4			
Theatre Quality and Safety Programme	• Scope, define and design improvement role and objectives with QPS and Division	• Advertise and appoint • Define work programme to include: – Reducing never events – Building quality improvement capability – Human Factors in Safety programme – Safe Care Collaborative – Acute Workstream	• Progress reporting commences		• Dedicated time for improvement and accountability from within the Division	• Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events	See annual report
Implement Human Factors as a HB wide approach	• Define programme of work and scope of the simulation programme	• Schedule sessions and design of QI programme	• Training and wider team engagement • Reporting the QI action plan established	• Publication of case studies	• Training and simulation programme in place with improvement programme of work	• Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events	See annual report
To implement Datix as the main method of reporting	• Awareness campaign to Divisions about the reporting requirements	• Review of reports and incidents • rolling action plan in place • Review of informatics requirements	• Implementation of informatics infrastructure as required	• Include learning in the Annual Learning festival	• The ability to report and highlight incidents to improve patient safety	• Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events	
Reporting – redesign the reports and implement an outcome framework	• Scope and define the outcomes and measures • Align with the Assurance Governance Framework	• Approval at Exec and Board • First report produced • Realign the PQSOC reporting	• Refine and design the report • Implement the new reporting processes	• Review and revise Action Plan as a result of learning from the indicators	• Improved oversight governance and assurance to provide learning and insight to be able to make improvements	• QOF • Updated Board and PQSOC paper format	
Review the QPS infrastructure to drive and spread improvement and learning	• QPS resource being mapped within Divisions • Working with HR to devise the OCP	• Draft proposal • Undertake OCP for staff with HR	• Review structure and interdependencies with Divisions and QPS		• An infrastructure designed for improvement	• Standardised agenda for Divisions on Patients Safety, Quality and risk	
To complete a Mortality Review to learn and identify improvement	• Through morbidity and mortality reviews and findings from the Medical Examiner Mortality Reviews • Mortality framework being developed	• Action Plan and reporting in place • Validate mortality measures • Work collaboratively with All Wales Mortality group and NHS Exec to define measures	• Devise a report for Board and Divisions on mortality data • Drill into CHKS data for improvements and deteriorating data	• Refine mortality report and measures	• Identification and learning opportunities used to focus improvements	• RAMI • Crude mortality rare	See annual report
Pressure Ulcers Improvement Programme		• Revisit and refresh the learning from the collaborative • Redesign the information extracted from Datix	• Datix learning report established		• Improvement in the numbers of HA pressure ulcers and a reduction in harm.	• Decrease in the number of HA pressure ulcers by grade • Decrease in the number of HA pressure ulcers • Decrease in the severity of medicines incidents • Decrease in the number of incidents under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	
Falls Improvement Programme	• Embed the multifactorial risk assessment • Falls prevention training • Falls review panel in place	• From the Fall Review Pannel, Themes identified to inform an improvement action plan • Review the Community Falls action plan and revise and update improvement action plan	• Hold a learning and design event for Community and Inpatient falls		• Reduced risk and prevalence of falls • Prevention of risk for those vulnerable to fall	• Decrease in the number of falls treated in ED which have had a previous admission – reattendance • Improvement in the severity of harm following a fall in hospital • Decrease in the number of Falls by 10,000 occupied IP Bed days	See annual report

Our SAFE COMMITMENTS

QUALITY PRIORITY 2: Provide **SAFE** care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

What we said we would do:	What we did:
To implement Datix as the main method of reporting	The Incident Reporting module of Datix Cymru was implemented within the Health Board in December 2021. Using Datix as the main method of reporting has highlighted the need for better incident management, the need for increased resources, and improved processes. This will ensure comprehensive closure and follow-up on reported incidents, ultimately aiming to enhance patient and staff safety. From December 2021 to 31 March 2024, 70,645 incidents were reported, with 95.75% of them closed. • Incidents: ◦ 76.6% of these incidents were reported as No or Low Harm. ◦ 2,905 incidents remain open as of March 2024. ◦ 72% of these open incidents are coded as No or Low Harm. ◦ 71.3% are classified as patient safety incidents, with the top three types being pressure damage, slip/trip/fall, and medication-related incidents. ◦ 383 incidents affecting staff remain open. • Datix Team Resources: ◦ Aneurin Bevan UHB’s Datix Team is significantly under-resourced compared to other NHS Wales organizations. ◦ The Health Board’s current team consists of 0.8 WTE compared to the NHS Wales average resource is 3.9 WTE. ◦ A business case is being developed to increase resources for the Datix Team. • Recommendations ending 2023/24 ◦ Review of 4,144 closed incidents with no conclusion data. ◦ Rapid review of 1,157 open incidents without a ‘Managers Interim Harm Assessment’. ◦ Develop plans to close the 2,905 open incidents. ◦ Implement sustainable incident management processes. ◦ Progress a business case to enhance Datix Team resources through the Pre-Investment Panel (PIP).

Our SAFE COMMITMENTS

QUALITY PRIORITY 2: Provide **SAFE** care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

What we said we would do:	What we did:
Reporting – redesign the reports and implement an outcome framework	The Health and Care Quality Standards guide healthcare planning, delivery, and monitoring. Over the past year, Aneurin Bevan University Health Board developed a Quality Outcomes Framework (QOF), aligned with the quality domains and enablers. This framework establishes indicators for care, outcomes, safety, patient experience, and efficiency, aiming for continuous improvement. Key objectives include identifying improvement areas, standardising practices, enhancing patient satisfaction, and ensuring regulatory compliance. The QOF has been key to the development of our approach to a ‘Quality Management System’. It fosters a culture of learning, accountability, and transparency, setting and monitoring performance targets to maintain high care standards. The framework integrates patient experiences and data to provide comprehensive quality insights, promoting a person-centred approach and collaborative service development. This has been continually refined throughout our first year. The end of year report can be found here.
Review the QPS infrastructure to drive and spread improvement and learning	In 2024, the Health Board achieved significant milestones in enhancing quality, patient safety, and shared learning: • Centralisation of Teams: The Quality Patient Safety (QPS), Putting Things Right (PTR), and Quality Improvement (QI) teams were centralised, leading to improved knowledge retention, consistency, and effective triangulation of complaints and incident processes. This centralisation supports a culture of shared learning and person-centred care. • Team Building and Workplan Alignment: The QPS leads embarked on a Team Building Programme to enhance team performance. A QPS workplan was also developed, aligned with the Health Board's Quality Strategy and Priorities, ensuring focused delivery on key objectives. • Training and Education Initiatives: A comprehensive suite of training specific to complaints and incident investigation is being developed. Collaborations with Welsh Risk Pool colleagues and the Public Services Ombudsman for Wales (PSOW) are underway to create accessible video training and bespoke patient safety incident training. • Patient Engagement and Involvement: Progress continues on the Patient Engagement and Involvement Strategy, with ongoing efforts in patient participation panels and evaluations of the Patient Advice & Liaison Service (PALS) and bereavement services. • Process Improvement: The Patient Safety Incident team is refining incident management processes to ensure timely, high-quality, and person-centred responses. The Health Board is also developing a Quality Management System and refining its Quality Outcomes Framework in collaboration with data and digital teams to support continuous, automated reporting. • Quality and Accountability Frameworks: Collaborative efforts with divisional and central teams are focused on developing a QPS Accountability Framework and a Commissioning Assurance Framework (CAF). These initiatives reflect the Health Board's commitment to enhancing quality, safety, and patient experience across all services.

Our SAFE COMMITMENTS

QUALITY PRIORITY 2: Provide **SAFE** care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

What we said we would do:	What we did:
Pressure Ulcers Improvement Programme	The Health Board reported increased numbers of unstageable and grade 3&4 Health Acquired Pressure Ulcers (HAPU's). Divisions report data via the HAPU Steering Group and the Quality and Patient Safety Operational Group. Pressure Ulcer Faculty 2023 launched, led by Nursing Directorate and Senior Nurses with ABCi support, with a focus on reducing HAPUs to meet Welsh Government's 0% avoidable HAPU standard. Faculty Aim: • Reduce HAPU incidences by 25% within 4 months. • Eradicate grade 3 & 4 avoidable HAPUs within 4 months. Progress and Actions 2023/24: • Noted downward trend from January to April 2024. • Develop pre-recorded PowerPoint for teaching. • Use PANDO app for timely wound review and treatment. • Implement PDSA cycles for testing changes across all sites. • Share resources via SharePoint and developed posters across divisions. • Updated driver diagram. • Commenced Pressure Ulcer Pilot in February 2024. • Evaluate collected data at April meeting for signs of improvement.

Priority 3: Timely Care



QUALITY PRIORITY 3: Provide **TIMELY** care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time

Objective	Actions for each Quarter for 2023				Delivering (so what)	Indicators
	Q1	Q2	Q3	Q4		
Discharge Programme Board programme	- Delivery of Move it May campaign. - Visit to Swansea to view Signal IT system - Short term digital solution – design and analysis	- Away Day RGH Hub - Trusted Assessor workshop - Short term digital solution – development - Prepare operational process for capturing D2RA/Red to Green - Roll out of Nurse Led Discharge	- Short term digital solution – development - Continue to prepare operational process for D2RA/Red to Green - Implement Trusted Assessor model - Full role out of Optimising Patient Flow Framework	- Implement Trusted Assessor model - Short term digital solution – test and run - Continue to develop and review the RGH Discharge Hub	- Optimal hospital care and discharge practice at the point of admission - A Home First approach to reduce re-admission	- Reduce time from surgery to discharge - Reduce Time spent on a waiting list - Reduction of handovers >1 hour - Reduction in time for patients to be seen by first clinician - Reduction in time for bed allocation from request
Support individuals to stay at home or close to home	- Pilot for extended hours - Start OCP	- Conclude OCP - Publish navigable pathway for ambulatory care offer - Produce strategy and action plan for Community Hospitals	- Service transition to extended hours - Develop the professional hub - Changes to ambulatory care model	- Continuation of existing workstreams - Commence Phase 2	To support individuals to stay at home or close to home, where this is both safe and appropriate. To support all health care professionals to engage with what is right for individuals, first time.	- Decrease in ED waits >12hrs - Increase in discharges before midday; - Decrease in LoS OVER 21 DAYS - Time from Flow Centre call to discharge/ admission from assessment? - Number of emergency admissions in hospital over 7 days
Improve Ambulance handovers	- Review Q4 APP pilot and whether permanent roll out beneficial or justifiable - Implement outcome of PRU winter service activity - Complete recruitment process and on-board remaining therapy practitioners, OT and Physio - Identify and recruit Care of the elderly (COTE) locum for duration of the pilot	- System wide engagement on risk stratification and subsequent effect of regular patient flow from ED utilizing eLGH and community sites - Recruitment of locum resilience to enable Frailty assessment - Feasibility assessment of GP resilience to eLGH and GUH front door, possibly utilizing SDEC space	- Procure e-Triage solution and focus on the long lead time aspect (relating to technical integration with Welsh Patient Administration System (WPAS)) - Agree mechanism to be used (i.e. CWS watchlist) and risk management approach for a pilot of a new ED referral process	- Utilize lessons learned from Same Day Emergency Care (SDEC), Integrated Assessment Centre (IAC) and early e-Triage experience to shape new ways of working - Continuous Data and PREM Review	Maximising and individuals time and outcomes and improving system safety	- Decrease in the time from request to step up/down to a different site - Decrease Overnight bed moves and patient transfers
Improved Cancer outcomes	- Programme priorities agreed - Programme structure agreed	- Prehabilitation Business Case - Establishment of NHH working groups	- WG approval of NHH Cancer Centre - Patient Group initiated	- Acute Oncology Regional model rolled out - ABUHB Cancer 'Blueprint' agreed	Maximising cancer outcomes	- Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion - Increase in 5 year cancer survival rates
Timely completion of Duty to Report	Meet with Local Authorities to understand the prevalence of delayed referrals	Work with clinical teams to understand the barriers to timely referral	Review of pathways for referral with Safeguarding committee and Partnership Boards	Update clinical teams with changes to referral process to strengthen practice	Referrals will be made via the appropriate route in a timely way, to ensure appropriate and suitable responses	Reduction in complaints from local authorities in regard of delay in reporting

Our SAFE COMMITMENTS

QUALITY PRIORITY 3: Provide **TIMELY** care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time

What we said we would do:	What we did:
Discharge Programme Board Programme	The Discharge Programme Board has taken significant strides to improve patient discharge processes, focusing on enabling individuals to stay at home or close to home. Key achievements include: • Training and Protocols: Refreshed Optimising Hospital Flow Framework training and a ratified Nurse-Led Discharge protocol are being implemented. • Initiatives: The "Move it May" campaign was successfully delivered, with ongoing work to support hospital flow. • Team Development: The Hospital to Home (H2H) team is fully operational in Monmouthshire and Newport, with the programme now under evaluation. • Facility Upgrades: The RGH Discharge Lounge is complete and operational, and NHH Discharge Lounge is running under a new pull model. Planning for a new GUH Discharge Lounge is underway. • Digital Solutions: The CWS2 (D2RA) digital solution was piloted across three wards, with wider rollout expected post-resolution of technical issues. • Strategic Workshops: Future Flow Design workshops identified key areas for improvement in bed allocation and workforce models. The upcoming plan for 2024/25 emphasises: • H2H Program Expansion: Building on the 2023 pilot, this initiative aims to reduce acute care stays by transitioning patients to home care more efficiently, with an average pathway duration of 26 days. • System Reconfiguration: Focus on optimizing care delivery at St. Woolos Hospital and improving timely discharge through Patient Safety Team events and bed plan implementation. • Performance Goals: Reducing Delayed Transfers of Care (DTOCs), improving ambulance handover times, and speeding up ED clinician assessments. These initiatives are aligned with the goal of enhancing patient flow, reducing hospital stays, and improving overall care quality.

Our SAFE COMMITMENTS

QUALITY PRIORITY 3: Provide **TIMELY** care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time.

What we said we would do:	What we did:
Improve Ambulance handovers	Progress has been made in reducing ambulance handover delays at the Emergency Department (ED). Previously, around 860 patients per month faced delays over 60 minutes. However, through focused efforts, these delays have significantly decreased from 1,497 cases reported in March 2023. Key Initiatives: APP Role Review: The Q4 APP pilot at GUH did not significantly reduce patient conveyance to the ED. The clinician grade in the Flow Centre will continue to be monitored as options are considered for various access points into Health Board services (e.g., Flow Centre, GP OOH, Frailty, SPA). Frailty Pathway: A trial with a Frailty Consultant in the Flow Centre has been undertaken, and will end in 13 June 2024, and its impact on the frailty pathway is under ongoing evaluation within the Six Goals E&U Programme. Falls Pathway: A revised falls pathway, implemented on 23 December 2023, has better distributed activity across eLGH sites for patients not meeting GUH falls criteria. PRU Activity Review: A cost-benefit analysis (CBA) of PRU activities has been conducted and is awaiting review at a future Executive meeting. WAST will continue PRU support as agreed until 30 September 2024. These improvements highlight the ongoing efforts to optimise patient care and service efficiency within the Health Board. Improved Cancer outcomes From 2019/20 to 2023/24, there was a 34% increase in suspected cancer referrals, impacting diagnostic capacity. Despite increased referrals, the cancer conversion rate has not increased, indicating a consistent identification rate despite higher scrutiny. The backlog of patients waiting over 62 days has been consistently high, although there was a slight reduction in percentage terms from 2019/20 to 2023/24. The overall goal is to enhance patient outcomes through more efficient pathways, better patient preparation and support, and targeted training and community engagement initiatives.

Our SAFE COMMITMENTS

QUALITY PRIORITY 3: Provide **TIMELY** care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time

What we said we would do:	What we did:
Improve Ambulance handovers (cont.)	Quality Initiatives for 2023/24 included: • Prehab options appraisal presented to cancer board, not progressed for funding. Cost neutral universal model requested • Getting Ready for Treatment Initiative (universal prehab model): Focuses on preparing patients for treatment through early engagement and resources, improving patient understanding and emotional readiness. • ABUHB Cancer patient partnership and engagement group initiated. Improving our knowledge of how cancer services are felt and experienced by users. Three workstreams identified for 2024/2025. • Six domain programme to support psychological wellbeing in cancer patients developed. Includes, staff education, reducing inequality, volunteers, group interventions, third sector and digital inclusion. An example of the work are the cancer cafes located across the Health Board: Provide emotional support through peer interaction, showing positive feedback and participation from patients and carers. • Established health inequalities working group. AOS regional Model: • Increase in number of AOS nursing referral seen within 24hours, (95% versus 81% in 2022/2023). • Embedded standardised pathways for oncological emergencies, across 4 main sites. • Regional CUP (Cancer of unkown primary) MDT implemented and outreach nursing service to ABUHB. • Established an outreach virtual oncology clinic, weekly. • SDEC (same day emergency care) pathways for oncology emergencies implemented.
Timely completion of Duty to Report	An upcoming audit aims to assess the timeliness of duty to report entries within the Wales Safeguarding procedures. Although most reports are submitted within the expected timeframe, concerns have been raised by partners about delays in some cases. The audit will focus on determining how widespread these delays are and understanding the reasons behind them. The introduction of the national Safeguarding Datix Module will be a key tool in this effort, as it will enable the tracking of the time elapsed between incidents and the submission of reports. This data should help identify specific areas where delays are occurring, allowing for a more focused improvement plan to address the issues and enhance the overall safeguarding process.

Priority 4: Effective Care



QUALITY PRIORITY 4: Provide EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome

Objective	Actions for each Quarter for 2023				Delivering (So what)	Indicators	
	Q1	Q2	Q3	Q4			
Implement robust Audit processes and plans	- Develop action plan and agreed forward work plan for audit - Implement AMAT as a reporting and analysis tool	Compliance with the audit plan	Compliance with the audit plan	Compliance with the audit plan	- Reduced variation in Care - Increased understanding of variation to focus Improvements	- Increase in the SMART action plans with accountability in National Clinical Audit - Increase in the numbers of wards participating in accreditation (Audits via AMaT) - Increase in the actionable audit recommendations by National Clinical Audits	See annual report
Implement Duty of Candour reporting	Awareness campaign to Divisions about the reporting requirements	Review the DoC reports and effectiveness of the process	Compliance with DoC audit requirements	Compliance with DoC audit requirements	Increased understanding of variation to focus Improvements	- Implement Duty of Candour reporting - Compliance the number of incidents triggering Duty of Candour within 5 days	See annual report
Ward accreditation	Test the ward accreditation programme	Increase in the numbers of wards participating in accreditation	Reporting against the implementation of the accreditation	Roll out to clinical areas areas	- Reduced variation in Care - Increased understanding of variation to focus Improvements	Audit report available via AMaT to include quality measures and organisational measures	
Safe Care Collaborative (also Safe Care)	- Driver diagrams completed for teams - Leadership work plan agreed - Training programme agreed	- Charter complete - Attend action calls and learning session - Monthly reporting - Measurement of progress - Project score	- Leaders for Safety Improvement starting training programme - Safety Coaches starting coaching training		- Reduced variation in Care - Increased understanding of variation to focus Improvements		See annual report
Implement a Quality Training Programme to drive and spread improvement	Define and share the programmes available.	Safety Coaches starting coaching training	- Implement a Quality Training Programme to drive and spread improvement - Leaders for Safety Improvement starting training programme	Define and share the programmes available.	Leadership and skills at all levels and part of what we do to embed our QMS and culture of continuous improvement	Implement a Quality Training Programme to drive and spread improvement	
Medicine Management	- Validate incidents via Datix - Implement medicines safety strategy	Track progress with medicines safety strategy	Track progress with medicines safety strategy	Track progress with medicines safety strategy	Reporting and action plan via Medicines Safety Group	Delivery of objectives set medicines safety strategy	

Our EFFECTIVE COMMITMENTS

QUALITY PRIORITY 4: Provide **EFFECTIVE care** – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome

What we said we would do:	What we did:
Implement Duty of Candour reporting	The Duty of Candour was implemented on 1 April 2023 under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This mandate requires all NHS bodies to report, manage, and investigate notifiable adverse patient safety events openly and promptly. It applies when a patient experiences, or could experience, more than minimal harm during NHS-funded care, with healthcare provision potentially being a factor. Key Actions and Progress: • Training: All staff have access to Duty of Candour training via the Health Board's electronic platform, with active encouragement to complete it. • Team Centralisation: The Quality, Patient Safety (QPS) teams were centralised in February 2024, with identified Duty of Candour leads working to embed the Act's requirements and ensure consistent training. • Reporting Tool: A Duty of Candour reporting tool is now integrated within the incident and complaint system for continuous monitoring and validation. Ongoing Challenges and Next Steps: • Harm Categorisation: Initial challenges were faced in distinguishing between actual and healthcare-related harm in lower harm incidents. Ongoing education and support are improving understanding across the Health Board. • Future Focus: In 2024/25, efforts will focus on encouraging staff to complete training, running further sessions, using incident reports to identify improvement areas, and fostering a culture of continuous learning. Quarterly data will be reviewed in QPS meetings, and learning will be discussed at the Patient Quality and Safety Learning and Improvement Forum.

Our EFFECTIVE COMMITMENTS

QUALITY PRIORITY 4: Provide **EFFECTIVE care** – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome

What we said we would do:	What we did:
Ward accreditation	The Health Board has launched an accreditation pathway for all wards and teams, utilising the digital system (AMaT) to capture audit data and provide ward-to-board assurance. This system promotes continuous improvement in safety and patient experience through monthly audits. A dashboard allows for easy viewing and sharing of results with the public, staff, and patients. Key Achievements: • Phased Rollout: Successfully piloted at Ysbyty Aneurin Bevan, with Phase 1 implemented across various wards and Phase 2 and 3 planned. • Structured Improvement: System supports continuous improvement, using audits based on six quality domains and five quality enablers. • Real-Time Data: Utilised AMaT platform for real-time audit results, with accreditation levels (Bronze, Silver, Gold, Platinum) based on 85% compliance. • Independent Validation: Accreditation compliance independently reviewed and validated. Performance and Metrics: • Evidence-Based: Teams present evidence covering performance indicators, workforce metrics, clinical incidents, complaints, and feedback. • Visibility: Accreditation journey and audit results are displayed on Patient Safety Boards. Challenges: • Audit Proforma Development: Time-consuming process with monthly updates causing delays. • Staff Support: Need for more support in completing action plans in AMaT. • Scheduling Conflicts: Work pressures impacting meeting schedules. Goals for 2024/25: • Metrics and Standards: Establish meaningful, evidence-based metrics, balancing quantitative data with patient experiences. • Staff Engagement: Empower staff to lead improvements, overcoming resistance, and managing work constraints. • Sustaining Improvements: Maintain momentum with ongoing support, training, and real-time data monitoring. • Operational Needs: Recruitment of a Business/Data Analyst to enhance digital platform support and data analysis.

Our EFFECTIVE COMMITMENTS

QUALITY PRIORITY 4: Provide **EFFECTIVE care** – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome

What we said we would do:	What we did:
Implement a Quality Training Programme to drive and spread improvement	ABCi Quality Improvement Skills Development Programme Objective: Empower staff with the skills, time, and resources necessary for quality improvement. Key Activities: • PocEd Measurement Course: Trains staff to use data for tracking improvement progress. • Basic QI Training: Over 230 staff trained in quality improvement principles. • Quality Coach Development: 17 QI coaches trained to support local continuous improvement. • Spread and Scale Initiative: Plans to train additional QI coaches over the next four years. • Online Resources: Development of tools like ABCi Charts and Problems to Solutions to support quality improvement efforts. Challenges and Areas for Improvement: • Team Participation: Three teams withdrew from the Safe Care Collaborative due to service pressures. • LifeQI Implementation: The adoption of the LifeQI system for recording quality improvement has been slower than anticipated. 2024/25 Challenges: • Staff Time: Ongoing challenges with staff availability for quality improvement work. • Embedding Practices: Difficulty in integrating quality improvement into daily clinical and management routines. • Quality Management System: Need to build a system that balances quality improvement with quality control and planning. • Financial Constraints: Budget limitations affecting the scope of quality improvement efforts.

Our EFFECTIVE COMMITMENTS

QUALITY PRIORITY 4: Provide **EFFECTIVE care** – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome

What we said we would do:	What we did:
Medicine Management	Key Achievements 2023/24: Exception Reports: This was part of the Medication Safety Group (MSG) Initiatives: Implemented Exception Reports for Divisions to review medication safety incidents, identify trends, and share lessons learned. A collaborative culture was promoted and recognised successful initiatives, with MSG determining further actions like policy changes or education. Time Critical Medication: A benchmarking exercise was progressed on all ten patient safety recommendations for Parkinson’s disease time-critical medication. There was a campaign commitment with continued focus on improving timely administration and education. Training and Awareness was undertaken, included released "Time matters: It’s critical" training video and service user posters to emphasize timely medication. Thematic Reviews: Insulin Safety was a priority and included collaboration with the Diabetic Inpatient Care and Education (DICE) team for a thematic review, issued an Insulin Safety Bulletin, and promoted Insulin Safety Week. As part of anticoagulation safety, the Health Board conducted a thematic review for oral anticoagulant safety. This included updating policies, provided training, and enhanced patient counselling by upskilling pharmacy technicians. Gabapentinoid Safety: An audit provided insights when conducted an audit on high prescribing practices, leading to ongoing targeted support. Resource development focused on creating a Gabapentinoid Prescribing Resource Pack and offered training sessions in collaboration with the Chronic Pain Group. Yellow Card (YC) Scheme: There was improved reporting, by forming a cross-sector group, increasing Yellow Card reporting from Secondary Care. Improved reporting accessibility via QR codes and provided targeted training. Collaboration included working with YCC Wales to align national campaigns and celebrate milestones. Medication Safety Week: A full programme for the week allowed awareness of this week and achieved high engagement during #MedSafetyWeek, focusing on opioid use, yellow card reporting, emergency medication, safe storage, and oxygen safety. An increased visibility of best practices was established as new Medication Safety Boards across wards were used to highlight best practices.

Priority 5: Efficient Care



Objective	Actions for each Quarter for 2023				Delivering (so what)	Measure	
	Q1	Q2	Q3	Q4			
Datix infrastructure	Review resources and infrastructure for Datix management and reporting	- Establish reporting processes - Datix awareness and use training	Datix awareness and use training	Datix awareness and use training	Patient experiences are visible and acted on	- Qualitative feedback use of the learning section in Datix - Increase in the number of actions plans completed	See SAFE To implement Datix as the main method of reporting
Falls (also an Objective under Safe)	- Embed the multifactorial risk assessment - Falls prevention training - Falls review panel in place	- From the Fall Review Pannel, Themes identified to inform an improvement action plan - Review the Community Falls action plan and revise and update improvement action plan	Hold a learning and design event for Community and Inpatient falls		- Reduced risk and prevalence of falls - Prevention of risk for those vulnerable to fall	- Decrease in the number of falls treated in ED which have had a previous admission – reattendance - Improvement in the severity of harm following a fall in hospital - Decrease in the number of Falls by 10,000 occupied IP Bed days	See annual report Falls Improvement Project

Priority 6: Equitable Care



QUALITY PRIORITY 6: Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory.

Objective	Actions for each Quarter for 2023				Delivering (so what)	Measure
	Q1	Q2	Q3	Q4		
Safeguarding resources and processes	- Review of resources and processes for reporting, staff and patients - Review of training available to different staff groups within the Health Board	- Actions from reviews communicated and action plan development with Operations, Workforce and OD and leadership teams - Develop and mandate safeguarding training in line with All Wales Guidance. - Develop a model of safeguarding supervision for Adult Safeguarding	- Delivery of Safeguarding Training - Role out of Safeguarding Supervision in targeted teams	- Formal evaluation of Safeguarding Training continued delivery - Evaluation of safeguarding supervision - Roll out of additional safeguarding supervision - Continued delivery of Safeguarding Training	- Improving quality of life and equitable access - Timely response to concerns - People and staff able to raise concerns to prevent as well as address - Staff will better understand their role and duty in the safeguarding of children and adults. - Staff will feel supported to support and manage the care of patients who require safeguarding	- Increase in the access to Safeguarding Training - Timely closure of Safeguarding incidents - Appropriate responses irrespective of where the patient presents
Violence and aggression incidents	- Review and analyse V&A incidents - Return to face-to-face Management of Violence & Aggression training	Review and update the ABUHB Violence & Aggression Policy and develop supporting procedures & protocols, including the internal sanctions procedure	Launch Violence & Aggression campaign across the Health Board	- Conduct staff survey relating to violence and aggression incidents - Continued delivery of Management of Violence & Aggression Training	Improving staff experience	Decrease in the incidents of violence and aggression towards staff

Our EQUITABLE COMMITMENTS

QUALITY PRIORITY 6: Provide **EQUITABLE care**, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory

What we said we would do:	What we did:
Safeguarding resources and processes	The Health Board is actively working on improving safeguarding training compliance and is effectively identifying and responding to safeguarding issues within the community. However, there are challenges related to staff availability for training and recording compliance in certain areas. Key points for 2023/24: Training Requirements and Compliance Levels: • There is a national requirement for health board staff to undergo safeguarding training suitable for their roles. • Current compliance levels for five out of seven training areas are documented. ESR does not yet record compliance for Level 3 Child or Adult Safeguarding, and efforts are underway to address this. • There is a slow uptake in Level 3 face-to-face training due to staff availability, and some improvement is needed for Level 1 Safeguarding Adults and Ask and Act training to reach the 85% target. • This compliance issue has been escalated to Divisional Leadership Teams via the Safeguarding Committee. Safeguarding Activity Data: • The data on safeguarding activities should be interpreted with caution when used as a quality improvement marker. • For 2023/24, a substantial number of safeguarding referrals were made or addressed by the ABUHB Safeguarding Team. • The volume of referrals is influenced by external factors beyond control, indicating potential increased harm, but also reflects the workforce’s effectiveness in recognising neglect and abuse.

Our EQUITABLE COMMITMENTS

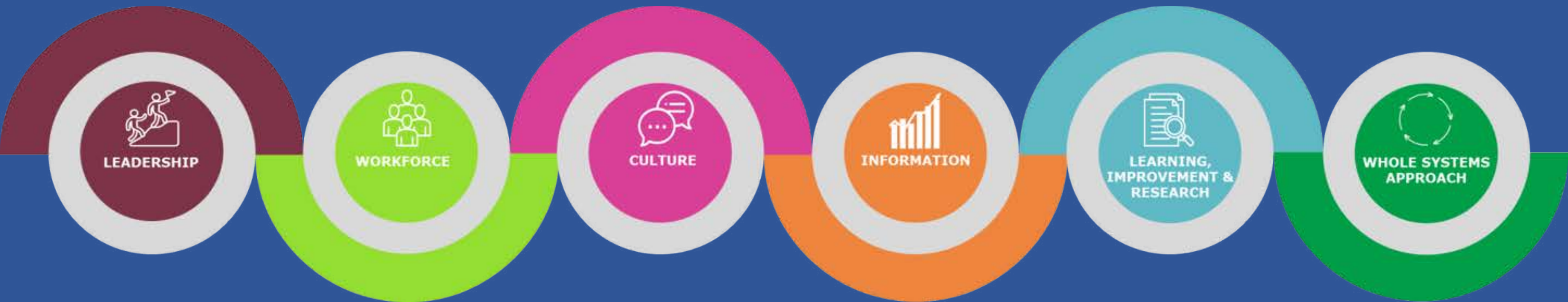
QUALITY PRIORITY 6: Provide **EQUITABLE care**, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory.

What we said we would do:	What we did:
Violence and aggression incidents	This summary highlights the Health Board’s commitment to addressing violence and aggression through multi-agency collaboration, data-driven strategies, and proactive policy development and implementation. Multi-Agency Risk Assessment Conference (MARAC) • Purpose: MARACs are meetings where information is shared on high-risk domestic abuse cases among various local agencies. • Participation: In Q4 2023/24, the Corporate Safeguarding Team attended 33 MARACs. • Impact: Contributed to safety plans for 432 domestic abuse survivors. • Trend: 87% increase in individuals discussed in MARAC. • Future Focus: Sustainability of MARAC, led by Gwent MARAC Steering Group and Gwent VAWDASV work. Sexual Safety • Context: National report by Women’s Rights Network on sexual assaults in hospital settings. • Incidents: 48 incidents reported from 1 August 2023 to 31 January 2024. ◦ Nature: Mostly inappropriate behaviour by patients towards staff, followed by patient-on-patient incidents, and two allegations against staff. ◦ Severity: No incidents resulted in physical harm or met the national definition of serious sexual assault. • Current Efforts: ◦ Developing a Chaperone Policy. ◦ Refreshing referral pathway to the Sexual Abuse Referral Centre (SARC). ◦ Creating an overarching sexual safety policy covering risk assessment, incident recording, and escalation. Serious Violence • Legislation: The Serious Violence Duty 2022 mandates Health Boards to engage in regional strategy development for tackling serious violence. • Data Contribution: ABUHB provides a dataset to the Office of the Police and Crime Commissioner (OPCC) for strategic needs assessment and strategy development. • Funding and Initiatives: ◦ Funding for 2023/24 allocated to violence reduction in urgent care areas. ◦ Hiring a Violence Reduction Worker to engage in emergency areas and minor injury units. ◦ Focus on staff training, data collection improvement, and early intervention for individuals at risk of serious violence or organised crime/exploitation.

Quality Enablers

As part of the Health and Care Quality Standards here are some highlights of the work undertaken on the Quality Enablers in 2023/24.

Throughout 2023/24, the Health Board has made collective efforts to enhance leadership capabilities, optimise workforce management, and foster a positive organisational culture that supports staff wellbeing and engagement through the People's Plan.



Leadership

The Health Board has made a commitment to Person-Centred Care: Emphasising that patients and families are equal partners in healthcare planning, development, and monitoring. There has been a Quality and Safety Pledge: Promoting a culture of openness, transparency, and continuous improvement, with staff encouraged to raise concerns and engage in quality improvement initiatives. Other progress in 2023/24 includes:

- **Leadership Development Programs:**

- The Clinical Directors (CDx) and Directorate Managers (DMx) training programs continue to support leadership development, emphasizing collaborative, inclusive, and compassionate leadership skills. Over 300 colleagues have participated in bespoke leadership development programs tailored to their challenges.
- The Leading People Programme, now in its eighth cohort, has shown positive impacts on leadership confidence, self-awareness, and the ability to foster psychologically safe and compassionate cultures.

- **Raising Concerns and Speaking Up:**

- The NHS Wales Speaking Up Safely Framework's self-assessment and action plan have been implemented, with initial engagement and awareness events held. An internal raising concerns email address and an external Employee Assistance Programme are being launched.

- **Occupational Health and Wellbeing:**

- Initiatives like the Wellbeing Centre of Excellence and integrated psychological wellbeing practitioners aim to support staff health. The avoidable employee harm programme has significantly reduced investigations, sick days, and costs, promoting a culture of minimising harm in HR processes.

Workforce

The Workforce Demographics of the Health Board are vast, employing 13,117 WTE (15,558 individuals), with an increase in clinical services and nursing staff. Efforts focus on reducing turnover and addressing the aging workforce, where 36% are over 50 years old. The Health Board recognises staff contributions and enhancing their experience through feedback and learning opportunities.

- **Workforce Sustainability and Planning:**

- Actions include promoting Band 4 opportunities, creating promotional videos, and increasing training for Healthcare Support Workers (HCSWs) to transition into professional roles like registered nurses.
- The Clinical Futures Workforce Group has been re-established to align people management strategies with Health Board priorities. A workshop with local authorities helped outline key deliverables, which were reviewed by the Gwent Workforce Board.

- **Workforce Analytics and Optimisation:**

- A workforce establishment controls workstream is linking financial budgets with electronic staff records for better workforce planning and vacancy management. The rollout of systems like SafeCare and new medical e-systems supports this initiative.

- **Recruitment and Retention:**

- Efforts have led to a reduction in turnover from 11.36% to 9.04%, decreased sickness from 6.9% to 6.2%, and successful international recruitment of 74 nurses. The time to hire has been reduced, meeting the national target of 70 days.
- Vacancy reductions include 100WTE HCSWs, 60WTE registered nurses, and 47WTE medical vacancies over 12 months. Variable pay has been reduced by approximately £18 million.

The Health Board is focused on learning from Experience: emphasising the importance of learning from patient and staff feedback to improve care quality and safety. There is a focus on ensuring a culture of Openness and Transparency, encouraging a culture where issues can be raised and addressed proactively, fostering a safe and supportive work environment. Supporting the work on culture:

- **Employee Wellbeing:**
 - The Wellbeing Centre of Excellence provides a supportive environment for staff, increasing capacity for clinical space. Psychological therapy services have seen a 20% increase in demand, with additional support secured to manage this.
 - The avoidable employee harm program has been instrumental in reducing the negative impacts of employee investigations, contributing to a healthier culture.
- **Diversity and Inclusion:**
 - The Strategic Equality Plan was launched, focusing on equality, diversity, and inclusion over the next four years. There has been an increase in the translation of Welsh language materials and self-reported Welsh language competencies.
- **Engagement and Experience:**
 - The Leadership Development Program (LDP) is fully subscribed, indicating strong engagement. The coaching network and various learning masterclasses have been established to enhance leadership skills and team success.

Freedom to speak up

We are committed to fostering an open, learning organisation with a 'Just Culture' that promotes safety through support and psychological safety. Our aim is to nurture quality and system safety, valuing people in a collaborative and inclusive workplace where they feel safe to raise concerns and try new approaches.

We encourage staff and patients to 'Speak up for Patient Safety,' raising awareness of escalation processes and early learning mechanisms. Our learning and improvement forum enables sharing of errors, near misses, and incidents.

Over the past year, our human factors development program has supported openness and transparency in patient safety incidents, using simulation sessions and debriefs for all involved staff. We ensure that staff involved in incidents receive support for reflective practice, embedding learning, and preventing recurrence.

Following the NHS Wales Speaking up Safely Framework, the Health Board conducted a self-assessment and developed an action plan for its implementation. An initial engagement event was held in October 2023, and a cross-organizational steering group was established in March 2024. Workforce & OD launched an internal email for raising concerns, transitioning to an external Employee Assistance Program and Speaking Up service by July 2024.

We are rolling out a ward and team accreditation process to ensure teams understand their quality and safety data, fostering ownership of learning and improvements for sustainable change. This cultural shift engages staff in quality improvement and supports them in raising concerns and receiving organisational backing for learning and improvement.

Information

The integration of digital, data, and technology into healthcare is pivotal for enhancing patient safety and quality. By focusing on real-time information, patient access to health data, Artificial Intelligence and health data analytics, the health board aims to improve service delivery and patient outcomes. Addressing challenges like digital inclusion and cybersecurity, and leveraging strategic initiatives, ensures a sustainable digital transformation that benefits both healthcare providers and patients.

Digital technology is integral to daily operations, improving accessibility and connectivity in healthcare. The demand for digital services is increasing, providing numerous opportunities to enhance healthcare processes and patient experiences.

Opportunities for Improvement

- **Real-Time Information:** Electronic ward boards and data dashboards improve patient flow by providing real-time updates on patient and bed status.
- **Patient Access:** Local and national applications empower patients with access to their health data, giving them control over their healthcare decisions.
- **Artificial Intelligence (AI):** AI is being used in radiology, delivering tangible benefits in diagnosis and treatment.
- **Health Data Analytics:** Advanced analytics offer insights into population health, guiding public health initiatives and helping citizens maintain their health at home.

Welsh Nursing Care Record (WNCR) Implementation:

Achievements: Significant progress in rolling out WNCR across most wards. High engagement and substantial digital documentation recorded.

- Rolled out to 86% of wards, with all adult in-patient wards expected to be live by September 2024, including Critical Care Areas.
- Over 34,000 assessments opened, with significant numbers recorded, such as 44,000 Falls assessments and 821,000 skin bundles.
- Monthly user engagement around 3,700, resulting in 1,476,744 risk assessments and 3,724,000 in-patient notes recorded.
- Introduction of additional digital documentation, such as Bowel Chart, Skin Inspection & Repositioning Chart, and Mouthcare risk assessment.
- Upcoming Version 2.5 will include comprehensive IV catheter and urinary cannula bundles.

Areas for Improvement

Multi-Disciplinary Record Limitation: WNCR is not implemented as a multi-disciplinary record in high turnover areas like medical assessment units, leading to continued use of paper nursing notes. National challenges in standardizing and digitizing nursing documents result in dual record-keeping (digital and paper), impacting nursing efficiency.

Digital Access and Capability: Some nursing staff face challenges with digital systems due to lapsed Nadex accounts, unfamiliarity with laptops, and limited typing skills. Implementation required additional support and training, particularly for hard-to-reach staff, such as night shift workers.

Challenges for 2024/25

Expansion to Paediatric Settings: The move to paediatric settings is complex due to the multi-disciplinary nature of admission and assessment records, delaying full digital integration. Digital Health and Care Wales is pausing development for paediatrics while standardization continues.

New Functionality and Support: Regular updates (2-3 versions annually) will introduce new forms, requiring extensive training and support from nurse educators, specialist nurses, and other stakeholders.

Data Utilisation: With the system operational, the focus will shift to leveraging available data for quality improvement initiatives. Development of tools to provide meaningful ward-level data to managers, identifying at-risk patients and compliance with patient assessments.

Learning, Improvement and Research

These have been included in the main body of the report.

- **Listening and Learning**
- **Participation in clinical audit**
- **Quality improvement**

Participation in clinical research

Key Achievements for 2023/24:

Implementation of the 2022-2027 Research and Development Strategy

- **Research Champions Scheme:** Volunteers from staff and the public enrolled.
- **Leadership Appointment:** Associate Medical Director for Research and Development appointed.
- **Non-Commercial Studies:** 112 studies open and recruiting, with 1587 patients enrolled.
- **Welsh Government Key Indicator:** 97% of studies recruiting to Time and Target compared to All Wales' 76%.
- **Commercial Trials:** Increased from 7 (2022/23) to 16 (2023/24), with 52 patients recruited; additional trials in setup and awaiting approval.
- **Industry Partnerships:** Established relationships with industry partners like Sanofi.
- **Haematology Research:** Funded a full-time Band 6 Research Nurse, facilitating growth in commercial research.
- **Budget Autonomy:** Regained control over the budget from HCRW due to high achievement in metrics.
- **Global Recruitment Achievement:** Reached 10% of the global recruitment target for a commercial Haematology clinical trial involving Chronic Myeloid Leukaemia.
- **Quality Management:** Established a Quality Management group and an Inspection Ready sub-group.

Areas for Improvement:

- **Lung Cancer Study Sponsorship:** Faced challenges and had to withdraw from the extension stage due to contractual complexities.
- **Staffing Issues:** Vacancies and inexperienced staff affected timely processing of research projects.
- **Funding Limitations:** Covid funding ended, limiting permanent staffing and research capacity.
- **Communication:** Poor communication of service redesigns affected research continuity.
- **Accommodation Shortages:** Lack of R&D accommodation at YYF and GUH sites hindered research delivery and oversight.

Challenges for 2024/25:

- **Research Fellow:** Employ to work with Principal Investigators to expand clinical trials.
- **Capacity Building:** Increase research delivery team capacity to set up and oversee a commercial hub.
- **Promotional Materials:** Develop a brochure to showcase clinical trials facilities for building commercial relationships.
- **Commercial Portfolio:** Establish a phased commercial portfolio focusing on areas with existing expertise.
- **Sponsorship Role:** Update documentation and establish a Sponsorship group for study oversight.
- **Commercial Trial Setup:** Improve setup times for commercial trials.
- **IT Infrastructure:** Review and enhance IT systems to support commercial activity and regulatory compliance.
- **Sustainable Commercial Research:** Collaborate with HCRW/WG to develop a sustainable commercial research presence in Wales with UK Government VPAG funding.
- **Velindre Radiotherapy Unit:** Ensure research opportunities for patients at the new unit.
- **R&D Committee:** Re-establish to meet current departmental needs.

Whole Systems Approach

Integrated Care: Fostering collaboration across different care settings to ensure continuity and coordination of care, with a focus on holistic and person-centred approaches. The Health Board plans to coordinate and develop the Integrated Medium-Term Plan (IMTP) for an integrated planning group. Key Activities include:

- **Integration and Connectivity:** Align short-term plans with long-term strategies. Ensure coordination across Divisions, Corporate Functions, and wider partnerships like Regional Partnership Board and Cluster Plans.
- **Bottom-Up Planning:** Develop plans based on demand and capacity, grounded in Executive Team directives.
- **Alignment with Priorities:** Ensure plans meet Ministerial and National Priorities.
- **Financial Management:** Deliver plans within financial limits, articulating risks and consequences.
- **Community of Practice:** Standardise planning approaches, share best practices, and promote consistent methodology.
- **Championing Planning:** Embed planning principles across teams, acting as planning advocates within respective areas.
- **Issue Resolution:** Provide guidance and mediate conflicts to maintain the plan's progress.
- **Population Health Management:** Addressing broader health determinants through programs focused on prevention, early intervention, and comprehensive care models.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	An Approach to Developing a Quality Assurance Framework for Commissioned Services
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing Dr James Calvert, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Ann-Marie Matthews, Lead for Clinical Commissioning/IPFR Tracey Partridge-Wilson, Deputy Director of Nursing

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This paper seeks to introduce the proposed approach to developing a Quality Assurance Framework for Commissioned Services, and explain the current limitations, and proposed further development work required.

Cefndir / Background

Aneurin Bevan University Health Board has a statutory responsibility to provide healthcare services that meets the needs of our population. Our strategic aim is to ensure there is equitable access to safe, effective, and sustainable services, as close to a patient's home as possible, within available resources. We achieve this by directly providing healthcare or by commissioning healthcare from other service providers.

Aneurin Bevan University Health Board, like many health boards, have had to respond to more challenging performance and financial positions, as well as changes within the commissioning landscape, particularly since the COVID pandemic. Commissioning plays a critical role in driving quality and improvement and setting out longer term goals with providers by way of setting standards, focussing on improvement in effectiveness, whilst ensuring that patients are at the forefront.



This approach to developing a Quality Assurance Framework for Commissioned Services (QAF-CS) sets out the key principles and approach to commissioning for quality, providing a structure which should be used to support the development of consistent, high quality commissioning practices and associated improvements in outcomes to ensure the Health Board is operating effectively to commission safe, high-quality and sustainable services for our residential population – including the ability to recognise any early action and systematic deterioration in care within a provider organisation.

Asesiad / Assessment

The Health Board is primarily a provider organisation; however, a proportion of its budget is devoted to securing healthcare services, including unscheduled and planned care from neighbouring NHS Wales Health Boards and NHS Trusts in England. This in part is due to our geographical location and cross-border arrangements. The QAF-CS seeks to describe a continuous assurance process to ensure that the services we commission are safe, personal, effective and continuously improving.

What is commissioning

In basic terms, commissioning is often described as the purchasing of NHS services from other organisations to meet the health needs of a local population. Aneurin Bevan University Health Board aims to commission services that improve the health and wellbeing of our residential population using a continual process of planning, agreeing, and monitoring our healthcare services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

This shift towards a more collaborative approach to planning and improving services means that, instead of focusing on procurement and contract management, we will continue to work closely with key partners across the system (including providers) to understand population needs, determine key priorities, and design, plan, and resource services to meet those needs.

Commissioning for Quality

Quality should be at the heart of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales.

Poor quality care can also be costly in terms of harm, waste, and variation. The Health Board needs to ensure that we are operating effectively to commission safe, high-quality, and sustainable services within the resources available, delivering on our statutory duties whilst driving continuous improvement in the quality of services and outcomes achieved for patients.

NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these quality governance arrangements is



to help organisations and their staff both monitor and where necessary, improve standards of care.

The Health Board already has a clear commitment to ensure the provision of safe and high-quality services, supported by corporate frameworks and improving risk management. Value and behaviours are well established, and the introduction of the new Quality Strategy is further strengthening the Health Boards operational governance. The synergy between these two documents therefore ensures that quality and safety is at the forefront of all we do.

Record of providers and Quality Assurance Data

NHS Long Terms Agreement (LTAs) and Service Level Agreement (SLAs) between NHS bodies for healthcare in relation to NHS statutory functions are embedded in the NHS (Wales) Act 2006. They are not legally enforceable contracts. Within Wales the arbitration process is through the Welsh Government.

Where there is private sector involvement, contracts are legally binding, and procurement is via the NHS shared Services Partnership in line with Standing Financial Instructions. All Wales Frameworks should therefore be used where available.

The commissioning arrangements for some healthcare services are on a collective all-Wales basis. The Joint Commissioning Committee (JCC) is responsible for the joint planning and commissioning of specialised and tertiary services on behalf of all Health Boards in Wales.

Where Aneurin Bevan University Health Board is the commissioner, the principles of good contract management remain an important part of the wider commissioning process. However, commissioning goes beyond ensuring providers meet their agreed obligation as it can not only help the Health Board identify and manage its own and its providers risks but can help achieve saving and continuous improvement.

Each Division is responsible for ensuring the services that fall within their service areas are commissioned appropriately and effectively and have adequate monitoring arrangements in place. Further work however may be required by some Divisions to strengthen these arrangements following agreement of this approach to a QAF-CS. As such, whilst the fundamental principles underpinning this approach should be adhered to, we recognise that due to the diversity of each service area, the implementation frameworks for each Division will need to be tailored to drive forward the quality assurance and quality improvement of their respective service areas.

The Central Financial Commissioning team are responsible for agreeing the Health Boards larger LTAs and SLAs, with regular monitoring and performance meetings taking place with providers to ensure adherence to the contracts.

There are currently several ways in which Divisions receive and feedback information regarding commissioned services. This includes inspection reports and both



qualitative and quantitative feedback. Whilst some Divisions have developed registers and systems to aid their commissioning processes, it is recognised that the Health Board does not have a standardised register of commissioned services, and some Divisions hold better records than others.

Further development

Further work is required to identify what information is currently available in relation to commissioned services, such as what documented agreements are available, and what areas require further detailed work including whether adequate monitoring processes are in place. A working group should therefore be developed to review commissioning for quality processes within each Division and to consider processes for testing change and implementation.

In relation to patient experience, the Datix system provides an option to record which organisation the concern relates to and who is leading on that concern. Further work is required to ascertain the process by which Divisions are reviewing the numbers of concerns/incidents reported for providers in order to detect any potential deteriorating quality in service provision.

Discussions have taken place between the Lead for Clinical Commissioning/IPFR and the Finance Business Partner – Commissioning, and work has commenced with the Divisions to create a central map/register of commissioned services across the Health Board.

Development of a small commissioning working group is also proposed to identify any areas where further support is required to wider aspect of commissioning, including the development of best practice guides and thus developing a pool of 'experts' by building knowledge in this areas

Argymhelliad / Recommendation

The Board is asked to ENDORSE the approach set out to developing a Quality Assurance Framework for Commissioned Services and to NOTE the progress and direction for further areas of development in relation to quality for commissioned services.



Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.3 Quality Improvement, Research and Innovation Governance, Leadership & Accountability 3.1 Safe and Clinically Effective Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee Patient Quality, Safety & Outcomes Committee

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



Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives



Quality Assurance Framework for Commissioned Services



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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1 INTRODUCTION

Aneurin Bevan University Health Board has a statutory responsibility to provide healthcare services that meets the needs of our local population in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). Our strategic aim is to ensure there is equitable access to safe, effective, and sustainable services, as close to a patient's home as possible, within available resources. We achieve this by either directly providing healthcare or by commissioning healthcare from other service providers.

Commissioning is defined as the continual process of planning, agreeing, and monitoring our healthcare services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

Quality assurance is the responsibility of all who work in healthcare, and dependent on our role, we become accountable in different ways for the decisions we make. At the heart of those decisions is the need to ensure that the Health Board is operating effectively to commission safe, high-quality, and sustainable services within the resources available, delivering on our statutory duties whilst driving continuous improvement in the quality of services and outcomes achieved for patients.

This Quality Commissioning Assurance Framework sets out the key principles and the approach to commissioning and should be used to support the development of consistent, high quality commissioning practices and associated improvements in outcomes for our residential population.

This document does not seek to dictate every step taken in commissioning, given the wide scope of service commissioning across the Health Board. **Rather, it is a compass to guide our work and decision-making,** recognising the professional expertise and vital systems we already have in place throughout the organisation.

We will be able to fully meet our ambitions for quality health and care services by collaborative commissioning in partnership with external local and regional providers and partners, with our patients, with colleagues from across the Health Board, and with other colleagues supporting public services. This framework sets out a shared set of principles and practical guidance for actions, responsibilities, and expectations for commissioning.

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

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

The development of our Health Board's Quality Strategy supports the new legislative requirements.

The Health Board's Quality Indicators have been aligned to the six domains of quality: person-centred, safe, timely, effective, efficient and equitable. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Boards priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

This framework does not sit in isolation and should be read in conjunction with both the Health Boards wider strategies and any National Frameworks in place in relation to the service area.

2 QUALITY

Numerous definitions of quality relating to health and care services have been described by various global organisations, including the Institute for Healthcare Improvement and World Health Organisation. However, *The Duty of Quality Statutory Guidance and Health and Care Quality Standards 2023 WG23-12*, issued by the Welsh Government on 1st April 2023 serves a dual purpose of providing statutory guidance which helps NHS bodies in Wales deliver the requirements of the duty of quality, and also sets out the new Health and Care Quality Standards issued under section 47(1) of the Health and Social Care (Community Health and Standards) Act 2003.

Quality is considered to be defined as continuously, reliably, and sustainable meeting the needs of the population that we service. In order to achieve this, Aneurin Bevan University Health Board needs to ensure that the health services we provide, and commission are in line with the six domains of quality outlined in our Quality Strategy - **S**afe, **T**imely, **E**ffective, **E**fficient, **E**quitable and **P**erson-Centred. These quality dimensions provide a framework to assess quality and guide improvement and will be at the forefront of the services we provide.



3 QUALITY IN COMMISSIONED SERVICES

It is recognised that health services may be provided across geographical boundaries through commissioning arrangements with NHS and non-NHS services providers. Commissioning involves planning, buying/procurement, and monitoring/evaluation services to meet people's needs; therefore, the Health Board must exercise its function to ensure the services we commission for our patient population are of sound quality. This includes services provided by: -

- Another Local Health Board in Wales
- Primary care, dental, optical, and pharmaceutical services in Wales
- Non-NHS bodies.
- Services commissioned outside of Wales

Long Term Agreements (LTAs) and Service Level Agreements (SLAs) between NHS organisations in relation to NHS statutory functions are entrenched throughout the NHS (Wales) Act 2006. Where Aneurin Bevan University Health Board commissions services from other providers, the principles of good contract management play an important part of the wider commissioning process. This ensures that providers meet their agreed obligations and helps the Health Board identify and manage its own and its providers risks, achieve savings, and seek continuous improvement.

At a basic level, good contract management is about attention to detail such as understanding what the contract contains, who has responsibility for managing it, and whether performance and costs are on track. This is achieved when those who are involved in commissioning and running a service work together to manage the agreement and have clear, agreed processes and procedures in place.

4 FRAMEWORK

The framework captures two fundamental elements of strategic commissioning:

1. The key stages of the commissioning 'cycle' teams should consider in order to achieve the best outcomes for our patient population.
2. The key principles that staff involved in commissioning should follow, guiding by how we work together to achieve the best results.



Once we have identified needs, requirements, resources and opportunities, a strategic approach to prioritisation should be undertaken to ensure our commissioning efforts have the most impact.

Fundamental principles underpinning the framework's implementation include:

- Taking a patient centred approach. Ensuring that **the patient is at the centre of the services we commission**. To inform quality improvements, the patient experience should be captured alongside quality indicators.
- Ensuring that **quality indicators are clinically led** and reflect the nature of the service being delivered.
- Develop mechanisms to **analyse and report quality indicators and outcomes**.
- **Work in partnership** with providers to agree service specifications.
- Embed a culture whereby **quality becomes part of our everyday business**.
- **Identify lessons that can be learnt** and to drive improvement in the quality of service.

The framework is not introducing any new concepts for the Health Board but builds on the foundations of current practice. We recognise that the Health Board is operating under a changing environment, with considerable challenge to both the Health Board and the patients we support.

5 LEVELS OF ASSURANCE

The Health Board needs to provide effective and robust monitoring arrangements to ensure performance, quality and efficiency of all services are delivered. This can be undertaken in several ways, depending on the commissioned service and the provider. However, most approaches to monitoring will be undertaken through routine internal contractual processes and clinical governance structures. Providers are also required to have their own quality monitoring processes in place through delivering the **Duty of Candour**. As a minimum the Health Board require the following for assurance purposes:

- Oversight of any quality reports produced by the provider. Including individual/safeguarding or serious incidents reports.
- Copy of annual quality account
- Any peer reviews and benchmarking data
- Any safe staffing reviews.
- Care Quality Commission (England), Healthcare Inspectorate Wales or Care Inspectorate Wales visits or other external reviews relating to commissioned services.

The contractual relationship the Health Board has with commissioners should include the provision of information which provides assurance on a system wide approach to improving quality and with the aim of achieving a learning and improving environment.

Agreeing **s**pecific, **m**easurable, **a**chievable, **r**elavant, and **t**ime-bound (**SMART**) actions and making decisions about the use of resources in accordance with this framework.

S	SPECIFIC	A very clear statement of what you are trying to achieve.
M	MEASURABLE	Include measurements that will evidence improvement.
A	ACHIEVABLE	Is realistic and attainable in the time allowed.
R	RELEVANT	Is linked to the Health Boards strategic aims and relates to patient outcomes.
T	TIME-BOUND	Include a clearly defined timeframe within which the aim should be achieved.

Each provider should be rated to help compare services, highlighting where services are good or outstanding, and exposing where services are inadequate or require improvement. Information should also be collated in relation to governance and strategic change. Special measures and/or levels of Government intervention should also be recorded.

Departments should develop a 'dashboard' to show at a glance the provider rating for the aspects they've chosen to rate. This could include areas such as access, finance/activity, quality & safety, and patient experience. The scoring levels should be as follows: -

Green	On target
Amber	Risk to delivery/patient safety
Red	Not on target

6 ESCALTION PROCESS

The escalation process should provide clear methodology by which both providers and the Health Board understand the reporting mechanisms, are able to identify any issues and understand the actions required to find a joint resolution. This process should not be seen as a punitive one, but a means to identify problems

as early as possible, with the aim of working in partnership to improve the services commissioned.

Reasons for escalation could be triggered by a single event or a combination of factors which may relate to, but are not limited to: -

- Issues that present an immediate challenge to service continuity which may affect the reputation of the Health Board and/or the provider and could result in any closure or partial closure of a service.
- Concerns arising from the examination of qualitative and quantitative data. For example, raised mortality rates, deteriorating infection profiles, or concerning patient harm reports.
- Alternatively, a worrying set of workforce metrics (for example in relation to Nurse Staffing Levels (Wales) Act 2016, or credible soft intelligence which is not readily accounted for by the provider.
- Repeated failure to deliver agreed improvement plans and/or an inadequate response to address the concerns raised.
- Financial management.
- Serious concerns raised by Healthcare Inspectorate Wales, Care Inspectorate Wales, Llais, Welsh Government intervention processes or other professional bodies.

Routine monitoring should be undertaken for all commissioned services and is the terms used when there are no identified concerns with delivery of the service. These are currently mapped to the pillars of quality and include: -



Where there are concerns, and a lack of assurance in terms of improvement, the escalation process takes place. This process is structured to allow engagement with providers, local and regional commissioners, and regulators where necessary. It is a system whereby there is continuous service improvement or decommissioning if necessary.

Whilst we recognise each service will have its own escalation process in place based on the services commissioned, these should be aligned to a tiered approach

similar to the Welsh Government (NHS Wales Escalation and Intervention Arrangements 2014): -

- Routine monitoring
- Escalated monitoring
- Escalated intervention
- Escalated measures
- Decommissioning

Risks should be reported within Divisional Risk Registers and shared with the Patient Safety and Quality Operational Group.

The approach to escalation and intervention where there are matters of concern that need to be addressed should also be aligned to the organisations Operational Framework.

ESCALATION METHODOLOGY

Each Division should have in place processes for the routine monitoring of commissioned services to ensure they are effective and deliver quality and safe care to patients, including performance monitoring. A critical gap in the system of oversight of quality and safety was identified in the Francis report, which arose from the inability of commissioners to collect information on provider quality and to understand and make use of contractual mechanisms that were available to them. This methodology outlines the process for managing the escalation process in response to such concerns.

The escalation process should be a 'step-up, step down' process. There should be a proportionate approach which considers the degree of risk for Gwent patients. For example, a small number of Gwent residents may attend a large organisation in Special Measures, but the specific service used by Gwent residents may not be a cause for concern.

ESCALATED MONITORING

The Division must demonstrate that it is taking a pro-active response to put in place effective processes to address the issue(s) and drive improvement. Monitoring will be more frequent than that carried out under routine arrangements and may also take a wider variety of forms, including regular communication and meetings in addition to written progress updates and submission of evidence, including updated action plans and qualitative and quantitative data.

The investigation will lead to one of three possible outcomes: -

- No further action necessary. Concerns and finding logged and routine monitoring continue.
- Action and review date agreed. Concern(s), findings and action plan logged, and monitoring of the action plan arranged. Consideration should be given as to whether a risk assessment is required.
- Commissioning quality visit required i.e. further escalation required

ESCALATED INTERVENTION

The nature and focus of a commissioning quality visit will vary depending upon the circumstances of the issue in question. In instances where there is insufficient evidence available to make a judgment on the degree of concern further evidence collection may be required prior to the visit. This might include an external review, collection of patient experience data, a self-assessment report from the provider etc.

The visiting representatives from the HB will be in line with each Division's Implementation Framework. Where sufficient evidence already exists to support the concerns raised, it is likely that the visit will take the form of an action planning meeting. These meetings will typically utilise a flexible agenda based around developing an action plan for addressing the issue(s) with agreed timescales and responsibilities.

The visit may lead to one of the following outcomes: -

- No further action necessary. Concerns and findings logged and routine monitoring continues.
- Action and review date agreed. Concerns, findings and action plan logged and monitored.
- Risk assessment undertaken and logged on the Divisional Risk Register.
- Insufficient progress leading to a serious concern regarding on-going patient care at the provider. The provider will be designated to 'escalated measures.'

Dependent on the seriousness of the issue(s), the Deputy Chief Operating Officer will arrange a meeting between the Medical Director of the Health Board and the provider organisation. The Health Boards Commissioning Team should also be notified.

ESCALATED MEASURES

Where there is evidence that the Action Plan emanating from the escalated intervention has failed to meet the required outcomes as agreed by the Division, the following should be considered: -

- Further action planning
- Penalties
- Decommissioning

Issues to be raised with Chief Executive Officer and with the Executive Committee if necessary. An update should also be provided to the Patient Quality Safety and Outcomes Committee.

	Level of monitoring	Escalation	Meeting frequency
Level 1 Green	Routine monitoring – Evidence and data should be provided through quality schedules, national assessments and	None – routine monitoring	As per Divisional implementation plan

	usual data sources and information		
Level 2 Amber	Escalated monitoring – Enhanced monitoring via exception and associated remedial actions and trajectory for improvement agreed.	Enhanced Monitoring	As per Divisional implementation plan – Enhanced monitoring
Level 3 Red	Escalated intervention Commissioning Quality visit required. Escalated performance monitoring requiring detailed action plans for exceptions	Commissioned Quality Visit required. Escalate to Medical Director and Director for Commissioning if required	As per Divisional implementation plan – Enhanced monitoring
Level 4 Red	Escalated measures for performance monitoring and requirement for detailed action plan. As a minimum monthly meeting to review areas where commissioners have serious concerns about quality and patient safety	Escalate to Chief Executive Officer / Executive Committee. Reported to Patient Quality Safety Outcomes Committee	AS per Division implementation plan. CEO led escalated meetings if there are significant and persistent concerns.

7 DE-ESCALATION PROCESS

As the performance improves and the risk assessments indicate a reduction in the level of intervention required, de-escalation should be considered. Discussions should take place within Divisions and an update provided to the Patient Safety and Quality Operational Group.

8 DECOMMISSIONING

The withdrawal from or closure of an internal or external service by ceasing funding or ending a contract is defined as decommissioning and is an integral part of the commissioning cycle. It is most likely to occur at the end of a contractual agreement, however, could occur during the contract term due to unforeseen circumstances. It is vital that the process of reviewing contracts, including quality of provision, value for money and strategic relevance begins before the contract is due for renewal.

Factors that may lead to the decommissioning of a service may include evidence of poor-quality services; services not aligning to our strategic priorities; the level and type of demand for services has changed; the introduction of alternative or innovative delivery models, service failing to comply with legislative requirements e.g. safeguarding. A natural end to the contract may also lead to the decommissioning of a contract/service.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Integrated Performance Report: Quarter 1
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Executive Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Trish Chalk, Assistant Director of Planning and Performance Marie-Claire Griffiths, Head of Strategic Planning Jennifer Keyte, Senior Planning and Service Development Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this paper is to provide the Board with a progress report against the Aneurin Bevan University Health Board's Annual Plan 2024/25. This report summarises the Health Board's progress during Quarter 1, through the lens of the following chapters:

- Performance Summary
- Cabinet Secretary Priorities
- Our Performance and System Change

Our performance and system change section details the performance against activity and performance targets; annual plan milestones; quality safety and experience, workforce and culture; and financial performance.

The Executive Committee is asked to:

- Note the progress achieved during Quarter 1

Cefndir / Background

The Annual Plan was presented to the Board in March in the context of significant financial and operational challenges, reflecting the heightened escalation arrangements that the Health Board are now subject to. Alongside the targeted action the Health Board is taking to deliver in year improvements is the clear and emerging priorities for the strategic and tactical planning and required for services

and estates to achieve sustainable services and financial balance in three years' time. The stated ambition of the plan is to be in financial balance by 2026/27.

As part of the plan development a suite of performance ambitions were agreed against each system change theme. Following the submission of the plan in March 2024 the Health Board was asked for a resubmission in May 2024 to improve planned trajectories against Cabinet Secretary Priorities. These changes are reflected in the performance report.

The plan outlined the priorities and system change required under the five priority areas:

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

These five priority areas are presented alongside Workforce and Culture; Quality, Safety and Experience; and Financial Performance to align to the NHS Performance Framework measures and the quadruple aims.

Aim 1	People in Wales have improved health and well-being with better prevention and self-management	• Embedding Prevention and Population Health in all that we do
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	• Progressing place based models of care and sustainability in primary and community services • Improving our Urgent and emergency care system focusing on experience, access and discharge pathways • Continuing to prioritise cancer, urgent and the longest waiting patients for planned care • Improving our Mental health services
Aim 3	The health and social care workforce in Wales is motivated and sustainable	Workforce and Culture
Aim 4	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

1. Performance Summary

The below diagram summarises the performance across Quarter 1 overall.



2. Cabinet Secretary Priorities

There has been mixed performance across the Cabinet Secretary priorities, the measures where performance is reported within this period are summarised below and overleaf;

Cabinet Secretary Priority	Measure	In Month Trajectory	In Month Performance
Enhanced Care in the Community	Number of delayed transfers of care.	262	235 Jul-24
Urgent and Emergency Care	Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	1,328	1,374 Jun-24
	Number of ambulance patient handovers over 1 hour	873	697 Jul-24
Planned Care and Cancer	Number of patients waiting more than 52 weeks for a new outpatient appointment	14,477	16,142 Jun-24
	Number of patients waiting more than 104 weeks for referral to treatment	4,152	4,408 Jun-24
	Percentage of patients starting their first definitive treatment within 62	60%	59.8% Jun-24

Mental Health, including CAMHS	days from point of suspicion (regardless of the referral route)		
	Number of patients waiting more than 8 weeks for a specified diagnostic	3,762	4,219 Jun-24
	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	0%	4.2% Jun-24
	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	21%	17.9% Jun-24

3. Our Performance and System Change

An overarching assessment of performance against System Change Themes Workforce and Culture; Quality, Safety and Experience; and Financial Performance is provided below.

System Change Themes

Embedding Prevention and Population Health in all that we do	Four performance measures in reporting period, below target on all of them. Actions in place to improve performance against Healthy Child Wales programme measures and improve rates of stopping smoking particularly in pregnancy. Out of the 7 annual plan quarter 1 milestones; • 4 Off track within tolerance • 3 Complete/ On schedule
Progressing place based models of care and sustainability in primary and community services	Six performance measures in reporting period, target met or exceeded for all of them. With actions in place to improve access to community services and support the transfer of patients away from Emergency Departments. Out of the 11 annual plan quarter 1 milestones; • 2 Off track within tolerance • 9 Complete/ On schedule
Improving our Urgent and emergency care system focusing on experience, access and discharge pathways	Twelve performance measures in reporting period, seven did not meet the target. Actions in place to improve waiting times in Emergency Department and reduce ambulance handovers over four hours. Out of the 11 annual plan quarter 1 milestones; • 3 Off track within tolerance • 8 Complete/ On schedule

Continuing to prioritise cancer, urgent and the longest waiting patients for planned care	Ten performance measures in reporting period, six did not meet the target. Actions in place to address longest waiters in the challenging specialities and improve urgent suspected cancer test capacity. Out of the 16 annual plan quarter 1 milestones; • 5 Off track within tolerance • 11 Complete/ On schedule
Improving our Mental health services	Nine performance measures in reporting period, three did not meet the target. Actions in place to address capacity issues in psychological therapies and development of on-line therapy service and enhanced group-based provision. Out of the 14 annual plan quarter 1 milestone; • 5 Off track within tolerance • 9 Complete/ On schedule

Quality, Safety and Experience

The Quality and Safety performance is reported against a condensed range of indicators compared to the comprehensive Quality Outcomes Report which is produced for the Quality and Patient Safety Committee. The Top-level indicators provided for the integrated performance mapped to the six pillars of quality:

Patient Experience:	• Overall satisfaction increased to 90% for all surveys.
Incidents:	• The Health Board reported 20 National Reportable Incidents in April, 13 in May, with a decrease to 2 in June • In Quarter 1 2024/25 there were 6170 incidents affecting patients reported on the Datix Cymru system. • There have been 18 incidents that have triggered Duty of Candour. This figure is based on the question -Was Healthcare provided a factor? • Risk Adjusted Mortality Indicators (RAMI) has dropped below the All Wales peer but continues to vary with Quarter 1 at 107.
Complaints, concerns, compliments:	• Across quarter 1 we saw a 4% decrease in the number of concerns received by the Health Board.
Infection Control and Prevention:	• A total of 98 cases of C diff reported. This is 36 more than the equivalent period 23/24. • A total of 48 cases of Staph aureus bacteraemia reported. This is 26 more than the equivalent period 23/24. • A total of 87 cases of E coli reported. This is 5 less than the equivalent period 23/24. • A total of 32 cases of Klebsiella reported. This is 1 more than the equivalent period 23/24. • A total of 11 cases of Pseudomonas reported. This is 5 more than the equivalent period 23/24.
Health, Safety & Security:	• A total 540 incidents happened towards staff in quarter 1 with 306 being attributed as aggressive or threatening behaviour.

Safeguarding:	• Adult duty to report increase by 41% which is 50 more than same period in 23/24 • Child duty to report increase by 13% which is 127 more than same period in 23/24

Workforce and Culture

Our People Plan, 2022 -2025, ‘Putting People First’, outlines the Workforce and Organisational Development (OD) strategy in relation to workforce improvement, capability, and expertise with a clear focus on wellbeing, inclusion, and engagement of our people. A Workforce & OD Performance Dashboard has also been aligned to reflect the key workforce metrics of the People Plan objectives capturing the performance indicators of delivery of that plan and targets set in the Health Board Workforce MDS (24/25). Highlights from Quarter 1 include;

- Currently 12,995 WTE staff in post, a reduction of 94.02 WTE since March 2024 with largest decrease of 72.33wte in admin & clerical staff
- Sickness Absence in July 24 was 6.29% which has increased from 5.96 % as reported end of March 24
- A reduction of 142 WTE variable pay bank and sustained and supported by the variable pay programme recognising the importance of recruitment and retention
- Current locum usage is 57.87 WTE which a decrease in 5 WTE from this period last year
- Current Medical Agency WTE is 50.55 WTE, showing a sustained decrease in trend to achieving target.
- Current turnover rate is 9.08% a reduction from 9.55% the previous year which has been sustained over the last quarter
- Current PADR compliance is 74.25% a quarterly increase of 3% and we continue to work towards achieving 85% All Wales target
- Current mandatory training compliance rate is 82.53% an increase on the previous year of 78.23% and a quarterly increase of 6 % in achieving target of 85%

Financial Performance

The 2024/25 financial year to date budget performance as at month 3 is an adverse variance of £14.397m. The 2024/25 reported forecast is a £48.860m deficit reflective of the annual plan however there are risks to the forecast position in relation to the full delivery of savings and other operational pressures.

The 2024/25 forecast of £48.860m is £36m greater than the Welsh Government control total of a £13m deficit.

Argymhelliad / Recommendation

The Board is asked to NOTE the position against the Annual Plan 2024/25 commitments as at Quarter 1 and the mitigating and improvement actions in place.

Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements

	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.



Quarterly Integrated Performance Report

Quarter 1

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

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

Improving our **Urgent and emergency**
care system focusing on experience,
access and discharge pathways

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

Improving our **Mental health**
services



CONTENTS

Performance Summary

Section 1: Cabinet Secretary Priorities

Section 2: Our Performance & System Change Delivery

PERFORMANCE SUMMARY

What went well this Quarter?

- All managed practices were returned to independent status in April
- Met target of 5.4% of attendees waiting over 24hrs in Emergency Department
- 40% of patients assessed by Hospital 2 Home have now had their long-term package of care needs either reduced, or no longer required.
- Numbers of patients waiting over 104 weeks for planned care is at 4,408 which is a slight improvement on our target of 4,527
- % Stroke Patients Assessed by one of OT, PT, SALT within 24 hours is 61% exceeding target of 44.5%
- The 2024/25 reported finance forecast is on track at £48.860m deficit
- Significant increase to over 60% in assessment completed within 28 days for Adult Mental Health
- Achieved 100% in assessment completed within 28 days for Children and Adolescents Mental Health
- PADR Compliance is 74.25%, a quarterly increase of 3%
- Overall patient satisfaction increased from 85% to 90% for all surveys

What were the challenges this Quarter?

- Percentage of children with up-to-date vaccines at the age of 5 is at 86.7% below local target of 90.7% and national target of 95%
- Percentage of therapeutic interventions started within 28 days following an assessment by local primary care mental health support service for people age under 18 years is significantly low at 4.2% (National Target 80%)
- The number of patients waiting over 156 weeks for planned care is at 45 patients which is above our target of 0 patients
- Single Cancer Pathway 104-day backlog has increased to 145 which is above our target of 84
- Sickness Absence in July 24 was 6.29% which has increased from 5.96% as reported end of March 24

What actions are we taking to improve?

- Identifying community champions to increase childhood immunisation compliance
- Increased 6 week check (Healthy Child Wales) clinic provision across the Health Board with a realigned data collection process
- Developing a system for all General Medical Services practices to identify live Common Ailment service provision in their area
- Focused attention on ambulance handovers through weekly escalation meetings and monthly oversight with Welsh Government
- Bi-weekly Referral to Treatment Time (RTT) Directorate meetings focusing on elimination of 156 weeks.
- Demand and capacity completed in Cellular Pathology and recruitment strategy developed to meet demand for Urgent Suspected Cancer tests

What are our risks to delivery?

- 104 week waits until first outpatient appointment in ENT, Max Fax, and T&O
- Meeting 67% single cancer pathway compliance by Dec, current compliance is 58.9%
- Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic is below target, affecting delivery of ministerial measure by Dec
- Recruitment challenges in psychological therapies may affect ability to achieve performance standards
- Workforce gaps due to long term absences within Children's Neurodevelopmental services
- Workforce requirements identified to support a proposed recovery plan to reduce the extended waits for Primary Care CAMHS intervention.

Section 1: Cabinet Secretary Priorities

The Cabinet Secretary for Health and Social Services has set out National Programmes of work covering the priority areas of delivery. These priority areas are:

- Enhanced Care in the Community, with a focus on reducing delayed pathways of care
- Primary and Community Care, with a focus on improving access and shifting resources into primary and community care
- Urgent and Emergency Care, with a focus on delivery of the 6 goals programme
- Planned Care and Cancer, with a focus on reducing the longest waits
- Mental Health, including CAMHS, with a focus on delivery of the national programme

Further to these priority areas the Welsh Government and NHS Wales have identified 8 Key Performance Indicators across Urgent and Emergency Care, Cancer, Diagnostics, Elective Care and Mental Health Services.

Section 1 provides an overview of the Health Board performance of the Key Performance Indicators outlined by Welsh Government and Health Board commitments related to the delivery of the priority areas.

For a more in-depth view on performance for each priority, please follow the links in the NHS Performance Report column.

Cabinet Secretary Priorities

Priority	Aim	ABUHB Commitment	Ability to meet national standard?	In Month Performance against trajectory	Link in Performance Report
Enhanced Care in the Community	Measure: Number of delayed transfers of care. National standard/ambition: 12 month reduction trend Reporting period: Monthly	250 Mar-25	Yes	235 Jul-24 (Trajectory: 262)	Hyperlink to section
Primary and Community Care	Measure: General Medical Services (GMS) – Number of GP practices achieving core access standards National standard/ambition: 100% Reporting period: Annual – in month position for information	100%	Yes	100% Jun-24 (Trajectory: 100%)	Hyperlink to section
	Measure: General Dental Services (GDS) - % of contract value fulfilled National standard: 30% of contract value by end Q2, 100% Q4 Reporting period: Six Monthly	30% Sep-24 100% Mar-25	Yes	Reported in September	Hyperlink to section
Urgent and Emergency Care	Measure: Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge National standard/ambition: 20% reduction by September 2024, further 20% reduction by March 2025 Reporting period: Monthly	1,181 Sep-24 945 Mar-25	Yes	1,374 Jun-24 (Trajectory: 1,328)	Hyperlink to section
	Measure: Number of ambulance patient handovers over 1 hour National standard/ambition: 30% reduction by December 2024 Reporting period: Monthly	705 Dec-24	Yes	697 Jul-24 (Trajectory: 873)	Hyperlink to section
Planned Care and Cancer	Measure: Number of patients waiting more than 52 weeks for a new outpatient appointment National standard/ambition: 40% reduction by end of September 2024, 0 by end of March 2025 Reporting period: Monthly	15,352 Sep-24 16,500 Mar-25	No	16,142 Jun-24 (Trajectory: 14,477)	Hyperlink to section
	Measure: Number of patients waiting more than 104 weeks for referral to treatment National standard/ambition: 0 by end of December 2024 Reporting period: Monthly	3,929 Dec-24	No	4,408 Jun-24 (Trajectory: 4,152)	Hyperlink to section

Mental Health, including CAMHS	Measure: Percentage of patients starting their first definitive treatment within 62 days from point of suspicion (regardless of the referral route) National standard/ambition: 60% by end of December 2024, 70% by end of March 2025 Reporting period: Monthly	67% Dec-24 70% Mar-25	Yes	59.8% Jun-24 (Trajectory: 60%)	Hyperlink to section
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic National standard/ambition: 95% of patients waiting less than 8 weeks by end of December 2024 Reporting period: Monthly	3286 (79.7%) Dec-24	No	4,219 Jun-24 (Trajectory: 3,762)	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years National standard/ambition: 80% by end of December 2024 Reporting period: Monthly	87% Dec-24	Yes	4.2% Jun-24 (Trajectory: 0%)	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over National standard/ambition: 80% by end of December 2024 Reporting period: Monthly	92% Dec-24	Yes	17.9% Jun-24 (Trajectory: 21%)	Hyperlink to section

Section 2: Our Performance and System Change

The Performance Report section provides detail of Health Board performance across the quadruple aims and the system change themes identified in the Annual Plan 2024/25.

Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided under each aim against the Health Board's priorities and corresponding performance ambitions, including detail of annual plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim.

Quadruple Aim		Health Board's System Change Theme and Integrated Report
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Embedding Prevention and Population Health in all that we do
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	- Progressing place based models of care and sustainability in primary and community services - Improving our Urgent and emergency care system focusing on experience, access and discharge pathways - Continuing to prioritise cancer, urgent and the longest waiting patients for planned care - Improving our Mental health services
Aim 3	The health and social care workforce in Wales is motivated and sustainable	Workforce and Culture
Aim 4	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

Priority	Performance Measure	Performance against Q1 Trajectory	Data / Trend	Actions																																																																																																				
Health Protection & Vaccination	Increase percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	86.6% Below Trajectory of 90.7%	<table><caption>% children who are up to date with the scheduled vaccinations by age 5</caption><thead><tr><th>Quarter</th><th>ABUHB (%)</th><th>Target (%)</th></tr></thead><tbody><tr><td>Q1 2023/24</td><td>87.5%</td><td>90.7%</td></tr><tr><td>Q2 2023/24</td><td>87.4%</td><td>90.7%</td></tr><tr><td>Q3 2023/24</td><td>87.9%</td><td>90.7%</td></tr><tr><td>Q4 2023/24</td><td>86.6%</td><td>90.7%</td></tr></tbody></table>	Quarter	ABUHB (%)	Target (%)	Q1 2023/24	87.5%	90.7%	Q2 2023/24	87.4%	90.7%	Q3 2023/24	87.9%	90.7%	Q4 2023/24	86.6%	90.7%	- School Health Nurses undertaking robust vaccination plan coupled with dedicated MMR catch up clinics in Vaccination Centres and pop-up clinics. - Neighbourhood Care Networks (NCNs) to review the childhood immunisation queues across the boroughs, identifying uptake in the lower performing practices and support. - Identify community champions that could be created to assist in the education and increased uptake.																																																																																					
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Increase percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	67.9% Below Trajectory of 83.3%	<table><caption>% of children receiving the HPV vaccination by the age of 15</caption><thead><tr><th>Quarter</th><th>Compliance (%)</th><th>Target (%)</th><th>Median (%)</th><th>Upper Limit (%)</th><th>Lower Limit (%)</th></tr></thead><tbody><tr><td>Q1 20/21</td><td>88%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q2 20/21</td><td>88%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q3 20/21</td><td>87%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q4 20/21</td><td>87%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q1 21/22</td><td>88%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q2 21/22</td><td>88%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q3 21/22</td><td>70%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q4 21/22</td><td>72%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q1 22/23</td><td>73%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q2 22/23</td><td>75%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q3 22/23</td><td>80%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q4 22/23</td><td>80%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q1 23/24</td><td>80%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q2 23/24</td><td>80%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q3 23/24</td><td>68%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr><tr><td>Q4 23/24</td><td>68%</td><td>83.3%</td><td>80%</td><td>90%</td><td>60%</td></tr></tbody></table>	Quarter	Compliance (%)	Target (%)	Median (%)	Upper Limit (%)	Lower Limit (%)	Q1 20/21	88%	83.3%	80%	90%	60%	Q2 20/21	88%	83.3%	80%	90%	60%	Q3 20/21	87%	83.3%	80%	90%	60%	Q4 20/21	87%	83.3%	80%	90%	60%	Q1 21/22	88%	83.3%	80%	90%	60%	Q2 21/22	88%	83.3%	80%	90%	60%	Q3 21/22	70%	83.3%	80%	90%	60%	Q4 21/22	72%	83.3%	80%	90%	60%	Q1 22/23	73%	83.3%	80%	90%	60%	Q2 22/23	75%	83.3%	80%	90%	60%	Q3 22/23	80%	83.3%	80%	90%	60%	Q4 22/23	80%	83.3%	80%	90%	60%	Q1 23/24	80%	83.3%	80%	90%	60%	Q2 23/24	80%	83.3%	80%	90%	60%	Q3 23/24	68%	83.3%	80%	90%	60%	Q4 23/24	68%	83.3%	80%	90%	60%
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Health Protection & Vaccination	Maintain national target compliance of the uptake of the influenza vaccination amongst adults aged 65 years and over	Not Applicable	Applicable during: 01.09.2023 – 31.03.2024	
Best Start in Life	Maintain physical examination at 6 weeks rates (Healthy Child Wales) Increase weight and measurement at 8 weeks rates (Healthy Child Wales)	85.1% Below Trajectory of 92.7% 48.5% Below Trajectory of 50.2%	 	• Date collection is through GP appointments. • Increased clinic provision across the Health Board with a realigned data collection process. The objective for the next phase is implement an improvement cycle to increase performance of Healthy Child Wales Programme (HCWP). Improvement can already be attributed to HCWP 8,12,16 week contact from renewed clinic provision in September 23. • Primary Care Contracting Team carry out a regular audit every two months to reconcile the GP information against Child Health Systems in order to maximise uptake. Reports confirm that GPs average 92% compliance.

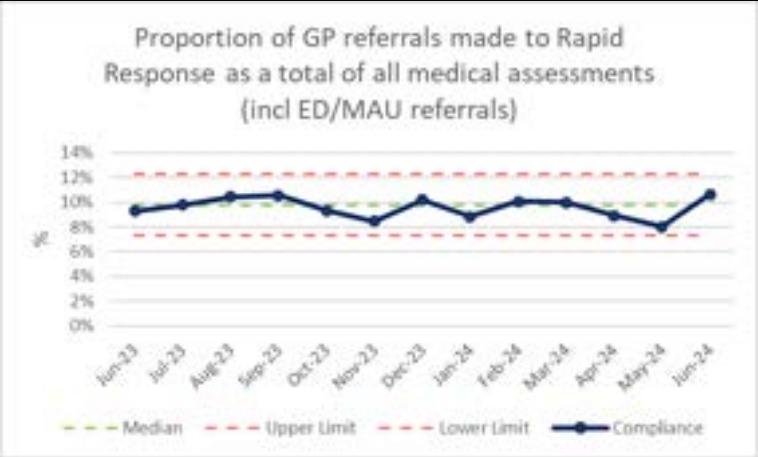
Milestones	Q1 Planned	Q1 Progress	Q1 Comments	Planned for Next Quarter

Population Health Management	Further develop and deploy public health intelligence resources with partners	Off track within tolerance	The Joint Strategic Assessment has been well received by partners. Agreements from the Public Service Board and Regional Partnership Board to use as the baseline data source. Further development of intelligence resources has been delayed by Information Governance process taking longer than planned.	Develop capability in population health management starting with two NCNs.
Health Protection & Vaccination	Implement targeted actions to increase % of children with up-to-date vaccinations by age 5	Complete/ On schedule	Increased communications to the general public advising to check their child's MMR vaccination. GPs have been given additional information with regards to MMR and measles. Work is ongoing with GP practices in Newport to proactively identify pre-school aged children not up to date with their MMR vaccination and offer catch up vaccination. The School Nursing service continue to deliver and optimise the school entry reviews.	Implement improvement programme for health protection and vaccination.
Premature Preventable Mortality, Cardiovascular & Cancer	Develop the Premature Preventable Mortality population health data model for cardiovascular & cancer	Off track within tolerance	The intent for a cardiovascular disease Risk Factor Management Programme Model was agreed. Development of the programme implementation plan with aim to launch this programme later this year (Winter).	Design cardiovascular disease risk assessment programme.
Diabetes	Develop the population health data model for diabetes	Complete/ On schedule	Populated health data model developed.	Assess and learn from implementation of diabetes prevention model already undertaken.
Best Start in Life	Develop Babies, Children & Young People's needs assessment through established engagement mechanisms	Complete/ On schedule	Project team running well, engagement sessions planned and data collection is going well.	Define in partnership Best Start in Life and gain partnership agreement for a Best Start in Life action plan.
Anchor Institution	Establish intelligence to support Anchor institutions and health promoting organisation to develop case for change	Off track within tolerance	Progress has been made, sharing a discussion with Executive Committee to agree required actions for the next year.	Develop theme of Anchor institutions as part of organisational strategy development.
Women's Health	Engagement and scoping events on Women's Strategy	Complete/ On schedule	Planned engagement sessions have been carried out embedded within the strategy engagement approach with a positive response.	Engagement with national Women's Health Programme.

Quadruple Aim 2	Progressing place based models of care and sustainability in primary and community services

Priority	Performance Measure	Performance against Q1 Trajectory	Data / Trend	Actions
Access	Maintain the number of appointments delivered in GMS	895,205 Trajectory Met of 886,953		- Appointment activity is reported on a regular basis, and this is monitored through the Primary Care Contracts Team against the expected levels. - Regular contract discussions are held with GMS contractors that express challenges and escalation levels are monitored and responded to. 100% achievements of Access Standards for 23/24 signed off. - Practices that apply through the sustainability assessment framework can apply for advice and resources as required. There are currently four practices in receipt of support. - All managed practices have moved to independent status and short-term support is being provided as part of the transition process.
	Maintain the number of patients accessing NHS Optometry Services	59,557 Above Trajectory of 39,910		

	Maintain the number of consultations undertaken by community pharmacy under the common ailments scheme	17,932 Exceeding Trajectory of 11,813		• All community pharmacies are now signed up to the common ailments scheme (CAS). The current priority is to support the increase in capacity. • Roll out of mandatory signage for pharmacies to display advertising the service. Signage now has links to the webpage outlining the services available to patients. • Feedback loop to the service managers providing a check of service availability. • Developing a system of access for all GMS practices to identify live service provision in their area. This will be for CAS, flu, and other services.
	Maintain the number of Units of Dental Activity (UDA) claimed	128,189 Above Trajectory of 116,878		• Two dental providers have recently provided notice and the division are reviewing provision. • From 1st April 24 there are 50 UDA practices and 25 practices have opted for contract reform. • Successful re-awarded GDS contracts following recent terminations (with affect from 1st July) • Two more terminations have been received and procurement process commenced with planned conclusion in September.
	Maintain 95% of Palliative Care referrals assessed within 2 days	97% Above Trajectory of 95%		• Regular monitoring of referrals assessed to meet targets. • Performance is maintained within the current service provision.

Community Care	Maintain proportion of GP referrals made to Rapid Response as a total of all medical assessments (incl ED/MAU referrals)	10.6% Trajectory Met of 10.15%		- The service is now accepting referrals up until 5pm within Community Resource Teams (CRT). - New pilot to be launched hosting a CRT consultant within the Flow Centre, with assessment by end of June. - The Redesign of Older Adults Programme has activities that will directly support the transfer of patients away from ED, e.g. Acute Frailty Response team at GUH. However, this does not directly influence GP referrals made.

Milestones	Q1 Planned	Q1 Progress	Q1 Comments	Planned for Next Quarter
Reduction of commissioned enhanced care	Continue to work in partnership through the Hospital 2 Home and Step Closer to Home reducing the need for enhanced care post discharge.	Complete/ On schedule	Hospital 2 Home: To date 181 patients have been assessed, of which 75% have been deemed suitable to be cared for by H2H. 40% of patients have now had their long term package of care needs either reduced, or are no longer required. A Step Closer to Home: Currently 5 active cases. Activity levels have declined since Oct 23. Quarter 2 will see a process review including the use of Discharge Coordinators, to determine if this is the optimum model of care.	Embed the learning from the model applied in Ty Brynwood specialist dementia care unit to reduce enhanced care through reduction in rapid escalation of behaviours.
Access & Sustainability for General Medical Services	Full completion of action plan to deliver the ambition of no managed practices in Gwent	Complete/ On schedule	All managed practices were returned to independent status in April 2024.	Address the workforce sustainability challenges by reviewing of workforce skill mix and identify alternative solutions and workforce models across NCNs using the Primary Care Academy
	Contract monitoring ensure all GP practices are meeting standards of performance	Complete/ On schedule	Contracts are monitored in line with requirements and uploaded to appropriate systems.	Contract monitoring ensure all GP practices are meeting standards of performance
Access & Sustainability for General Dental Services	Completion of procurement exercise in relation to Access	Complete/ On schedule	4 GDS contract terminations have been successfully re-tendered. New practice in Tredegar opened to patients from 1st April 2024	Support national roll out of dental digital system
	Implementation of 24/25 contract changes.	Off track within tolerance	Due to the change in contract payment mechanism across Wales we were delayed in issuing the Contract Variation Notices, but they have now been sent. However, practices have confirmed whether they are working to the new	Contract monitoring ensure all Dental practices are meeting standards of performance.

			contract reform from April 2024 and are being managed and monitored as such.	
Maximise Community Pharmacies	Undertake actions to increase Pharmacist Independent Prescribing	Complete/ On schedule	Number of Pharmacist that have Independent Prescribing status is 4,545 and 39 pharmacies across Gwent can independently prescribe.	Increase number of Common Ailment Scheme (CAS) Consultations and pharmacies across Gwent can independently prescribe to 59.
Maximise Community Optometry	Implementation of new and revised clinical pathways that shift care from ophthalmology in optometry	Off track within tolerance	WGOS 1,2, 3 and WGOS 5 Independent Prescribing Scheme and Occupational Health have all been implemented. We are currently awaiting Welsh Government sign off for the proposed WGOS 4 Transition plans.	Review Ophthalmic Diagnosis and Treatment Centre provisions in line with the national glaucoma pathway.
	Contract monitoring ensure all Optometry practices are meeting standards of performance (including WGOS activity)	Complete/ On schedule	Contracts are carefully managed through the Primary Care Contracting Team and any concerns are raised by the team directly with the Contractor.	Roll out of Digitisation and Connectivity
NCN Development & Partnerships incl ACD Programme	Commence implementation of the agreed plan to establish a range of services identified as best delivered at a NCN level or for a pan- NCN population	Complete/ On schedule	Work has been progressed through NCNs and ISPB's to determine what gaps exist at NCN level or for a pan -NCN population. This will be further developed through the results of the public engagement on the organisational strategy.	Following the engagement undertaken the delivery of a development programme for NCN/Collaborative leads and Professional Collaboratives to be fully functioning
	Completion of self-reflection and maturity matrices	Complete/ On schedule	Completed internally and uploaded to the Strategic Programme for Primary Care survey site for Health Board and National collation. National report anticipated with recommendations during Q2.	Further develop strong working relationships with Integrated Wellbeing Networks
Pathway Optimisation	Work in partnership with NCN leads to promote the use of Health Pathways across Gwent	Complete/ On schedule	Effective communication and engagement plan resulting in highest utilisation rate of Health Pathways among Health Boards (excluding Cardiff) so far in 2024/25	Through data analysis identify pathways to reduce unnecessary demand

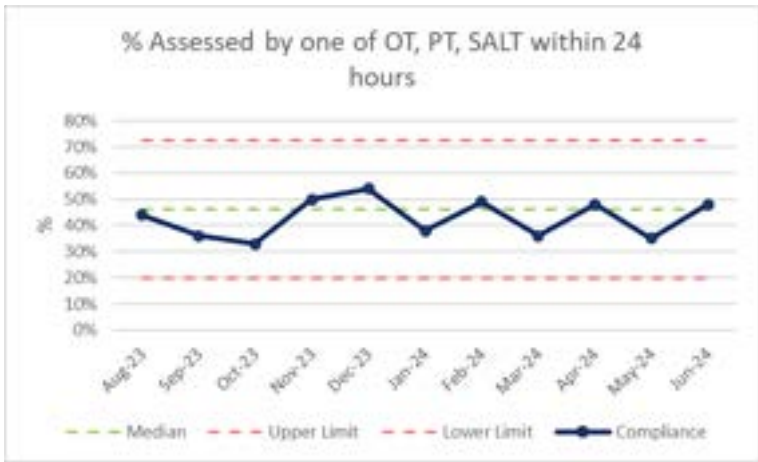
Quadruple Aim 2	Improving our Urgent and emergency care system focusing on experience, access and discharge pathways

Priority	Performance Measure	Performance against Q1 Trajectory	Data / Trend	Actions											
Timely Discharge	Reduction of number of Delayed Transfers of Care	235 Below Trajectory of 262		• Taking forward learning from Patient Safety Events • Robust validation process with Local authorities • Discharge to Recover and Assess Digital Solutions roll out across Health Board in Q1 enhanced data capturing including reason for delay, collation of meaningful data. • Single data repository, review of contemporary data and information • Education programme re. Red to Green, huddle to review day of value. • Head of Patient Discharge, locality Head of Service • Discharge Resource, alignment of Discharge Hub, Ready to Go Unit and Discharge Lounge at Royal Gwent Hospital (RGH).											
	Increase in Hospital 2 Home & Step Closer To Home Rates	221 Trajectory Met of month on month increase	<table><tr><th colspan="4">Hospital 2 Home Referrals to date:</th></tr><tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>221 (81 patients supported)</td><td></td><td></td><td></td></tr></table>	Hospital 2 Home Referrals to date:				Q1	Q2	Q3	Q4	221 (81 patients supported)			
Hospital 2 Home Referrals to date:															
Q1	Q2	Q3	Q4												
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Enhanced Monitoring	Reduction in average ambulance handover times at GUH	115 mins Above Trajectory of 95 mins		• Focus attention through weekly escalation meetings chaired by COO and monthly oversight with Welsh Government • Development of a business case for additional Emergency Department (ED) consultants with plan for some resource to be allocated to senior rapid assessment (funding dependent) • Tracking Ambulance Flow Centre compliance across GUH and our other Enhanced Local General hospitals. • Supporting ambulance timely assessment, as per Welsh Ambulance Service Trust (WAST) request for portering in December • Developed Physician Response Unit business case with full benefits evaluation of current service and to patients.
	Elimination of four hours ambulance handovers waits	289 Above Trajectory of 204		
	Reduction in time from arrival to ED triage - no waits over 30 minutes	21mins/ 2.2% >60mins Above Trajectory of 0 >60mins		
	Decrease in ED			• Implemented e-triage at end of Q1 with plan to evaluate and maximise further opportunities. • Re-established Triage Faculty with ambition to improve time to triage across ED and Minor Injury Units (MIUs) • Developing service-level plans for ED Main Wait extension

	attendances waiting over 24 hours Increase and maintain national target of the percentage of patients waiting <4 hours in ED Reduction in time from arrival to ED to seen by clinician	418 / 5.6% >24hrs Met Trajectory of 5.4% >24hrs 74.8% Below Trajectory of 75.8% 202 mins / 17.2% >6hrs Above Trajectory of 0 >6hrs	Decrease in ED attendances waiting over 24 hours % patients waiting < 4 hrs in A&E figures inc. YAB & YYF Median time from arrival to an ED department to assessment by a senior clinical decision maker	• Exploring opportunities for Short Stay Unit to accommodate patient cohort currently experiencing the longest waits in ED. • Scoping opportunities to improve system flow through developing the discharge lounge model; undertaking mapping work with focus areas including the ED-Acute Medicine interface; undertaking community hospital and complex care teams capacity mapping; and establishing a comprehensive Operating Framework. • Planning to implement direct to specialty referrals and e-referrals to support timely communication between clinical specialties • Developed business case for additional ED consultants with plan for some resource to be allocated to senior rapid assessment and commitment to timely time to first clinician (funding dependent) • Exploring opportunities to ring-fence assessment space, particularly during periods of peak demand. • Developing service model for Phase 2 of ED Main Wait Extension with focus on wait to be seen by a clinician

Urgent Primary Care	Maintain the number of Urgent Primary Care contacts (inc. virtual)	24,395 Exceeding Trajectory of 11,043	Urgent Primary Care Cases - Total Contacts	• Demand has increased this quarter and being managed within current service capacity. • Multi-Disciplinary team sustainability - robust recruitment campaign ongoing for senior nurse and nurse practitioners. • Opening of the nurse led Urgent Primary Care Centre in Ysbyty Ystrad Fawr (YYF) (Mon- Fri daytime) • Prioritised work on-going around consistency of practice which has supported management of demand and maintaining the status of the service, thus avoiding escalation.
Stroke	% of patients directly admitted to an acute stroke ward <4hrs of clock start	13% Below Trajectory of 14.5%	% of patients directly admitted to an acute stroke ward <4hrs of clock start	• Agreement to ring-fence some stroke beds with breaches permitted via approval only to ensure patient safety and capacity.
	% of unique stroke patients given thrombectomy (all stroke types)	1.4% Below Trajectory of 3%	% of stroke patients given thrombectomy (all stroke types)	• Brainomix Artificial Intelligence implemented and in use. • Extension of South Mead's thrombectomy service from 6am to midnight • Covering 12-hours per day seven days per week with Community Neurological Services team

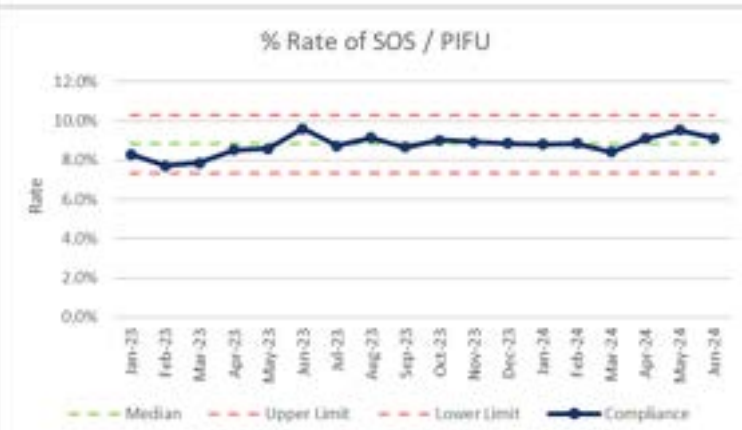
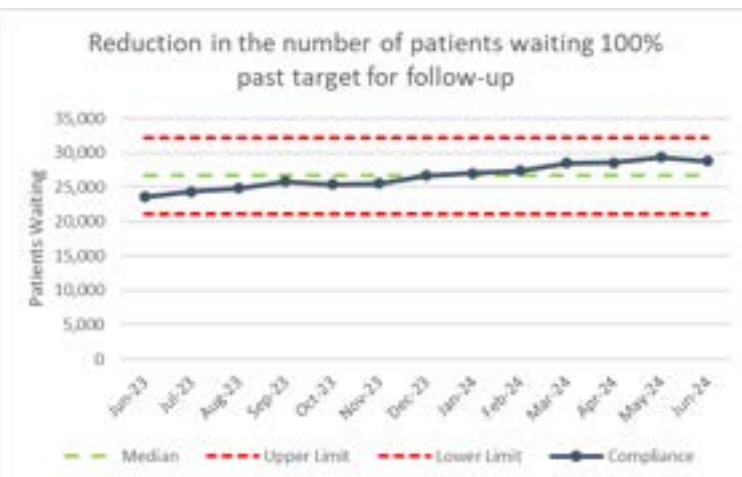
	% Stroke Patients Assessed by one of OT, PT, SALT within 24 hours	61% Exceeding Trajectory of 44.5%		- Executive Committee proposal submitted and intrinsically linked with this action area. - Discussion around business case to increase therapy staffing to recommended levels

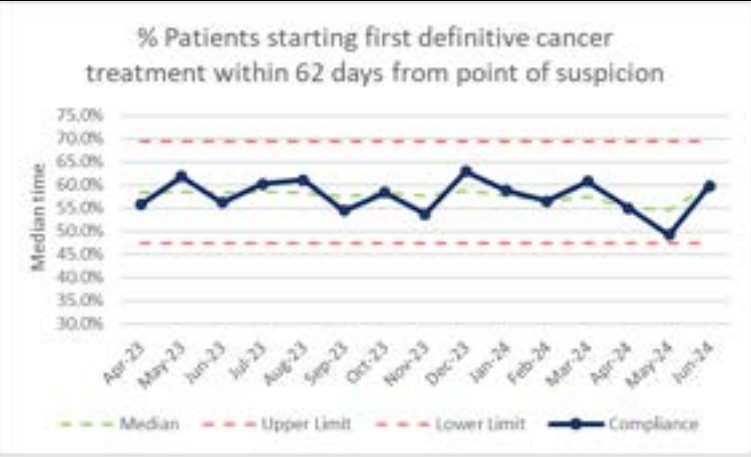
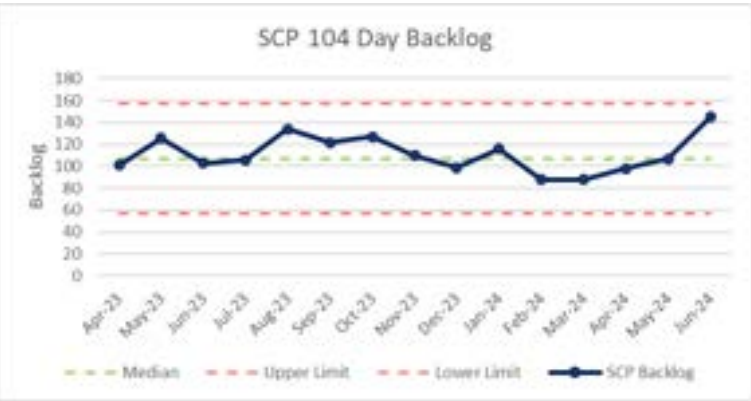
Milestones	Q1 Planned	Q1 Progress	Q1 Comments	Planned for Next Quarter
System Flow	Supporting initiatives to enable flow in collaboration with Welsh Ambulances Services Trust	Complete/ On Schedule	Progress started to develop and agree data sharing mechanism to review / audit for opportunity those that have an ED outcome from 111 / CSD	Implement agreed Flow Centre Service Model
	Initial Review of etriage outcomes including PREMS	Complete/ On Schedule	eTriage live in 3 sites over June. Time spent initially focused on ensuring system integration is robust and patient safety is maintained. Next steps will be focused on adoption and benefits	Patient adoption of etriage and data collection for benefits realisation
System Reconfiguration	St Woolos Hospital consolidation and review of model of care to meet system need	Complete/ On Schedule	St Woolos Hospital move complete and evaluation of ready to go unit undertaken.	(No further milestones in Annual Plan)
Enhanced Monitoring	Establish improvement trajectory in line with Improvement Plan to support timely ambulance handovers	Complete/ On Schedule	The improvement trajectory was established following Welsh Government's communication around expected improvements. Action plans are now in development to support the improvement targets with weekly systemwide meetings in place to deliver improvements via a sprint methodology.	Improved performance metrics in line with Improvement Plan trajectories supported by a system flow dashboard
	Implement NHH and YYF MIU Service Change	Complete/ On Schedule	The service change was implemented on 6 May 2024 with the completion of: new nursing rotas; up-to-date signage at both sites; and updated information communicated across the Health Board, 111 and WAST platforms.	Implement and share learnings from Improvement Plan activity
	Establish working groups for Safety Huddles, Flow Centre Workforce Model and centralised bed management system	Complete/ On Schedule	The working groups were established following Welsh Government's communication around expected improvements. Action plans are now in development across each working group to support the improvement targets with actions to date including: - Removal of medical model at Flow Centre	Implement changes to Flow Centre workforce model

			- Two workshops undertaken around bed management - New Standard Operating Procedures in development for safety huddles.	
Redesigning Services for Older People (Goal 1)	Commencement of LUSCII technology pilot in partnership with WAST.	Off track within tolerance	-Training delivered to care home staff involved in the pilot. -Revised go live date to be confirmed (August 2024). -Development of pathways for phase two (residential homes) commenced.	Pilot Luscii technology in agreed nursing homes; evaluate and agree next steps.
Urgent and Acute Transformation (Goals 2,3 &4)	Improved ED direct to Same Day Emergency Care (SDEC) pathway	Off track within tolerance	SDEC and Ambulatory Care workshop held with strong engagement cross divisionally. Actions include exploration of a next day 'scheduling of unscheduled care' model for ED / SDEC	Take forward actions, present options back to the workshop group. Actions include next day pathways for SDEC and integrated front door model
	Introduce Acute oncology SDEC pathway following pilot	Complete/ On Schedule	Acute oncology pathway introduced to SDEC GUH and YYF. Acute oncology awareness day held at GUH	Maintain pathways, review data and collect feedback. Review if other ambulatory services could benefit
	Implementation of service improvements/discharge practices monitored via Discharge Improvement Board	Complete/ On Schedule	Number of service improvements implemented including revised operating model at RGH & Nevill Hall Hospital (NHH) discharge lounge, Ready to Go Unit at RGH, H2H service working with three localities.	Alignment of WAST/Pharmacy resource with Discharge Lounge model.
NHH Service Model	Complete detailed service model including the workforce plan	Off track within tolerance	-Project Board established -Professional advisors scope expanded to support Strategic Outline Case development -Clinical Model workshops progressing	Develop and implement an engagement plan to shape and further develop service model

Quadruple Aim 2	Continuing to prioritise cancer, urgent and the longest waiting patients for planned care

Priority	Performance Summary	Performance against Q1 Trajectory	Data	Actions
Longest waiting patients	Numbers of patients waiting over 52 weeks (all stages)	26,988 Below Trajectory of 28,961		• Resubmitted planned care plans on 31st May. • Deep dives undertaken in ENT, Orthopaedics and Ophthalmology • Approval of plans in ENT, Max Fax, and T&O to reduce 104-week outpatient position. • 85% theatre utilisation in Max Fax and Ophthalmology drive for 24/25. • Treat in turn – speciality specific targets to deliver improvements necessary for stage 1 and 4 to achieve a significantly improved 104 positions. • Ophthalmology – progress with regional solution to increase capacity for cataract outpatient and inpatient stages to eliminate 104 weeks by December 2024. • Virtual spines clinic with SAS Doctor is resulting in a 70% discharge rate. • Increased volume lists (colorectal UGI) and increase productivity. • Bi-weekly Referral to Treatment Time (RTT) Directorate meetings focusing on elimination of 156 weeks. • Weekly reporting to Welsh Government in place.
	Numbers of patients waiting over 104 weeks (all stages)	4,408 Below Trajectory of 4,527		

	Elimination of total waits over 156 weeks (all stages)	47 Below Trajectory of 0		
Outpatient Transformation	Increase in the rate of See On Symptom (SOS) and Patient Initiated Follow-ups (PIFU)	9.1% Below Trajectory of 13.50%		• Scoping exercise of pathways in place in other Health Boards in Wales to identify potential opportunities, information on potential gaps to be shared with relevant teams to identify current process/if SOS/PIFU would be appropriate (or if alternative pathways e.g. straight to discharge are in place) • Working with specialties to support implementation of national recommendations for Discharge protocols/SOS/PIFU
	Reduction in the number of patients waiting 100% past Outpatient follow-up target date	28,825 Below Trajectory of 20,980		

Single Cancer Pathway	Increase in Single Cancer Pathway 62-day compliance	59.8% Trajectory Met (within tolerance) of 61.0%		- Task and Finish group established for x 3 tumour sites, gynae, urology and lower GI. - Demand and capacity exercise completed in Cellular Pathology and recruitment strategy developed in response to meet demand for Urgent Suspected Cancer tests, additional workforce will result in 75 average number of Urgent Suspected Cancer (USC) cases to pending per day by Q3 (currently 60) - Roche Ventana equipment to go live on 22nd July which will bring Immunocytochemistry (ICC) tests inhouse for lung cancer and reduce wait for these patients starting on treatment. - Additional consultant staff in Pathology to support increase in reporting and reduction in urgent and USC reporting backlog. - Weekly Performance meetings with service managers within Pathology to maintain focus on output. - Quarterly Directorate Assurance meetings instigated to focus on delivery, workforce, finance, risk, and governance including in pathology and Cancer Services
	Reduction in backlog of patients waiting over 62 days (SCP)	420 Above Trajectory of 309		
	Reduction in backlog of patients waiting over 104 days (SCP)	145 Above Trajectory of 84		
		87.9%		

	Increase in rate of cancer diagnosis or discharges within 28 days	Above Trajectory of 80%		
Diagnostics 8 Week Wait	Reduction in the number of patients waiting more than 8 weeks for a specific diagnostic	4,221 Above Trajectory of 2,417		• Mobile MRI scanner retained and supporting capacity. • Directing 60% of endoscopy capacity to USC backlog (partially caused by Industrial Action) • Options appraisal under development for Diagnostic Board around future of Neurophysiology service considering current fragility. • Workstreams and small cases of change identified from Toyota coaching groups implemented and actioned-further detail available once coaching groups commenced

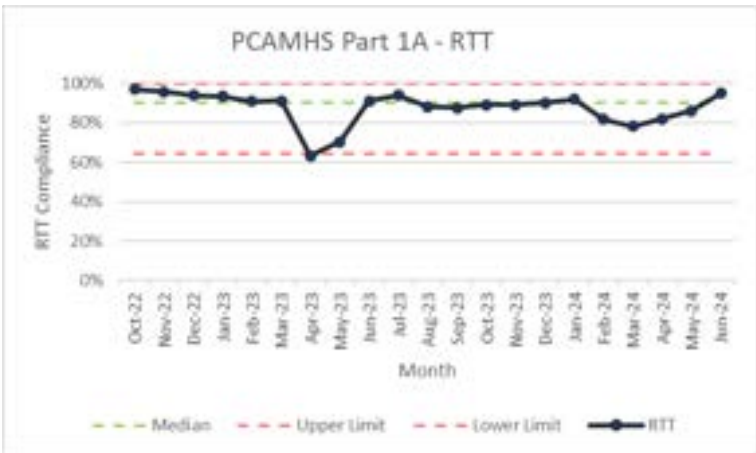
Milestones	Q1 Planned	Q1 Progress	Q1 Comments	Planned for Next Quarter
Single Cancer Pathway	Establish Task and Finish Groups for tumour sites	Complete/ On Schedule	Urology, Colorectal and Gynaecology Task and Finish Groups meeting monthly. Taking on audits, pathway improvement work and deep dives to improve compliance	Review and reset workplans for each tumour site
	Teams engaging with Toyota coaching and regular project task groups	Complete/ On Schedule	Teams are engaging with Toyota or absorbed into business as usual.	Teams engaging with Toyota coaching and regular project task groups.
	Urology: Introduce Frank Haematuria pathway Head and Neck: Explore opportunities for Straight to Test pathways in H&N	Off track within tolerance	-Haematuria is in place and being audited for effectiveness to ensure that it is the correct process for our patients. Head and Neck straight to test pathway not implemented yet. There is still an ambition to put suspected cancer neck lump through the Rapid Diagnostic Clinic pathway but that is unlikely to be developed until Q3.	-Gynae: Improve the scope-to-scan pathway and Improve biopsy-to-scan pathway for uterine carcinoma and endometrial carcinoma -Colorectal: improve/introduce Straight to Test pathway for colorectal

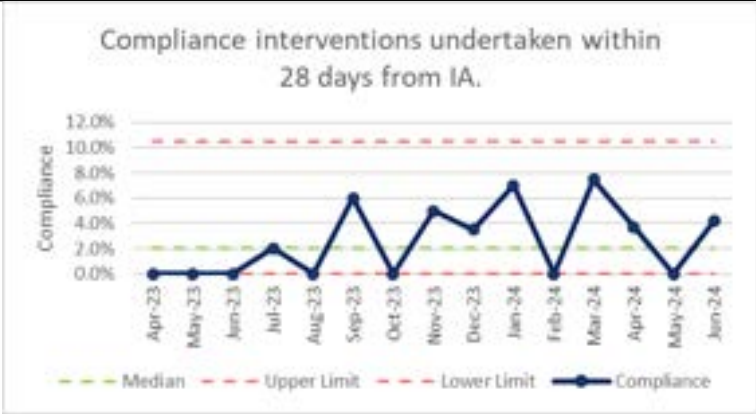
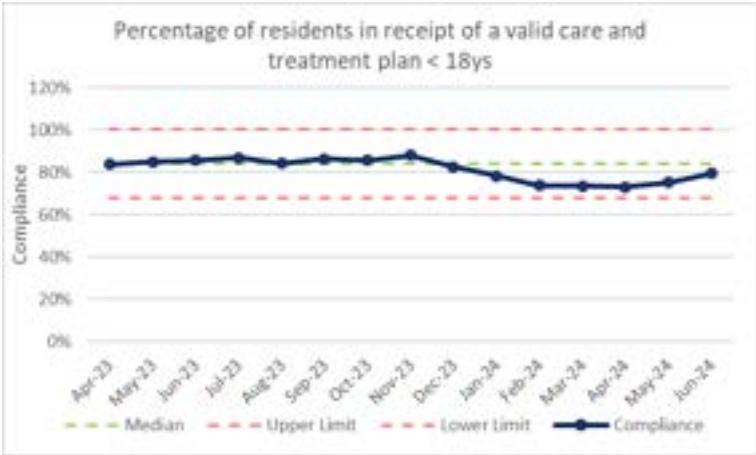
Longest waiting patients	Waiting Well single point of contact service launched and evaluated in 12 months	Complete/ On Schedule	-Waiting well brochure has been completed and is due to distribution. -Spend plan has been submitted and funding to be secured pending submission of the project planning. -Band 5 registered nurse role has been advertised. -5 week training programme for Band 3 call handlers to be undertaking including public health training (mental health, smoking cessation, alcohol consumption etc). -Engagement with services regarding call handler scripts to ensure awareness of all services available within region.	Achieve and maintain zero patients waiting > 156 Weeks
	Evaluate GP gatekeeper model in ENT to assess impact and explore opportunities (subject to funding) in other specialties	Off track within tolerance	Evaluation of GP gatekeep model in ENT complete. Between Jan and Jun 23: -76 sessions took place -3,343 referrals evaluated -798 rejected (24%) -An average of 43.99 referrals reviewed per session -An average of 10.5 referrals rejected per session Next steps include consideration of evaluation to identify opportunities to roll out to other specialties	Continue targeted approach to Treat in Turn to address current variability between specialties
Health Pathways	Platform launch in March 24 – embedding and tracking impact	Complete/ On Schedule	- Health Pathways platform launched, 12,161 page views, 2706 user sessions during Q1 2024-25. Communications and engagement plan ongoing to include launch webinar in April, presentation at key forums. -Engagement with Clinical Workstation developments for two-way eAdvice functionality. -Process for capturing and reporting pathway optimisation and refinement opportunities established.	Phase 2 pathways to go live and wraparound processes embedded within specialties – targeted approach to challenged specialties including ENT
Theatre Maximisation	Draft plans for Key Performance Indicators (KPIs) aligned to Model Hospital metrics to be finalised.	Complete/ On Schedule	-Qlik dashboard with KPI 1, 2 and 3 launched and monitoring in place through monthly cross-divisional Theatres Utilisation Group established. -Plans in place for further development of KPI 4 and model hospital metrics during Q2.	Delivery of improvement plan that responds to GIRFT (Elective Optimisation Programme) opportunities focusing on priority HVLCs, cancellations and late starts and early finishes.
	TiM studies across all Theatre sites to be completed.	Complete/ On Schedule	Time in Motion studies completed across all theatre sites.	Scoping of NHH flow and day surgery improvements and opportunities.
Getting it Right First Time (GIRFT) & Interventions not normally undertaken (INNUs)	Continued monitoring of use of INNUs recognising there are minimal areas which require targeted focus to achieve	Complete/ On Schedule	Data analysis was undertaken and completed during Q1 which revealed that specialties are adhering to the guidance and policies. No areas for targeted focus were therefore identified. INNUs will continue to be monitored to identify any potential further opportunities.	Implementation of Ear Nose and Throat GIRFT recommendations including reviewing day case rates and efficiency schemes.
Outpatient Transformation	Plan to respond to utilisation analysis to include scheduling, job plans and templates	Complete/ On Schedule	-Workstream plan as part of the Outpatient Transformation Programme has been identified and developed to maximise capacity, e.g. focus on reduction of DNA's, clinic	Implementation of Hospital Initiated Cancellations Policy and development

			cancellations and maximising use of Outpatient space through clinic utilisation audits/development of Clinic Room Booking System and introduction of 6, 4, 2 process for Outpatients will impact both New and Follow up capacity - As part of the plan, a data gathering exercise has taken place to allow for clinic templates to be reviewed against job plans, team effectiveness and demand in relation of USC, new and follow-up patients. The review will take place during July and outputs will determine areas of targeted focus.	of action plan to reduce cancellations linked to policy.
	Targeted validation of patients on multiple waiting lists to reduce total number of delayed follow ups with a focus on 100% past target	Off track within tolerance	-Patient contact and validation team have undertaken some clerical validation of lists whilst letter validation for new patients has paused. -Validation lists produced by the Performance team have been focused on identifying duplicates across the patient pathway to identify areas to support targeted validation	Development of proof-of-concept Automated Booking System
Diagnostics Week Wait	8 Continue to deliver 8-week target	Complete/ On Schedule	End of Q1 figures: Cardiac CT= 0 breaches Non-Cardiac CT= 5 breaches MRI= 12 breaches	Continue to deliver 8 week target
	Make improvements to reach 8-week target	Off track within tolerance	Ultra Sound breaches= 974 This is due to increased long term sickness in term. Mitigating actions taken to manage this and following months numbers look set to improve,	Make improvements to reach 8-week target.
	Implement trans-nasal endoscopy	Complete/ On Schedule	The test of change was undertaken in an endoscopy theatre, but the service will be moved into another space which is not suitable for endoscopy; this will free-up valuable endoscopy estate to increase capacity.	Submitting Joint Advisory Group Accreditation for Endoscopy application.
	Submission of Decontamination Unit business case	Complete/ On Schedule	The Business Justification Case was approved by Board on 22 May 2024 and submitted to Welsh Government on 28 May 2024.	Response to Welsh Government scrutiny questions on Business Justification Case

Quadruple Aim 2	Improving our Mental health services

Priority	Performance Summary	Performance against Q1 Trajectory	Data	Actions
Adults	Increase in Part 1a to national target for Adult MH (assessment completed within 28 days)	64% Exceeding Trajectory of 41%	Assessment by LPMHSS within 28 days of referral.	- Action plan in place to improve service delivery. - Cleansing of waiting list achieved reduction of approximately 1500 clients in last six months. - Robotic Process Automation process for E-referrals being set up. All GPs referrals will now have direct sharing between clinical systems to reduce the time to put referrals onto the system and allow more time for assessment within 28 days. - Implementation of pilot of BRYN (brief review of your needs) this will allow prioritisation/triage of assessments and quicker access to intervention support.
	Increase in Part 1b to national target for Adult MH (interventions completed within 28 days)	17.9% Below Trajectory of 20%	Interventions <= 28 days following assessment by LPMHSS	- Action plan in place to improve service delivery. - Development of on-line therapy service and enhanced group-based provision (Cognitive Behavioural Therapy course) - Pilot of on-line therapy service completed and made live. - Next steps are to consider patient booking onto online courses. - Additional funding agreed to support 600 waiters for counselling. This will not impact compliance but will reduce waiting lists and ensure longest waiters are accessing appropriate interventions.

Children and Young People	Maintain Part 2 rates for Adult MH (number of individuals with a valid care and treatment plan)	84.2% Exceeding Trajectory of 68.3%		- Supporting the roll-out of the version 5 National Assessment Form which will support more accurate reporting of data around Part 2 compliance. - Working with directorate to ensure all Care Treatment Plans are accurate and up to date. - Caseload cleansing for data accuracy.
	Maintain rate of psychological therapy received within 26 weeks for Adult MH	49.6% Below Trajectory of 64%		- Ongoing cleansing of caseload. - Recruitment challenges ongoing however there is a continuous campaign to address vacancies. - Performance Team has identified further work is needed in this area and an improvement plan required.
	Maintain Child and Adolescent Mental Health Services (CAMHS) Part 1a national target compliance (assessment completed within 28 days)	95% Exceeding Trajectory of 90%		- Signposting to other sources of advice and support i.e. the Third Sector to support patients. - Advice and support to the referrer on future management - Referrals within Integrated CAMHS to continue to meet the needs of the child or young person.

Children and Young People	Maintain CAMHS Part 1b national target compliance (intervention completed within 28 days)	4.2% Met Trajectory of 0%, below Target of 80%		- Extended waits for 1B interventions, workforce requirements identified to support a proposed recovery plan to reduce the extended waits for the large cohort of children and young people who are waiting for Primary Care CAMHS intervention. - The Service are scoping the requirements for additional resource to recover the new core partnership interventions. The service has identified high complexity and acuity of children and young people's mental health needs waiting. - Paediatric Locum Consultant is now in place to support workforce gaps but there remain challenges due to ongoing absences. - New Speech and Language Therapists for <5 pathway have commenced for new patients with more focus on screening. Coupled with the establishment of joint clinics with community Paediatricians. - Recruitment to < 5 pathways underway for lead Occupational Therapy. - Assessment completed and recruitment progressed for a community embedded role to ensure linking across CAMHS portfolio. - Patients attending ISCAN in West from April 1st have been added to central waiting list. - Neurodevelopment CHOICE documentation drawn up to mirror Portsmouth domains, all referrals being
	Maintain CAMHS Part 2 national target compliance	79.4% Met Trajectory of 80%		
	Improvement in Neurodevelopment (iSCAN) compliance	38.5% Met Trajectory of 40%		
	Maintain 80% compliance of SCAMHS Choice	92% Exceeding		

	Assessments within 28 days from referral	Trajectory of 80%		screened using these domains as trial. Soft launch planned for September 2024. - Continued weekly performance meetings and validation of CHOICE assessment and waiting lists demand and capacity. - Expressions of interest sought for Clinical Lead for Care and Treatment planning to ensure the quality of care and treatment plans and completion in a timely manner

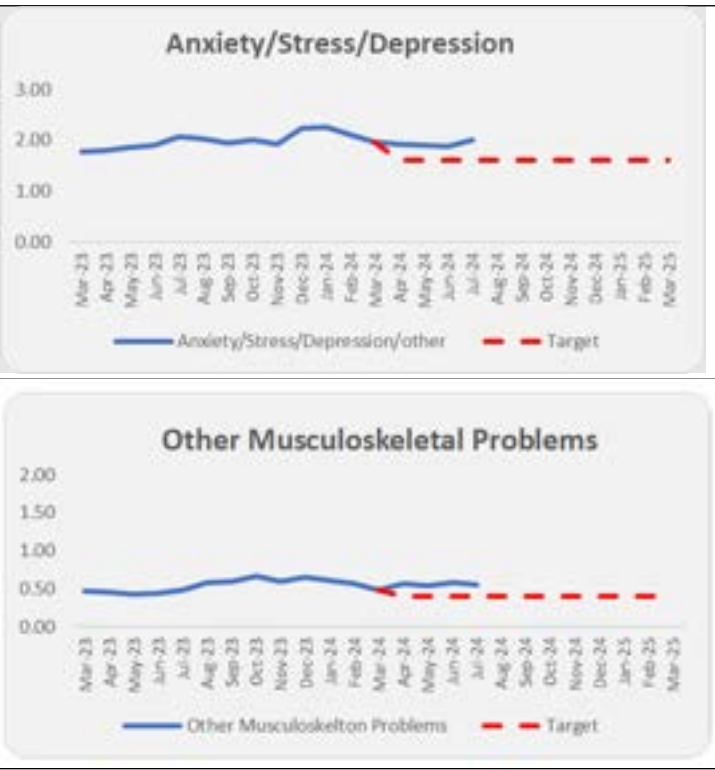
Milestones	Q1 Planned	Q1 Progress	Q1 Comments	Planned for Next Quarter
Quality Improvement Plan	Following 90-day improvement plan delivered in 2023/24, maintain momentum and identify areas of further improvement	Complete/On schedule	Reviewed progress of improvement plan and areas of focus being identified.	Continue to strengthen governance and ensure the recommendations from the recent review are implemented
Recovering Part1 MH Performance (over 18)	Continue focus on improving performance for part1a and part1b through targeted action plans for adults (over 18)	Complete/On schedule	Team to continue to work on improvement plan including changes to referral process and reviewing current waiting list.	Address the backlog to improve performance targets through review of demand and capacity model.
Recovering Part1a MH Performance (under 18)	Continued performance monitoring of capacity and demand, job planning to meet 80% compliance target	Complete/On schedule	Continuing to deliver this metric, have correct capacity to meet current demand.	Continued performance monitoring of capacity and demand, job planning to meet 80% compliance target
	Continue focus on improving performance for part1 b through targeted action plans for children (under 18)	Complete/On schedule	Improving slowly and the SWELL study will support improvement in compliance. Planning shows we should reach this by our December 2024 deadline.	Continue focus on improving performance for part1 b through targeted action plans for children (under 18)
SCAMHS Choice Assessments 80% compliance (28 days referral to assessment)	Continued performance monitoring of capacity to delivery CHOICE assessments to continue to maintain RTT compliance	Complete/On schedule	Currently mobilising enough resource to meet 28-day target for CHOICE however don't have steady state therefore concerns about longer waiting list build up.	Continued performance monitoring of capacity to delivery CHOICE assessments to continue to maintain RTT compliance
CAMHS Part 2 Care and	Continued monitoring of Care and Treatment Plans within Part	Complete/On schedule	Following no applications for the first attempt a second round of expressions of interest has been sought for a Clinical Lead for Care and Treatment planning.	Continued monitoring of Care and Treatment Plans within Part 2 Mental Measure to ensure RTT compliance

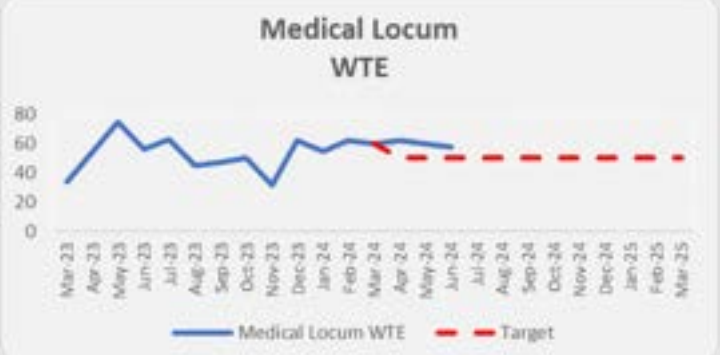
Treatment Plan	2 Mental Measure to ensure RTT compliance			
	Continued working on WCCIS to ensure correct compliance is reported	Complete/On schedule	Work is ongoing to ensure correct compliance is reported through WCCIS with progress being made.	Monitoring of SCAMHS CMHT capacity to undertake care coordination
Rightsizing Inpatient Services	Undertake demand and capacity for adults and older adults recognising the fragility of the workforce models	Off track within tolerance	Demand and Capacity started for older adults and engagement started with adults to progress their demand and capacity.	Analyse the current learning disability inpatient service provision to ensure it meets the requirements of the learning disability strategy
111 Press 2	Formal consultation on changes to service to become a single point of contact	Off track within tolerance	Following delays in recruitment a new manager for this area is due to start on 1st July to drive forward service changes.	Undertake detailed funding and resource review to develop a proposal for sustainable model.
Complex Needs	Develop and implement action plan for commissioning of low secure placements.	Complete/On schedule	Action plan developed and placement panel established which is starting to see improvements in both patient outcomes and costs.	Work in partnership to develop community accommodation model
Neurodevelopmental services (Over 18)	Review the existing ADHD service model and resources required to deliver the service.	Complete/On schedule	Demand and capacity completed supported through the establishment of a Neurodevelopmental Strategic Group to deliver required service changes.	Consider demand and capacity for ADHD and IAS with aim to develop a universal model for primary care adult Neurodevelopmental services.
Neurodevelopmental services (under 18)	Engagement with whole ND Pathway to develop and agree ND Recovery Programme and approach	Off track within tolerance	Changes to under 5 pathway underway to increase capacity to improve compliance and improve trajectory to meet Welsh Government targets.	Implement the children's neurodevelopmental recovery plan that will enable the pathway to adapt to manage the increasing variable demand
Transforming Community Services	Undertake demand and capacity analysis for adults, older adults, learning disabilities and specialist services	Off track within tolerance	Work started on Demand and Capacity analysis for Community Services using mathematical modelling support and applying the NHS England Model.	Develop services based off demand and capacity aligned with right sizing inpatients that provide care in the most appropriate setting (Quarter 3)
Mental Health Strategy	Complete the needs analysis to inform the strategy development	Off track within tolerance	Two workshops were completed in July to understand the scope and set the direction. The lead responsibility has been embedded in the new Divisional Director portfolio in June 2024.	Co-produce the strategy through meaningful engagement with partners, staff and service users

The Health Board’s *People Plan, 2022 -2025, ‘Putting People First’*, outlines the Workforce and Organisational Development (OD) strategy in relation to workforce improvement, capability, and expertise with a clear focus on wellbeing, inclusion, and engagement of our people. A Workforce & OD Performance Dashboard has also been aligned to reflect the key workforce metrics of the People Plan objectives capturing the performance indicators of delivery of that plan and targets set in the Health Board Workforce MDS (24/25):

Reporting Period July 24

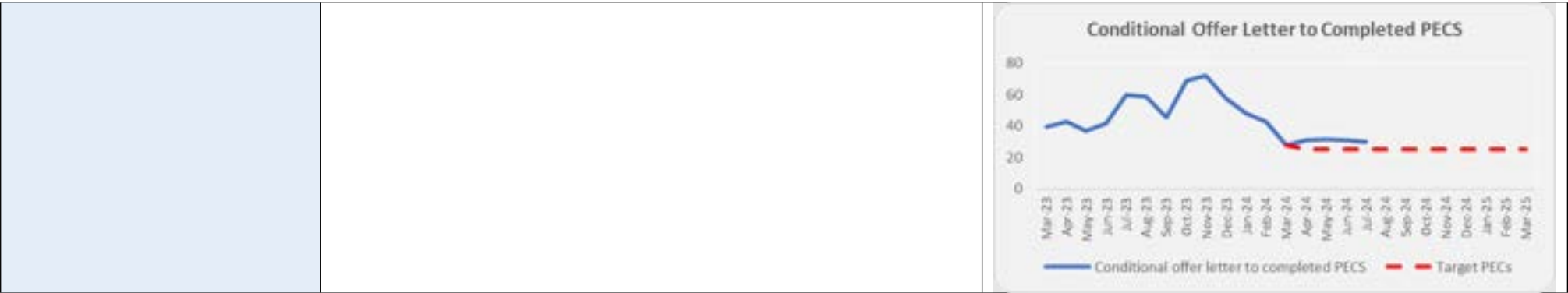
Priority	Performance Summary	Data																																																				
Staff in Post	There are currently 12,995 WTE staff in post, a reduction of 94.02 WTE since March 2024. This is mostly attributed to: • A decrease of 72.33wte in admin & clerical staff (see note below) • A decrease of 11.88wte Add Professional Scientific and Technical staff. Over half of the reduction has been due to TUPE transfers out of hosted teams and primary care managed practices and also services transferring to the newly established NHS Wales Executive.	Staff in Post WTE <table><thead><tr><th>Month</th><th>WTE - Staff in Post</th></tr></thead><tbody><tr><td>Mar-23</td><td>12650</td></tr><tr><td>Apr-23</td><td>12650</td></tr><tr><td>May-23</td><td>12680</td></tr><tr><td>Jun-23</td><td>12720</td></tr><tr><td>Jul-23</td><td>12750</td></tr><tr><td>Aug-23</td><td>12780</td></tr><tr><td>Sep-23</td><td>12950</td></tr><tr><td>Oct-23</td><td>13050</td></tr><tr><td>Nov-23</td><td>13080</td></tr><tr><td>Dec-23</td><td>13050</td></tr><tr><td>Jan-24</td><td>13150</td></tr><tr><td>Feb-24</td><td>13100</td></tr><tr><td>Mar-24</td><td>13000</td></tr><tr><td>Apr-24</td><td>12980</td></tr><tr><td>May-24</td><td>12950</td></tr><tr><td>Jun-24</td><td>12920</td></tr><tr><td>Jul-24</td><td>12950</td></tr><tr><td>Aug-24</td><td>12950</td></tr><tr><td>Sep-24</td><td>12950</td></tr><tr><td>Oct-24</td><td>12950</td></tr><tr><td>Nov-24</td><td>12950</td></tr><tr><td>Dec-24</td><td>12950</td></tr><tr><td>Jan-25</td><td>12950</td></tr><tr><td>Feb-25</td><td>12950</td></tr><tr><td>Mar-25</td><td>12995</td></tr></tbody></table>	Month	WTE - Staff in Post	Mar-23	12650	Apr-23	12650	May-23	12680	Jun-23	12720	Jul-23	12750	Aug-23	12780	Sep-23	12950	Oct-23	13050	Nov-23	13080	Dec-23	13050	Jan-24	13150	Feb-24	13100	Mar-24	13000	Apr-24	12980	May-24	12950	Jun-24	12920	Jul-24	12950	Aug-24	12950	Sep-24	12950	Oct-24	12950	Nov-24	12950	Dec-24	12950	Jan-25	12950	Feb-25	12950	Mar-25	12995
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Administration Staff in Post	An administration and clerical review has been undertaken which identified a significant growth in this staff group over the past 5 years. Therefore, the aim is to reduce the number of administration and clerical costs by 2% before the end of the year through turnover and vacancy controls and a review of service opportunities.	Administration WTE <table><thead><tr><th>Month</th><th>Admin Staff in Post</th></tr></thead><tbody><tr><td>Mar-23</td><td>2780</td></tr><tr><td>Apr-23</td><td>2750</td></tr><tr><td>May-23</td><td>2770</td></tr><tr><td>Jun-23</td><td>2775</td></tr><tr><td>Jul-23</td><td>2785</td></tr><tr><td>Aug-23</td><td>2790</td></tr><tr><td>Sep-23</td><td>2800</td></tr><tr><td>Oct-23</td><td>2810</td></tr><tr><td>Nov-23</td><td>2850</td></tr><tr><td>Dec-23</td><td>2845</td></tr><tr><td>Jan-24</td><td>2840</td></tr><tr><td>Feb-24</td><td>2835</td></tr><tr><td>Mar-24</td><td>2830</td></tr><tr><td>Apr-24</td><td>2760</td></tr><tr><td>May-24</td><td>2750</td></tr><tr><td>Jun-24</td><td>2740</td></tr><tr><td>Jul-24</td><td>2735</td></tr><tr><td>Aug-24</td><td>2740</td></tr><tr><td>Sep-24</td><td>2740</td></tr><tr><td>Oct-24</td><td>2740</td></tr><tr><td>Nov-24</td><td>2740</td></tr><tr><td>Dec-24</td><td>2740</td></tr><tr><td>Jan-25</td><td>2740</td></tr><tr><td>Feb-25</td><td>2740</td></tr><tr><td>Mar-25</td><td>2740</td></tr></tbody></table>	Month	Admin Staff in Post	Mar-23	2780	Apr-23	2750	May-23	2770	Jun-23	2775	Jul-23	2785	Aug-23	2790	Sep-23	2800	Oct-23	2810	Nov-23	2850	Dec-23	2845	Jan-24	2840	Feb-24	2835	Mar-24	2830	Apr-24	2760	May-24	2750	Jun-24	2740	Jul-24	2735	Aug-24	2740	Sep-24	2740	Oct-24	2740	Nov-24	2740	Dec-24	2740	Jan-25	2740	Feb-25	2740	Mar-25	2740
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Sickness	Sickness Absence in July 24 was 6.29% which has increased from 5.96 % as reported end of March 24. Short term sickness accounts for 2.23% and long term sickness (over 28 days) as 4.06%. Target in Graph was set as part of the IMTP performance framework to achieve pre- covid sickness levels. Top 3 highest sickness by staff group: 1. Additional Clinical Services (HCSWs) - 8.17% 2. Estates & Ancillary - 8.27% 3. Nursing & Midwifery - 6.35	 <table border="1"> <caption>Sickness Absence % Data</caption> <thead> <tr> <th>Month</th> <th>Sickness %</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Mar-23</td><td>6.00</td><td>5.00</td></tr> <tr><td>Apr-23</td><td>5.80</td><td>5.00</td></tr> <tr><td>May-23</td><td>5.70</td><td>5.00</td></tr> <tr><td>Jun-23</td><td>5.90</td><td>5.00</td></tr> <tr><td>Jul-23</td><td>6.10</td><td>5.00</td></tr> <tr><td>Aug-23</td><td>6.20</td><td>5.00</td></tr> <tr><td>Sep-23</td><td>6.30</td><td>5.00</td></tr> <tr><td>Oct-23</td><td>6.40</td><td>5.00</td></tr> <tr><td>Nov-23</td><td>6.50</td><td>5.00</td></tr> <tr><td>Dec-23</td><td>6.60</td><td>5.00</td></tr> <tr><td>Jan-24</td><td>6.70</td><td>5.00</td></tr> <tr><td>Feb-24</td><td>6.80</td><td>5.00</td></tr> <tr><td>Mar-24</td><td>6.90</td><td>5.00</td></tr> <tr><td>Apr-24</td><td>6.00</td><td>5.00</td></tr> <tr><td>May-24</td><td>5.90</td><td>5.00</td></tr> <tr><td>Jun-24</td><td>5.80</td><td>5.00</td></tr> <tr><td>Jul-24</td><td>6.29</td><td>5.00</td></tr> <tr><td>Aug-24</td><td>6.20</td><td>5.00</td></tr> <tr><td>Sep-24</td><td>6.10</td><td>5.00</td></tr> <tr><td>Oct-24</td><td>6.00</td><td>5.00</td></tr> <tr><td>Nov-24</td><td>5.90</td><td>5.00</td></tr> <tr><td>Dec-24</td><td>5.80</td><td>5.00</td></tr> <tr><td>Jan-25</td><td>5.70</td><td>5.00</td></tr> <tr><td>Feb-25</td><td>5.60</td><td>5.00</td></tr> <tr><td>Mar-25</td><td>5.50</td><td>5.00</td></tr> </tbody> </table>	Month	Sickness %	Target	Mar-23	6.00	5.00	Apr-23	5.80	5.00	May-23	5.70	5.00	Jun-23	5.90	5.00	Jul-23	6.10	5.00	Aug-23	6.20	5.00	Sep-23	6.30	5.00	Oct-23	6.40	5.00	Nov-23	6.50	5.00	Dec-23	6.60	5.00	Jan-24	6.70	5.00	Feb-24	6.80	5.00	Mar-24	6.90	5.00	Apr-24	6.00	5.00	May-24	5.90	5.00	Jun-24	5.80	5.00	Jul-24	6.29	5.00	Aug-24	6.20	5.00	Sep-24	6.10	5.00	Oct-24	6.00	5.00	Nov-24	5.90	5.00	Dec-24	5.80	5.00	Jan-25	5.70	5.00	Feb-25	5.60	5.00	Mar-25	5.50	5.00																																																																														
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Top Sickness reasons	Currently Anxiety/Stress and Depression account for 2% of overall sickness, the target is to reduce this to 1.6%. Musculoskeletal problems account for the second highest reason for sickness absence at 0.55% of overall sickness. The target is to reduce this to 0.4% Our health and wellbeing service continues to increase the support options available for staff including psychological therapy, counselling and self-help and guidance tools. In addition our “Wellbeing Matters” programme provides advice and support to those suffering with physical conditions (e.g. back problems). We have also introduced an Employee Assistance Programme to support access to wellbeing support which has reduced waiting times for our internal staff wellbeing service.	 <table border="1"> <caption>Anxiety/Stress/Depression Data</caption> <thead> <tr> <th>Month</th> <th>Percentage</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Mar-23</td><td>1.80</td><td>1.60</td></tr> <tr><td>Apr-23</td><td>1.90</td><td>1.60</td></tr> <tr><td>May-23</td><td>2.00</td><td>1.60</td></tr> <tr><td>Jun-23</td><td>2.10</td><td>1.60</td></tr> <tr><td>Jul-23</td><td>2.20</td><td>1.60</td></tr> <tr><td>Aug-23</td><td>2.10</td><td>1.60</td></tr> <tr><td>Sep-23</td><td>2.00</td><td>1.60</td></tr> <tr><td>Oct-23</td><td>2.10</td><td>1.60</td></tr> <tr><td>Nov-23</td><td>2.20</td><td>1.60</td></tr> <tr><td>Dec-23</td><td>2.30</td><td>1.60</td></tr> <tr><td>Jan-24</td><td>2.40</td><td>1.60</td></tr> <tr><td>Feb-24</td><td>2.50</td><td>1.60</td></tr> <tr><td>Mar-24</td><td>2.60</td><td>1.60</td></tr> <tr><td>Apr-24</td><td>1.80</td><td>1.60</td></tr> <tr><td>May-24</td><td>1.70</td><td>1.60</td></tr> <tr><td>Jun-24</td><td>1.60</td><td>1.60</td></tr> <tr><td>Jul-24</td><td>1.70</td><td>1.60</td></tr> <tr><td>Aug-24</td><td>1.60</td><td>1.60</td></tr> <tr><td>Sep-24</td><td>1.50</td><td>1.60</td></tr> <tr><td>Oct-24</td><td>1.40</td><td>1.60</td></tr> <tr><td>Nov-24</td><td>1.30</td><td>1.60</td></tr> <tr><td>Dec-24</td><td>1.20</td><td>1.60</td></tr> <tr><td>Jan-25</td><td>1.10</td><td>1.60</td></tr> <tr><td>Feb-25</td><td>1.00</td><td>1.60</td></tr> <tr><td>Mar-25</td><td>0.90</td><td>1.60</td></tr> </tbody> </table> <table border="1"> <caption>Other Musculoskeletal Problems Data</caption> <thead> <tr> <th>Month</th> <th>Percentage</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Mar-23</td><td>0.50</td><td>0.40</td></tr> <tr><td>Apr-23</td><td>0.45</td><td>0.40</td></tr> <tr><td>May-23</td><td>0.40</td><td>0.40</td></tr> <tr><td>Jun-23</td><td>0.45</td><td>0.40</td></tr> <tr><td>Jul-23</td><td>0.50</td><td>0.40</td></tr> <tr><td>Aug-23</td><td>0.55</td><td>0.40</td></tr> <tr><td>Sep-23</td><td>0.60</td><td>0.40</td></tr> <tr><td>Oct-23</td><td>0.65</td><td>0.40</td></tr> <tr><td>Nov-23</td><td>0.70</td><td>0.40</td></tr> <tr><td>Dec-23</td><td>0.75</td><td>0.40</td></tr> <tr><td>Jan-24</td><td>0.80</td><td>0.40</td></tr> <tr><td>Feb-24</td><td>0.85</td><td>0.40</td></tr> <tr><td>Mar-24</td><td>0.90</td><td>0.40</td></tr> <tr><td>Apr-24</td><td>0.50</td><td>0.40</td></tr> <tr><td>May-24</td><td>0.45</td><td>0.40</td></tr> <tr><td>Jun-24</td><td>0.40</td><td>0.40</td></tr> <tr><td>Jul-24</td><td>0.45</td><td>0.40</td></tr> <tr><td>Aug-24</td><td>0.40</td><td>0.40</td></tr> <tr><td>Sep-24</td><td>0.35</td><td>0.40</td></tr> <tr><td>Oct-24</td><td>0.30</td><td>0.40</td></tr> <tr><td>Nov-24</td><td>0.25</td><td>0.40</td></tr> <tr><td>Dec-24</td><td>0.20</td><td>0.40</td></tr> <tr><td>Jan-25</td><td>0.15</td><td>0.40</td></tr> <tr><td>Feb-25</td><td>0.10</td><td>0.40</td></tr> <tr><td>Mar-25</td><td>0.05</td><td>0.40</td></tr> </tbody> </table>	Month	Percentage	Target	Mar-23	1.80	1.60	Apr-23	1.90	1.60	May-23	2.00	1.60	Jun-23	2.10	1.60	Jul-23	2.20	1.60	Aug-23	2.10	1.60	Sep-23	2.00	1.60	Oct-23	2.10	1.60	Nov-23	2.20	1.60	Dec-23	2.30	1.60	Jan-24	2.40	1.60	Feb-24	2.50	1.60	Mar-24	2.60	1.60	Apr-24	1.80	1.60	May-24	1.70	1.60	Jun-24	1.60	1.60	Jul-24	1.70	1.60	Aug-24	1.60	1.60	Sep-24	1.50	1.60	Oct-24	1.40	1.60	Nov-24	1.30	1.60	Dec-24	1.20	1.60	Jan-25	1.10	1.60	Feb-25	1.00	1.60	Mar-25	0.90	1.60	Month	Percentage	Target	Mar-23	0.50	0.40	Apr-23	0.45	0.40	May-23	0.40	0.40	Jun-23	0.45	0.40	Jul-23	0.50	0.40	Aug-23	0.55	0.40	Sep-23	0.60	0.40	Oct-23	0.65	0.40	Nov-23	0.70	0.40	Dec-23	0.75	0.40	Jan-24	0.80	0.40	Feb-24	0.85	0.40	Mar-24	0.90	0.40	Apr-24	0.50	0.40	May-24	0.45	0.40	Jun-24	0.40	0.40	Jul-24	0.45	0.40	Aug-24	0.40	0.40	Sep-24	0.35	0.40	Oct-24	0.30	0.40	Nov-24	0.25	0.40	Dec-24	0.20	0.40	Jan-25	0.15	0.40	Feb-25	0.10	0.40	Mar-25	0.05	0.40
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Variable Pay Bank	In the last quarter the target continues to be achieved with a reduction of 142 WTE and sustained and supported by the variable pay programme recognising the importance of recruitment and retention. 55% of bank usage is Health Care support workforce 32% is Midwifery and 10% is Facilities. The target in graph was set as part of deliverables set out in IMTP performance framework.	 Bank WTE Y-axis: 0 to 1200 WTE. X-axis: Mar-23 to Mar-25. Legend: Bank A4C Usage WTE (blue line), Target (red dashed line).
Variable Pay Agency	Current Agency usage is 170.26 WTE, a reduction of 166 WTE in the last quarter. There has been significant reduction on agency usage since last year and 94% of agency usage is Registered Nursing. There will be sustainable reduction supported by the variable pay programme. Target in Graph was set as part of the deliverables set out in IMTP performance framework.	 Agency WTE Y-axis: 0 to 400 WTE. X-axis: Mar-23 to Mar-25. Legend: Agency Usage WTE (blue line), Target (red dashed line).
Variable Pay Medical Locum	Current locum usage is 57.87 WTE which a decrease in 5 WTE from this period last year. There is ongoing work with the development of a medical workforce bespoke strategy and the introduction of medical E-Systems to support this work. Target in Graph was estimated as part of the IMTP performance framework and will be interchangeable with agency usage.	 Medical Locum WTE Y-axis: 0 to 80 WTE. X-axis: Mar-23 to Mar-25. Legend: Medical Locum WTE (blue line), Target (red dashed line).

Variable Pay Medical Agency	Current Medical Agency WTE is 50.55 WTE, showing a sustained decrease in trend to achieving target. Target in Graph was set as part of the IMTP performance framework and will be interchangeable with Locum usage.	
Turnover	Current turnover rate is 9.08% a reduction from 9.55% the previous year which has been sustained over the last quarter. Nursing and Midwifery have the lowest turnover rate of 7.59% whilst Allied Health Professionals have the highest 12.27%. The Stability Index (which is the employee numbers by head count at the end of a reporting period) is 97.61% for the first quarter of this year. The target in Graph was set as part of the IMTP performance framework.	
PADR	Current PADR compliance is 74.25% a quarterly increase of 3% and we continue to work towards achieving 85% All Wales target through divisional reporting, renewed tools and training for managers.	

Job Planning	Current compliance rate is 24% although this is in part due to the introduction of a new medical e-system. Once fully implemented, the target is set at 85%. There are 317 senior medical staff (Consultant and SAS doctors) recorded in progress in the e-system which once completed will take our compliance to 67%.	 Consultant Job Planning Y-axis: 0 to 40. X-axis: Mar-23 to Mar-25. Legend: Job Planning - Consultants.
Mandatory training	Current compliance rate is currently 82.53%, which is an increase against the same period the previous year (78.23%) and a quarterly increase of 6 % in achieving target of 85%.	 Mandatory & Statutory Training Y-axis: 0 to 100. X-axis: Mar-23 to Mar-25. Legend: Mandatory & Statutory Training %, Target.
Time to Hire	The All-Wales target for recruitment Time to Hire (the time interval between vacancy creation and successful candidate ready for start date) is 71 days, Currently Health Board is achieving this in 69 days and is showing month on month improvements. Conditional offer letter is 31 days which is higher than expected All Wales target of 25 days	 Vacancy Creation to Unconditional Offer Y-axis: 0 to 150. X-axis: Mar-23 to Mar-25. Legend: Vacancy creation to unconditional offer, Target conditional offer.



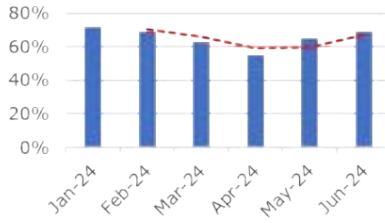
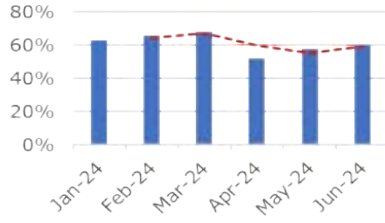


The Quality and Safety performance is reported against a condensed range of indicators compared to Quality Outcomes Report which is produced for the Quality and Patient Safety Committee and Board. The Top-level indicators provided for the integrated performance mapped to under the pillars of quality:

- Patient Experience:** Patient feedback- CIVICA data
- Incidents:** National Reported Incidents, Duty of candour,Mortality
- Complaints, concerns, compliments:** Concerns – 30 day performance
- Infection Control and Prevention:** Infection Control
- Health, Safety & Security:** Violence and aggression towards staff
- Safeguarding:** Duty to report

Priority	Performance Summary	Data
Patient Experience CIVICA	On 20th February 2023, the CIVICA platform was launched across the Health Board. Posters with QR Codes displayed across hospitals and clinics, and feedback provided anonymously by scanning this code on your personal phone/device. Quarter One - Overall satisfaction increased to 90% for all surveys (benchmark is 85%).	Number of Responses 1663 Responses Overall Satisfaction 90% Satisfaction Responses Trend Graph Health Board Wide - 01/04/2024 to 30/06/2024 All Questions Emergency Department Survey - Standard Number of Responses Apr May Jun 18 14 50 Export Options

Incidents National Reportable Incidents	The Health Board reported 20 National Reportable Incidents in April, 13 in May, with a decrease to 2 in June. In May 2023, the Health Board met with NHS Executive colleagues, to discuss the reporting criteria. As a result, the number of reported NRI's saw a significant increase in June 2023. We have since seen stabilisation of reporting, and continue to monitor.	National Reportable Incidents Reported Q1 2023 Q1 2024 <table><tr><th>Month</th><th>Q1 2023</th><th>Q1 2024</th></tr><tr><td>Apr</td><td>3</td><td>20</td></tr><tr><td>May</td><td>4</td><td>13</td></tr><tr><td>Jun</td><td>17</td><td>2</td></tr></table>	Month	Q1 2023	Q1 2024	Apr	3	20	May	4	13	Jun	17	2																																																																		
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Incidents Duty of Candour	In Quarter 1 2024/25 there were 6170 incidents affecting patients reported on the Datix Cymru system. There have been 18 incidents that have triggered Duty of Candour. <i>This figure is based on the question - Was Healthcare provided a factor?</i> The Duty of Candour was introduced in April 2023. The way in which Duty of Candour is captured on RL Datix, and reporting criteria has been refined for 2024/25. Due to this change, we are unable to provide comparative data.	Duty of Candor Triggered - Q1 2024/25 Apr-24 May-24 Jun-24 <table><tr><th>Division</th><th>Apr-24</th><th>May-24</th><th>Jun-24</th></tr><tr><td>Medicine</td><td>1</td><td>5</td><td>0</td></tr><tr><td>Primary Care</td><td>0</td><td>0</td><td>1</td></tr><tr><td>Surgery</td><td>2</td><td>1</td><td>3</td></tr><tr><td>F&T</td><td>1</td><td>0</td><td>1</td></tr><tr><td>Mental Health</td><td>0</td><td>0</td><td>0</td></tr><tr><td>CSS</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Urgent Care</td><td>1</td><td>1</td><td>0</td></tr><tr><td>Complex Care</td><td>0</td><td>0</td><td>0</td></tr></table>	Division	Apr-24	May-24	Jun-24	Medicine	1	5	0	Primary Care	0	0	1	Surgery	2	1	3	F&T	1	0	1	Mental Health	0	0	0	CSS	0	0	0	Urgent Care	1	1	0	Complex Care	0	0	0																																										
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Mortality	Risk Adjusted Mortality Indicators (RAMI) has dropped below the All Wales peer but continues to vary. Crude mortality and the mortality rate are flat and consistent. Individual mortality reports will enable Directorates to undertake deep dives in high mortality specialties. Q1 RAMI is 107.	Time Series ABLHB Wales <table><tr><th>Month</th><th>ABLHB</th><th>Wales</th></tr><tr><td>2023-01</td><td>105</td><td>105</td></tr><tr><td>2023-02</td><td>105</td><td>105</td></tr><tr><td>2023-03</td><td>105</td><td>105</td></tr><tr><td>2023-04</td><td>105</td><td>105</td></tr><tr><td>2023-05</td><td>105</td><td>105</td></tr><tr><td>2023-06</td><td>105</td><td>105</td></tr><tr><td>2023-07</td><td>105</td><td>105</td></tr><tr><td>2023-08</td><td>105</td><td>105</td></tr><tr><td>2023-09</td><td>105</td><td>105</td></tr><tr><td>2023-10</td><td>105</td><td>105</td></tr><tr><td>2023-11</td><td>105</td><td>105</td></tr><tr><td>2023-12</td><td>105</td><td>105</td></tr><tr><td>2024-01</td><td>105</td><td>105</td></tr><tr><td>2024-02</td><td>105</td><td>105</td></tr><tr><td>2024-03</td><td>105</td><td>105</td></tr><tr><td>2024-04</td><td>105</td><td>105</td></tr><tr><td>2024-05</td><td>105</td><td>105</td></tr><tr><td>2024-06</td><td>105</td><td>105</td></tr><tr><td>2024-07</td><td>105</td><td>105</td></tr><tr><td>2024-08</td><td>105</td><td>105</td></tr><tr><td>2024-09</td><td>105</td><td>105</td></tr><tr><td>2024-10</td><td>105</td><td>105</td></tr><tr><td>2024-11</td><td>105</td><td>105</td></tr><tr><td>2024-12</td><td>105</td><td>105</td></tr><tr><td>2025-01</td><td>105</td><td>105</td></tr></table>	Month	ABLHB	Wales	2023-01	105	105	2023-02	105	105	2023-03	105	105	2023-04	105	105	2023-05	105	105	2023-06	105	105	2023-07	105	105	2023-08	105	105	2023-09	105	105	2023-10	105	105	2023-11	105	105	2023-12	105	105	2024-01	105	105	2024-02	105	105	2024-03	105	105	2024-04	105	105	2024-05	105	105	2024-06	105	105	2024-07	105	105	2024-08	105	105	2024-09	105	105	2024-10	105	105	2024-11	105	105	2024-12	105	105	2025-01	105	105
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Concerns 30-day performance	Welsh Government target for responding to concerns is 75% within 30 working days Across Q1 2024/25 we saw a 4% decrease in the number of concerns received by the Health Board. Although the Health Board has received on average 20 more concerns per month across the period than have been closed. Despite this, organisationally we have managed to ensure more than 57% of the complaints received are being completed within the 30-working day target, compared with 54% across the same quarter in 2023/24. The number of concerns received both Managed through Putting Things Right and via Early Resolution has increased by approximately 40% on the same reporting period 2023-24. The themes for the period remain unchanged from Q3 and Q4. At the end of Q1 the number of concerns exceeding 12 months has reduced to 6, which is a positive decrease from 11.	6 Monthly Early Resolution Performance <table><tr><th>Month</th><th>Performance (%)</th></tr><tr><td>Jan-24</td><td>70%</td></tr><tr><td>Feb-24</td><td>68%</td></tr><tr><td>Mar-24</td><td>62%</td></tr><tr><td>Apr-24</td><td>55%</td></tr><tr><td>May-24</td><td>65%</td></tr><tr><td>Jun-24</td><td>68%</td></tr></table> 6 Monthly Managed Under PTR Performance <table><tr><th>Month</th><th>Performance (%)</th></tr><tr><td>Jan-24</td><td>62%</td></tr><tr><td>Feb-24</td><td>65%</td></tr><tr><td>Mar-24</td><td>68%</td></tr><tr><td>Apr-24</td><td>52%</td></tr><tr><td>May-24</td><td>58%</td></tr><tr><td>Jun-24</td><td>60%</td></tr></table>	Month	Performance (%)	Jan-24	70%	Feb-24	68%	Mar-24	62%	Apr-24	55%	May-24	65%	Jun-24	68%	Month	Performance (%)	Jan-24	62%	Feb-24	65%	Mar-24	68%	Apr-24	52%	May-24	58%	Jun-24	60%
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Infection Prevention & Control	A total of 98 cases of C diff reported from Apr 2024 - Jul 2024. HB rate of 49.07 per 100,000 population. This is 36 more (56% higher) than the equivalent period 23/24. A total of 48 cases of Staph aureus bacteraemia reported from Apr 24 - Jun 24. HB rate of 32.55 per 100,000 population. This is 26 more (118% higher) than the equivalent period 23/24. A total of 87 cases of E coli reported from Apr 2024 - Jun 2024. HB rate of 59.01 per 100,000 population. This is 5 less (6% lower) than the equivalent period 23/24. A total of 32 cases of Klebsiella reported from Apr 2024 to Jun 2024. HB rate of 21.07 per 100,000 population. This is 1 more (3% higher) than the equivalent period 23/24. A total of 11 cases of Pseudomonas reported from Apr 2024 to Jun 2024. HB rate of 7.46. This is 5 more (83% higher) than the equivalent period 23/24.	<table><caption>Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Jun 24</caption><thead><tr><th>Additional filters for Table 1</th><th>C. difficile</th><th>MRSA bacteraemia</th><th>MRSA bacteraemia</th><th>E. coli bacteraemia</th><th>Klebsiella sp. bacteraemia</th><th>P. aeruginosa bacteraemia</th></tr></thead><tbody><tr><td>Select month or FY</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Current FY</td><td>49.07</td><td>1.38</td><td>32.55</td><td>59.01</td><td>21.07</td><td>7.46</td></tr><tr><td>Select organism group</td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>All organisms</td><td>49.07</td><td>1.38</td><td>32.55</td><td>59.01</td><td>21.07</td><td>7.46</td></tr><tr><td>< than same period last FY</td><td>47.21</td><td>1.79</td><td>33.05</td><td>61.81</td><td>22.82</td><td>1.17</td></tr><tr><td>= same period last FY</td><td>49.22</td><td>0.79</td><td>36.49</td><td>53.33</td><td>24.39</td><td>4.26</td></tr><tr><td>> than same period last FY</td><td>51.94</td><td>0.9</td><td>34.03</td><td>55.68</td><td>24.38</td><td>3.81</td></tr><tr><td>Penryn TMB</td><td>56.24</td><td>0.11</td><td>29.18</td><td>60.62</td><td>33.81</td><td>9.37</td></tr><tr><td>Stowman Bay TMB</td><td>21.97</td><td>0</td><td>3</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Helodra HSE</td><td>61.01</td><td>1.05</td><td>26.15</td><td>64.26</td><td>20.97</td><td>1.05</td></tr><tr><td>Wales</td><td>48.18</td><td>1.46</td><td>28.81</td><td>67.21</td><td>21.77</td><td>4.48</td></tr></tbody></table>	Additional filters for Table 1	C. difficile	MRSA bacteraemia	MRSA bacteraemia	E. coli bacteraemia	Klebsiella sp. bacteraemia	P. aeruginosa bacteraemia	Select month or FY							Current FY	49.07	1.38	32.55	59.01	21.07	7.46	Select organism group							All organisms	49.07	1.38	32.55	59.01	21.07	7.46	< than same period last FY	47.21	1.79	33.05	61.81	22.82	1.17	= same period last FY	49.22	0.79	36.49	53.33	24.39	4.26	> than same period last FY	51.94	0.9	34.03	55.68	24.38	3.81	Penryn TMB	56.24	0.11	29.18	60.62	33.81	9.37	Stowman Bay TMB	21.97	0	3	0	0	0	Helodra HSE	61.01	1.05	26.15	64.26	20.97	1.05	Wales	48.18	1.46	28.81	67.21	21.77	4.48
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Health & Safety	Violence and aggression towards staff: We have implemented comprehensive support systems for staff who experience violence and aggression through the Violence and Aggression Case Management Team. These systems include clear pathways to support services such as Employee Wellbeing, Connect to Gwent, and other Employee Assistance Programs. In addition, we offer advice and guidance on criminal matters, internal policies and procedures, and broader risk management practices to help ensure a safe working environment. We strongly encourage employees to report all incidents of violence and aggression through Datix Cymru, and to Gwent Police when appropriate. By doing so, we aim to address issues promptly and effectively, providing the necessary support to our staff while maintaining a safe and secure workplace.	<table><thead><tr><th>Type of Violence towards Staff</th><th>Q1 – 2024/25</th></tr></thead><tbody><tr><td>Aggressive/threatening behaviour</td><td>306</td></tr><tr><td>Harassment</td><td>11</td></tr><tr><td>Inappropriate use of social media</td><td>1</td></tr><tr><td>Patient clinically challenging behaviour</td><td>9</td></tr><tr><td>Physical assault (physical contact)</td><td>179</td></tr><tr><td>Sexual (inappropriate) behaviour</td><td>15</td></tr><tr><td>Sexual assault</td><td>4</td></tr><tr><td>Verbal assault (gender/sexual orientation)</td><td>1</td></tr><tr><td>Verbal assault (racial abuse)</td><td>4</td></tr><tr><td>Verbal assault (swearing etc.)</td><td>10</td></tr><tr><td>Total</td><td>540</td></tr></tbody></table>	Type of Violence towards Staff	Q1 – 2024/25	Aggressive/threatening behaviour	306	Harassment	11	Inappropriate use of social media	1	Patient clinically challenging behaviour	9	Physical assault (physical contact)	179	Sexual (inappropriate) behaviour	15	Sexual assault	4	Verbal assault (gender/sexual orientation)	1	Verbal assault (racial abuse)	4	Verbal assault (swearing etc.)	10	Total	540																																																												
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Safeguarding

Duty to report: Safeguarding activity data must be used with caution when being utilised as a marker of quality improvement. However, the current data available for 2024/25 highlights there has been a substantial number of safeguarding referrals made, or responded to, by the ABUHB Safeguarding Team. This is influenced by a number of potentially negative factors (increased harm) over which we have no control but is also testimony to the effectiveness of the workforce in being aware of neglect and abuse within our population.

It should be noted that the duty to report figures represent those that were generated by the Health Board and quarter 1 comparisons have been made between 23/24 and 24/25.

	2023/24	2024/25	Increase
Adult Duty to Report	72	102	41%
Child Duty to Report	963	1090	13%

The 2024/25 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board’s performance against them.

Jun-24
 Performance against key financial targets 2024/25
 +Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Movement	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. <i>This confirms the YTD and forecast variance.</i>	£'000	4,490	14,397		48,860
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. <i>This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.</i>	£'000	10,576	18,029		0
	£59,093	17.9%	30.5%		
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)	%	97.4%	97.2%		>95%

The 2024/25 financial year to date budget performance as at month 3 is an adverse variance of **£14.397m**. The 2024/25 **reported forecast is a £48.860m** deficit reflective of the annual plan however there are risks to the forecast position in relation to the full delivery of savings and other operational pressures.

The 2024/25 forecast of £48.860m is £36m greater than the Welsh Government control total of a £13m deficit.

Performance against requirements 23/24		21/22	22/23	23/24	3 Year Aggregate (21/22 to 23/24)
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue		(249)	36,842	49,754	86,347
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital		(50)	(43)	(41)	(134)
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers					

Underlying Financial Position (Brought Forward ULP)	21/22	22/23	22/24	24/25 Forecast
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	£20.914m Deficit	£89.6m Deficit	£89.600m Deficit	£56m Deficit



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Performance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT
Sefyllfa / Situation The Health and Care Quality Standards provide a clear framework to support the planning, delivery and monitoring of healthcare services in Aneurin Bevan University Health Board. The Quality Report is mapped to the six domains of quality and the six quality enablers and structured under the Health Board’s Six Pillars of Quality. The outcomes and indicators reported here are a set of quality indicators that align with the Health Board’s priorities and strategic goals. The indicators cover aspects of care, clinical outcomes, patient safety and patient experience. This is a combined report that includes the measures within quality outcomes framework (QOF) and a narrative on the data. This provides the Board/ Committee with an overview of the Health Board’s quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality.

Cefndir / Background

The Quality Report provides current data on quality and patient safety as mapped against the Health and Care Standards:

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person Centred

For future reporting the Quality Outcomes Framework will be Mapped to the Health and Care Standards but will be reported against the pillars of quality as defined by the Health Board. These Pillars are:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

Asesiad / Assessment

Areas of Improvement in Quarter 1

- RAMI - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator with a focus on Learning from Deaths reporting based on the English model.
- The PALS service continues to develop and to focus on early intervention and support for patients and their families when they have concerns, the service will develop to further support the PTR process
- Civica satisfaction rate remains over the 85% benchmark albeit a text solution to increase uptake has been agreed.
- There have been no new Never Events since November. The theatres safety programme has been shared with the Committee to demonstrate the success of the improvement methodology and human factors approach.
- Improved uptake of Level 1 and Level 2 Safeguarding training continues and increased safeguarding referrals are demonstrating greater awareness of safeguarding thresholds
- Improved Health and Safety assurance through the Health and Safety Committee

- The operational approach to Quality Assurance is developing with standardised agendas and standardised data sets built upon the Quality Pillars and the STEEEP principles promoting Ward to Board assurance
- Ward Accreditation is currently being rolled out across several Divisions; the first ward to be formally accredited has been approved in August
- A further workshop on the Quality Outcomes Framework has been held with plans for a revised QOF for the November Board.
- The safer care collaborative is moving in-house and there will a quality faculty developed within the Health Board. This includes developing a quality improvement strategy.

Areas to Highlight in Quarter 1

There are several issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. For Board consideration the areas are summarised below.

- Infection rates continue to rise. An improvement plan has been developed and an enhanced monitoring process has been put into place.
- Significant improvement has been made but there is continued focus on the quality and safety of care within Mental health and Learning Disability Services
- Quality outcomes and timeliness of care within urgent care. This work continues and relates to several metrics including Ambulance Handover times, 12 and 24 hour waits in ED and improving patient experience.
- Falls remain an area of focus and scrutiny; themes relate to risk assessment and the enhanced care framework. Improvement plans are in place and a SWARM methodology approach in conjunction with the new enhanced care framework is being tested
- Safeguarding Level 3 training remains an area for improvement with a revised training approach planned, to be compliant with the intercollegiate guidance Level 3 training is required for all clinical staff.
- Themes from incidents continue to include the deteriorating patient, which has been part of the safer care collaborative, and the impact of extended waits. The recent work on Call 4 Concern has been shared in the report
- The compliance with closure of Putting Things Right concerns within 30 days remains of concern. There has been steady improvement in aged complaints over 12 months. The Health Board has developed a plan to return to the required level of compliance which will be 75% of PTR concerns closed within 30 days.

For the Health and Care Quality Standards that are limited in reporting e.g. Equitable, these will be reviewed to establish what else is being reported that can be inserted into the QOF and what additional measures should be included (i.e. more data is required in relation to safeguarding & domestic violence and children and young people's outcomes).

As part of this work, we will continue to strengthen our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

Listening and Learning

The Health Board recognises that organisational learning plays a vital role in the continuous improvement and development of organisational assurance and therefore improvement plans are in place to focus on:

- Implementation of the Health Board’s Listening and Learning Framework which demonstrates our commitment to promote a culture that values, facilitates, and embeds learning and in which the lessons learned are used to improve the quality of patient care, safety and experience.
- This framework demonstrates how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry and continuous improvement in health care services.
- We continue to strive for a ‘Just Culture’ of shared learning and a triangulated approach to quality, patient safety and experience.
- A bi-monthly learning and improvement forum has been developed and a highlight report is now available, as well as the minutes and actions from the forum.
- The learning repository has been tested in July 2024, which will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice.

Key priorities for the next six months include automation and revision to the Quality Outcomes Framework, development of Integrated reporting with Finance, Workforce and Planning, strengthening of Quality Patient Safety structures within Divisions, refreshing the Quality Improvement Plan and strengthening assurance and reporting.

Argymhelliad / Recommendation

The Board is requested to NOTE the progress of the quality performance report and to take assurance from this report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau)

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



Quality Outcomes Framework

Quarter One: 2024/25



Quality Outcomes Framework Overview

This is a combined report that includes the measures within quality outcomes framework (QOF) and a narrative on the data. This provides the Board with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality.

This also covers the Health Board's quality priorities including the Quality and Safety Pillars, as included in the Quality Strategy, ensuring that the Patient Experience and Involvement Strategy has been embedded throughout the report.

This reports focuses on learning and improvement throughout quarter one. It also includes:

- Indicators mapped to the existing Quality Outcomes Framework that was developed for 2023/24
- Narrative on indicators
- Additional information is available in the report to provide assurance against these standards
- Areas of escalation
- Good practice
- Learning and Improvement Forum highlights

Background

The current indicators within the Quality Outcomes Framework are being refined for 2024/25. The indicators will be reduced to enable reporting for 4-5 indicators per domain of quality. The QOF has been aligned to the Health and Care Quality Standards:

- Person Centred Care
- Safe Care
- Timely Care
- Effective Care
- Efficient Care
- Equitable Care



For this year, these will also be mapped to the 'Pillars of quality'.

As part of the newly refined QOF, reporting of the indicators will involve working with Digital, Data and Technology Directorate. This will allow automation of reporting and enable reports to be standardised. The use of iconography will provide detail on trends.

For quarter one the existing QOF indicators have been mapped where possible. Some of these indicators that were previously reported quarterly by planning has now changed. Updated data for these indicators has not been possible for quarter one. This will be taken into account in the development of the updated QOF. ³

Quality Outcomes

Areas to Highlight – Quarter 1

There are several issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. For Board consideration the areas are summarised below.

- Infection rates continue to rise. An improvement plan is in development and an enhanced monitoring process will be put into place. The report includes the work on antimicrobial prescribing
- Continued focus on the quality and safety of care within Mental health and Learning Disability Services
- Quality outcomes and timeliness of care within urgent care. This work continues and relates to several metrics including Ambulance Handover times, 12 and 24 hour waits in ED and improving patient experience.
- Falls remain an area of focus and scrutiny; themes relate to risk assessment and the enhanced care framework. Improvement plans are in place and a SWARM methodology approach in conjunction with a new enhanced care framework is being tested
- Safeguarding Level 3 training remains an area for improvement with a revised training approach planned and to be compliant with the intercollegiate guidance Level 3 training is required for clinical staff.
- Themes from incidents continue to include the deteriorating patient, which has been part of the safer care collaborative, and the impact of extended waits. The recent work on Call 4 Concern has been shared in the report
- The compliance with closure of Putting Things Right concerns within 30 days remains of concern. There has been steady improvement in aged complaints over 12 months. The Health Board has developed a plan to return to the required level of compliance which will be 75% of PTR concerns closed within 30 days.

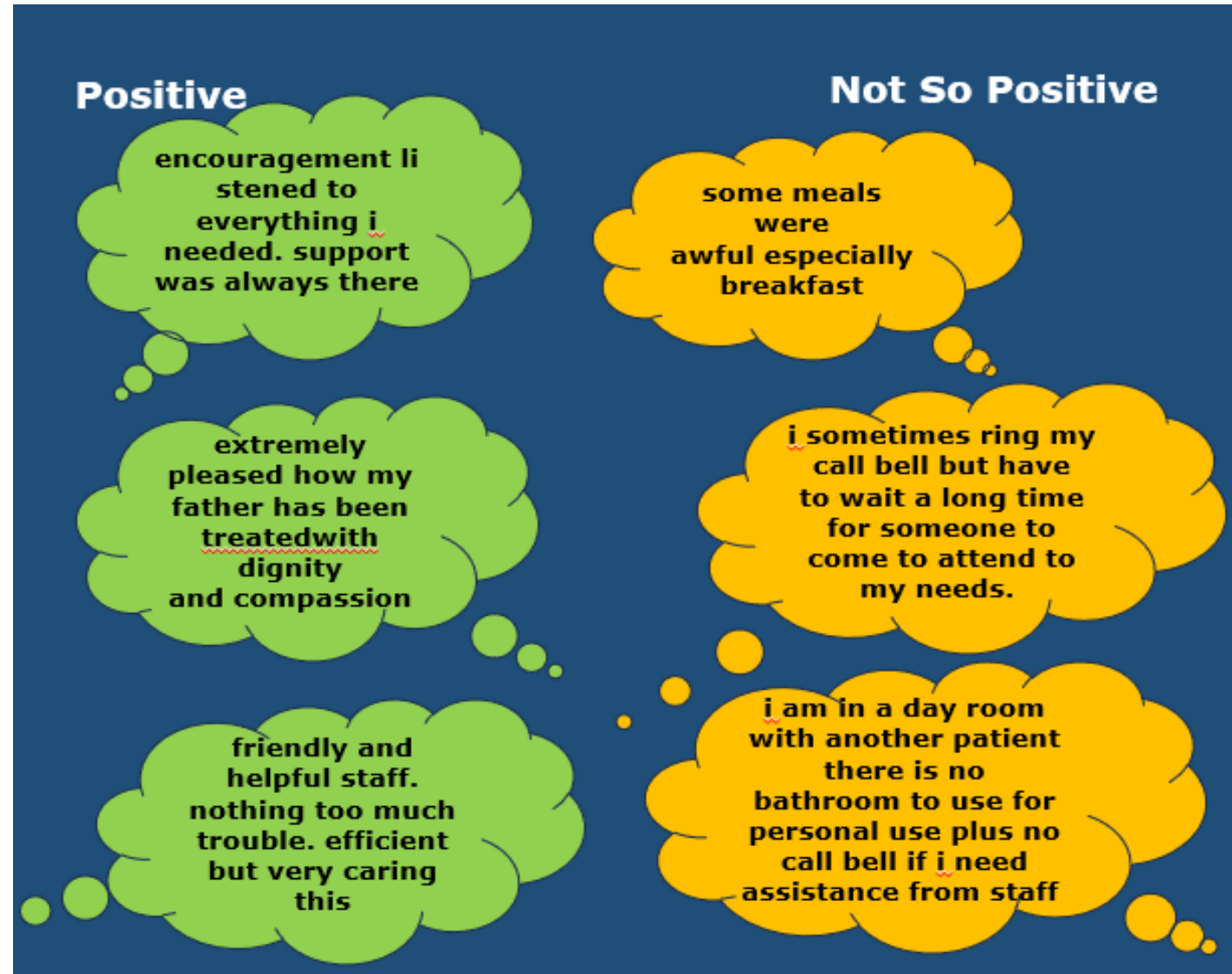
Priority 1: Person Centred Care



Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 1 - Person Centred	Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations	General experience rating of episode of care	87%	88%	90%	Improved	Overall satisfaction increased to 90% for all surveys (benchmark is 85%). Q1 patient experience feedback captured in Emergency Department (79 responses and 68% satisfaction).
		Number of complaints closed	410	406	385	Decreased	Decrease in number of complaints closed
		Complaints backlog	773	859	816	Improved	Across Q1 2024/25 we saw a 4% decrease in the number of concerns received by the Health Board. Although the Health Board has received on average 20 more concerns per month across the period than have been closed. Despite this, organisationally we have managed to ensure more than 57% of the complaints received are being completed within the 30-working day target, compared with 54% across the same quarter in 2023/24.
	Increased patient, public and staff involvement.	Increase in number of responses in Civica	327	598	1663	Improved	All Surveys - Q4 2023/2024 was 594, due to late additions, Q3 was 282. Significant increase for Q1 2024/2025 of 1663, which is more than the whole of 2023/24. CIVICA is live in 265 areas (end of Q1) across the Health Board.

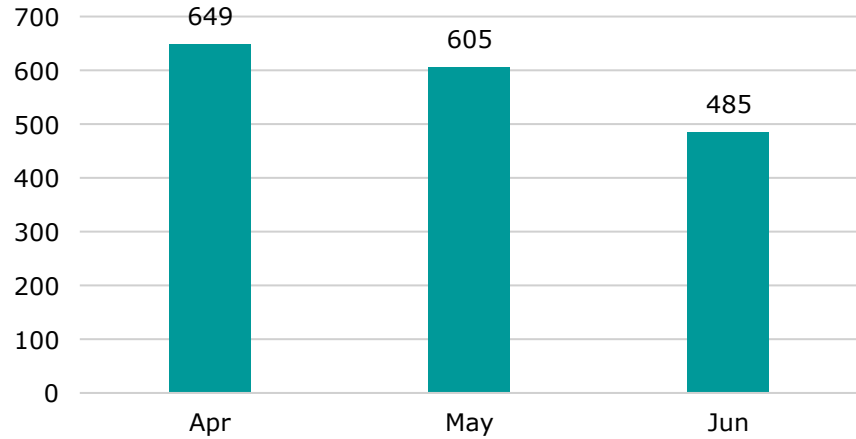
Top 3 Themes from PCC Survey

What did we do well? Q9	What could we have done better? Q10
Top 3 themes 268 comments around Emotional & Physical support •252 comments around Compassion •208 comments around Friendliness	Top 3 themes • 60 comments around Food & Beverages •40 comments around Waiting •24 comments around Facilities

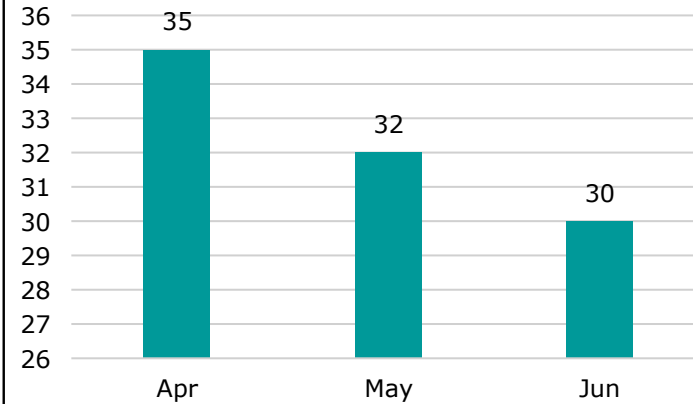


Patient Advice & Liaison Service

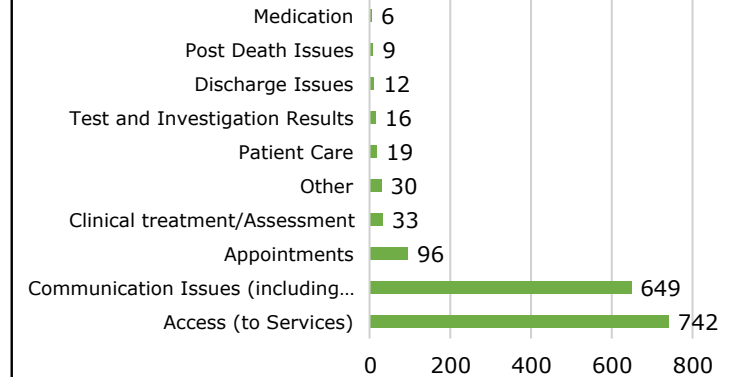
**Enquiries Managed via PALS / PSO
April - June 24**



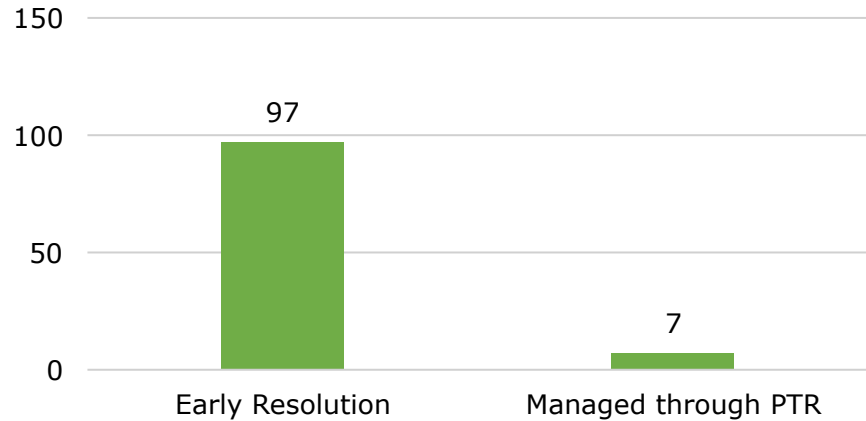
**Early Resolution Complaints
Managed via PALS
April - June 24**



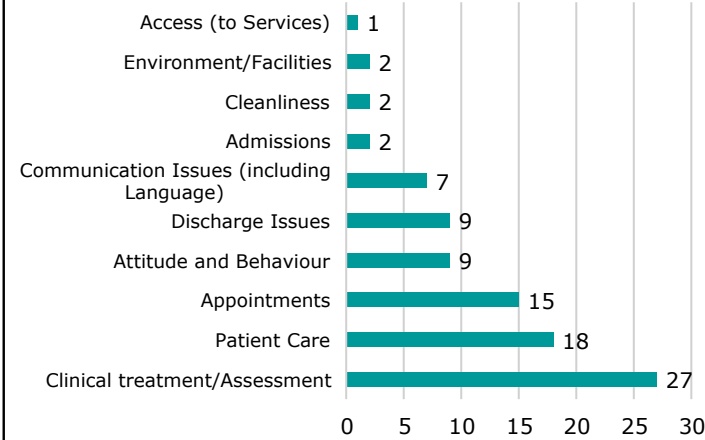
**Top 10 Enquiry Themes via
PALS/PSO
April - June 24**



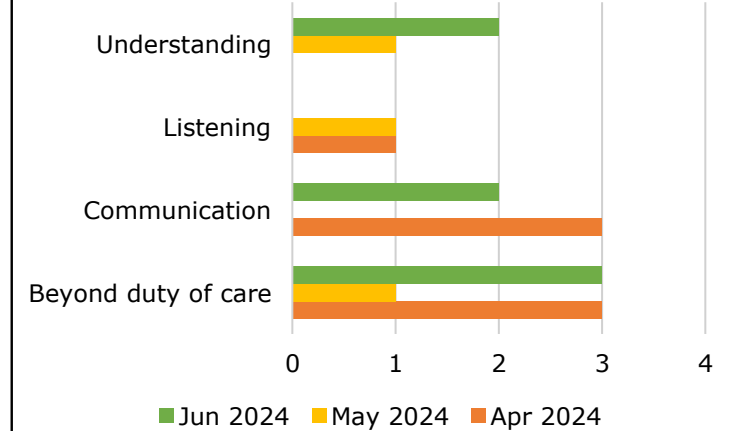
**Early Resolutions Complaints managed via
PALS / Escalated to PTR
April - June 2024**



**Top 10 Early Resolution Complaint
Themes via PALS, April- June 24**

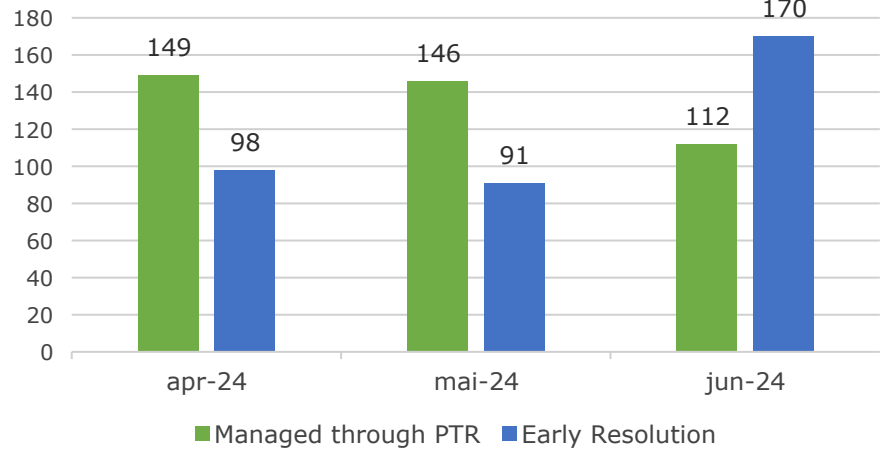


**PALS Compliments
April - June 24**

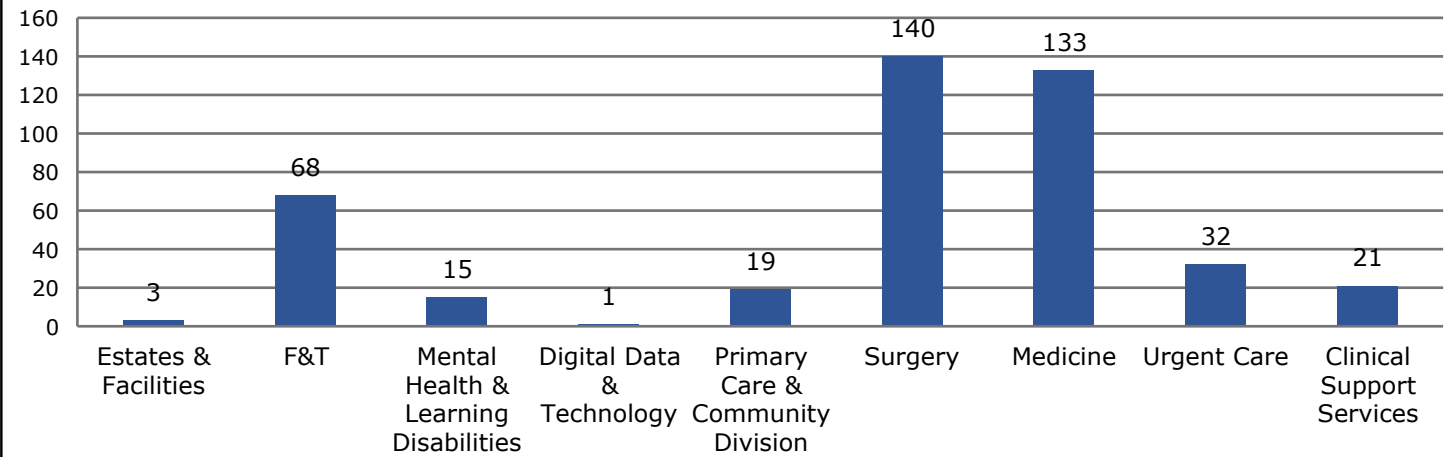


Complaints and Compliments

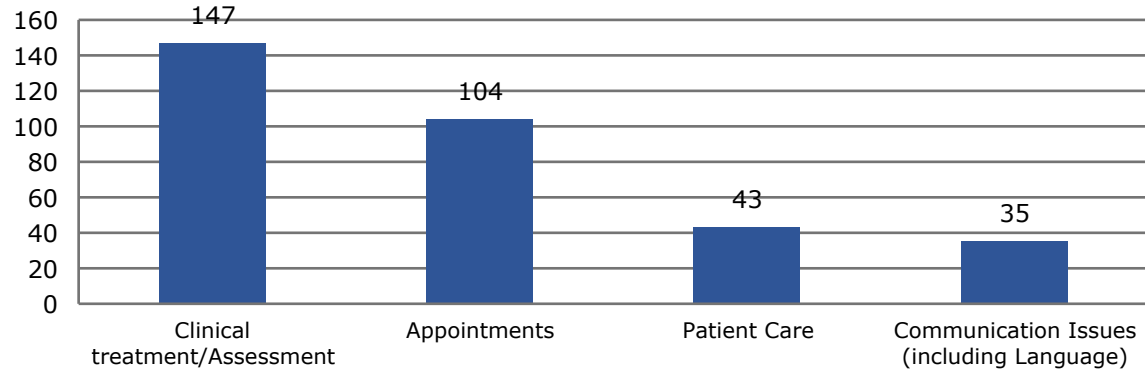
**Number of Concerns Received
Q1 Apr - Jun 2024**



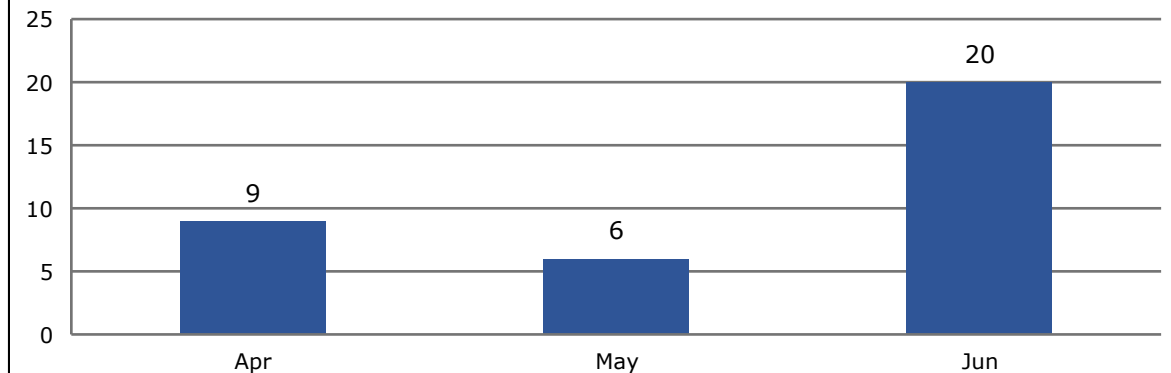
**Concerns Managed Under PTR by Division
Q1 Apr - Jun 2024**



**Concerns Managed under PTR by Theme (Top 4)
Q1 Apr - Jun 2024**



**Compliments received
Q1 Apr - Jun 2024**



Listening and Learning

- The approved framework is being implemented which aims to demonstrate how learning will be identified, triangulated, disseminated, and implemented into practice, to facilitate and embed a culture of appreciative enquiry, continuous improvement in health care services.
- The learning repository is being tested and will allow us to collate, store and utilise this learning, enabling us to share knowledge, shape change, embrace innovation, implement quality improvement and create opportunities to develop excellence in practice. This has enabled progress in ensuring learning is continually captured within an accessible Learning Repository and builds an Organisational Memory. The Learning Repository was demonstrated at the meeting and showed how all staff employees would be able to use it once live on Pulse.
- The most recent organisational Patient Quality and Safety Learning and Improvement Forum took place on 9 July 2024.
- The forum was well attended with a wide range of professions, both clinical and non-clinical, represented.
- Good news – Aneurin Bevan Continuous Improvement (ABCi) piloted the first test cohort of Quality Improvement (QI) coach programme. Positive feedback was received. The next cohort will be held in Autumn and is fully booked. Three cohorts a year will take place, with an aim to develop 75 QI coaches per year.
- Divisions provided presentations on learning based on the six pillars of quality
- There were three presentations presented at the forum that related to: -
 - **Safer Care:** The memory rehab service
 - **Quality Improvement:** What matters most in Neuro Rehab (Bevan submission)
 - **QPS:** SWARM Methodology – learning from falls

Priority 2: Safe Care

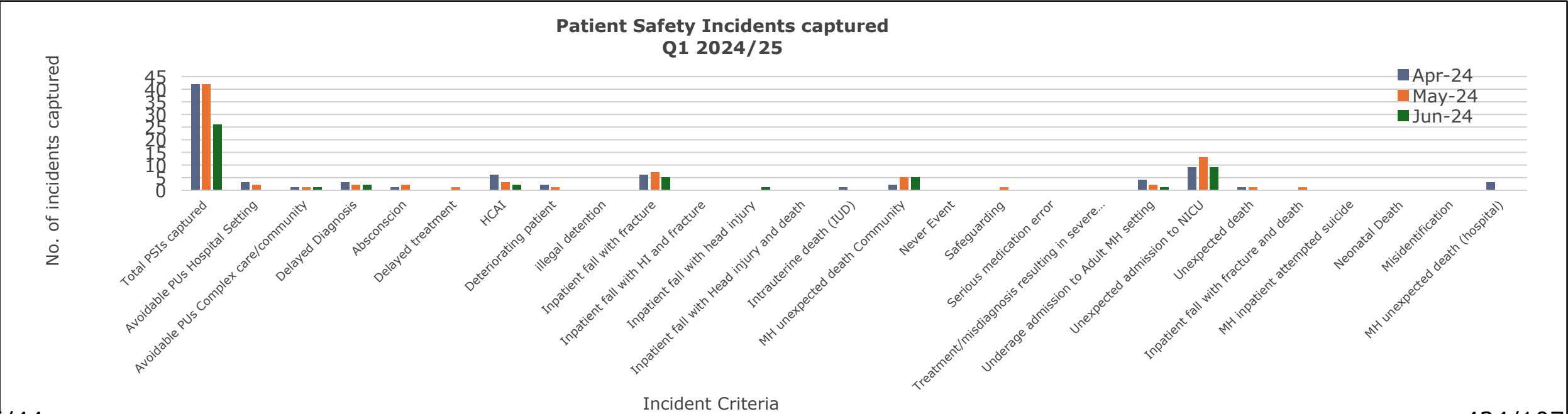
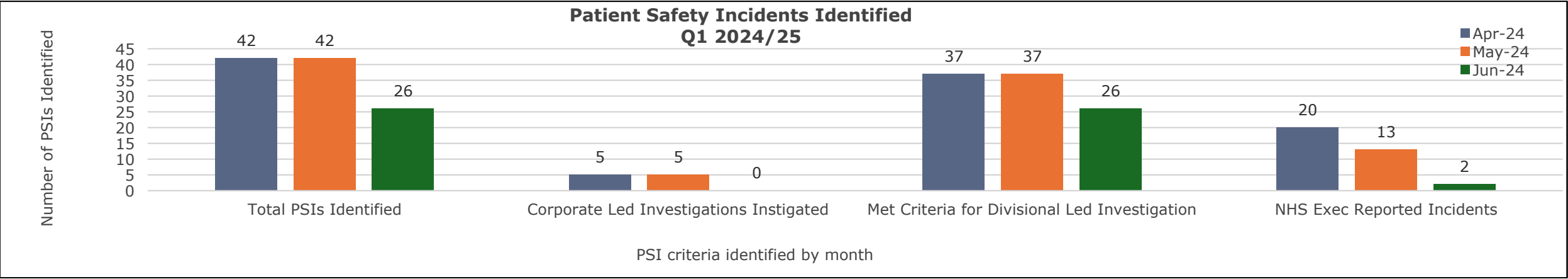


Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 2 – Safe Care	Fewer repetitive incidents in the priority areas and across the Health Board	Reduction in the number of SI's, by harm category	147	151	110	Decreased	A total of 110 Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified during Quarter 1 2024/25. This is in comparison to 109 in Q1 of 2023/24.
		Reduction in the number of National Reportable Incidents	45	40	35	Decreased	The Health Board reported 20 NRIs in April, 13 in May, with a decrease to 2 in June. In May 2023, the Health Board met with NHS Executive colleagues, to discuss the reporting criteria. As a result, the number of reported NRI's saw a significant increase in June 2023. We have since seen stabilisation of reporting, and continue to monitor.
		Reduction in the number of Never Events	4	0	0	Decreased	0 Never Events reported for Q1 2024.25. Improvement work continues.
		Decrease in the number of reportable IPAC incidents	29/week	See table	See slides	See slides	Q1: 14/66 (21%) patients (11 HCAI, 1 CAI), majority of suboptimal prescribing related to piperacillin/tazobactam use in secondary care
		Increase in the compliance of Health and Safety Statutory and Mandatory Training	86%	87%	87%	Consistent	There has been an increase in all the health and safety areas compared with the previous report. H&S 87%, fire safety 84%, manual handling 58% and V&A 86%.

Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		
Priority 2 – Safe Care	Improved clinical outcomes	Decrease in the time to complete safety alerts	4 days	4 days	4 days	No Change	The average time to report has stabilised however the data is highly variable with regular peaks above four days.
		Decrease in the number of Falls by 1,000 occupied IP Bed days	7.24	7.35	6.7	Decreased	Q1 has seen a decrease in falls/1000 occupied bed days
		Improved RAMI Score	105	116	107	Decreased	There is a delay in coding data which results in the RAMI being delayed as an accurate indicator. There has been a decrease in RAMI from Q3 – Q4. The Health Board is currently outperforming the Welsh Peer Group Average of 113.46. Positioned as 2 nd best RAMI out of Welsh peer group.
		Improved Crude mortality by hospital	4.9	5.15	4.27	Decreased	Deaths per 1000 bed days has remained stable and decreased for Q1
		Decrease in the number of HA pressure ulcers by grade	25%	20%	See table	See table	Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty. Marked reduction in reported HCAI. Data is being collected from all Divisions (see charts).
		Decrease in the number of HA pressure ulcers	23/week	23 /weeks	See table	See table	Work underway with improvement collaborative which has shown a decrease in reported PU of 2,3,4 grade 1 remain static. Data is being collected from all Divisions (see charts).
		Decrease in the severity of medication incidents	469	448	530	Increased	Moderate & severe Q1 69, Q2 67, Q3 85, Q4 69, Catastrophic Q2-4 is 0 last report in Q1-2.
		Decrease in the number of incidents under - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	21	19	16	Decreased	Q1 -16 incidents reported to the HSE in accordance with RIDDOR, 68.8% of these cases were reported within the legal timeframes within the legislation.
		Decrease in Preventable Hospital Acquired Thrombosis (HAT) incidents	0	0	0	No change	Quarterly data presented in the narrative. Non preventable HAT incidents – 3 month delay on data and requires case notes review.
		Increase in the number of PREM Audit and actions					Measure to be refined.

Patient Safety Incidents

A total of **110** Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified during Quarter 1 2024/25. This is in comparison to **109** in Q1 of 2023/24.



Patient Safety Incidents - Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Outstanding/overdue NRI forms - compliance percentage is decreasing. There is, on occasion a breakdown in communication in the QPS and divisional teams closing the investigation on RL DATIX and informing the corporate team. Hence there may be NHS exec NRI's in the system that can be closed more expediently.	Focused piece of work being undertaken by Assistant Head of Patient Safety to analyse delays.	Meet with QPS leads aligned to divisions weekly to maintain pace. Report to CEO and EDoN monthly outstanding PSI's and escalate blocks.	Corporate PSI Team	Ongoing with review at end of August 2024.
Increased number of NRI's and Divisional investigations open. Reported NRI's peaked at 125 at the beginning of Q1. This figure reduced to 98 by the end of Q1, however there are still significant delays in completion of reports and closures reported.	Closer alignment, communication and direction for all participants involved in a PSI investigation process.	Bespoke rather than generalised training is being provided for Investigating Officers on a 1-2-1 basis to guide them through the investigation process supported by a member of the Corporate Patient Safety Incident team. Bespoke development of Chair, Investigating Officer and staff responsibilities for Patient Safety Incidents has been established. There has been an increase in the number of Executive Chairs to address delays in the initiation of investigation meetings.	Corporate PSI Team / QPS Business partners	Ongoing with review at end of August 2024.
Disparate approaches to investigation level across divisions.	Centralisation of decision making.	All moderate and above harm incidents are presented to the weekly Executive Huddle for an investigation level decision, identification of an appropriate Chair and allocation of Executive Sign off lead.	Clinical Executives	Complete
Some feedback from patients/ families subject to a PSI investigation, is that their contribution/input in to the Terms of Reference and communication throughout the process is below expectations.	Inclusion of families/patients in the PSI process.	A review of the Health Board's Patient Safety Incident Policy in November 2023 to align with the All-Wales Directive and to reflect patient and family feedback on the Safety Incident process. This Policy also more explicitly outlines expectations and procedures. A further update is planned to be approved by the Board in September following a further strengthening of the approach. Inclusion of update of family/patient added to PSI agendas.	Corporate Patient Safety Team	September 2024 Complete

Never Events

- **0 Never Events reported during Quarter 1.**
- **2 Never Events were closed in Quarter 1.**
- **0 Never Events have been reported since November 2023.**

Improvement Work

Key changes to Dermatology Patients accessing services through 'see and treat' route to mandate marking of lesions in marker pen with arrow, and recording number of lesions present and marked. Procedure not conducted if lesion not marked and has been clarified with the patient and the requesting clinician in clinic. *N.B NatSIPPs 2 recommends circling areas to be excised but not recommended in Dermatology due to need to visualise clearance margins.*

Ongoing spot audits to be carried out in 'see and treat' Dermatology clinics to monitor compliance with marking of lesions.

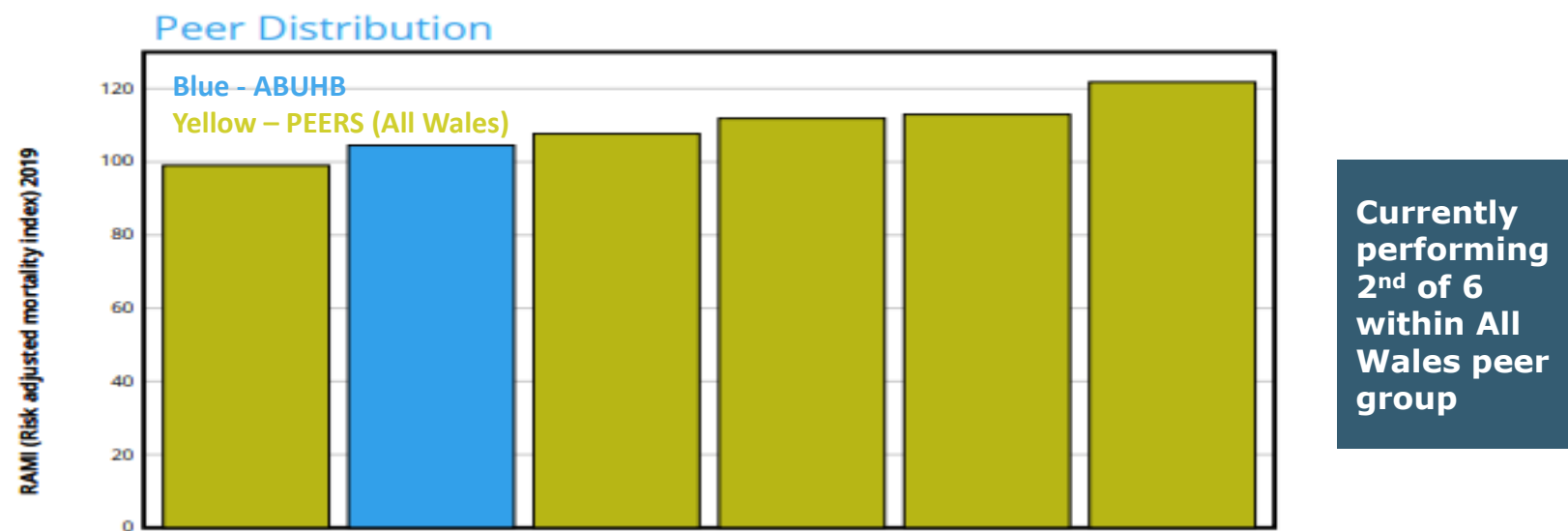
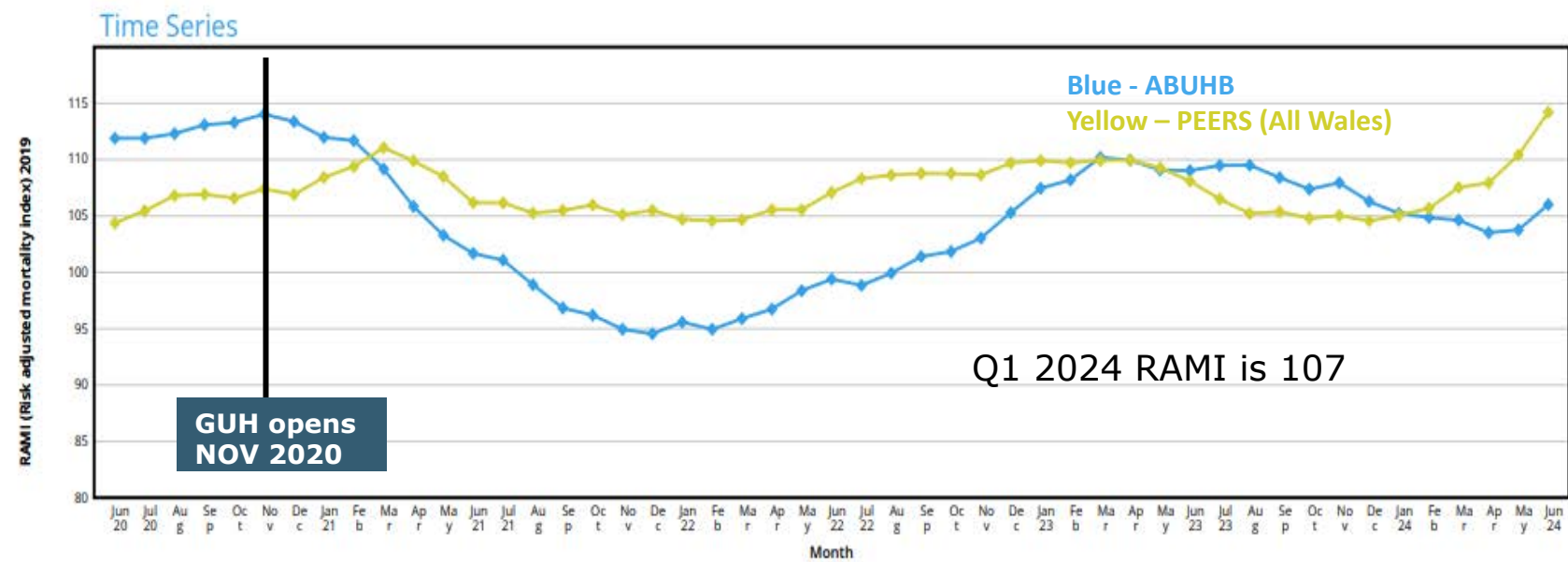
Identification of a dedicated block bay within each hospital site where anaesthetic blocks can be performed safely with adequate resources.

Design of a Local Safety Standard for Invasive Procedures (LocSSIP for Regional Anaesthesia/ Nerve blocks, focusing on the Prep, Stop Block process. Standardised LocSSIP used by all specialities who perform nerve blocks (including Anaesthesia, Orthopaedics, and Interventional Radiology). Education of all staff groups on new LocSSIP once developed.

To provide standardised and formalised training for all Regional Anaesthesia assistants through a mixture of electronic learning and / or lectures. Stop before you block teaching is being included in 'back to basics' teaching programme. E-learning resource created and currently final edit stage.

Provision of a dedicated Regional Anaesthesia assistant on all Health Board sites.

RAMI (Risk Adjusted Mortality Index)



Mortality Learning and Improvement

Issue	Cause	Learning and Improvement	Who	When
Understanding mortality data and how we implement learning from mortality	There is a need to understand what is reported to PQSOC and to Board for mortality. England produce a Learning from Death framework which enables a standardised mortality report.	Mortality report presented at April PQSOC. Will be reported every 6 months. Includes development of Learning from Death Framework. Includes learning from the Medical Examiner service and the mortality review screening panel. Reviewing our end to end mortality process.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistency of mortality reporting and data.	Mortality framework developed for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports RAMI and crude mortality. There is an All Wales Mortality review group working to standardise reporting of mortality.	QPS Team and Information Manager	Ongoing
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 80% because of increasing activity.	Working with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	On-going
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHL D deaths and suicide.		
	Mortality indicators not available to all	Once mortality indicators are agreed, the team will develop as a QLIK app to provide instant access to data.		

Pressure Ulcer Faculty – Introduction and Aims

The Health Board reported increased numbers of unstageable and grade 3&4 Health Acquired Pressure Ulcers (HAPU's). Divisions report data via the HAPU Steering Group and the Quality and Patient Safety Operational Group. The Executive Director of Nursing requested a new focus on reduction and prevention of HAPU's within ABUHB to meet the Welsh Government standard of 0% avoidable Health Acquired Pressure Ulcers.

Aim of the Faculty

- Reduce HAPU incidences by 25% of baseline within 4 months from the commencement of the faculty.
- Eradicate incidence of grade 3 & 4 avoidable HAPUs 4 months from the commencement of the faculty.

Update

- The faculty continue to meet and now collect data for all Divisions.
- A driver diagram has been produced to look at change concepts.
- These change concepts are being implemented as part of the faculty following improvement methodology, supported by ABCi.

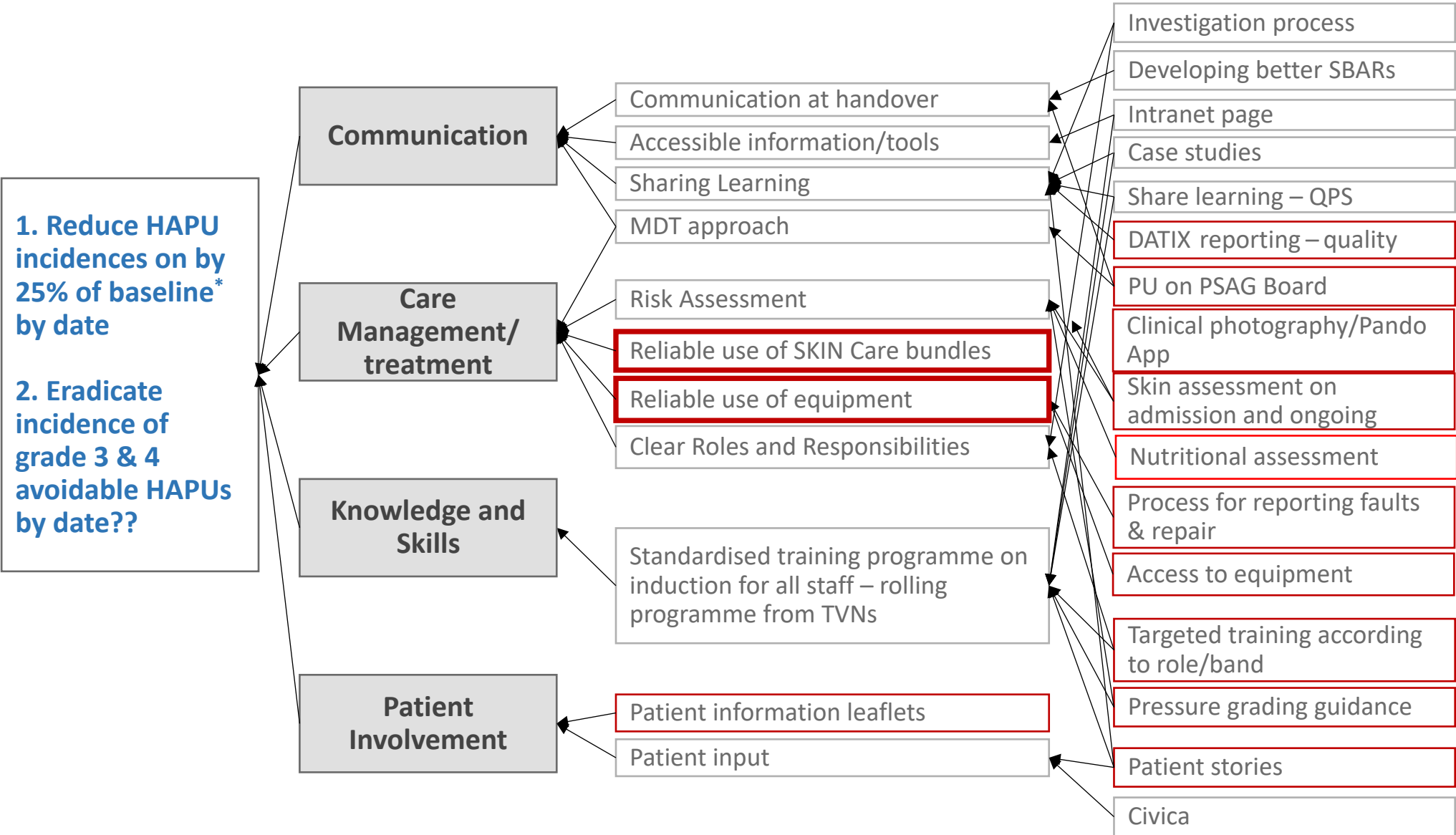
Pressure Ulcer Driver Diagram

OUTCOMES (AIMS)

PRIMARY DRIVERS

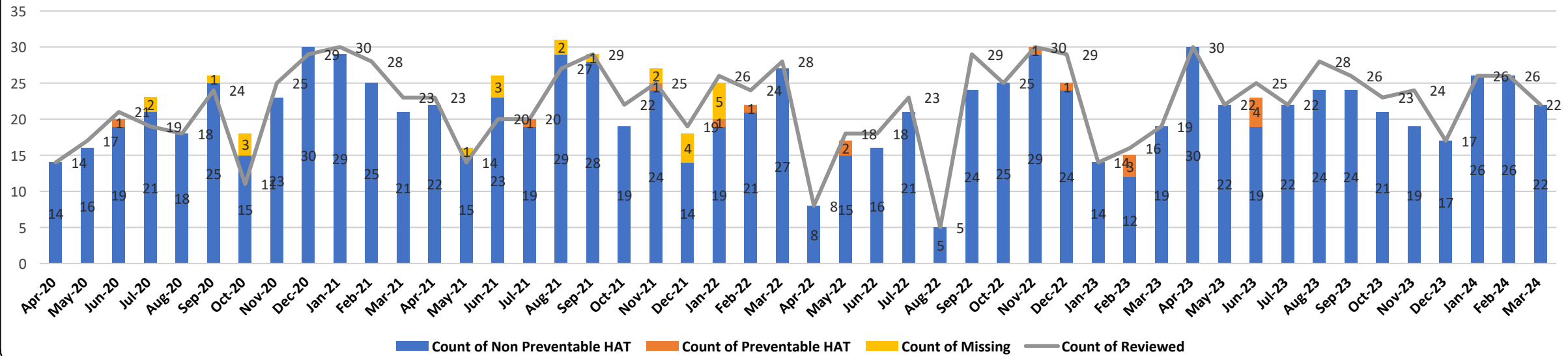
SECONDARY DRIVERS

CHANGE CONCEPTS



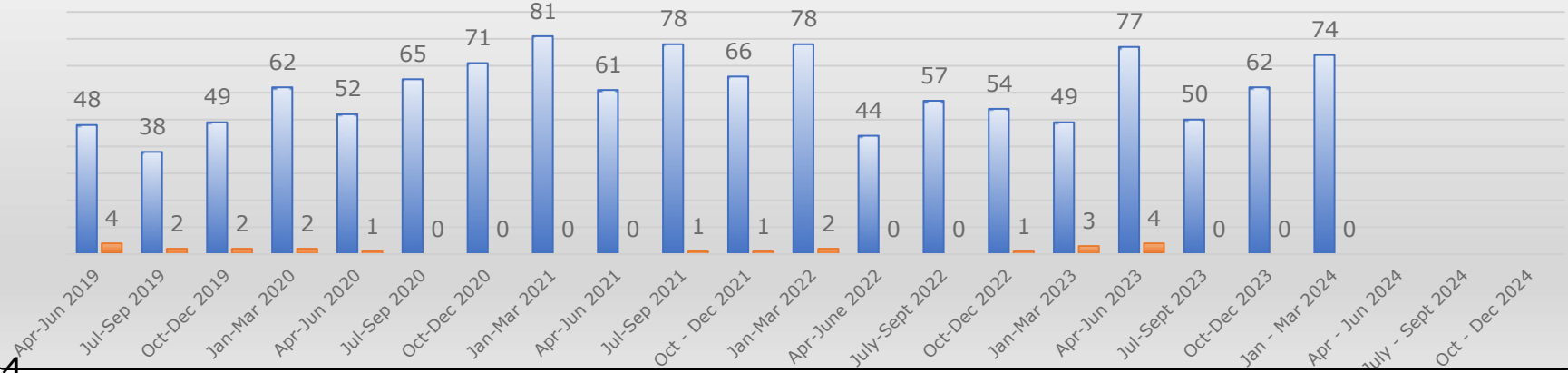
Hospital Acquired Thrombosis (HAT)

Hospital Acquired Thrombosis (HAT)
April 2021 - March 2024



Hospital Acquired Thrombosis - Quarterly Data
2019/20 - 2020/21 - 2021/2022 - 2022/2023 - 2023/2024

Hospital associated VTE Potentially preventable HAT



All suspected cases of HAT have a review of the case notes to define if this was prevented. The process and learning for preventable HATs is being reviewed to ensure they are captured as an incident on Datix and the learning is documented.

Meetings are currently taking place with Divisions to share the HAT data by speciality and to ensure there are points of contact within directorates to discuss best practice of thromboprophylaxis and appropriate risk assessment.

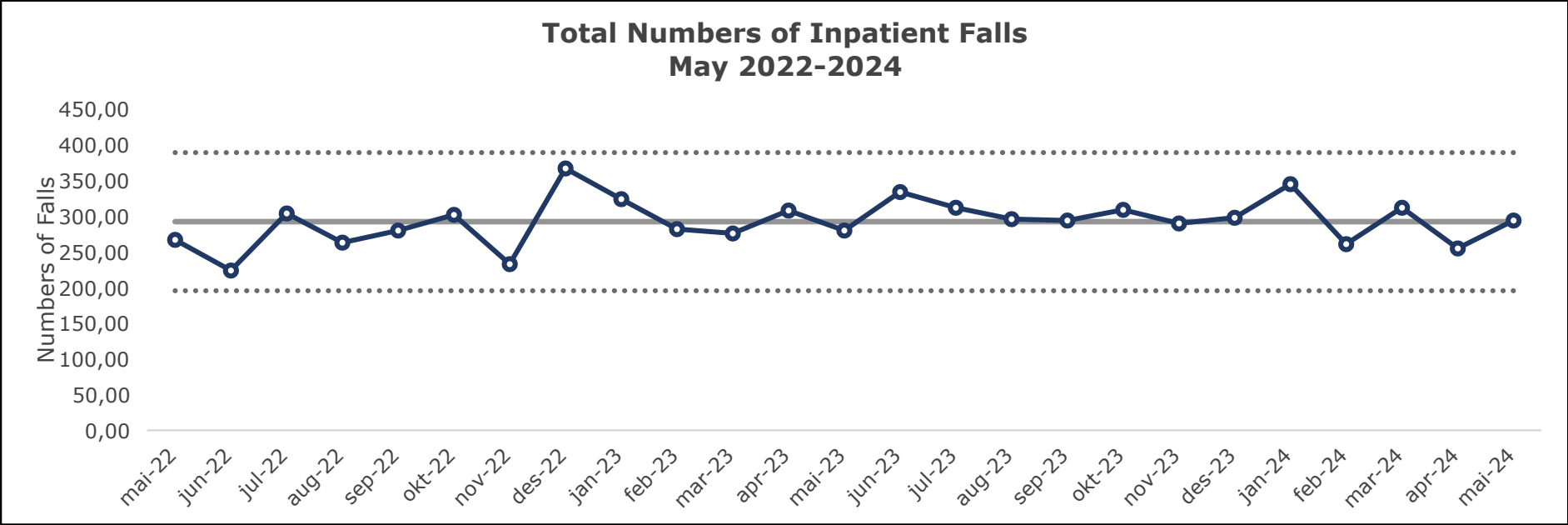
Infection Prevention & Control

All Wales comparison – WG Goals

Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Jun 24								
Additional filters for Table 1.			C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Select month or FY								
Current FY								
Select organism group								
All organisms								

Issue	Cause	Remedial Action	Who	When
Wards closed due to outbreak of Covid infection	- Visitor Covid positive - Symptomatic staff – no longer testing	- Cohorted affected patients - Covid safety measures assurance completed by ward managers – good compliance	Infection Prevention Ward Managers	June 2024
Increase in C difficile infection June Total = 24 HAI = 8 CAI = 9 Relapse = 7	- Antimicrobial stewardship - Compliance with fundamental IP measures	Enhanced cleaning strategy approved & HPV programme commenced		Ongoing
Increase in Staph Aureus Blood stream infections. June Total = 22 HAI = 8 CAI = 14	6 skin & soft tissue 5 bone & joint 5 respiratory 2 line associated 2 urinary 1 Gastro 1 unknown	- Promoting ANTT - Reviewing standardisation devices available via Procurement - QI project for admission screening - TVN Wound assessment and management training now available for staff to book via ESR - Viewing skin preparation products	Ward Managers Senior Nurses Tissue Viability	Ongoing
Increase with Gram Negative blood stream infections – fewer cases in June. June Totals E coli = 23 (3 HAI – 20 CAI) Klebsiella – 7 (2 HAI – 5 CAI) Pseudomonas = 3 (3 HAI)	18 urinary tract 9 Hepatobiliary 2 respiratory 2 gastro 1 unknown 1 skin & soft tissue	- Revisiting the 9 key standards for UTI prevention - Study session arranged for 13th August - Promoting Start Smart then Focus Antibioitic audits - Rapid roll out of the HOUDINI “make the catheter disappear initiative - Review adult antimicrobial guide in line with resistance patterns	Infection Prevention Bladder & Bowel Service Antimicrobial Pharmacists	Ongoing

Total Number of Inpatient Falls



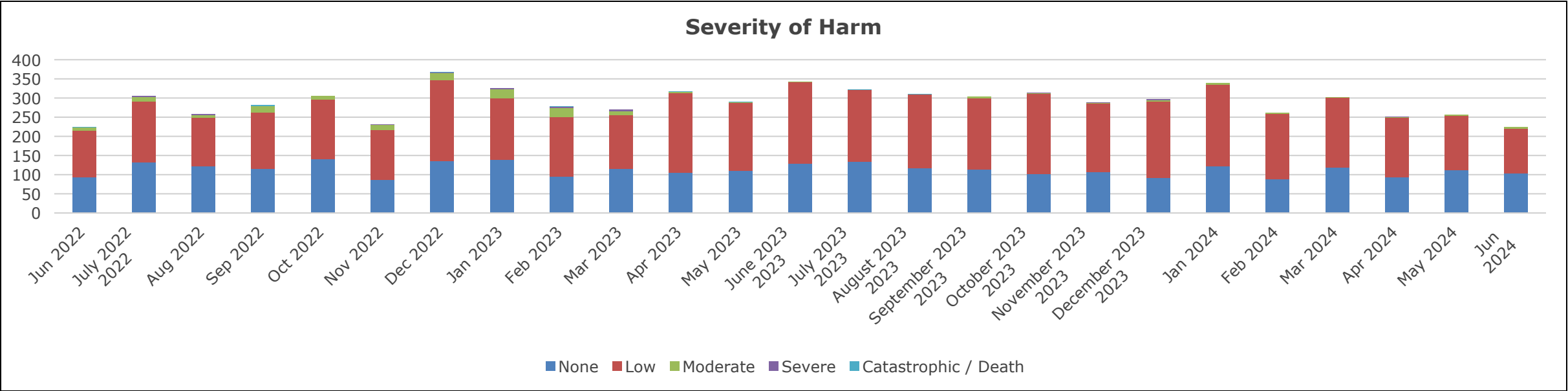
July 2024 - Context

The data used in this chart has been retrieved from RLDatix.

The data represents the collective information for ABUHB and refers to the total numbers of reported falls incidents for the period May 2022-2024. This period length for this data is selected to ensure the analysis is statistically valuable.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	- For the given period of analysis, the mean average of fall incidents is 276 which represents a decrease since the last report presented in March 2024 - Following a downwards trend from January 2024 the months of February and April 2024 have seen the lowest recorded values for falls incidents since November 2022.	Although January to May 2024 have seen increased levels of variation as compared to the preceding months some of the values are a positive representation of a decrease in the numbers of reported inpatient falls.

Inpatient Falls Data by Severity of Harm



Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 6537. Of this figure the following is identified. • 97% No or low harm. • 2.5% - Moderate harm • 0.4% Severe harm • 0.1% Catastrophic	The severity data is now reflective of the identified level of harm recorded post investigation. As compared to previous reports the % no or low harm is significantly higher than previously represented with a % reduction in the other associated categories of harm.

July 2024 - Context

The data represents the collective information for ABUHB and refers to the severity of reported falls incidents for the period June 2022- 2024.

Medical Safety Group (MSG)

Reporters View on Levels of Harm				
	Q2 2023/24	Q3 2023/24	Q4 2023/24	Q1 2024/25
None	194	187	174	210
Low	128	197	205	249
Moderate	60	77	57	55
Severe	7	8	12	14
Catastrophic	0	0	0	2
Total	389	469	448	530

- Overarching report discussed at MSG to review Datix incidents of moderate severity and above and to consider learning and actions.
- Divisional exception report is produced for the Medicines Safety Group. This includes numbers of incidents related to medication errors. Reviews common themes and trends.
- Immediate learning within the Division and organisational learning is shared. Linking into the leaning framework and repository.
- Internal safety alerts related to medicines are reviewed and drug safety updates discussed.

Focused Outcomes

- Continue to deliver on the corporate action plan for anticoagulant incident review e.g., pharmacy intervention report, thematic review, SOP update.
- Support DICE with teaching session on insulin/ VRIII in areas requiring support e.g., ED.
- Develop and issue an Internal Alert on Desmopressin following a trend of missed doses of this critical medication.
- Continue to support Mental Health and Neurology to deliver on the Sodium Valproate action plan as per MHRA.

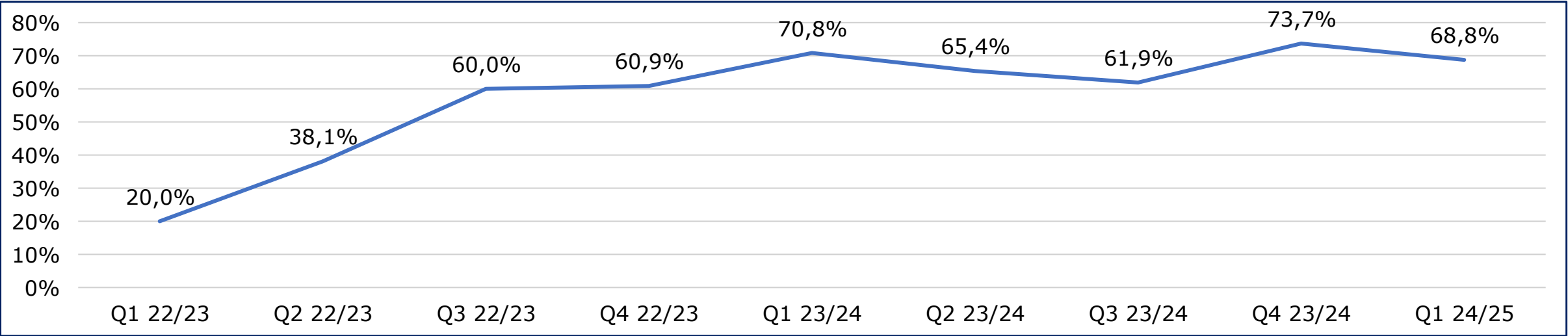
All Wales Patient Safety Solutions: Compliance Status

Alert	Compliance Deadline	Action to achieve compliance	Status
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	Has the deadline has not been met a SBAR has been completed to highlight the challenges, risks and planned work and mitigations with this notice. Work is still on-going.	In-progress

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During Q1 (April to June 2024) the Health Board have reported **16 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

68.75% of these cases were reported within the legal timeframes within the legislation.



Health, Safety & Security – Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Manual Handling Training Compliance: the education and training requirements associated with manual handling presents a risk to staff & patient safety	- Implementation of a targeted training programme focusing on high risk areas i.e. patient handling - Review completed on the frequency of update training from 2 to 3 years - Local manual handling trainers to ensure they are competent to support the updates training - Consider additional resource in the Corporate Health and Safety Team to support the demands of delivering foundation training to new starters	76 manual handling foundation training courses planned for 2024/25, offering 929 spaces - Frequency of manual handling updates changed to 3 years and updated on ESR increasing Health Board compliance to 67% (at end of July 2024) - Review and cleanse of the local manual handling trainers. Currently 241 active trainers, however, 74 (30.7%) are overdue their update - The level of recruitment within the Health Board, including Bank presents demands that are not sustainable for the Corporate Team to manage with the current resourcing	Executive Director of Therapies & Health Science Head of Health, Safety & Fire Divisional Triumvirates	Ongoing
RIDDOR Reporting: the compliance with reporting to the HSE to comply with RIDDOR for 2023/24 was 67.7%	- Ensure timely incident management and investigation is undertaken to support early identification of RIDDOR reportable incidents - Monitor RIDDOR reporting compliance via the Health and Safety Committee	29 incidents were reported outside of the legal timeframe in 2023/24. Whilst this is progress on the 2022/23 performance further improvements are required to ensure timely reporting and investigation	Executive Director of Therapies & Health Science Head of Health, Safety & Fire Divisional Triumvirates	Ongoing
Health and Safety Risk Assessments: the failure to undertake suitable and sufficient risk assessments presents an issue to the Health Board	- Ensure competent risk assessors are available to undertake workplace health and safety risk assessments - Health and safety risks scoring 15+ to be reviewed and updated prior to the Health and Safety Committee planned for September 2024	- A programme of risk assessment training has been implemented - Health and safety risks to be regularly reviewed and updated to ensure the appropriate controls are implemented	Divisional Triumvirates	Ongoing

Priority 3: Timely Care



Reported within the Integrated Performance Report

Priority 4: Effective Care



To ensure reporting in this domain going forward, the QOF will be reviewed to have indicators that are reported in line with effective.

Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 4 Effective	Reduced variation in Care	Increased Get It Right First Time (GIRFT) implementation plans by area						Reviewing measure
		Insert ward accreditation measures – to be confirmed						Reviewing measure
	Increased understanding of variation to focus Improvements	Increase in the SMART action plans with accountability in National Clinical Audit						Reviewing measure- see Clinical Audit slides
		Increase in the numbers of wards participating in accreditation (Audits via AMaT)						Reviewing measure- see Clinical Audit slides
		Increase in the actionable audit recommendations by National Clinical Audits						Reviewing measure- see Clinical Audit slides
	Improvement is part of the AB way	Staff Survey – increase in the score for staff being able to raise concerns						Reviewing measure
		Compliance the number of incidents triggering Duty of Candour within 5 days	No Data	No Data	No data	No Data	No Data	Reviewing measure
		QI projects outcomes (Non SCC)	No Data	No Data	No Data	No Data	No Data	Reviewing measure
		Outcomes of the SCP teams	No Data	No Data	No Data	No Data	No Data	Reviewing measure
	Improving Good Health in Pregnancy	Decrease in low birth weight rates	2021	5.10%	2022	6.10%	Deteriorated	Increase in indicator between 2021 and 2022. In line with the All Wales average. Next update due June 2024 (provisional).
		Decrease in stillbirths	2021	3.9	2022	4.5	Deteriorated	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	Q2 2023/24	63.2%	No Data	No Data	Improved	Indicator value has improved by 7.3% between Q4 22/23 and Q2 23/24.
		Increase of eligible children measured and weighed at 8 weeks	Q3 2022/23	39.70%	No Data	No Data	Improved	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average.

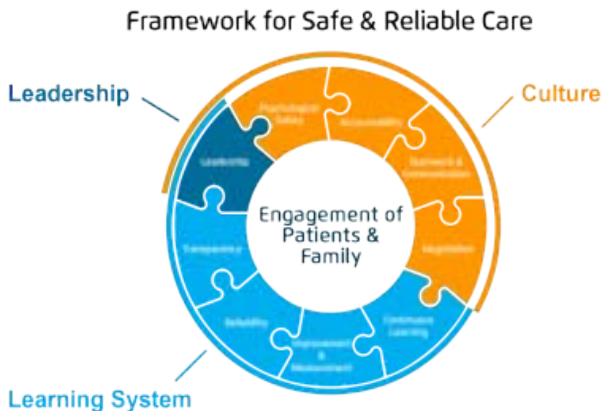
Safe Care Collaborative: Final Update

Organisational Update: Stage-Collaborative Closed in May 2024

- **Learning Session, May 14th**– Face to Face Learning Session held at the ICC focussing on 'Sustaining Successful Improvement'
- **ABUHB Deteriorating Patients Collaborative** – Review to be undertaken around what is next for a local collaborative, reflecting ABUHB strategic direction and the forthcoming National Programme. 'Improvement Cymru', who led SCC, now forms part of the 'Quality, Safety and Improvement' directorate within the NHS Executive are identifying their national priorities.
- **Leadership programme of work** –Executive Safety walkarounds set up for 2024, some cancelled at the start of the year but more completed during April/May.
- **Quality Outcomes Framework**–Maxine Power facilitated session around development of the QOF measures. Aim to reduce these to up to 5 measures per component of STEEP. Qtr 4 QOF reported.
- **QI Skills Development**– Spread & Scale aim: '*To unleash a million minutes of quality improvement coaching to enable our people to improve their services over the next 4 years*'. Cohort 1 of new QI Coach programme in Autumn focussing on QPS staff, Primary Care and others. 3 programmes 2025 onwards aiming to develop 75 QI Coaches embedded in divisions each year.
- **QI/Nursing Directorate** – ABCi QI Unit moved to QPS/Nursing

Teams Update

- **Storyboards** - Updated for Learning session 6
- **Ward C0** –Up until the end of April, there hasn't been a Cardiac Arrest for 155 days. Next stage of visual management, screen accessible for full MDT at handover between shifts.
- **Monmouthshire** – Invited to present as spotlight session at final learning session. Reduction in Package of Care hours for medically optimised patients. Reduction in median LOS. Exploring potential to spread Mon integrated model.
- **AMU** – Workforce changes in AMU leadership/ team/coach. Ongoing support for QI within AMU under consideration
- **OT Early Intervention** – Invited to present as spotlight session at final learning session. 6 week Home Based Memory Rehabilitation (HBMR) programme reduced from 770-670 minutes for each patient, allowing for an extra patient to undertake the programme each month. Testing pre-hab memory strategy leaflet for patients on waiting list & planning for spread.
- **Theatres** – Up until the end of May, there hasn't been a Never Event in theatres for over 195 days, equating to 3.9 events avoided. Improvement Advisor in post whose work is aiming to reduce retained material/wrong sided block Never Events in theatres. Work focussing on two areas: Developing Safety Culture via Human Factors training/simulation and QI, plus reliable introduction of NatSSIPS 2. Testing Safety Culture survey as part of Human Factors, updated WHO checklist and 'Pause for the Gauze' being tested and spread across theatres.

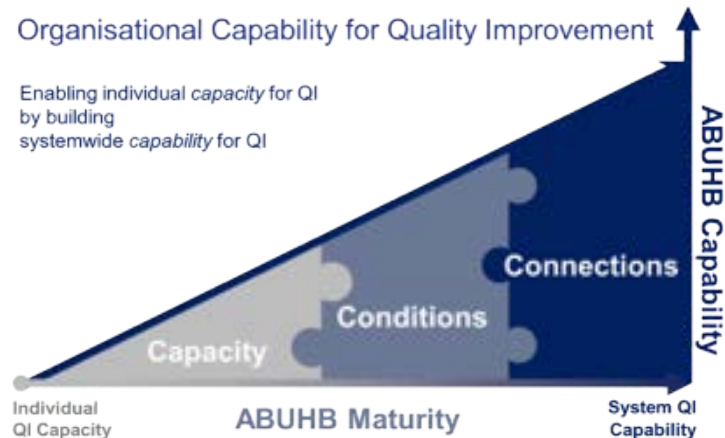


Workstream	ABUHB Team	Score
Acute	Medical Assessment Unit at GUH	2.5
	Ward C0 (ENT surgical ward) at GUH	3.5
	Theatres – Human Factors	2.5
Ambulatory	North Monmouthshire Integrated Team	3.5
Community	OT/MH Early Intervention for Cognitive Impairment Team	3
Leadership	Executives, Leaders for Safety, Faculty	3.5

Score	IHI - Stage of Project Scoring
0.5	Intent to participate
1.0	Forming team
1.5	Project plan begun
2	Activity but no changes
2.5	Changes tested but no improvement
3	Modest improvement
3.5	Improvement
4	Significant improvement
4.5	Sustainable improvement
5.0	Outstanding sustainable improvement

Quality Improvement

"Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement."



Our QI Capability strategy is to build: ∞

Capacity for QI – knowledge, skills, experience

- **QI Coaches integrated into divisions** ∞
- QI Knowledge and Skills Development Framework

Conditions for QI – Enablers for QI

- Clinicians as QI Leaders
- Data systems supporting QI
- Resources to support teams working to improve services
- Patient involvement in QI
- **Human Factors and Safety Culture** ∞

Connections for QI – QI Networks sharing learning

- QI Networks, both internal and external
- Strategic Partners
- **Safe Care Partnership/ Collaborative** ∞
- QI Collaboration

Progress:

ABUHB NHS IMPACT Self Assessment survey - initial results

Spread and Scale Integrated QI Coaches – 90 Day Plan

Aim - "To unleash a million minutes of quality improvement coaching to enable our people to improve their services over the next 4 years"

QI Coach development programme ([click for more info](#))

- **Plan** – Each year x 3 Cohorts x 25 participants = 75 participants each year = 300 QI Coaches in 4 years
- Celebration event for pilot QI Coach Programme in June
- 27 booked on Cohort 1 planned for Autumn 2024 targeted at key staff e.g. QPS, Primary Care, QI Project teams.
- 2025 dates for QI Coach Programme booked
- 16/300 QI Coaches trained in ABUHB
- 4140/1,000,000 minutes of QI Coaching delivered to QI teams between April – May 2024

Human Factors and Safety Culture

- ABCi Improvement Advisor supporting work to reduce Never Events in Theatres – presented to PQSOC
- 195 days since last Never Event in theatres (data to May) equating to 3.9 events avoided
- Testing SCORE safety culture survey
- Updated WHO checklist and 'Pause for the Gauze' being tested and spread across theatres

Safe Care Partnership (SCP)/Collaborative(SCC)

- Safe Care Collaborative ended in May 2024
- Improvement Cymru part of NHS Executive 'Quality, Safety & Improvement Directorate scoping priorities for next stage of SCP work

Priority 5: Efficient Care

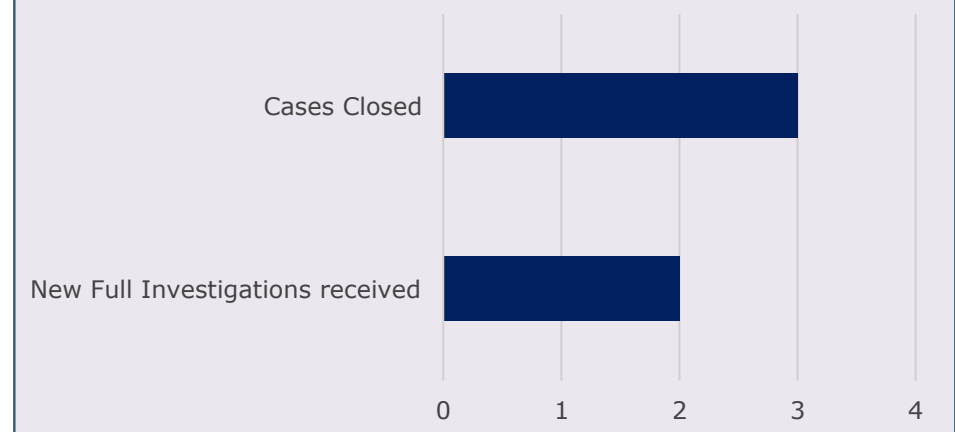


Priority	Outcome Description	Indicator	Reported Position 2023/24		Current Reported Position	Change over the last time period	Latest findings
			Q3	Q4	Q1 2024/25		

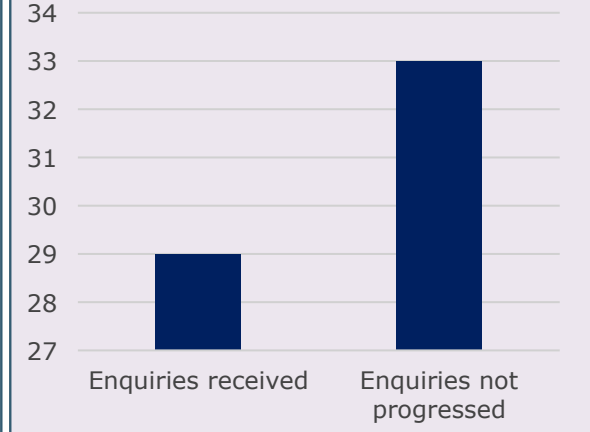
Priority 5 Efficient	Patient experiences are visible and acted on	Decrease in the number of open personal injury claims	76	69	71	Increased	No financial Penalties at May 2024 WRP Committee
		Decrease in the number of open clinical negligence claims	657	676	659	Decreased	No financial Penalties at May 2024 WRP Committee
		Decrease in the number of open Coroner inquests	188	205	199	Decreased	Decrease for Q4
		Response time to Public Services Ombudsman for Wales(PSOW)	4 days	3 days	6 days	Improved	Reporting 6 days earlier than PSOW target
		Decrease in the number of medically fit for discharge patients	Q2 2023	280	No Data	No data	No longer valid – measure has been discredited
		Decrease in the number of patients cancelled on the day of surgery	Q1 2023 130	Q2 2023 110		Decreased	There has been a decreasing trend in the numbers cancelled in the day of surgery the numbers over the past quarter remain circa 110 per week
		Decrease in the % of hospital as a place of death	3.00%	3.00%		Decreased	There has been a notable decrease in the % of hospital as a place of death in the past quarter outside of normal season trends from 3.2% to 2.75%

Ombudsman (PSOW)

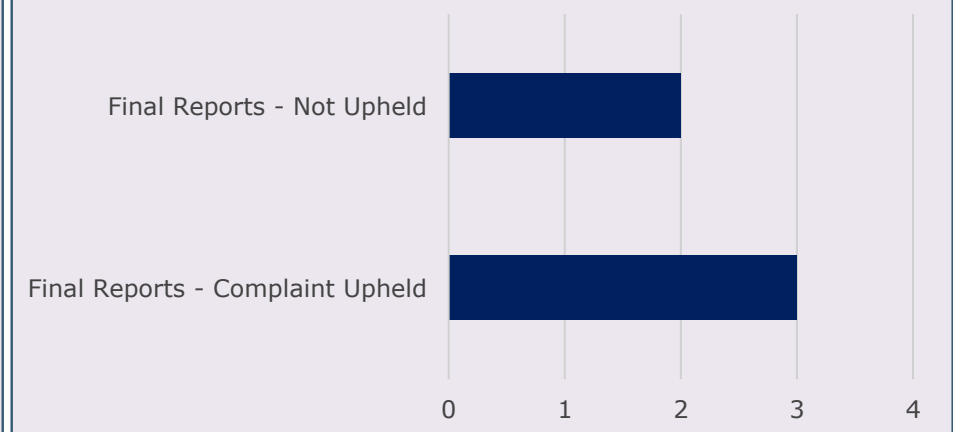
**PSOW Open & Closed
April - June 2024 (Q1)**



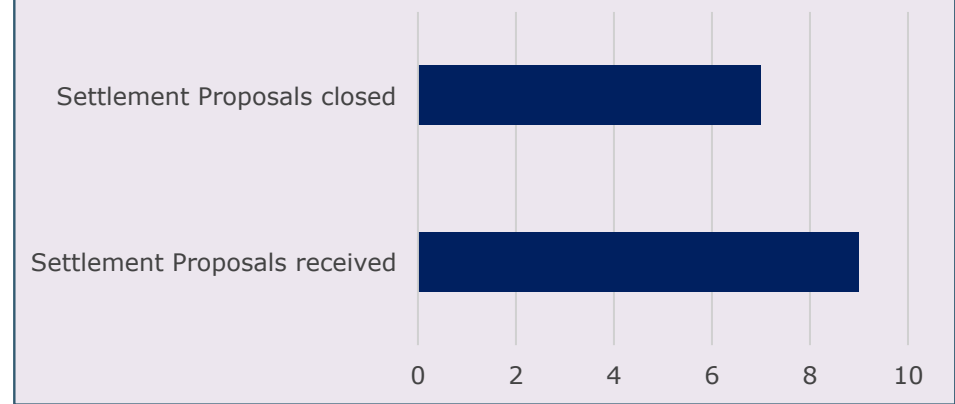
**Enquiries
April - June 2024 (Q1)**



**Final Report Outcomes
April - June 2024 (Q1)**

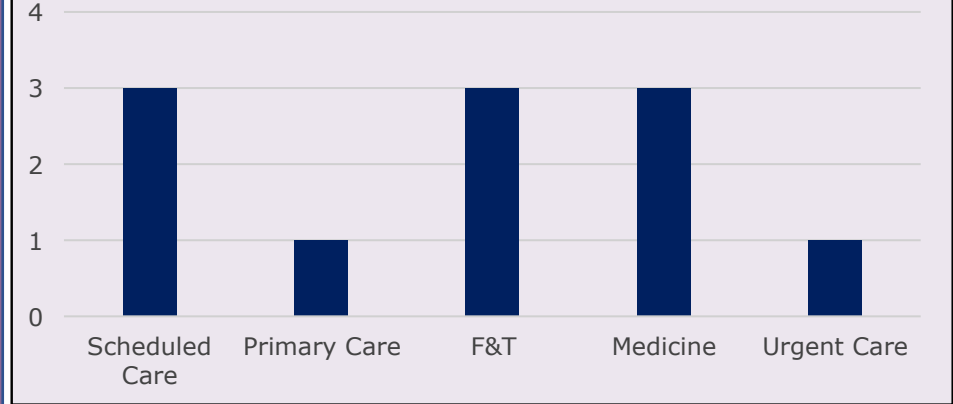


**PSOW Settlements
April - June 2024 (Q1)**



Positively, although the number of enquiries received has been higher, the number progressed by PSOW has been lower. Indicating that the PSOW has been satisfied following receipt of evidence from the Health Board. Overall settlements and final reports upheld has reduced across the period. The Health Board continues to perform above average and the target performance timescales when providing evidence to PSOW.

**Settlements by Division
April - June 2024 (Q1)**



Priority 6: Equitable Care



Priority	Outcome Description	Indicator	Last Reported Position		Current Reported Position		Change over the last time period	Latest findings
			Latest data available	Indicator value	Latest data available	Indicator value		
Priority 6 Equitable	Improving quality of life and equitable access	Increase in the access to Safeguarding Training	Q3 2023.24	Level 1 Adult 79% Children 85% Level 2 Adult 88% Children 86%	Q4 2024	Level 1 Adult 87% Children 86% Level 2 Adult 90% Children 88%	Improving	Compliance with training has improved (with tolerance of 85%)
		Narrowing of the life expectancy Gap across our Health Board	Q4 2020	Women 20 years Men 13 years	Q4 2020	Women 20 years Men 13 years	N/A	The current the 13yr (men) and 20yr (women) gap in healthy life expectancy between our wealthiest and poorest communities
		Timely closure of Safeguarding incidents		Measure in development		4 Child Practice Reviews 1 Adult Practice Review 5 Domestic Homicide Reviews		Reviewing measure
		Decrease in the incidents of violence and aggression towards staff	See 2023/24 in table		Q1 2024	540	Increased	Violence and aggression towards staff data presented for 2023/24 and increase for Q1 2024/25.

Safeguarding: Activity

Safeguarding activity data must be used with caution when being utilised as a marker of quality improvement. However, the current data available for 2024/25 highlights there has been a substantial number of safeguarding referrals made, or responded to, by the ABUHB Safeguarding Team. This is influenced by a number of potentially negative factors (increased harm) over which we have no control but is also testimony to the effectiveness of the workforce in being aware of neglect and abuse within our population.

	2023/24	2024/25	Increase
Safeguarding Children Strategy Discussion	377	512	36%
Adult Duty to Report	72	102	41%
Child Duty to Report	963	1090	13%

It should be noted that the duty to report figures represent those that were generated by the Health Board and quarter 1 comparisons have been made between 23/24 and 24/25.

Safeguarding: MARAC/Sexual Safety/Serious Violence

Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

In QTR 1 2024/25, the Corporate Safeguarding Team attended 32 MARAC, providing information and contributing to safety plans for 394 survivors of Domestic Abuse. An increase in MARAC activity has been noted by the Gwent MARAC Steering Group, with current work on MARAC sustainability being a focus of the Gwent VAWDASV work for the current year.

Sexual Safety

The 2023 the Women's Rights Network published a national report in regard of the volume of sexual assaults that have taken place in hospital settings. A recent report, generated at the request of the National Safeguarding Team, highlights that there have been 48 incidents, in the period 1 August 2023 to 31 January 2024. Analysis of this data has highlighted that most of the incidents related to inappropriate behaviour by patients towards staff, followed by patent on patient and only two incidents where the allegation was made towards a member of staff. In addition, it is noted that none of the incidents resulted in physical harm or fulfilled the national definition of serious sexual assault.

In response to this, a Chaperone Policy and Sexual Safety Policy are currently in draft form and awaiting approval from internal processes. The sexual safety policy will in addition provide guidance on risk assessment, recording of sexual safety incidents and timely escalation.

Serious Violence

The Serious Violence Duty 2022 sets an expectation on Health Boards to actively engage with the development of a regional strategy to tackle serious violence. As such, ABUHB has produced a data set which is provided to the OPCC as lead agency and which enables us to actively participate in the strategic needs assessment and production of the strategy.

In addition, funding has been made available for 2023/24 to support work in violence reduction via our urgent care areas. This funding will commission a Violence Reduction Worker to in reach to our emergency areas and minor injury units, with a focus on staff training, improving data collection and early intervention with individuals that may be involved in serious violence and potentially organised crime or exploitation.

In addition, working groups in some localities have been formed to commence multi-agency work in response to the increased activity of the topic.

Sharing Good Practice

A Patient Safety Service

Now live on wards B0, C4 & Critical Care discharges within GUH.



Martha Mills



Martha Mills was a 13 year old girl who died in 2021 after developing sepsis in hospital. She was admitted following a pancreatic injury after falling off her bike.

During Martha's admission, her family repeatedly raised concerns about her deteriorating condition, however were wrongly reassured that this was all normal for this type of injury and there was no need to be concerned.

In 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

Martha's Rule

The 3 proposed components of Martha's Rule are:

- All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
- All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

Call 4 Concern

- The Call 4 Concern service enables hospital patients and their families to call for immediate help and advice if they are worried that the health care team has not recognised or acted upon concerns regarding deteriorating health.
- The service is being introduced at ABUHB by the critical care outreach team (CCOT) and will provide a timely and appropriate response to patients with acute and sudden changes in condition
- In March CCOT launched the C4C service for patients discharged from ICU to GUH wards 7am – 7pm
- In April the core site safety team enable this to be available 24 hours
- In August this has been piloted on B0 & C4 and in October this will be rolled out to additional wards within the Grange C0 & A4 with further roll out planned

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance Performance Report – August 2024 (2024/25 Month 5)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rob Holcombe - Director of Finance, Procurement & VBHC
SWYDDOG ADRODD: REPORTING OFFICER:	Suzanne Jones – Interim Assistant Director of Finance

Pwrpas yr Adroddiad Purpose of the Report

Er Sicrwydd/For Assurance

This report sets out the following:

- The financial performance at the end of August 2024 and the forecast position against the statutory revenue and capital resource limits,
- The savings position for 2024/25,
- The revenue reserve position on the 31st of August 2024,
- The Health Board's underlying financial position,
- The cash position,
- Public sector payment policy performance, and
- The Capital position.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report sets out the financial performance of Aneurin Bevan University Health Board, as at the 31st of August 2024 (month 5) for the financial year 2024/25.

The 2024/25 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met.

The table below summarises these and the Health Board's performance against them.

Aug-24

Performance against key financial targets 2024/25

+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Year-end Forecast	Movement
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. <i>This confirms the YTD and forecast variance.</i>	£'000	4,029	22,193	47,860	
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. <i>This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.</i>	£'000 £64,187	3,792 5.9%	29,225 45.5%	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)	%	97.7%	97.4%	>95%	

Performance against requirements 23/24		21/22	22/23	23/24	3 Year Aggregate (21/22 to 23/24)
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	x	(249)	36,842	49,754	86,347
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	(50)	(43)	(41)	(134)
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	x				

Underlying Financial Position (Brought Forward ULP)	21/22	22/23	23/24	24/25 Forecast
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	£20.914m Deficit	£89.6m Deficit	£89.600m Deficit	£55m Deficit

The 2024/25 financial year to date budget performance as at month 5 is an adverse variance of **£22.193m**.

The 2024/25 reported forecast is a £47.860m deficit which is a £1m improvement from the £48.9m deficit within the updated annual plan. There remain risks associated with this forecast position, particularly full achievement of saving opportunities, prescribing / drug cost growth, receipt of anticipated allocations and operational demand & workforce pressures.

The 2024/25 forecast of £47.860m is £35m greater than the Welsh Government control total of a £13m deficit.

The Board has made improvements to the financial forecast and has “de-risked” a number of pipeline opportunities. Work continues to progress further opportunities to minimise operational and savings delivery risks.

Cefndir / Background

Key points to note for month 5 include:

- Year to date position is a deficit of **£22.193m** with a reported full year position of **£47.860m deficit**
- Income includes anticipated funding for a number of areas including;
 - conditional WG recurrent funding
 - CHC real living wage funding where the exact value is yet to be confirmed by WG.
- In addition to the reported income funding is assumed for the following:
 - Optometry funding
 - PADM funding
 - Overseas nursing funding
- Pay Spend is £0.7m higher compared with July due to increased enhancement costs and medical substantive costs. Operational pressures including enhanced care, sickness and vacancy cover contribute to this pressure. Medical costs have increased due to cover for vacant posts as well as permanent appointments.
- Non-Pay Spend (excluding capital adjustments) – has decreased by c.£2m compared with July due to reduced WHSSC and External Commissioning costs (WG funded LTA pay matrix pass through in July) as well as decreased drugs and funded TEC Cymru costs.
- Savings – total annual plan savings were £40.5m with a current forecast delivery of £43.5m. The improved delivery is due to the CTM arbitration case with the resulting benefit of £1.5m greater than plan and medicine management savings for Rivaroxaban. Overall in-month achievement is £3.4m (YTD £13.3m).

At Month 5, the reported revenue position is a £22.193m deficit and the reported capital position is break-even. There are risks in achieving the reported forecasts.

The underlying financial deficit coming into the 2024/25 financial year is £81.4m, the underlying financial deficit for 2024/25 is assessed as a **£55m** deficit which was revised following a quarter one review and the recurrent benefit due to the CTM arbitration case in month 4. This position has informed the updated 3 year route map to recovery.

Asesiad / Assessment

- **Revenue Performance**

The financial forecast deficit is summarised by the following elements:-

- Stated underlying deficit - +£81.4m
- New year cost pressures - +£59.8m
- Additional discretionary funding – (£51.8m)
- Identified savings of (£40.5m)

Annual Plan Forecast Deficit £48.9m

- Month 4 –
 - CTM arbitration on base LTA case (£1.5m),
 - WHSSC forecast over-performance +£0.7m,
 - Operational pressures such as drugs +£0.9m,
 - Assumed income for PADM's / Dispensing Dr's funding (£1.1m),

Annual Forecast Deficit @ Month 4 £47.9m

- Month 5 –
 - Additional prescribing costs above plan due to increased average price per item using quarter 1 24/25 PAR data and Apixaban NCSO (+£3.1m),
 - Acute drugs growth Haematology, Gynae medical staff and Nursing maternity leave +£1.2m
 - Assumed income for International recruitment (£0.9m)
 - CTM month 5 under-delivery at marginal rates forecast (£1.4m),
 - Optometry contract income (£0.8m),
 - Increase in forecast savings (£1.2m)

Annual Forecast Deficit @ Month 5 - £47.9m

The table below describes the updated position following the annual plan submission (31st of May) in further detail:-

Category	March submission	May submission	Month 4	Month 5
Underlying deficit b/f (£m)	81.4	81.4	81.4	81.4
Cost pressures identified (£m)	59.8	59.8	59.8	59.8
WG discretionary funding (£m)	(51.8)	(51.8)	(51.8)	(51.8)
Identified savings (£m)	(29.1)	(34.4)	(40.5)	(40.5)
Pipeline opportunities (£m)	(11.4)	(6.1)	-	-
Sub-total deficit (£m)	48.9	48.9	48.9	48.9
CTM arbitration case benefit & revised performance	-	-	(1.5)	(1.5)
CTM under-delivery at marginal rates				(1.4)
Prescribing average price per item increase and NCSO				3.1
WHSSC forecast pressure (£m)			0.7	0.7
Operational pressures in particular Surgery drugs, Gynae medical and nursing maternity leave			0.9	2.1
Increase in forecast savings (Month 5 inc. Rivaroxaban)				(1.2)
PADMs & Dispensing Drs, International Recruitment and Optometry funding			(1.1)	(2.8)
Total deficit	48.9	48.9	47.9	47.9

A summary of the year to date financial performance is provided in the following table, by delegated area.

Summary Reported position - August 2024 (M05)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	292,500	564	435	129
Prescribing	116,133	83	55	28
Community CHC & FNC	69,209	915	941	(26)
Mental Health	141,678	309	317	(8)
Total Primary Care, Community and Mental Health	619,519	1,872	1,748	124
Surgery	139,593	2,483	1,384	1,099
Clinical Support Services	125,980	296	190	106
Medicine	161,059	779	473	307
Urgent Care	39,276	(82)	(47)	(34)
Family & Therapies	133,550	1,012	839	172
Estates and Facilities	93,806	(21)	(159)	138
Director of Operations	10,754	(324)	(351)	27
Total Director of Operations	704,018	4,143	2,329	1,815
Total Operational Divisions	1,323,537	6,015	4,077	1,938
Corporate Divisions	103,974	(1,005)	(1,133)	128
Specialist Services	194,347	300	183	117
External Contracts	95,719	(1,208)	(500)	(708)
Capital Charges	74,749	(35)	(21)	(14)
Total Delegated Position	1,792,326	4,067	2,606	1,461
Total Reserves	(38,239)	18,126	15,558	2,568
Total Allocations	(1,741,894)	0	0	0
Other Corporate Income	(12,193)	0	(0)	0
Total Reported Position	0	22,193	18,164	4,029

Summary of key operational points for Month 5

- During August 2024, pay expenditure was £66.8m an increase of c.£0.7m (1.1%) compared with July.
- Substantive pay spend was £60m (July £59.2m).
- Variable pay spend was £6.7m (July £6.8m).

Key **Pay** issues include:

- Additional enhancement costs due to 5 week pay month - £0.3m
 - Medical agency/locum cost increase (consultant cover / vacant posts) - £0.1m
 - Increased medical staffing appointments - £0.25m
 - Increased overtime payments across several Divisions - £0.1m
- Non-Pay Spend (excluding capital adjustments) was £87.1m, a decrease of c.£2m (2.2%) due to decreased Neurology acute drugs, this is expected to return to previous levels in future months, and External commissioning / WHSSC costs.

- Demand pressures for elective and urgent care across all services, including primary care, mental health, acute and community hospitals remains above the pre pandemic levels. There are 319 inpatients who are fit for discharge as at the end of August; approximately 25% of the blocked bed days are health related, 46% are social care and package of care related with the remaining 29% relating to other reasons e.g. patient/family related, nursing homes, etc.
- The estimated cost for the year of continued blocked bed days for all reasons is c.£16.1m using a £150 cost per bed day. The demand and flow challenges across the Health Board drive surge bed capacity requirements which result in increased demand in high cost temporary staff, impacting overspends and performance across the Health Board. The delays need to be reduced to avoid the requirement for this capacity and optimise appropriate bed capacity to support financial sustainability, this is being progressed through the discharge and bed reduction saving programme.
- In month other significant issues include:-
 - Prescribing costs present a significant financial pressure compared with Annual Plan financial forecasts. The average cost per item for 2024/25 has increased from £7.29 (Annual Plan) to £7.52 for the full year forecast (June PAR). Growth is assumed to be 0.8% for 2024/25 and will be reviewed further using future PAR data. The material risk relating to updated April/May PAR average cost per item (and tariffs for Category M and Non-Category M drugs) have now been reflected in the full year forecast along with the increase using June PAR data.
 - Additional prescribing cost pressures linked to Apixaban NCSO has also been included in the forecast
 - CHC fees and growth pressures continue in Adult CHC / Mental Health and Paediatrics off-set by FNC numbers below annual plan
 - Reduced numbers of patients are following the Step Closer to Home pathway, previously this was c.49 patients it is currently down to 6, this is funded by RIF and utilisation should be maximised
 - Enhanced cleaning, additional security and other facilities covid legacy costs continue
 - Additional WLI and backfill costs above plan to support cancer and 156-week targets
 - Mobile MRI expenditure in YYF
 - On-going use of variable pay by mental health wards for acuity as well as sickness and vacancy cover, (Mental Health nursing variable pay estimated over 50% linked to enhanced care in August)

Expenditure run-rates

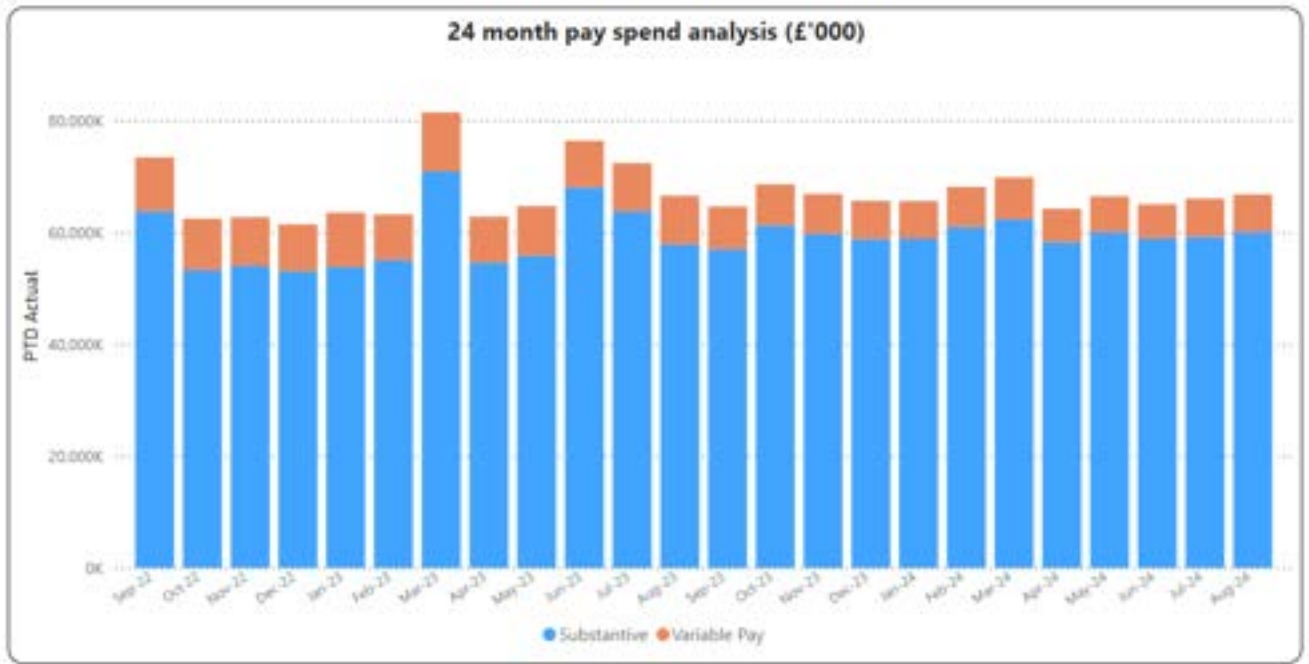
Pay and Non-Pay expenditure run-rates for the last six financial years are shown below; assuming the current level of income, the expenditure run-rates need to reduce in order for the Health Board to meet its annual plan deficit and even more so to a break-even position in future financial years.



Workforce

The Health Board spent £66.8m on workforce in month 5 24/25, an increase of £0.7m compared with July. To note 2023/24 monthly average expenditure was £67.7m – excluding year-end adjustments for employer pension contributions and annual leave.

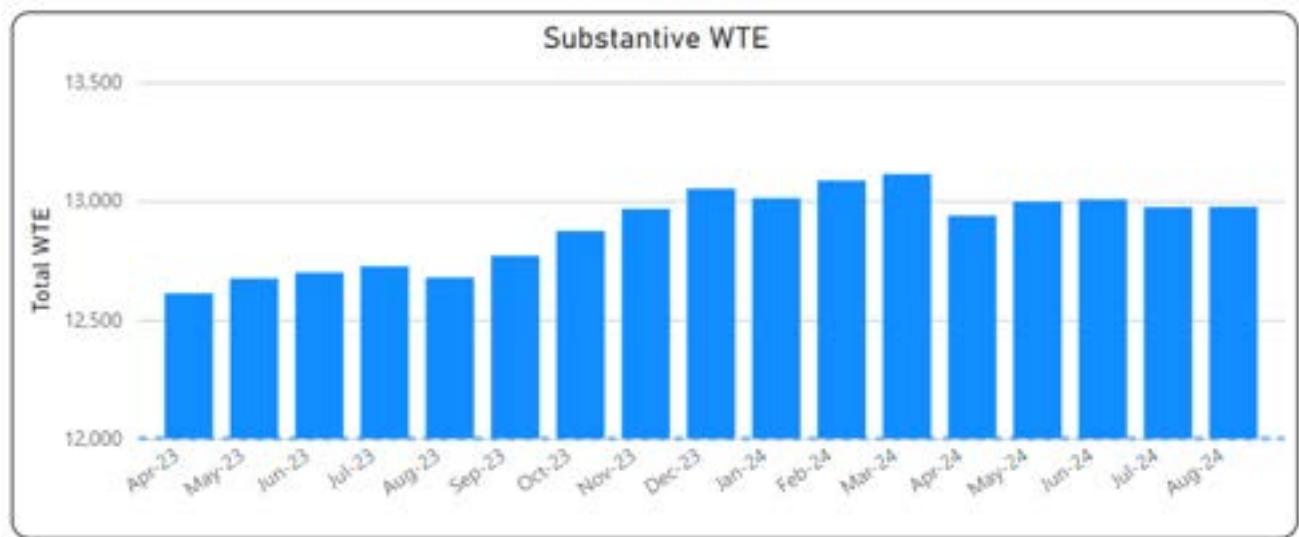
Workforce expenditure is shown below differentiating between substantive and variable pay¹:



¹ To enable useful comparisons and trends all references to 23/24 pay expenditure exclude the month 12 expenditure for additional employer pension contributions (6.3%/£32.1m).

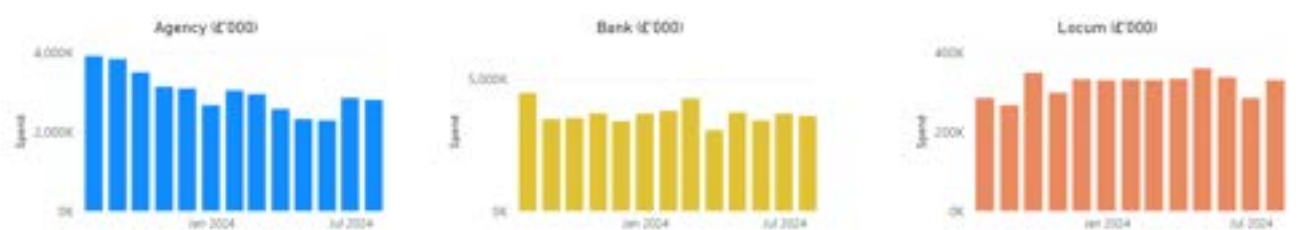
Substantive staff

Substantive pay was £60m in August - costs increased by £0.8m compared with July. Month 5 includes 12,975 wte employed staff, a similar level (12,974) compared with the prior month.



Variable pay

Variable pay (agency, bank and locum) was £6.7m in August compared with £6.8m in July. The monthly average variable pay was £7.75m for 2023/24 (£9.2m average 22/23). Vacancy cover along with sickness and enhanced care continue to drive a financial pressure as well as pressure on our staff. In August nurse cover for vacant shifts increased, a possible explanation could be increased annual leave and bank availability.



Bank staff

Month	Spend
Apr-23	2,500
May-23	2,500
Jun-23	2,500
Jul-23	2,500
Aug-23	2,500
Sep-23	2,500
Oct-23	2,500
Nov-23	2,500
Dec-23	2,500
Jan-24	2,500
Feb-24	2,500
Mar-24	2,500
Apr-24	2,500
May-24	2,500
Jun-24	2,500
Jul-24	2,500
Aug-24	2,500

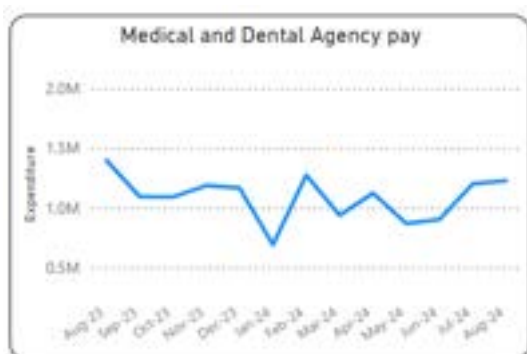
In-month spend of £3.6m, a £0.1m decrease compared with July, (2023/24 average monthly spend £3.9m).

- Continued pressures in Medicine wards/ Urgent Care, GUH Acute Medicine and GUH ED - £1.5m
- Facilities bank staff - £0.3m
- Community Hospitals/localities - £0.4m
- Mental Health shifts particularly linked to enhanced care / observation - £0.5m
- Continued expenditure in Surgery and Clinical Support Services linked to elective activity - £0.6m

- Family & Therapies (Maternity leave cover, Neonatal and Paediatrics) - £0.2m

Agency

Total agency spend in August was £2.8m compared with £2.9m in July.



- In-month spend of £1.2m, a similar level compared with July (2023/24 average monthly spend of c.£1.2m).
 - On-going expenditure in specialist Mental Health, Managed Practices and Community Hospitals - c.£0.4m
 - Continued pressures in Medicine wards and Urgent Care to cover operational pressures - c.£0.5m
 - Trauma & Orthopaedics costs for junior rota (vacancies), ophthalmology vacancy cover and orthogeriatric cover that was implemented post GUH - c.£0.3m
 - On-going Gynaecology agency cover costs - c.£0.1m



- In-month spend of £1.2m, a similar level compared with July. (2023/24 average monthly spend of c.£1.5m).
- Reasons for use of registered nurse agency include:
 - Vacancy cover
 - Additional service demand
 - Enhanced care and increased acuity of patients across all sites, and
 - On-going sickness and international recruitment costs
- On-going costs in GUH Emergency Department and Medicine wards (total c.£0.7m) linked to enhanced care, sickness pressures as well as vacancy cover. Mental Health and Primary Care agency costs of c.£0.3m mainly linked to enhanced care cover.



- In month spend of £0.2m on Estates & Ancillary agency, a similar amount of spend compared with July.
- Reasons for use of agency include:
 - Meeting enhanced cleaning standards,
 - Other additional surge capacity,
 - Sickness,
 - Vacancies
- Estates and Ancillary agency spend averaged £0.65m per month 2023/24.
- Decrease in agency costs linked to substantive appointments for posts linked to enhanced cleaning.



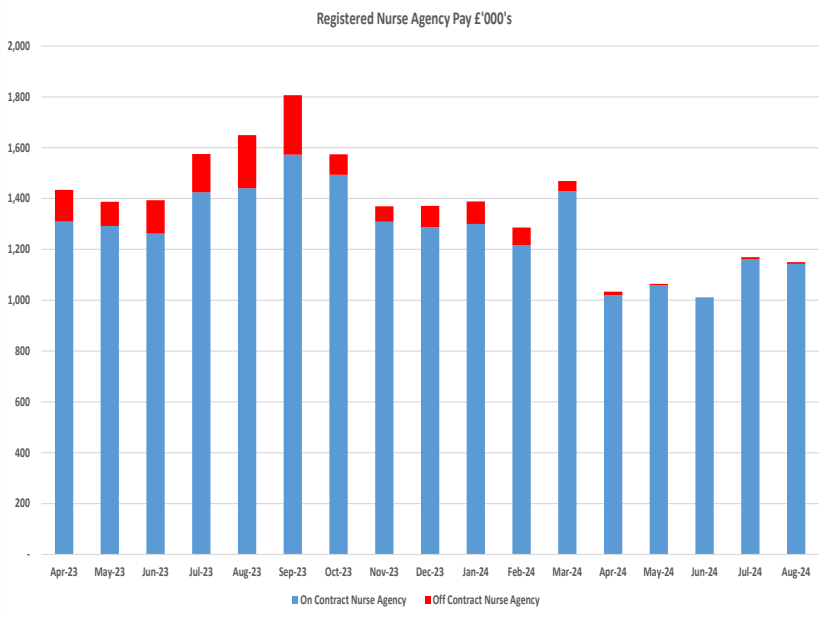
- In month spend of £0.04m on HCSW agency, a similar level to previous months (2023/24 average monthly spend of c.£0.16m).
- Areas where spend remains are:
 - MH&LD £17k,
 - PCCS (Community hospitals) £10k,
 - Family & Therapies (CAMHS) £16k

Registered Nurse Agency

Health Board spend in August 2024 is £1.2m on RN agency compared with £1.2m in July 2024. If spend continues at the average of 2024/25 levels throughout the financial year then spend on RN agency would be c.£13m.

Registered nurse agency spend totalled £17.7m in 2023/24, £22m in 2022/23, £22.8m in 2021/22, £18.1m in 2020/21 and £10.2m in 2019/20.

The use of “off-contract” agency i.e. not via a supplier on an approved procurement framework usually incurs higher rates of pay, is minimal but remains a last resort for the Health Board.



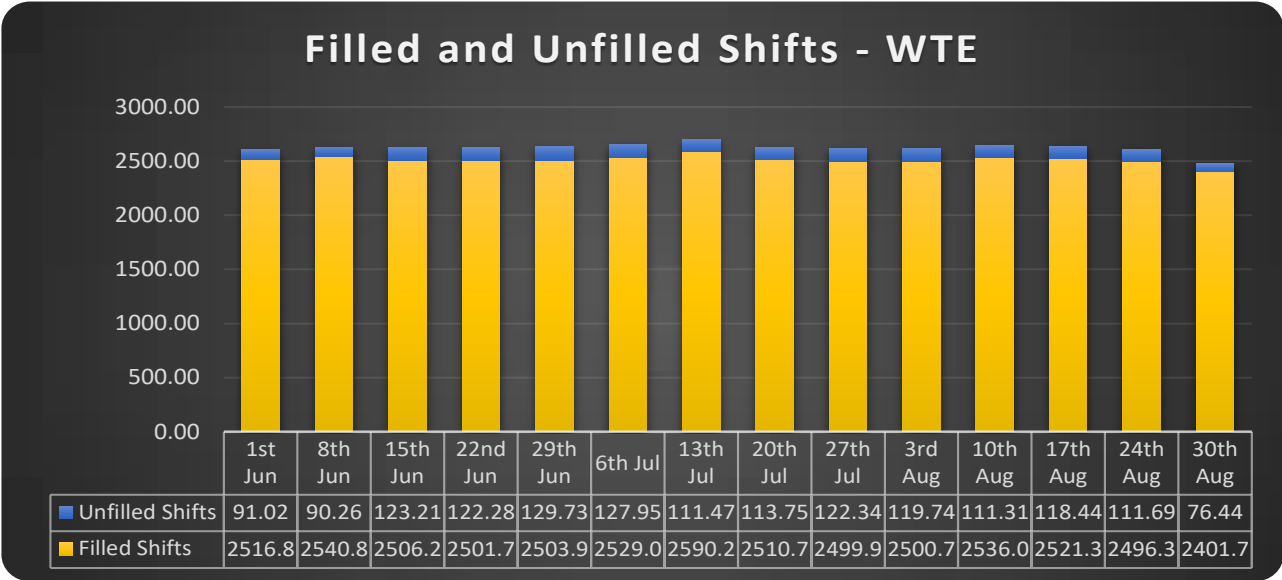
Off-contract Registered Nursing agency costs are now at minimal levels (£7k) which is a significant improvement compared to previous financial years. Agency costs reflect the on-going vacancy cover as well as usage for other operational pressures within Primary Care & Community for:

- Enhanced care, and
- sickness

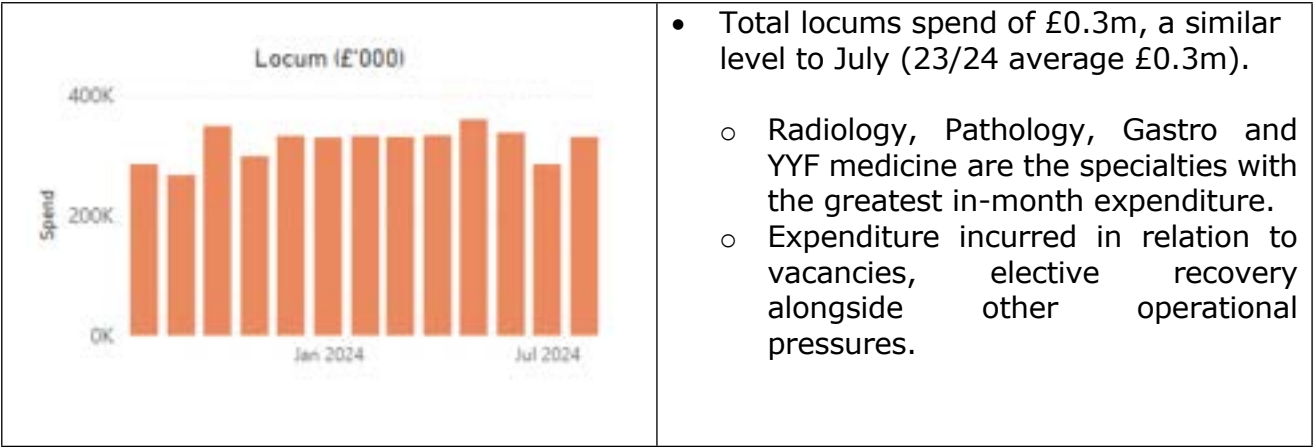
Implications of Nursing Shift 'Fill Rate'

It should be noted that there remain high levels of unfilled shifts. Whilst filling these shifts may improve workforce and service provision, there would be an increased cost. In August there were approximately 100 unfilled registered nursing shifts and 350 unfilled HCSW shifts, which could have increased the spend by a further c.£0.2m if these shifts were filled. The increase in substantive appointments continues to

decrease the level of unfilled shifts which should demonstrate service improvement but presents a financial risk in terms of the variable pay saving opportunity due to possible increased availability to cover more shifts. The graph below shows the overall filled and unfilled shifts over the last 3 months.



Medical locum staff

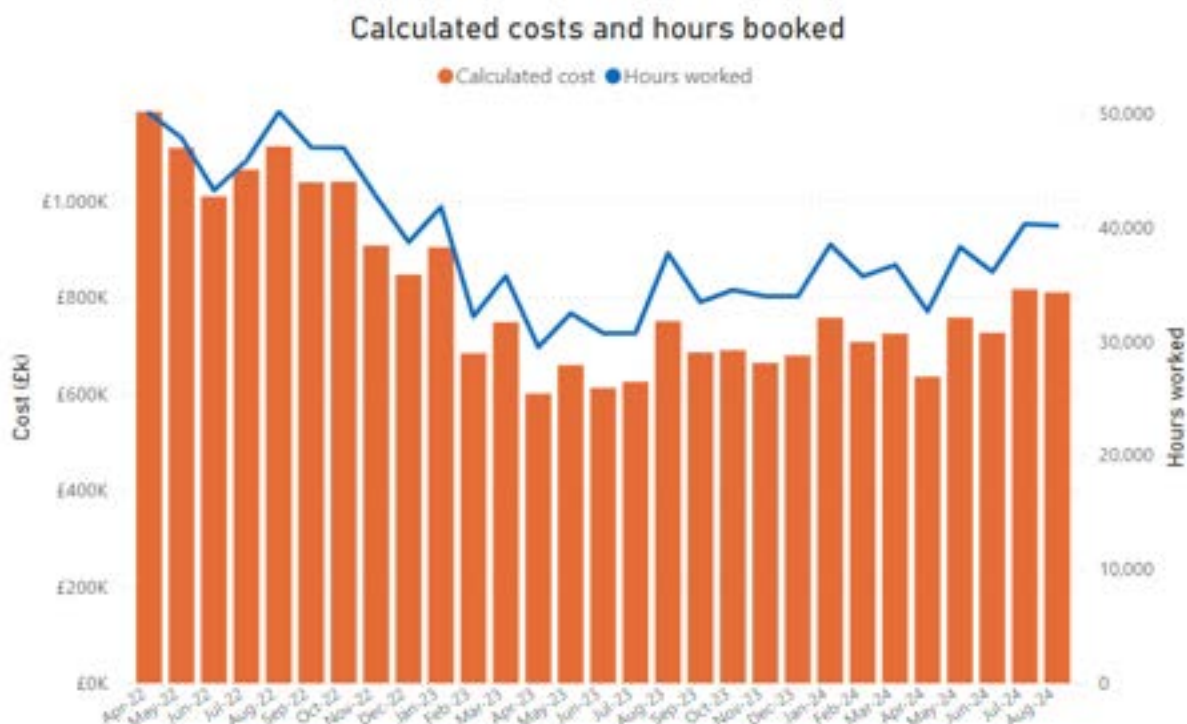


Enhanced Care

Enhanced Care, also known as ‘specialling’, can be provided for a variety of reasons ranging from the provision of assistance to mobilise a patient or avoid falls through one-to-one patient monitoring. Enhanced care is designed to ensure an appropriate level of safety and supervision for patients with additional care needs.

The following graph highlights the hours attributed to enhanced care and Mental Health levels of observation for the period April 2022 to August 2024 (£0.8m ‘notional calculated’ expenditure in August) using bank and agency registered nurses and health care support workers.

Enhanced Care (inc. MH levels of observation) bank and agency calculated costs and hours booked.



The level of the provision of enhanced care for patients within the Medicine Division for 2024/25 is shown below and will be monitored throughout 2024/25.

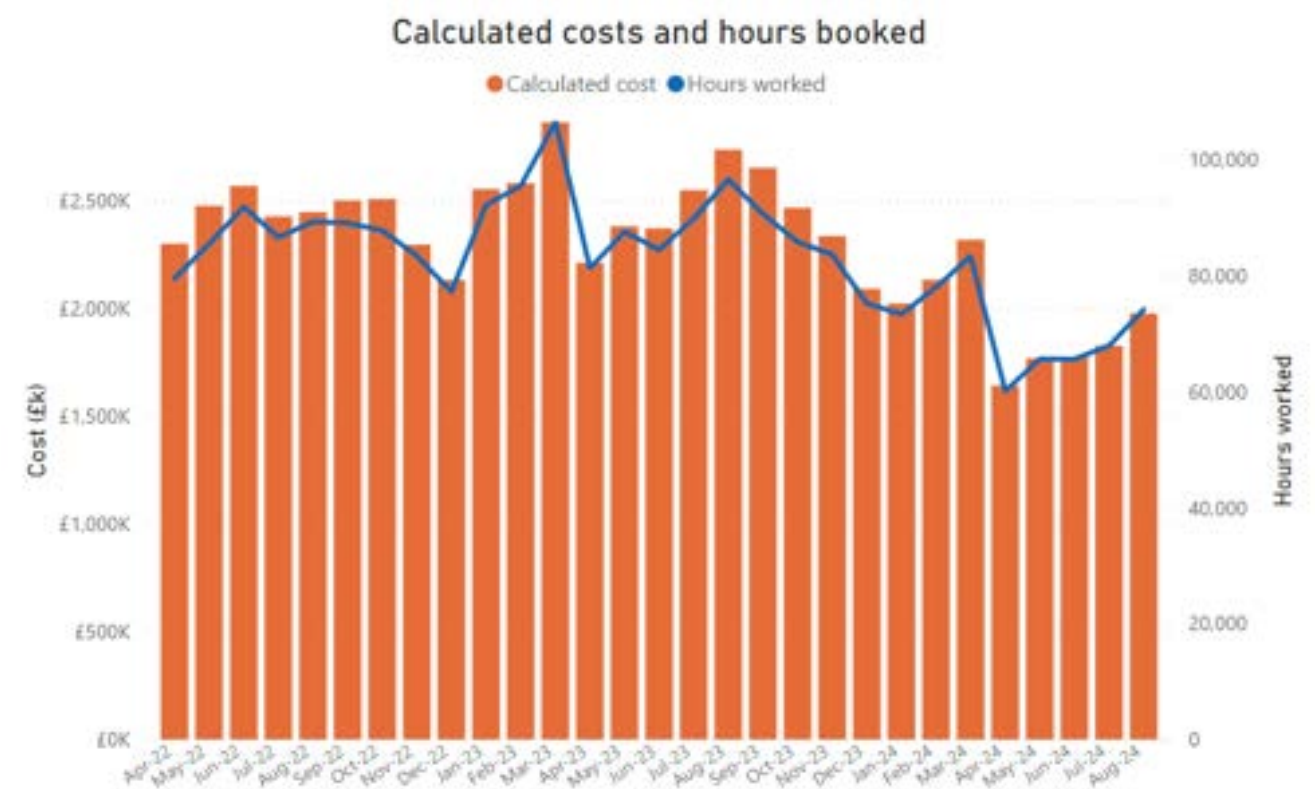
	2023/24 average	Apr-24	May-24	Jun-24	Jul-24	Aug-24
RGH						
Total no of Medicine beds	192	192	192	192	192	192
Monthly average enh care patients	34	28	26	21	21	26
%age of beds in receipt of enh care	18%	15%	14%	11%	11%	14%
NHH						
Total no of Medicine beds	164	164	164	164	164	164
monthly average enh care patients	22	23	16	18	21	26
%age of beds in receipt of enh care	13%	14%	10%	11%	13%	16%
GUH						
Total no of Medicine beds	91	91	91	91	91	91
monthly average enh care patients	12	13	15	12	11	13
%age of beds in receipt of enh care	13%	14%	16%	14%	13%	14%
YYF						
Total no of Medicine beds	148	148	148	148	148	148
monthly average enh care patients	24	27	22	24	26	25
%age of beds in receipt of enh care	16%	18%	15%	16%	18%	17%
Total						
Total no of beds	595	595	595	595	595	595
Total monthly average enh care patients	92	91	79	75	80	90
	15%	15%	13%	13%	13%	15%

A review of enhanced care was presented to the Value & Sustainability Board in July, this presents a valuable opportunity to avoid costs and improve patient experience. This work is being led by the Nurse Director as a quality and savings initiative.

Nursing vacancy cover

The graph below presents the bank and agency hours and costs relating to those shifts where ‘to cover vacancies’ is provided as the reason for use. The graph highlights that in August 2024 variable pay relating to vacancies is c.£2m (‘notional calculated’ expenditure).

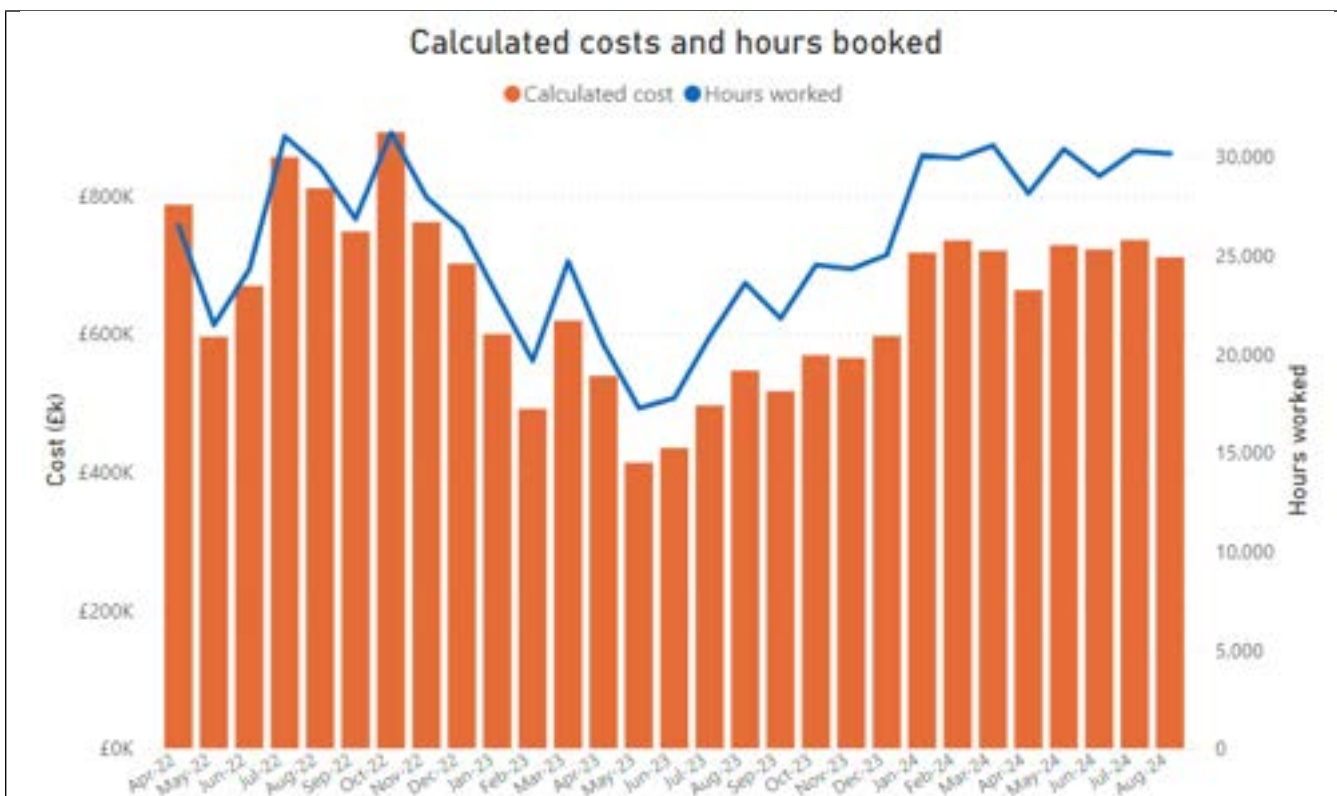
Calculated bank and agency costs / hours booked to cover shifts resulting from vacancies.



Nursing sickness cover

The graph below presents the bank and agency hours and costs relating to those shifts booked to cover sickness as input onto the e-roster system. The graph highlights that in August 2024 variable pay relating to sickness is c.£0.7m (‘notional calculated’ expenditure).

Calculated bank and agency costs / hours booked to cover shifts resulting from sickness.

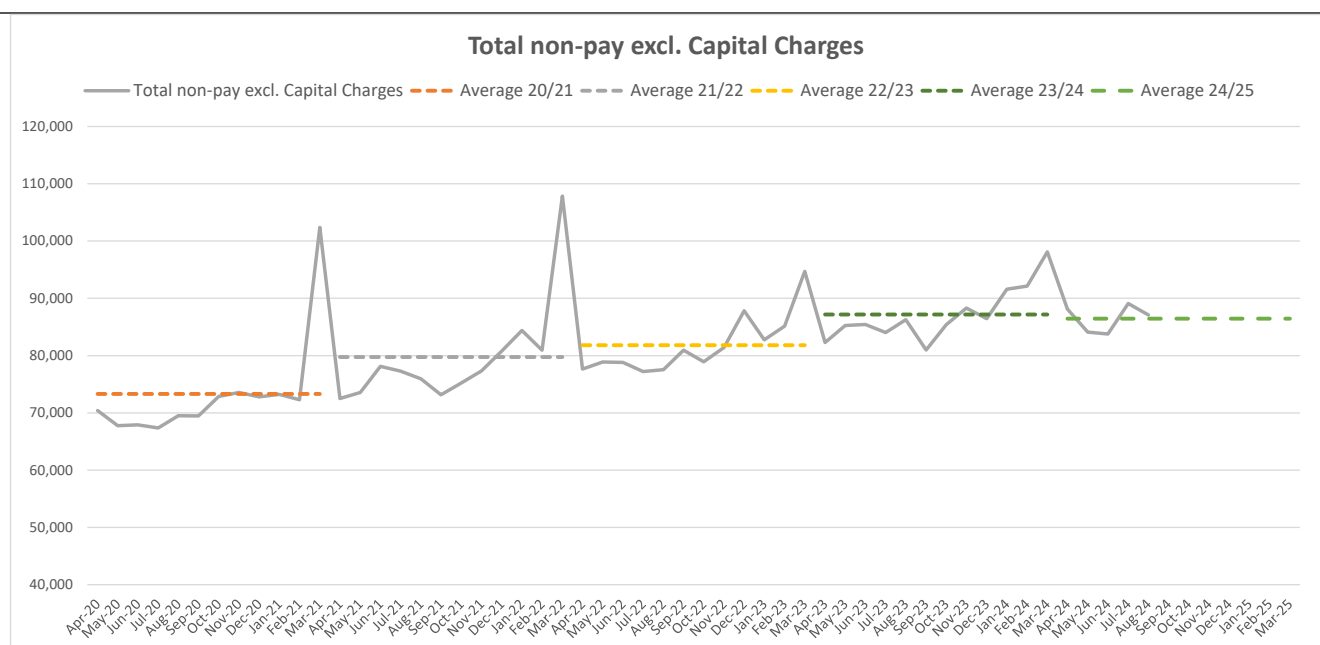


Non-Pay

Spend (excluding capital) was £87.1m in August, which is a £2m decrease when compared with July spend (£89.1m). Key reasons include:-

- WHSSC and External Commissioning service, pass-through wage award ('pay matrix') and performance costs in month 4 - £1.9m decrease
- Drugs in Neurology (expected to increase in September) and M&SE disposable costs - £0.8m decrease
- Funded TEC Cymru and Regional Programme Board expenditure profile adjustments - £0.9m increase

The graph below presents non-pay expenditure since April 2020 (it should be noted that the peaks are year-end adjustments and Month 12 items):-



Energy

Energy costs remain a volatile cost pressure with a forecast annual growth of £0.1m compared with 2023/24 expenditure following the latest energy forecast received in June. The following table reflects the current position for 2024/25:-

Gas & Electricity	2022/23 Actuals £'000	2023/24 Actuals £'000	2024/25 Forecast £'000	2024/25 Plan £'000
Total Shared Service Contract Energy Cost	21,612	16,834	17,305	18,961
Total Other Energy costs	571	777	396	447
Total	22,183	17,611	17,700	19,408

Other energy costs outside of the shared service contract are under review. Given the volatility of non-commodity energy prices these may have further updates later in the year.

To note the budget relating to the reduced energy forecast (£1.66m) has been taken from Estates & Facilities Division back to reserves to underpin the bottom line.

Note 2022/23 experienced a significant energy cost increase over 21/22 of £13.7m, the increase has been partly funded by WG.

CHC

- CHC Mental Health – the patient numbers at the end of August were 431 at a cost of £4.7m (429 patients at a cost of £4.5m in July).
- CHC Adult / Complex Care - 543 total active placements on 31st of August at a cost of £5.1m in-month (528 placements at a cost of £5.1m in July). There was a decrease in the number of D2A patients of 5 and an increase of 5 to the number of 'Step Closer to Home' (SCTH) patients in July.

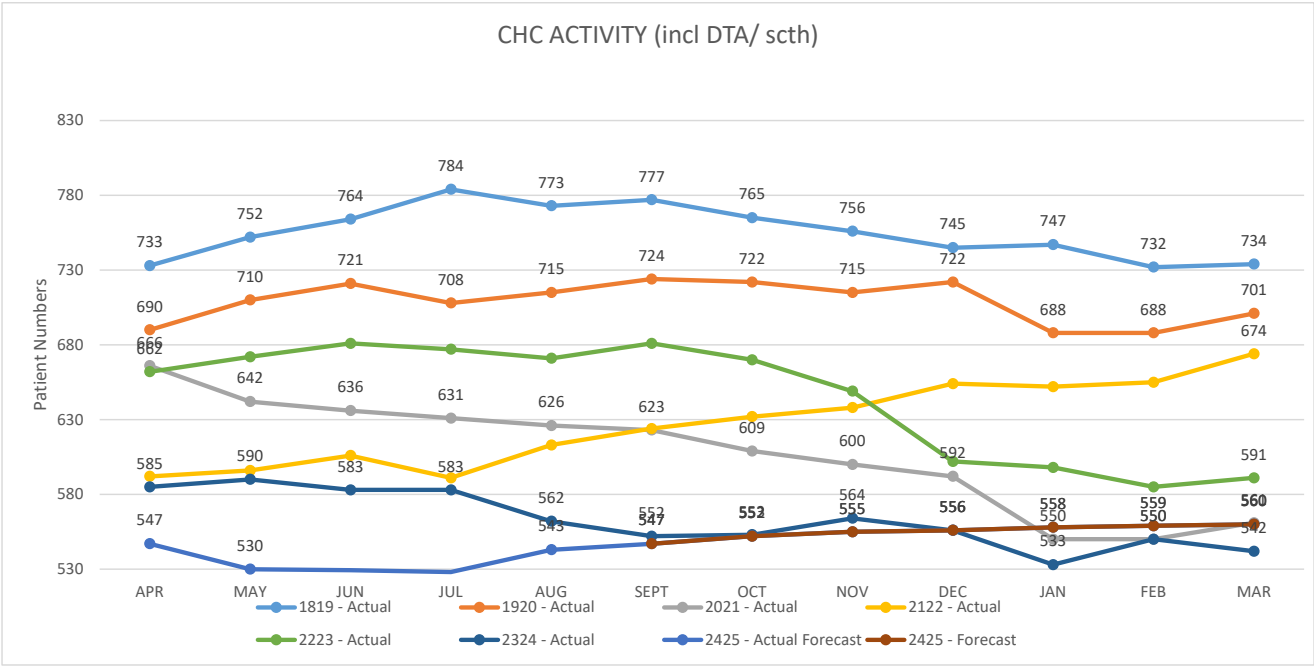
- A reduced number of patients on the step closer to home pathway is impacting the number of patients being discharged. This pathway is funded by the RPB and has previously had c.49 patients on the pathway but this has reduced to 6 in August. Utilisation is being reviewed.
- It should be noted that Newport Local Authority have negotiated and agreed further uplifts to their nursing rates for 2024/25 (8.5% as opposed to the annual plan assumption uplift of 7.7%) which will impact the rate the Health Board pays. Care at Home staffing forecasts have decreased but continue to present a forecast financial pressure of c.£0.5m.
- The table below summarises the current position (patient numbers and costs):

Activity	August 2024	July 2024	Movement
D2A	11	16	-5
Step Closer to Home	6	1	+5
All Other CHC	526	511	+15
Total	543	528	+15

£'000	2024/25 forecast as at M5	2024/25 forecast as at M4	2023/24 out- turn position
D2A	1,321	1,920	2,093
Step closer to home	207	207	407
All other CHC	41,727	41,218	41,053
Total	43,255	43,344	43,553

- FNC - currently 1,063 active placements, which is an increase of 14 compared with July (expenditure of £1m in August compared with £1m in July).

Adult Complex Care CHC activity over the last seven financial years is summarised in the chart below: -



- CHC Paediatric – currently 25 Out of County patients, cost for August of c.£0.1m, a similar level compared with July. Forecast 24/25 spend is £2.15m, (2023/24 total cost of £4.1m). In addition there are 13 internal packages (12 patients) provided during August compared with 14 packages (12 patients) for July.

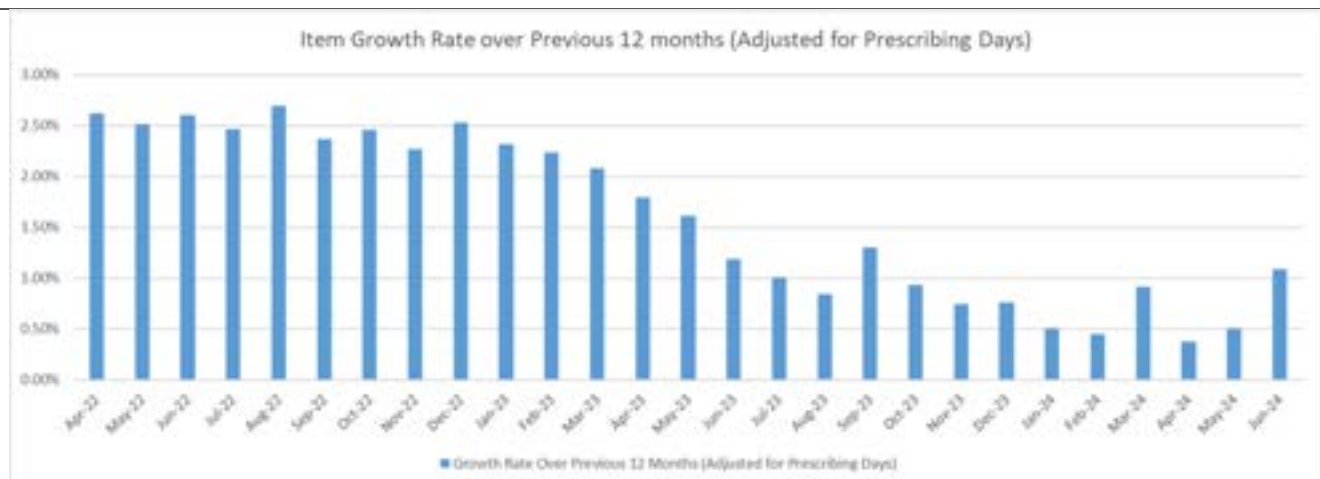
There are 9 external and 6 internal high cost packages which continue to be a cost pressure (>£100k per annum expenditure each). There is also a very high cost case awaiting a dispute panel discussion.

Prescribing

- Primary Care prescribing – August 2024 expenditure is £9.7m, with a forecast cost of £119m, the annual plan forecast was £116.9m spend, (2023/24 cost was £121.9m). The August 2024 costs are based on June PAR data:
 - Annual Plan item growth rate for 2024/25 of 0.8%, (forecast volume of items based on the number of prescriptions for 24/25 is c.16.9m)
 - The growth rate for the 12 months to June 2024 is 1.09%, adjusted for the number of prescribing days.
 - Forecast average cost per item for 2024/25 is £7.52 and is reflected in the increased forecast. The annual plan estimated £7.29 cost per item.
 - Average actual cost per item for 2022/23 was £7.21.
 - Average cost per item price for 2023/24 is £7.57.

The graphs below show the monthly average price per item and item growth: -





Scheduled Care treatments and outpatients

Elective Treatments for August '24 is 1,960 (July '24 was 2,230).

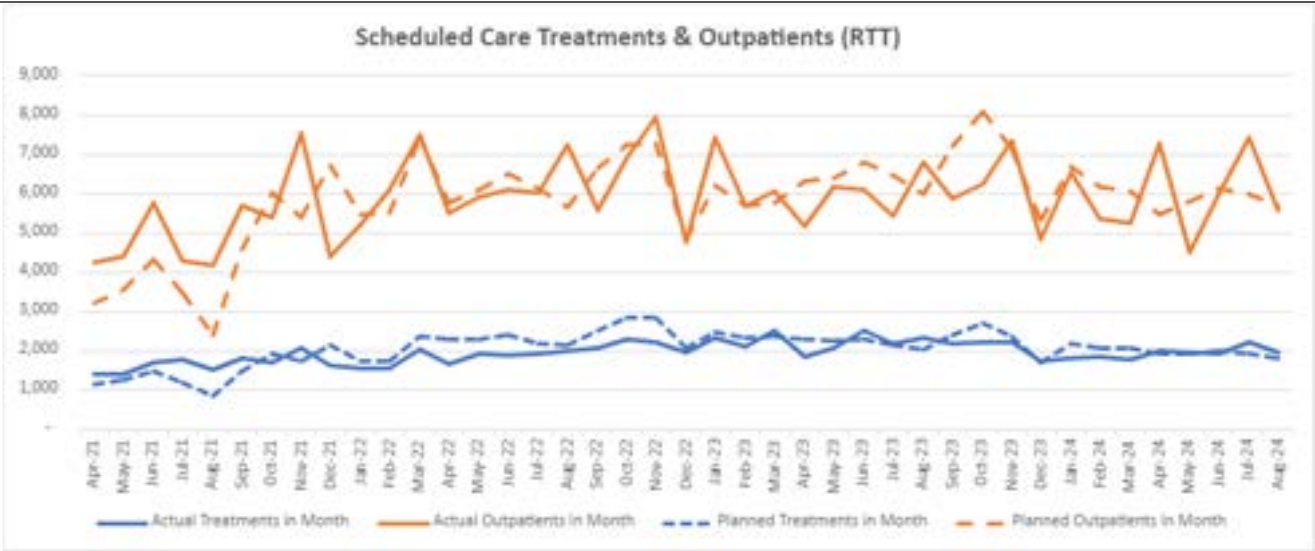
Elective Activity in August has decreased by 270 treatments compared with July (12.1% decrease). The number of in month treatments are 147 above plan for August including 115 'backfill' and 16 WLI treatments. Increased activity to reduce Tier 1 waiting list targets remains a priority.

Outpatient activity for August '24 is 5,577 (July '24 was 7,427).

Outpatient activity has decreased as expected given annual leave resulting in reduced capacity in August. Activity remains greater than previous years and includes backfill, WLI and other activity outside of core in order to reduce waiting list pressures for 104 and 156 week waits.

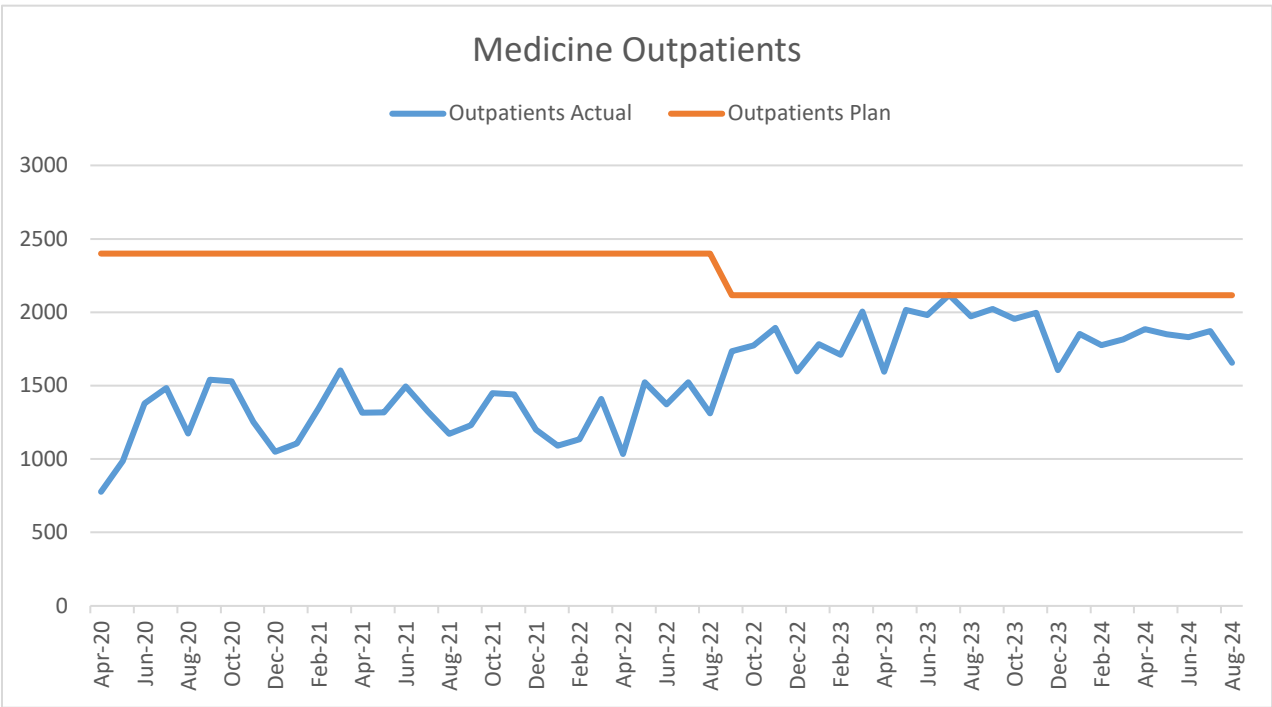
There were WLIs in-month for cancer treatments and elective work to improve the 156 week position for ENT (157 outpatients) and Max Fax (57 outpatients).

There remain significant efficiency opportunities in the delivery of elective care which need to be progressed as part of the Planned Care programme. The graph below presents performance compared to the current plan.



Medicine Outpatient Activity

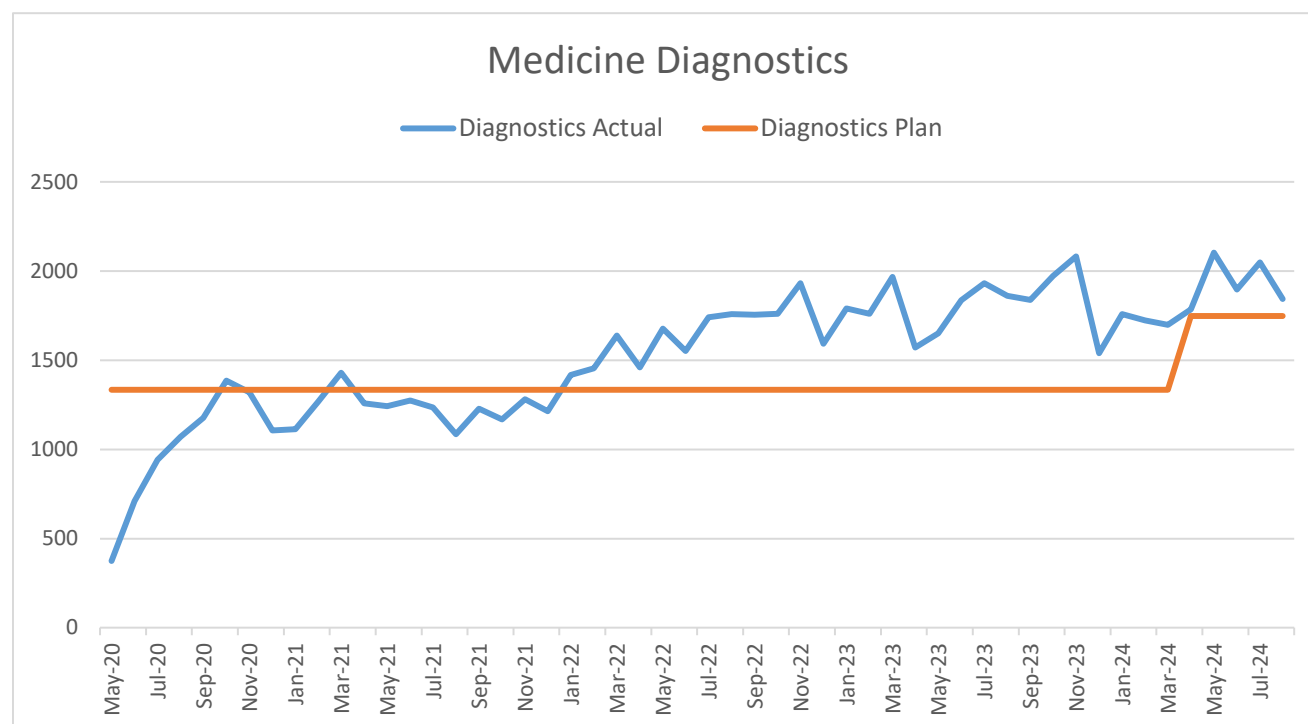
Medicine Outpatient activity for August '24 was 1,655 attendances, which was 461 below plan (July '24 was 1,871 attendances), the activity is presented below:



Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for August '24 was 1,843 procedures which is 94 cases more than the updated 2024/25 plan (July '24 activity was 2,049).

The activity undertaken since May '20 is shown below.



Divisional analysis

Summaries of the Divisional financial positions are included in the appendices. These include expenditure and budget profiles along with a list of savings schemes and their current progress.

The table below identifies operational divisional forecasts, all budget holders are required to achieve a break-even position however a number of forecasts highlight key operational pressures alongside non-delivery of savings and COO budgetary targets.

Summary Reported position - August 2024 (M05)	Annual Year Budget £000s	Full-year forecast at M5 £000s	Full-year forecast at M4 £000s	Movement £000s
Operational Divisions:-				
Primary Care and Community	292,500	1,628	1,460	168
Prescribing	116,133	2,843	773	2,070
Community CHC & FNC	69,209	233	379	(146)
Mental Health	141,678	1,830	2,202	(372)
Surgery	139,593	3,287	3,003	284
Clinical Support Services	125,980	803	945	(142)
Medicine	161,059	1,274	1,214	60
Urgent Care	39,276	252	389	(137)
Family & Therapies	133,550	3,184	2,907	277
Estates and Facilities	93,806	190	304	(114)

Key forecast movement issues include:-

- Prescribing – significant increase due to impact of quarter 1 2024/25 PAR average price per item increases and the increased cost related to the NCSO Apixaban price concession.
- CHC – FNC continued reduction in patient numbers compared to forecast plan.
- Mental Health & LD – CHC activity growth significantly below forecast.
- Surgery – Impact of Haematology NICE guidance and activity growth in Ophthalmology and Dermatology. Additional costs for treating 156 week waiting lists within overall Divisional forecast.
- Clinical Support services – theatres / anaesthetics consumable costs reductions and additional pathology income. On-going additional pressures in critical care (staffing and variable pay) and radiology.
- Family & Therapies – increase in forecast due to maternity leave cover (maternity) and gynaecology medical operational pressures
- Estates and Facilities – facilities staffing benefits and additional rates rebates above planned values.

The expectation and requirement is for Divisional forecasts to be break-even, but some of the current Divisional forecast positions present a risk to achieving the planned forecast deficit of £47.9m.

To note the forecast is underpinned by the following:

- COO £2.1m budget surplus
- Budget reserves and additional anticipated income

Covid-19 – 2024/25 Revenue Financial Assessment

Total Covid-19 costs are shown as £12.4m for which funding has been received as part of the Health Board's allocation letter and is broken down as follows:-

- Health Protection and Immunisation (Mass Vaccination) - £10.080m
- PPE - £1.120m
- Adferiad (Long Covid) - £1.216m

The expenditure reported is reflective of the funding.

The Health Board continues to have surge capacity open which is a legacy of Covid-19 responses. The Health Board also continues to incur legacy costs which form part of the underlying deficit linked to estates & facilities costs. The list below is not exhaustive but includes: -

- Enhanced Cleaning
- Additional security and rental of portacabins

Revenue Reserves

Health Board reserves are held by the Board, until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer. Agreed funding delegations approved by Board in March 2024 as part of budget setting have been actioned. Those adjustments which are part of the stage 2 budget delegation process were approved on the 22nd May and have also been delegated. Some allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific commitment.

An amount of c.£1.8m is being held in the reserve 'innovation and development fund' for approval by the CEO and Board as required for in year priorities.

A summary of all Health Board reserves on 31st of August, along with details of amounts approved for delegation by the CEO in Month 5 can be found in the appendices.

Long Term Agreements (LTA's)

LTAs have been agreed with all provider and commissioners with the exception of Velindre NHS Trust and CTMUHB.

Financial agreements have been reached with Velindre, however, there are some on-going discussions regarding activity delivery assumptions. This is being discussed and taken forward with the Velindre Director of Finance.

ABUHB sent a signed LTA document reflecting the Welsh Government arbitration outcome to CTMUHB on 31st July and we are awaiting the return of the document signed by the CTMUHB Chief Executive.

The month 5 forecast CTM position reflects an element (£1.4m) of in year underperformance against the contracted activity.

ABUHB has recognised the JCC current end of year forecast deficit risk share of £0.72m, however there are risks reported, on an overall basis, above this that have not yet been recognised. Including:

- Savings achievement – overall plans to be found for £3m
- NHS England wage award – assumed funding from WG
- The transfer of Velindre non -specialist and drugs pass through, where funding will be transferred on a 23/24 basis – no variances against this are currently shown as it was not clarified in the JCC IMTP but could be c£1.2m pressure for ABUHB
- WAST - £3.2m risk for Technician re-bandings. Currently assumed WG funding available.
- Any over-performance as a result of meeting the Ministers KPI's – ie Plastic surgery.

The JCC team have a work plan, where they will provide a full update on the forecast to the JCC and potential options required to break even overall, this may then result in a revised forecast for ABUHB.

ABUHB are currently reviewing in detail all the activity data and JCC assumptions underpinning these forecasts.

Underlying Financial Position (ULP)

The Underlying (U/L) forecast position is a brought forward opening deficit of £81.4m. The closing underlying position assumes recurrent savings planned are fully delivered and is reported in line with the 2024/25 forecast of a £55m deficit.

The analysis of the c/f underlying deficit is as follows:-

- Forecast 2024/25 deficit - £48.9m
- Non-recurrent savings – £6.1m (this has been reduced by £1m relating to the CTM benefits now included in the savings plan)
- Total £55m

Financial sustainability is an on-going priority and focus for the Health Board and a 3 year recovery plan is being developed following the agreed route map to sustainability.

The initial assessment indicated the cost drivers included in the table below as underpinning the c/f underlying position;

Underlying deficit 2024/25	2024/25 Deficit / (surplus) (£'m)
WG 2023/24 non-recurrent funding utilised to support workforce cost growth including variable pay	14
Medical staffing cost increases due to operational acuity including ED safer staffing and demand	13
Nursing pressures - due to nurse staffing act, additional capacity resulting from DTOCs, Acuity and urgent care	12
CHC	10
Medicines management (prescribing and acute drug costs)	19
Covid legacy (estates & facilities)	7
WHSSC / EASC (service growth in excess of funded levels)	6
Total underlying deficit b/f into 2024/25	81

After budget-setting Divisions were expected to break-even whilst the annual plan deficit of £48.9m is shown as a pressure within reserves.

Following further analysis as part of the quarter 1 review, the current breakdown of the c/f underlying deficit of £55m is now shown below using the underpinning cost drivers above, noting cost uplifts and non-recurrent savings within the plan. The increase in c/f underlying deficit compared with month 2 (£51.6m) relates to those pressures which have impacted the forecast outside of the annual plan with a recurrent effect. These pressures include additional cancer / urgent WLIs and diagnostic costs, increased prescribing / vaccine price costs, and workforce pressures within the Family & Therapies Division. In month 4 this was reduced primarily due to the CTM arbitration case.

The pressures listed are assumed to be recurrent however will be reviewed as part of on-going underlying deficit assessments to assess whether these can be mitigated

and/or whether some of the issues can be made non-recurrent thus reducing the underlying deficit.

Underlying deficit c/f 2024/25	Primary Care & Community £m	Complex Care £m	MH&LD £m	Surgery / CSS £m	Medicine £m	Urgent Care £m	F&T £m	E&F £m	External commissioning £m	Total £m
WG 2023/24 non-recurrent funding utilised to support workforce cost growth	0		3	3	5.5	1	1.5			14
Medical staffing cost increases due to operational acuity including ED safer staffing				1	1.5	3	1			7
Nursing pressures - due to nurse staffing act, additional capacity resulting from DTOCs, Acuity and Urgent Care	0		2.5		2.5	1	1			7
CHC		1.5	3.5				1			6
Medicines management (prescribing and acute drug costs)	7			2	2					11
Covid legacy (estates & facilities)								3		3
WHSSC / EASC (service growth in excess of funded levels)									5	5
Cancer additional activity delivery through WLI and additional diagnostics				2.5						3
Total	7	1.5	9	8.5	11.5	5	4.5	3	5	55.0

It should be noted that although the 2023/24 £64.5m mid-year support allocation is recurrent in the Health Board's 2024/25 allocation letter, it is **conditional** on making progress towards achievement of the WG target control total currently a £13m deficit for ABUHB. If this, or any other funding is clawed back by WG it will directly impact the forecast deficit.

Savings delivery

As part of the annual plan submitted by the Board to Welsh Government, the financial plan for 2024/25 identified an ambitious savings target of £40.5m. This was made up of £29.1m of savings plans plus a further £11.4m of pipeline opportunities.

The revised annual plan submitted by the Board on the 31st of May continued to identify a savings target of £40.5m. This target was made up of £34.8m of savings plans with the remaining £5.7m made up of pipeline opportunities, cost avoidance and other mitigating savings actions.

As at month 5, forecast savings are £43.5m this supports achievement of the £47.9m forecast deficit at present. Mitigating actions would be required for additional operational pressures, for non-delivery of forecast savings or to improve the position and deliver further underlying improvement.

The month 5 savings forecast includes several Divisional schemes which are assumed not to deliver against their initial plan, these are included in the Appendix but include the following:-

- Administrative & Clerical savings – several divisions
- CHC contract price reductions – little further opportunity likely.
- CHC hospital admissions / Premium contract cost reduction – start date moved following consultation period.

- Specific CHC related schemes – awaiting correspondence and dispute meetings
- Intersite transport (COO) – contract value likely to be higher than forecast due to additional vehicle usage.
- Bed reconfiguration and efficiency schemes – Medicine (15 bed reduction undertaken against a plan of 30).

In addition there are savings plans which have a high level of risk given the requirement for further detailed plans and potential delays in implementation, these schemes include:-

- Bed reconfiguration – Primary Care
- Bed day and Theatre efficiencies (Surgery / Clinical Support Services)
- Other schemes including bed contract and CHC savings

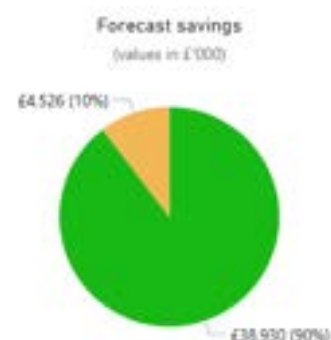
Other areas are currently being examined which may develop into further savings plans to mitigate the risks described above these include:-

- CHC package reviews
- Non-pay and litigation cost reductions
- Income / funding opportunities
- Variable pay mitigation through review of pay rates and substantive appointments, including enhanced care
- Further medicines management schemes
- Service redesign and theatre efficiency
- Prescribing cost avoidance, off-patent and related reviews
- National V&SB opportunities

Actual savings delivered to date for 2024/25 are £13.3m.

The table below presents the updated savings plan at a Budget holder level:

Division	% of total Plan	Annual Plan	YTD Plan	YTD Achieved	YTD Variance	Forecast	Forecast variance to Plan	% Achieved
Clinical Support Services	2.1%	£846	£204	£465	£261	£1,123	£277	132.8%
Complex Care	9.0%	£3,633	£514	£350	-£164	£3,061	-£572	84.3%
Contracting and Commissioning	1.7%	£706	£215	£840	£625	£2,206	£1,500	312.5%
Corporate	17.7%	£7,164	£2,084	£2,515	£431	£6,271	-£893	87.5%
Estates and Facilities	6.5%	£2,640	£745	£1,373	£628	£4,347	£1,707	164.7%
Families and Therapies	2.1%	£857	£250	£235	-£15	£900	£43	105.0%
Medicine	6.9%	£2,801	£726	£971	£246	£3,195	£394	114.1%
Mental Health and Learning Disabilities	14.6%	£5,906	£1,329	£929	-£400	£4,837	-£1,069	81.9%
Primary Care and Community	28.1%	£11,385	£3,568	£3,905	£338	£13,271	£1,886	116.6%
Surgery	4.6%	£1,855	£387	£564	£177	£1,520	-£335	81.9%
Urgent Care	0.2%	£81	£29	£42	£13	£91	£9	111.3%
WHSSC	6.5%	£2,633	£993	£1,097	£104	£2,633	-£0	100.0%
Total	100.0%	£40,508	£11,043	£13,288	£2,245	£43,456	£2,948	107.3%



Savings summary (£'000)

Value & Sustainability category	Number of schemes	YTD Annual Plan	YTD savings achieved	YTD variance to Plan	Full-year Annual Plan	Full-year Forecast savings	Full-year Variance to plan
CHC	14	£1,467	£973	-£494	£8,443	£6,871	-£1,572
Medicines Management	15	£1,011	£1,161	£150	£3,518	£5,185	£1,667
Procurement & Non-pay	98	£4,809	£6,866	£2,057	£15,115	£18,428	£3,313
Service Redesign	8	£392	£367	-£24	£3,624	£2,547	-£1,077
Workforce	59	£3,364	£3,920	£556	£9,808	£10,425	£617
Total	194	£11,043	£13,288	£2,245	£40,508	£43,456	£2,948

The Health Board will continue to pursue further opportunities to mitigate / offset the risk to the planned savings and increases in new operational pressures.

The Health Board continue to operate a Bi-weekly Value & Sustainability Board to identify and monitor savings delivery & new opportunities.

There are significant challenges and some opportunities to achieving the financial forecast for 2024/25, which include:-

Risks

- Continuing Healthcare fee uplifts - £1m
- Prescribing average price per item (and number of items) growth above quarter 1 PAR data and associated forecast - £2m

- Additional operational and service pressures outside of the annual plan. This includes costs for Health & Safety issues, Diabetes, CAMHS, Winter and the infected blood inquiry. This has increased this month given the continued pressures relating to Acute NICE drugs - £3.4m
- Delivery of savings plans including mitigating actions against operational pressures – c.£0.8m
- Delivery of 6 goals target with resultant income clawback risk - £1.4m
- Risks of non receipt (full receipt) of all assumed income in particular include funding for PADM's / Dispensing Drs, Optometry and overseas nurse recruitment - £2.9m
- CTM LTA not signed by CTM and under performance not recovered £1.4m

In addition, there are a number of further significant challenges to the financial forecast for 2024/25, which are currently assumed to be mitigated by the Health Board or require further information to enable an accurate financial value to be assigned. These include:

- Ensuring full delivery of savings plans identified in the annual plan including the pipeline opportunity values,
- Receipt of all anticipated allocations including performance requirements in order to secure full retention,
- Workforce absence / vacancies, availability of staff for safe service delivery,
- Delayed transfers of care due to LA service challenges,
- Funding for any wage award or change in terms and conditions,
- Impact on service delivery and performance on waiting times because of savings required,
- Establishment increases relating to patient safety issues,
- Inflationary impacts including provisions and supplies,
- Additional revenue costs due to IFRS 16,
- Specific economic factors such as supply chain issues and non-pay inflation including travel expense costs, and
- Health & Safety fines.

Opportunities

Opportunities for the Health Board include: The following items are listed as opportunities pending further analysis and delivery via the Value & Sustainability Board and relevant Divisions / Departments:-

- Variable pay reduction linked to Administration & Clerical and Enhanced Care service reviews
- Service re-design – bed reductions
- Commissioning – LTAs and EASC
- VAT rebate opportunities,
- Other income / funding opportunities,
- Energy forecast changes,
- Work to identify new pipeline opportunities, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.

Capital

The approved Capital Resource Limit (CRL) as at Month 5 totalled £64.187m. Forecast overspends totalling £2.007m against various All-Wales Capital Programme (AWCP) schemes (detailed further below) are being offset by a corresponding under spend against the Discretionary Capital Programme (DCP). The forecast outturn at Month 5 is breakeven.

The VAT reclaim for the Grange University Hospital scheme submitted in September 2023 continues to be progressed with HMRC. The forecast assumes that the claim will be finalised during 2024/25, however, this assumption will need to be reviewed prior to fixing the CRL allocations in October if the claim has still not been approved.

Phase 2 of Bevan Health and Well-being Centre (demolition of the existing Health Centre and car-parking) is anticipated to complete in November 24. The scheme is forecasting an overspend of £1.731m in 2024/25 which includes the settlement agreement reached with the contractor in respect of two disputed compensation events (£1.115m). The overspend is being offset by the DCP, with the settlement agreement being offset by the release of the provision set up within the DCP in 2023/24. The overspend figure has increased in month by £0.064m due to the inclusion of new compensation events in relation to asbestos found and an extension of time in relation to grouting. An additional funding bid to WG is planned to be made in 2024/25 for unfunded costs in relation to inflation allowances on works and fees, EV charging, disputed compensation events and other required changes. These currently unfunded costs total £2.2m plus VAT.

Works at NHH Satellite Radiotherapy Centre continue with completion forecast to be February 2025. The overall scheme is forecast to be £0.541m under budget largely because of VAT recovery savings. The 2024/25 resource limit was reduced during June by £0.500m to reflect the expected under spend in the current financial year. There is potential for further slippage if the contingency budget is not required in full in 2024/25, however, the project team are currently working through risks related to potential asbestos delays, PSBA installation delays and temperature control in relation to the linear accelerator installation.

Construction of 19 Hills Health and Well-being Centre (Newport East) is progressing well. Phase 1 handover is forecast to be 6th December 2024. The overall project budget remains under pressure due to additional asbestos and utility costs with a forecast overspend of £0.172m which is currently being funded by DCP. A further funding bid is intended to be submitted via the Integration and Rebalancing Capital Fund (IRCF) route to mitigate the position.

A forecast overspend of £0.110m is being reported against the RGH Blocks 1 & 2 Demolitions and Car Park scheme because of additional asbestos and delays due to nesting birds. This overspend is being funded via the DCP.

The CAMHS Sanctuary Hub scheme has been delayed further with expected completion now anticipated for October 2024. The scheme is currently anticipated to be within budget.

A revised programme of works has been received for the Grange Emergency Department Extension scheme. The anticipated completion of Phase 1 is now April 2025 with Phase 2 estimated to be July 2025, however, the project team are looking at potential options to accelerate the programme. The scheme is currently anticipated to be within budget.

Additional funding of £0.322m has been received during August in relation to new and amended capital leases.

The Health Board Discretionary Capital Programme (DCP) funding available for 2024/25 is £8.773m made up of:

- 2024/25 DCP Funding - £10.814m
- Less 30% EFAB contribution - (£0.725m)
- Less 2023/24 AWCP scheme brokerage - (£1.669m)
- Plus 2023/24 DCP scheme brokerage - £0.350m
- Plus Disposal Proceeds - £0.003m

The current forecast spend for approved DCP schemes is £6.766m. This equates to an under spend of £2.007m which is required to offset the reported overspends on AWCP schemes and includes the release of the provision set up within the DCP in 2023/24 in relation to Bevan Health and Well-being Centre totalling £1.115m.

During August urgent schemes totalling £0.309m have been approved including the creation of the bus lane at GUH (£0.064m), changes to the HSDU steam system at GUH (£0.074m), a kitchen refurbishment at Twyn Glas (£0.041m) and other urgent works and replacement equipment. The contingency budget remaining at Month 5 is £0.714m.

Cash

The cash balance on the 31st of August is £5.242m, which is within the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in August (97.7%) and for the year to date. ABUHB is continuing to work with those departments where invoices are being processed outside of the 30-day payment terms and where the NHS payment rate is below target.

The Health Board performance for the number of NHS creditors within 30 days of delivery of goods in August is 87.6%, which is a deterioration compared with July

and remains significantly below target. NHS Invoices in breach of the 30-day payment terms continue to be followed up accordingly with Divisional Managers as necessary. Further correspondence will be sent to other Health Board's to reiterate the need for purchase orders to be provided in advance and not retrospectively.

Category	Invoices	In Mth %	YTD %
NHS	Value Number	97.4 87.6	96.5 90.8
Non NHS	Value Number	94.1 97.7	96.0 97.4

Argymhelliad / Recommendation

The Board is asked to note for assurance:

- The financial performance at the end of August 2024 and forecast position against the statutory revenue and capital resource limits,
- The savings position for 2024/25,
- The revenue reserve position on the 31st of August 2024,
- The Health Board's underlying financial position,
- The cash position,
- Public sector payment policy performance, and
- The capital position.

Note: the appendices attached providing further detailed information.

The month 5 monitoring returns are included for information

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:
Datix Risk Register Reference and Score:

Safon(au) Gofal ac Iechyd:
Health and Care Standard(s):

7. Staff and Resources
Governance, Leadership & Accountability
All Health & Care Standards Apply
Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	ABUHB efficiency compendium
Rhestr Termau: Glossary of Terms:	A&C – Administration & Clerical A&E – Accident & Emergency A4C - Agenda for Change AME – (WG) Annually Managed Expenditure AQF – Annual Quality Framework AWCP – All Wales Capital Programme AP – Accounts Payable AOF – Annual Operating Framework ATMP – Advanced Therapeutic Medicinal Products B/F – Brought Forward BH – Bank Holiday C&V – Cardiff and Vale CAMHS – Child & Adolescent Mental Health Services C/F – Carried Forward CHC – Continuing Health Care Commissioned Services – Services purchased external to ABUHB both within and outside Wales COTE – Care of the Elderly CRL – Capital Resource Limit Category M – category of drugs CEO – Chief Executive Officer CEAU – Children’s Emergency Assessment Unit CTM – Cwm Taf Morgannwg D&C – Demand & Capacity

DCP – Discretionary Capital Programme
 DHR – Digital Health Record
 DNA – Did Not Attend
 DOSA – Day of Surgery Admission
 D2A – Discharge to Assess
 DoLS - Deprivation of Liberty Safeguards
 DoF – Director(s) of Finance
 DTOC – Delayed Transfer of Care
 EASC – Emergency Ambulance Services Committee
 ED – Emergency Department
 EDCIMS – Emergency Department Clinical Information Management System
 eLGH – Enhanced Local general Hospital
 EFAB – Estates Funding Advisory Board
 ENT – Ear, Nose and Throat specialty
 EoY – End of Year
 ETTF – Enabling Through Technology Fund
 F&T – Family & Therapies (Division)
 FBC – Full Business Case
 FNC – Funded Nursing Care
 GDS – General Dental Services
 GMS – General Medical Services
 GP – General Practitioner
 GWICES – Gwent Wide Integrated Community Equipment Service
 GUH – Grange University Hospital
 GIRFT – Getting it Right First Time
 HCHS – Health Care & Hospital Services
 HCSW – Health Care Support Worker
 HIV – Human Immunodeficiency Virus
 HSDU – Hospital Sterilisation and Disinfection Unit
 H&WBC – Health and Well-Being Centre
 IMTP – Integrated Medium Term Plan
 INNU – Interventions not normally undertaken
 IPTR – Individual Patient Treatment Referral
 I&E – Income & Expenditure
 ICF – Integrated Care Fund
 LoS – Length of Stay
 LTA – Long Term Agreement
 LD – Learning Disabilities
 MH – Mental Health
 MSK - Musculoskeletal
 Med – Medicine (Division)
 MCA – Mental Capacity Act
 MDT – Multi-disciplinary Team
 MMR – Welsh Government Monthly Monitoring Return

NCA – Non-contractual agreements
 NCN – Neighbourhood Care Network
 NCSO – No Cheaper Stock Obtainable
 NI – National Insurance
 NICE – National Institute for Clinical Excellence
 NHH – Neville Hall Hospital
 NWSSP – NHS Wales Shared Services Partnership
 ODTN – Optometric Diagnostic and Treatment Centre
 OD – Organisation Development
 PAR – Prescribing Audit Report
 PCN – Primary Care Networks (Primary Care Division)
 PER – Prescribing Incentive Scheme
 PICU – Psychiatric Intensive Care Unit
 PrEP – Pre-exposure prophylaxis
 PSNC –Pharmaceutical Services Negotiating Committee
 PSPP – Public Sector Payment Policy
 PCR – Patient Charges Revenue
 PPE – Personal Protective Equipment
 PFI – Private Finance Initiative
 RGH – Royal Gwent Hospital
 RN – Registered Nursing
 RRL – Revenue Resource Limit
 RTT – Referral to Treatment
 RPB – Regional Partnership Board
 RIF – Regional Integration Fund
 SCCC – Specialist Critical Care Centre
 SCH – Scheduled Care Division
 SCP – Service Change Plan (reference IMTP)
 SLF – Straight Line Forecast
 SpR – Specialist Registrar
 STW – St.Woolos Hospital
 TCS – Transforming Cancer Services (Velindre programme)
 T&O – Trauma & Orthopaedics
 TAG – Technical Accounting Group
 UHB / HB – University Health Board / Health Board
 USC – Unscheduled Care (Division)
 UC – Urgent Care (Division)
 ULP – Underlying Financial Position
 VCCC – Velindre Cancer Care Centre
 VERS – Voluntary Early Release Scheme
 WET AMD – Wet age-related macular degeneration
 WG – Welsh Government

	WHC – Welsh Health Circular WHSSC – Welsh Health Specialised Services Committee WLI – Waiting List Initiative WLIMS – Welsh Laboratory Information Management System WRP – Welsh Risk Pool YAB – Ysbyty Aneurin Bevan YTD – Year to date YYF – Ysbyty Ystrad Fawr
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Finance & Performance Committee

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

Aneurin Bevan University Health Board
Finance Report – August (Month 5) 2024/25
Appendices

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Pay Summary (1) (subject to change excluding annual leave effect Pension employer costs):



Substantive (£'000)

Pay category	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change	%	Avg 23/24
ADD PROF SCIENTIFIC AND TECHNICAL	2,342	2,351	2,330	2,361	2,354	2,344	2,336	-9	-0.4%	2,245
ADDITIONAL CLINICAL SERVICES	8,226	7,866	7,918	8,320	8,054	8,118	8,214	97	1.2%	8,134
ADMINISTRATIVE & CLERICAL	10,305	10,502	9,664	9,847	9,619	9,572	9,659	86	0.9%	10,394
ALLIED HEALTH PROFESSIONALS	4,140	4,159	4,093	4,098	4,038	4,040	4,070	30	0.7%	4,140
ESTATES AND ANCILLARY	3,049	2,920	3,008	3,191	3,061	3,038	3,157	118	3.9%	3,015
HEALTHCARE SCIENTISTS	1,146	1,167	1,130	1,168	1,157	1,155	1,153	-2	-0.2%	1,148
MEDICAL AND DENTAL	14,942	16,450	13,663	14,042	13,936	14,184	14,435	251	1.8%	14,112
NURSING AND MIDWIFERY REGISTERED	16,797	16,848	16,450	16,996	16,726	16,745	17,018	272	1.6%	16,722
STUDENTS	1	2	2	2	2	2	2	0	4.8%	3
Total	60,948	62,264	58,256	60,025	58,946	59,199	60,043	844	1.4%	59,912

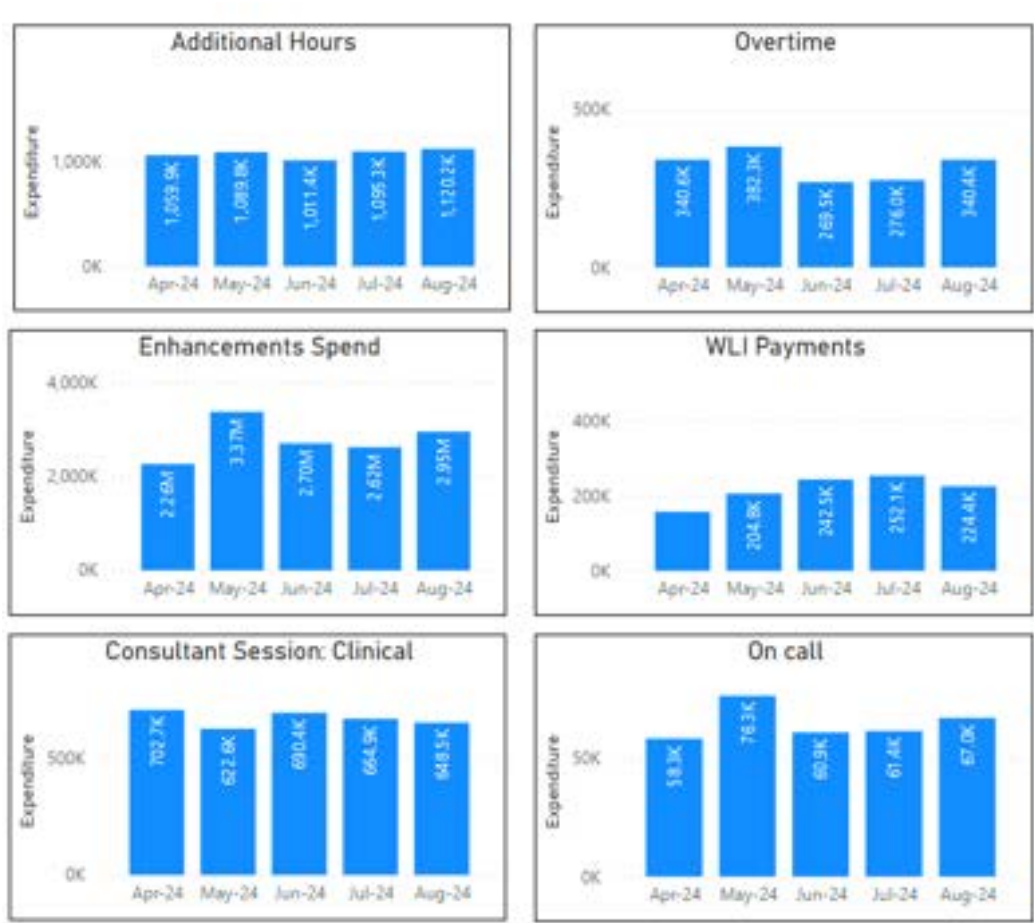
Variable pay (£'000)

Pay category	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change	%	Avg 23/24
Agency	3,040	2,948	2,571	2,318	2,286	2,852	2,805	-47	-1.7%	3,527
Bank	3,790	4,259	3,060	3,727	3,427	3,690	3,595	-96	-2.6%	3,919
Locum	332	330	333	360	337	285	330	45	15.9%	299
Total	7,162	7,537	5,964	6,404	6,051	6,828	6,730	-97	-1.4%	7,746

Total pay (£'000)

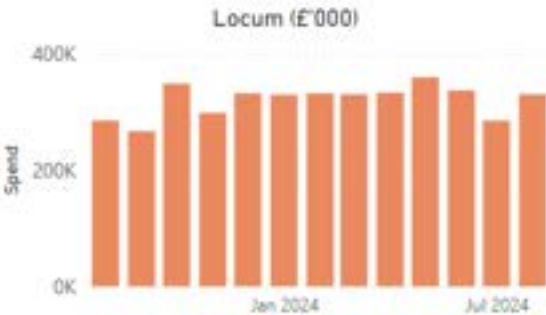
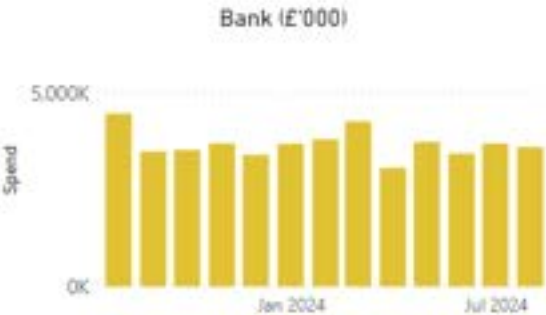
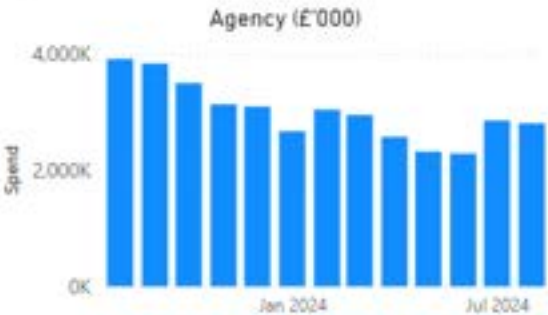
	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change	%	Avg 23/24
Pay	68,110	69,801	64,221	66,429	64,997	66,026	66,774	747	1.1%	67,658

Pay Summary (2): Substantive Pay

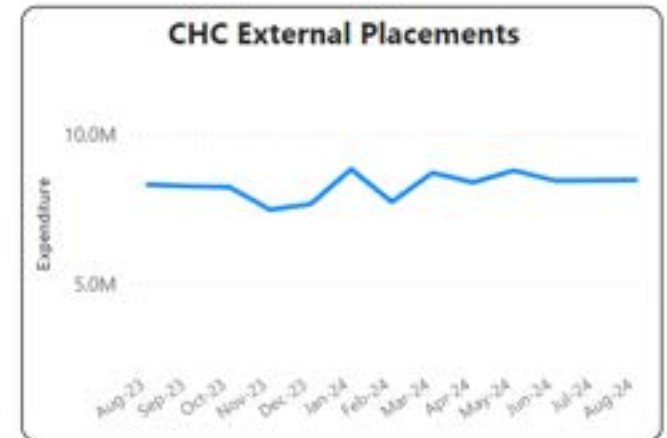
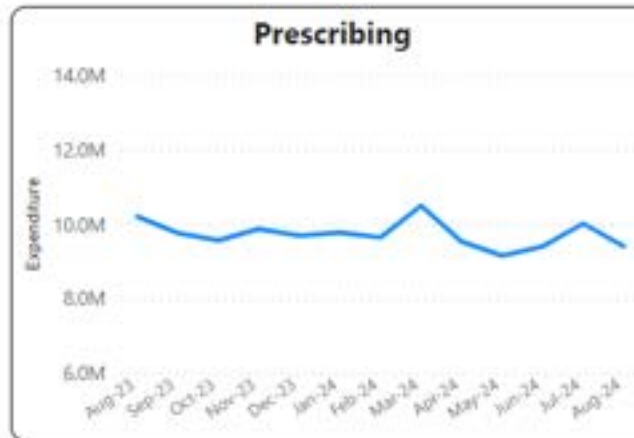
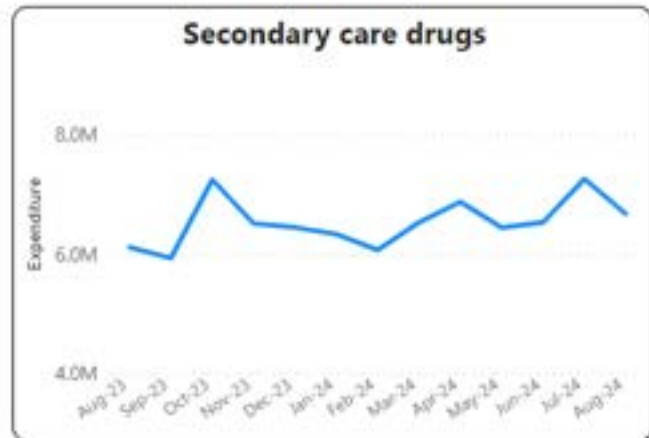
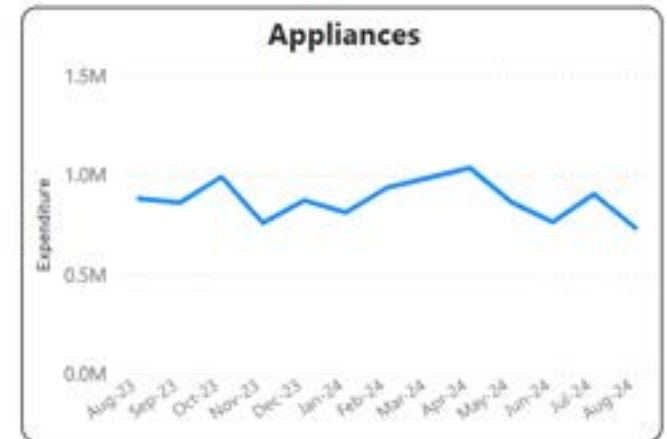
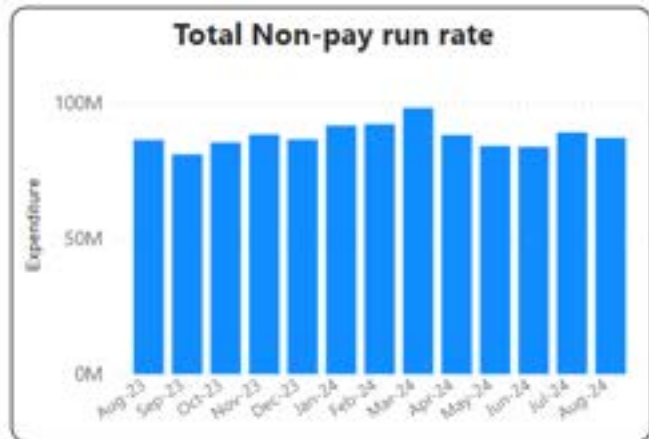


Pay Summary (3): Variable Pay (£'k)

Pay category	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Change	%	Avg 23/24
Agency																
Admin & Clerical Agency	41	39	86	38	29	67	82	59	28	8	19	-4	6	11	-243.0%	59
Allied Health Prof Agency	196	192	123	165	135	120	86	82	102	105	162	132	128	-4	-3.4%	153
Estates & Ancillary Agency	341	471	489	246	281	239	184	232	205	139	78	188	176	-13	-6.7%	401
Medical Agency	1,399	1,093	1,091	1,187	1,166	690	1,274	938	1,124	869	902	1,201	1,227	26	2.2%	1,222
Nurse HCA/HCSW Agency	236	183	89	79	89	65	88	59	26	39	38	57	37	-20	-35.9%	157
Other Agency	49	50	46	47	21	99	39	109	53	94	77	109	82	-27	-24.6%	60
Registered Nurse Agency	1,650	1,807	1,574	1,369	1,371	1,388	1,286	1,469	1,034	1,064	1,011	1,169	1,150	-19	-1.7%	1,475
Total	3,913	3,835	3,497	3,132	3,093	2,668	3,040	2,948	2,571	2,318	2,286	2,852	2,805	-47	-1.7%	3,527
Bank																
Admin & Clerical Bank	92	92	82	89	87	95	84	119	68	79	75	93	82	-11	-12.2%	95
Estates & Ancillary Bank	201	215	216	224	243	254	235	263	218	257	249	263	260	-3	-1.0%	210
Nurse HCA/HCSW Bank	1,816	1,438	1,520	1,572	1,473	1,711	1,523	1,784	1,428	1,680	1,548	1,614	1,656	42	2.6%	1,614
Other Bank	-1	0	2	-2	0	0	0	0	1	0	1	0	-1	-1	-319.2%	0
Registered Nurse Bank	2,352	1,736	1,699	1,808	1,589	1,620	1,949	2,093	1,345	1,711	1,555	1,721	1,598	-123	-7.1%	2,001
Total	4,460	3,480	3,519	3,692	3,392	3,681	3,790	4,259	3,060	3,727	3,427	3,690	3,595	-96	-2.6%	3,919
Locum																
Medical Locum	285	267	349	299	332	330	332	330	333	360	337	285	330	45	15.9%	299
Total	285	267	349	299	332	330	332	330	333	360	337	285	330	45	15.9%	299
Total	8,658	7,582	7,365	7,122	6,817	6,678	7,162	7,537	5,964	6,404	6,051	6,828	6,730	-97	-1.4%	7,746



Non-Pay Summary:



Referral to Treatment (RTT):

- Elective Treatments for August '24 was 1,960 (July '24: 2,230. 2023/24 total: 24,688, 22/23 total: 22,327, 19/20 total: 28,004)

Planned Treatments (M05)					Actual Treatments (M05)					Treatment Variance (M05)				
Treatment	Core	Backfill	WLI	Total	Treatment	Core	Backfill	WLI	Total	Treatment	Core	Backfill	WLI	Total
N107-Dermatology	178	0	0	178	Derm	193	33	0	226	Derm	15	33	0	48
N147-ENT	137	0	0	137	ENT	155	33	6	194	ENT	18	33	6	57
N105-General Surgery	291	0	0	291	GS	286	33	0	319	GS	-5	33	0	28
N146-Oral Surgery	188	0	0	188	Max Fax	223	0	0	223	Max Fax	35	0	0	35
N148-Ophthalmology	273	0	0	273	Ophth	266	0	0	266	Ophth	-7	0	0	-7
N108-Rheumatology	0	0	0	0	Rheum	0	0	0	0	Rheum	0	0	0	0
N115-Trauma & Orthopaedics	340	0	0	340	T&O	511	13	10	534	T&O	171	13	10	194
N106-Urology	404	0	0	404	Urology	195	3	0	198	Urology	-209	3	0	-206
Total	1,813	0	0	1,813		1,829	115	16	1,960		16	115	16	147

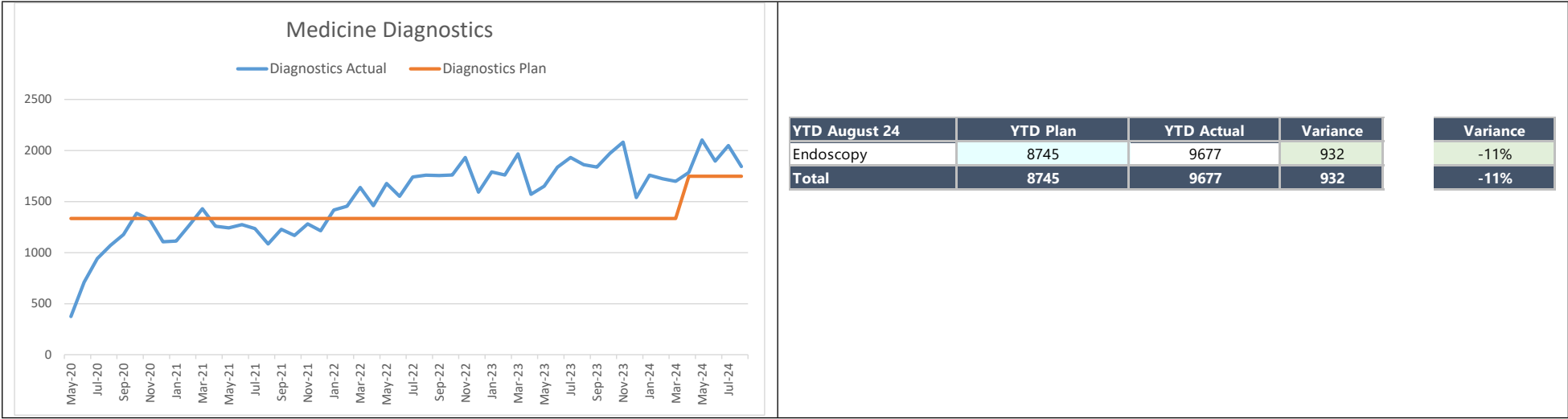
- Outpatient activity for August '24 was 5,577 (July '24: 7,427. 2023/24 total: 71,165, 22/23 total: 65,873, 19/20 total: 75,707)

Planned Outpatients (M05)						Actual Outpatients (M05)						Outpatient Variance (M05)					
Outpatient	Core	Backfill	WLI	Other	Total	Outpatient	Core	Backfill	WLI	Other	Total	Outpatient	Core	Backfill	WLI	Other	Total
N107-Dermatology	1,442	0	0	0	1,442	Derm	997	0	0	263	1,260	Derm	-445	0	0	263	-182
N147-ENT	509	0	0	0	509	ENT	615	0	157	0	772	ENT	106	0	157	0	263
N105-General Surgery	1,587	0	0	0	1,587	GS	1,287	153	0	0	1,440	GS	-300	153	0	0	-147
N146-Oral Surgery	252	0	0	0	252	Max Fax	196	8	57	0	261	Max Fax	-56	8	57	0	9
N148-Ophthalmology	652	0	0	0	652	Ophth	566	19	0	0	585	Ophth	-86	19	0	0	-67
N108-Rheumatology	215	0	0	0	215	Rheum	147	0	0	0	147	Rheum	-68	0	0	0	-68
N115-Trauma & Orthopaedics	569	0	0	0	569	T&O	625	0	0	0	625	T&O	56	0	0	0	56
N106-Urology	446	0	0	0	446	Urology	485	0	2	0	487	Urology	39	0	2	0	41
Total	5,672	0	0	0	5,672		4,918	180	216	263	5,577		-754	180	216	263	-95

Medicine Outpatients activity for August '24 was 1,655 (July '24: 1,871, 2023/24: 22,708 2022/23: 19,258):

Aug-24				Aug-24				
	Previous assumed monthly activity	Actual activity	Variance	YTD Aug-24	YTD Plan	YTD Actual	Variance	Variance
Gastroenterology	475	329	-146	Gastroenterology	2375	1986	-389	16%
Cardiology	430	304	-126	Cardiology	2150	1741	-409	19%
Respiratory (inc Sleep)	455	420	-35	Respiratory (inc Sleep)	2275	2050	-225	10%
Neurology	257	272	15	Neurology	1285	1448	163	-13%
Endocrinology	186	113	-73	Endocrinology	930	694	-236	25%
Geriatric Medicine	313	217	-96	Geriatric Medicine	1565	1173	-392	25%
Total	2116	1655	-461	Total	10580	9092	-1488	14%

Medicine Diagnostics activity for August '24 was 1,843 (July '24: 2,049, 2023/24: 21,466, 2022/23: 36,246):



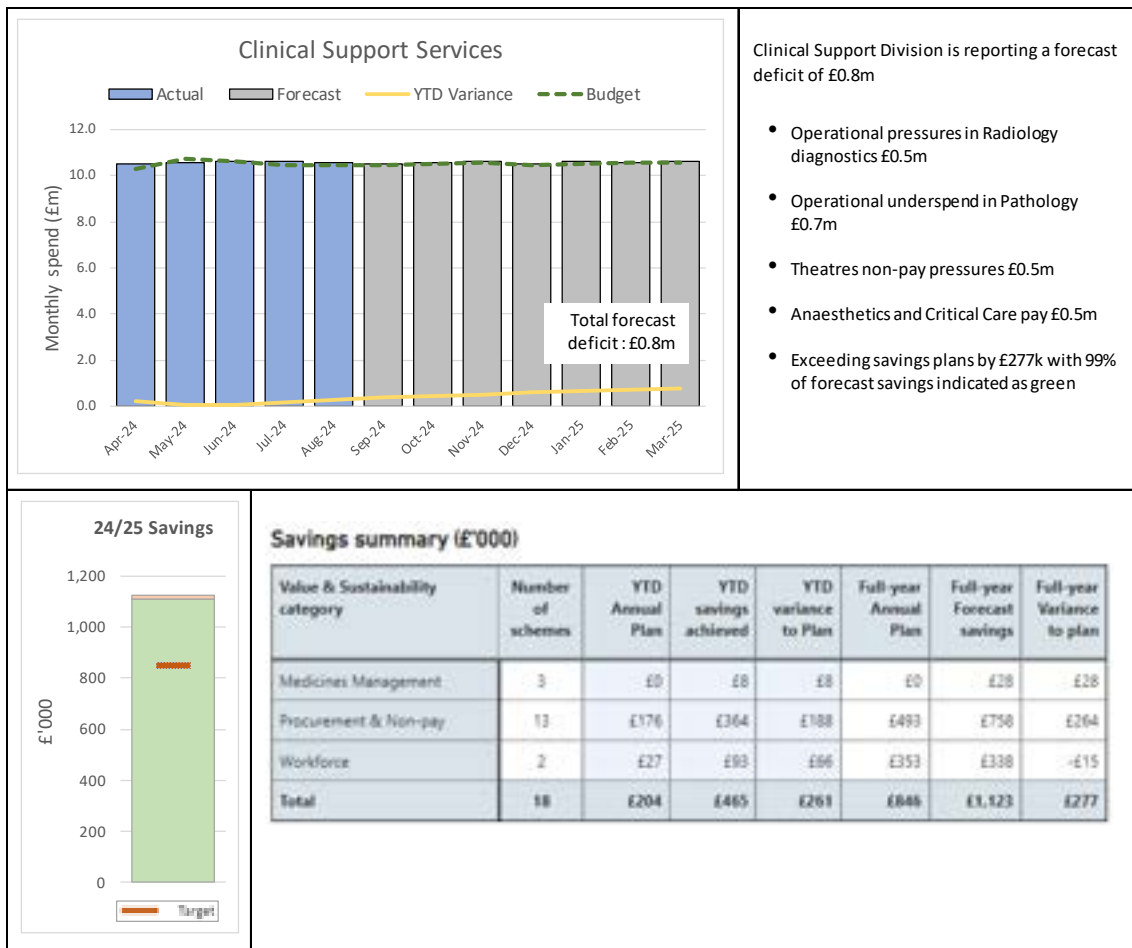
RAG rating category definitions

Savings schemes are categorised as *Red*, *Amber* or *Green* according to the certainty of the forecast achievement. Definitions for each rating are as follows:

- **Green scheme:** Started delivering in the current month or prior month and is expected to continue delivering for the remaining period.
- **Amber scheme:** Agreed plan in place and expected to deliver starting in a future month. Not yet started, therefore Amber due to the time factor risk.
- **Red scheme:** No plan in place and not expected to achieve.

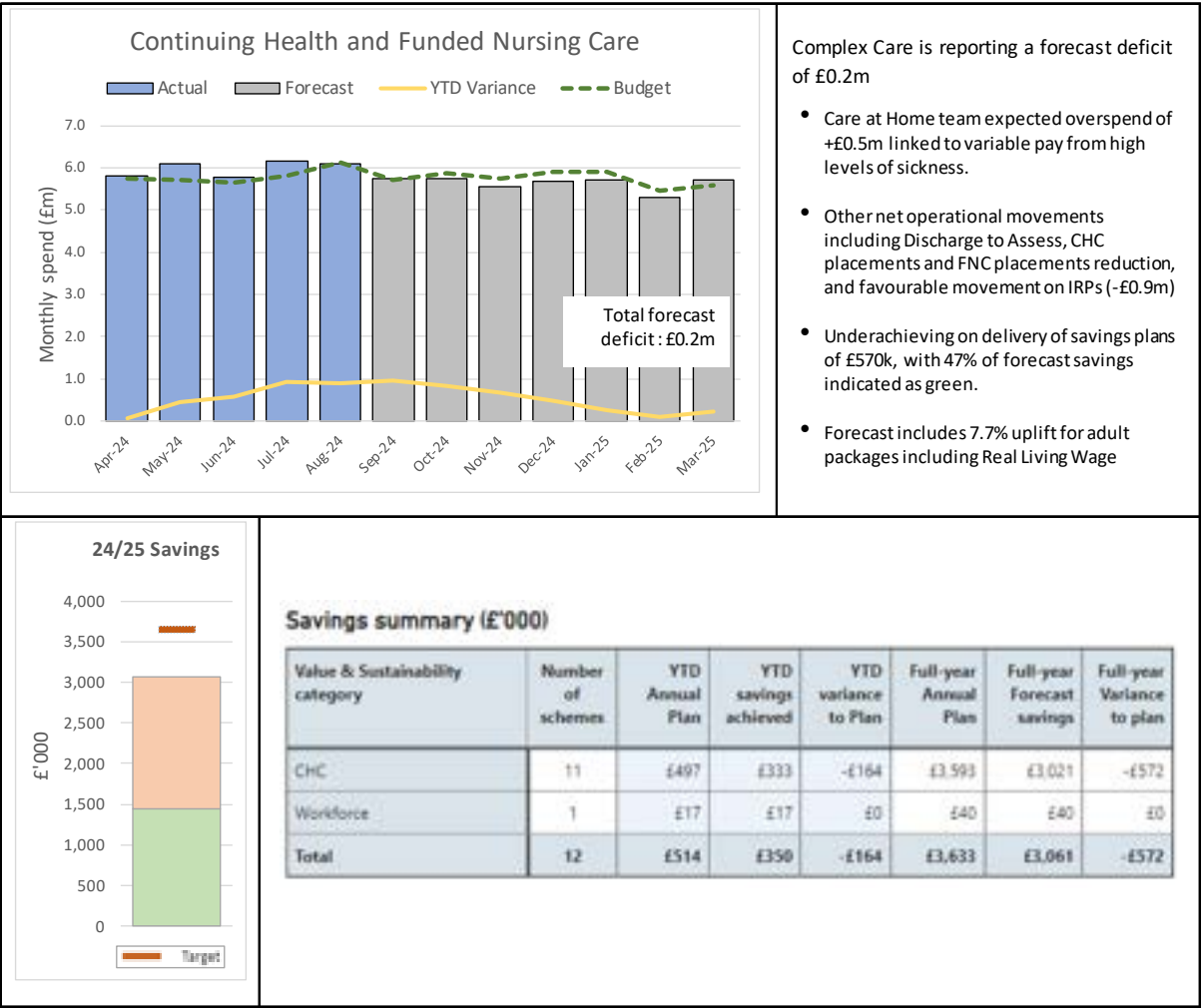
The definitions are consistent with Welsh Government guidance and have been communicated to Divisions.

Divisional analysis – Clinical Support Services



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CSS-01	Administration & Clerical review	R	Month 1	Green	53	123	158	35
CSS-02	Pathology - repatriation of tests	R	Month 1	Green	2	43	21	(22)
CSS-03	PFI saving (Llanwenarth suite)	R	Month 1	Green	125	300	300	0
CSS-04	Theatre Efficiencies	R	Month 1	Green	40	230	180	(50)
CSS-05	FIT Testing (Novation into Siemen's Managed Service cont	R	In Year	Green	9	0	29	29
CSS-06	Decommissioning NovaView Service & Maintenance	R	In Year	Green	8	0	19	19
CSS-07	Quantiliser Maintenance	NR	In Year	Green	2	0	5	5
CSS-08	Urine Collection Tubes	R	In Year	Green	4	0	10	10
CSS-10	Fuji - Equipment Inventory Review	R	In Year	Amber	0	0	7	7
CSS-11	MIU General Room - RGH - Decommissioned	R	In Year	Amber	0	0	3	3
CSS-12	MIU General Room - RGH - Replacement	NR	In Year	Amber	0	0	4	4
CSS-13	Drugs - Sevoflourane	R	In Year	Green	3	0	7	7
CSS-14	Maintenance Contracts (Theatres, Radiology, Pathology)	NR	In Year	Green	166	0	166	166
CSS-15	Price Reduction in Ethicon suturing materials (Theatres)	NR	In Year	Green	12	0	50	50
CSS-16	Radiology - Contrast Media	R	In Year	Green	4	0	21	21
CSS-17	Paracetamol IV to Oral Omnicell Implementation	R	In Year	Green	0	0	0	0
OPPS2-01	WHSSC Liver	R	Month 1	Green	26	116	116	0
OPPS2-02	Additional Savings Targets - Pathology NR maintenance sa	R	Month 1	Green	10	34	28	(7)
					465	846	1,123	277

Divisional analysis – Complex Care



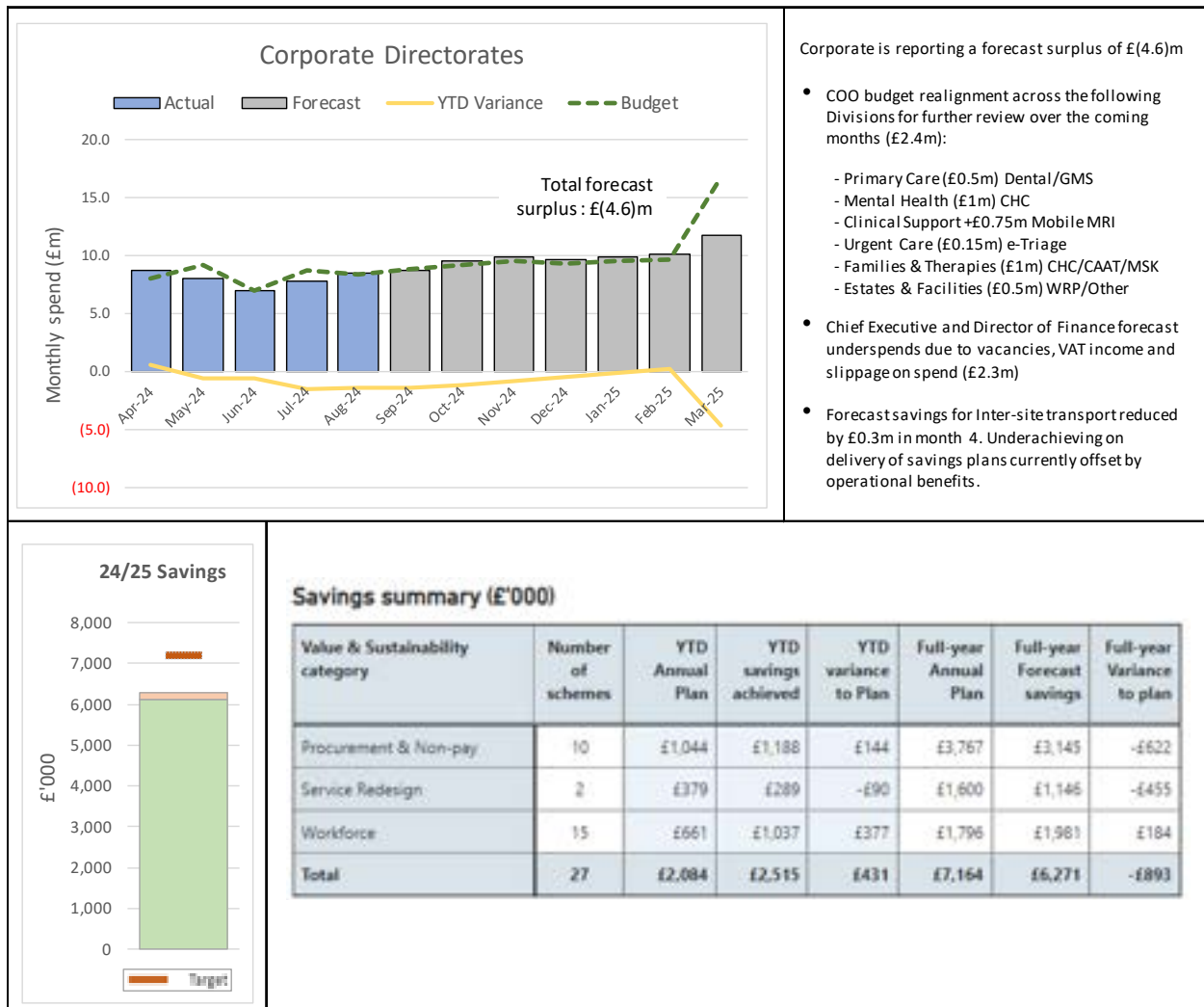
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CHC-01	Contract Adjustments - hospital admissions and days after	R	Month 1	Amber	0	314	105	(209)
CHC-02	Removal of CHC Premium for Gwent Care Homes with one	R	Month 1	Amber	0	179	60	(119)
CHC-03	23/24 staff vacancies - no further recruitment	R	Month 1	Green	17	40	40	0
CHC-04	Deputyship SLA	R	Month 1	Red	0	35	0	(35)
CHC-05	Cwmgelli Enhanced Care contract	R	Month 1	Green	14	33	28	(6)
CHC-06	Travel (Mileage rate reduction of 5p)	R	Month 1	Green	5	12	12	0
CHC-07	CHC - Adult reviews	NR	Month 1	Amber	0	1,440	1,440	0
CHC-08	Reduction in hospital payments for independent providers	R	Month 1	Red	0	203	0	(203)
CHC-09	New Direction Retainer	R	Month 1	Green	26	62	62	0
CHC-10	Administration & Clerical review	R	Month 1	Amber	0	15	15	0
CHC-11	FNC activity reduction schemes	R	Month 1	Green	156	700	700	0
CHC-12	CHC Care at Home and other vacancies	R	Month 1	Green	133	600	600	0
					350	3,633	3,061	(572)

Complex Care continued...

Red savings schemes (listed above) over £200k

Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
CHC-08	Reduction in hospital payments for independent providers for CHC & FNC patients	203	Savings target already incorporated into CHC-01

Divisional analysis – Corporate



Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CEO-01	Administration & Clerical review	R	Month 1	Green	12	53	52	(1)
COO-01	Administration & Clerical review	R	Month 1	Green	5	20	17	(3)
CORP-01	Generic CIP - Pay	R	Month 1	Green	13	53	44	(9)
CORP-02	Generic - Non-pay	NR	Month 1	Green	5	15	14	(1)
CORP-03	Hybrid mail	R	Month 1	Green	82	300	180	(120)
CORP-04	Intersite transport	R	Month 1	Green	208	1,300	966	(334)
CORP-05	Healthcare Pathways	R	Month 1	Red	0	120	0	(120)
CORP-06	Health Protection - Caerleon House	R	Month 1	Amber	0	273	150	(123)
CORP-07	Health Protection - Newport	R	Month 1	Green	92	220	220	0
CORP-08	Health Protection - LA / TTP	R	Month 1	Green	223	534	534	0
CORP-09	Health Protection - Microbiology	R	Month 1	Green	121	291	291	0
CORP-10	VAT income / over-recovery	NR	Month 1	Green	170	300	345	45

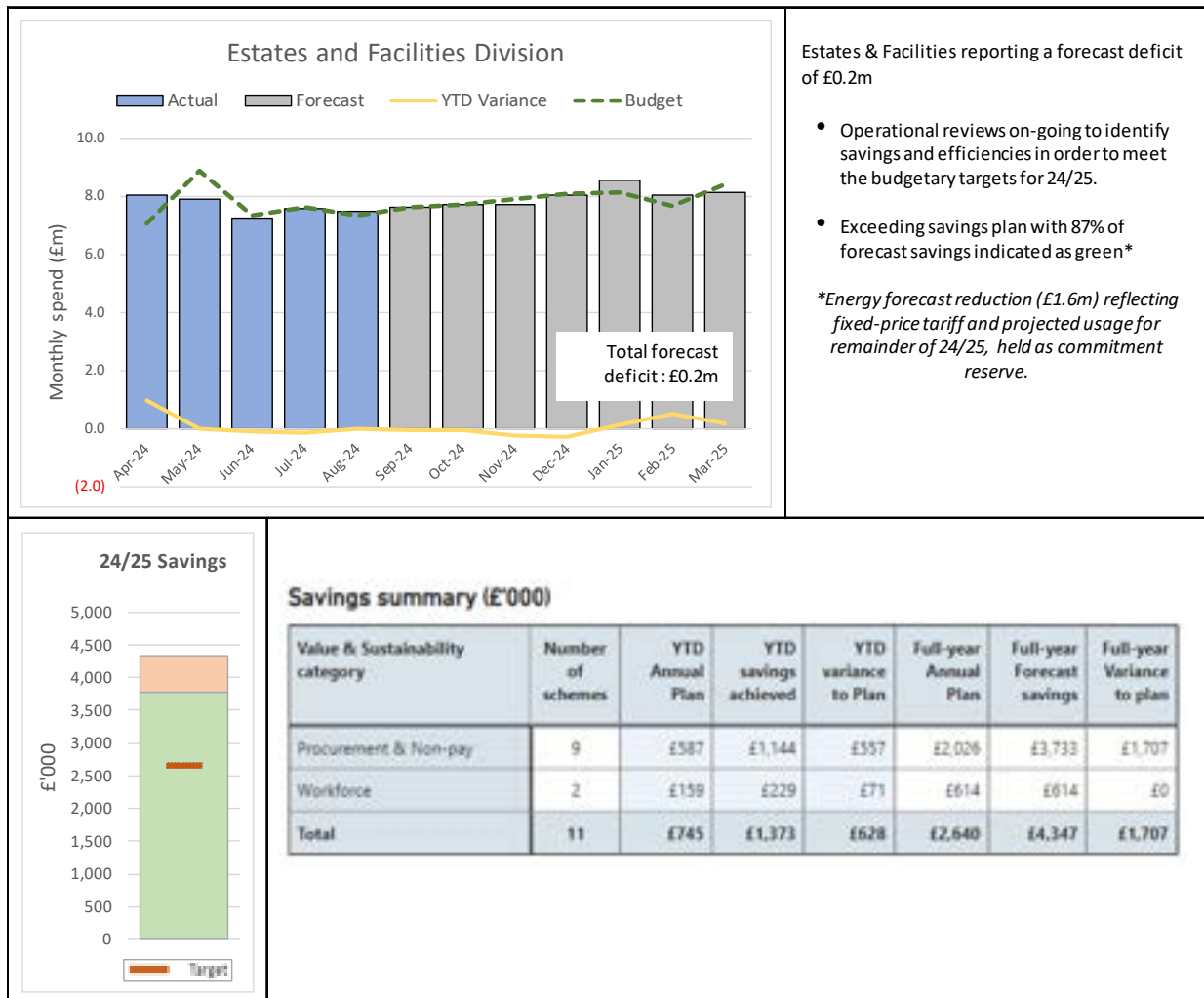
Corporate savings schemes continued...

Savings Scheme Number	Scheme / Opportunity	R/NR	Annual Plan v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
CORP-11	Finance administration savings	R	Month 1	Green	67	161	161	0
DIG-02	Administration & Clerical review	R	Month 1	Green	507	319	596	277
FIN-03	Administration & Clerical review	R	Month 1	Green	58	139	139	0
GOV-01	Administration & Clerical review	R	Month 1	Green	4	19	20	1
MEDR-01	Administration & Clerical review	R	Month 1	Green	15	59	49	(10)
NUR-01	Administration & Clerical review	R	Month 1	Green	13	53	44	(9)
PLA-01	Administration & Clerical review	R	Month 1	Green	39	68	81	13
THE-01	Administration & Clerical review	R	Month 1	Green	5	19	16	(3)
WOD-01	Administration & Clerical review	R	Month 1	Green	111	122	171	49
CORP-13	Litigation cost reductions	R	Month 1	Green	86	385	385	0
CORP-14	Other specific funding benefits	NR	Month 1	Green	67	300	300	0
CORP-15	Recovery of agency fees	NR	Month 1	Green	200	700	812	112
OPPS2-03	WRP	R	Month 1	Green	335	335	335	(0)
OPPS2-04	Further litigation schemes	R	Month 1	Green	78	350	350	0
OPPS2-05	Further Corporate schemes / opportunities inc. Public Health	R	Month 1	Red	0	655	0	(655)
					2,515	7,164	6,271	(893)

Red savings schemes (listed above) over £200k

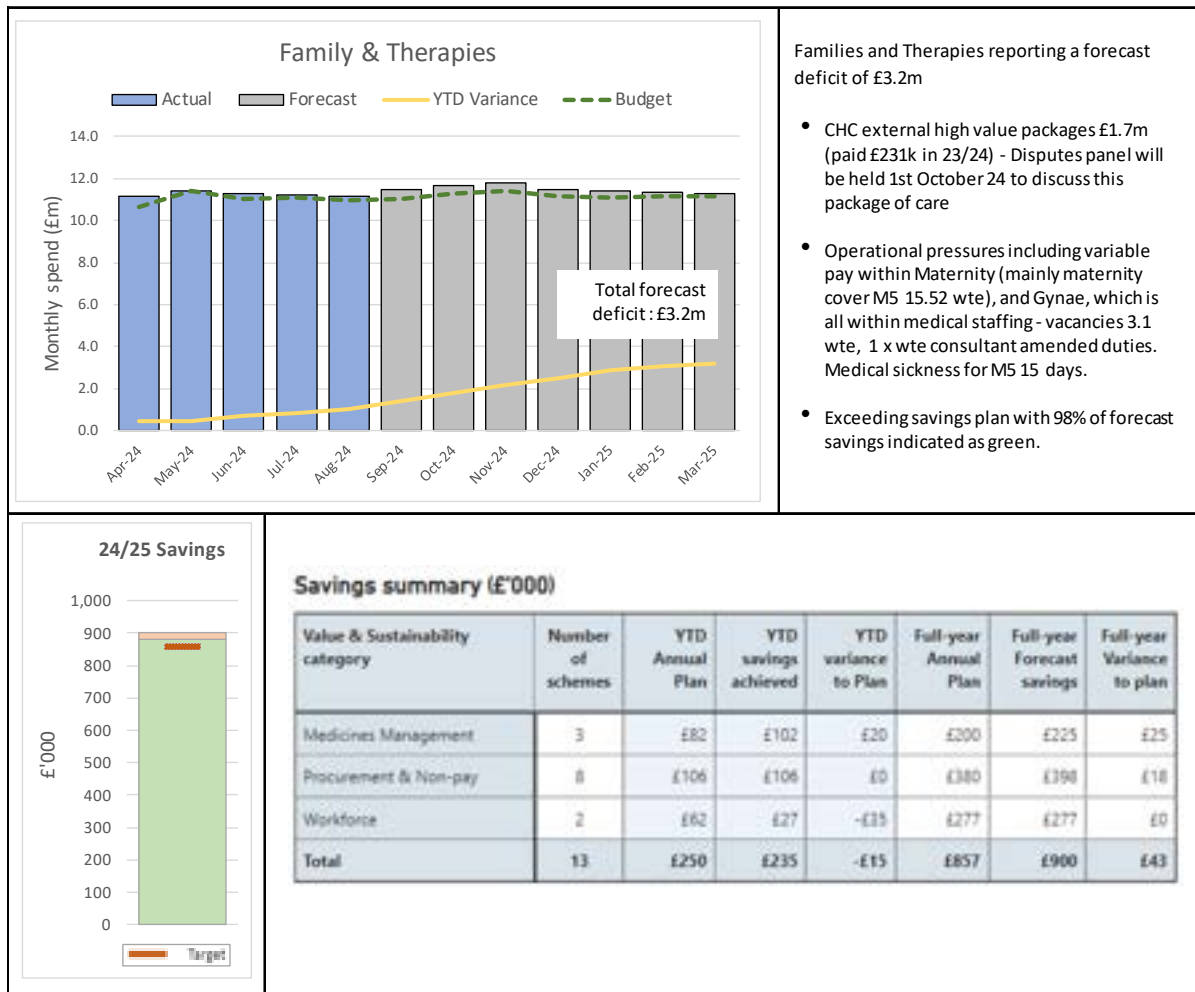
Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
OPPS2-05	Further Corporate schemes / opportunities inc. Public Health	655	Unachievement due to no specific plan. Mitigated by overachievement in other areas

Divisional analysis – Estates & Facilities



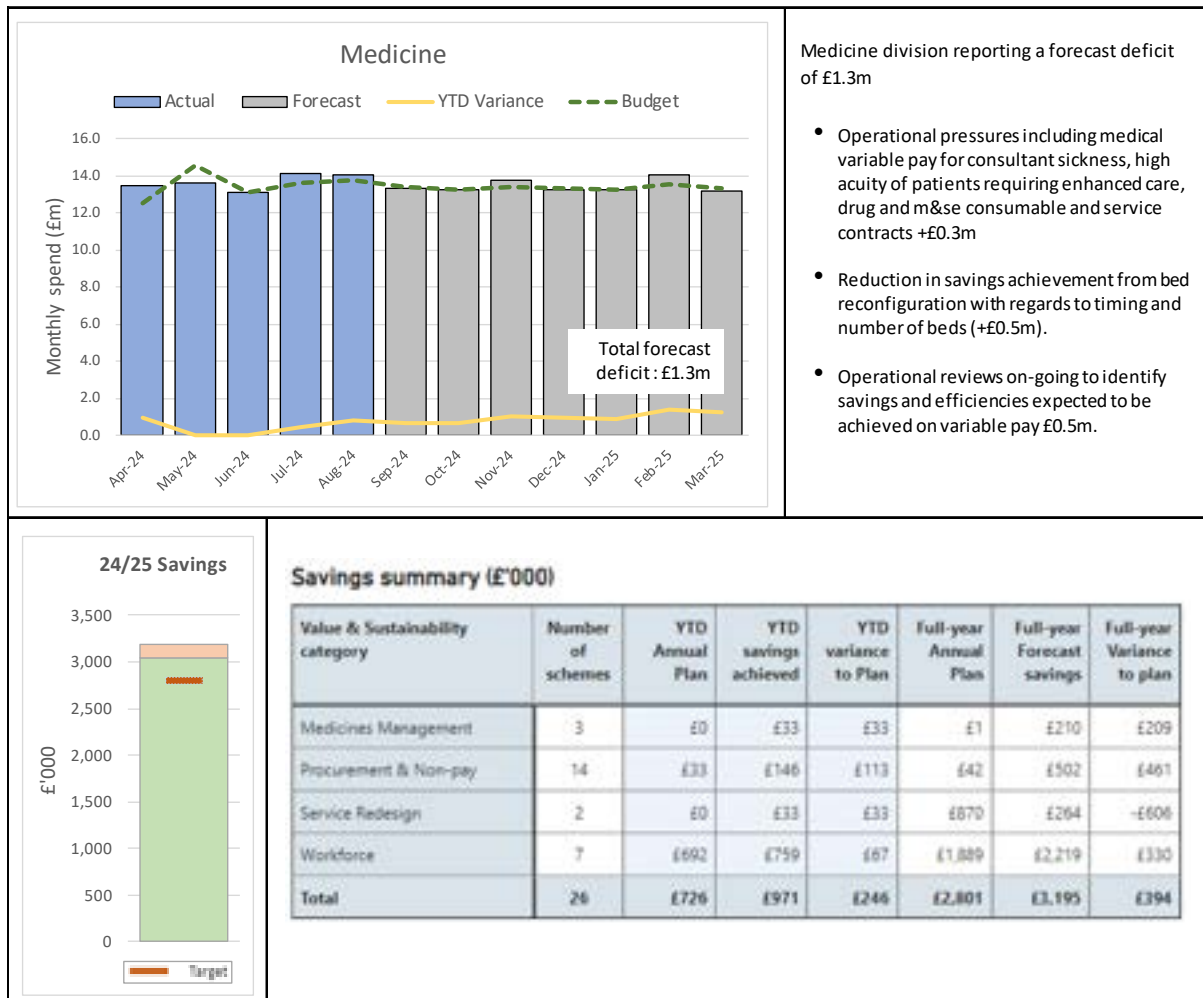
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
EF-01	Window Cleaning Capped at 1 clean per year per site	R	Month 1	Green	8	19	19	0
EF-02	Cease Liftshare software	R	Month 1	Green	6	14	14	0
EF-03	COVID A&E Portacabin	R	Month 1	Green	132	316	316	0
EF-04	Administration & Clerical review	R	Month 1	Green	48	114	114	0
EF-05	Discharge Lounge Portacabin	R	Month 1	Green	26	62	62	0
EF-06	NWSSP Energy Saving	NR	In Year	Green	368	0	1,657	1,657
OPPS2-06a	Rates Rebates - Newport Sites	NR	Month 1	Green	490	930	980	50
OPPS2-06b	Rates Rebates - NHH	NR	Month 1	Amber	0	70	70	0
OPPS2-07	Enhanced Cleaning	R	Month 1	Green	182	500	500	0
OPPS2-08	Bed contract	R	Month 1	Amber	0	500	500	0
OPPS2-09	WRP	R	Month 1	Green	115	115	115	0
					1,373	2,640	4,347	1,707

Divisional analysis – Family & Therapies



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
F&T-01	Maternity - Easy Pay Kiosk Additional Income (Ultrasound	R	Month 1	Green	11	50	50	0
F&T-02	TRUCLEAR - Replacing Myosure consumables	R	Month 1	Green	39	177	177	0
F&T-03	Konica Photocopier / Printer Review	R	Month 1	Green	9	40	40	0
F&T-04	Reduction in Mileage by 5p per mile	R	Month 1	Green	22	53	53	0
F&T-05	Reduction in Variable pay	R	Month 1	Green	8	34	34	0
F&T-06	SRH - Billing C&V for MIV drug costs for C&V patients treat	R	Month 1	Green	96	200	213	13
F&T-07	Medtronic pump & Sensor All Wales procurement savings	R	Month 1	Green	25	60	60	0
F&T-08	Administration & Clerical review	R	Month 1	Green	19	243	243	0
F&T-09	HIV - Dovato Switches	R	In Year	Green	5	0	11	11
F&T-10	Switching to SOL Gases	R	In Year	Amber	0	0	8	8
F&T-11	Enteral Feeding tubes	R	In Year	Amber	0	0	8	8
F&T-12	CTG Wallets	R	In Year	Amber	0	0	2	2
F&T-13	Paracetamol IV to Oral Omnicell Implementation	R	In Year	Green	0	0	1	1
					235	857	900	43

Divisional analysis – Medicine

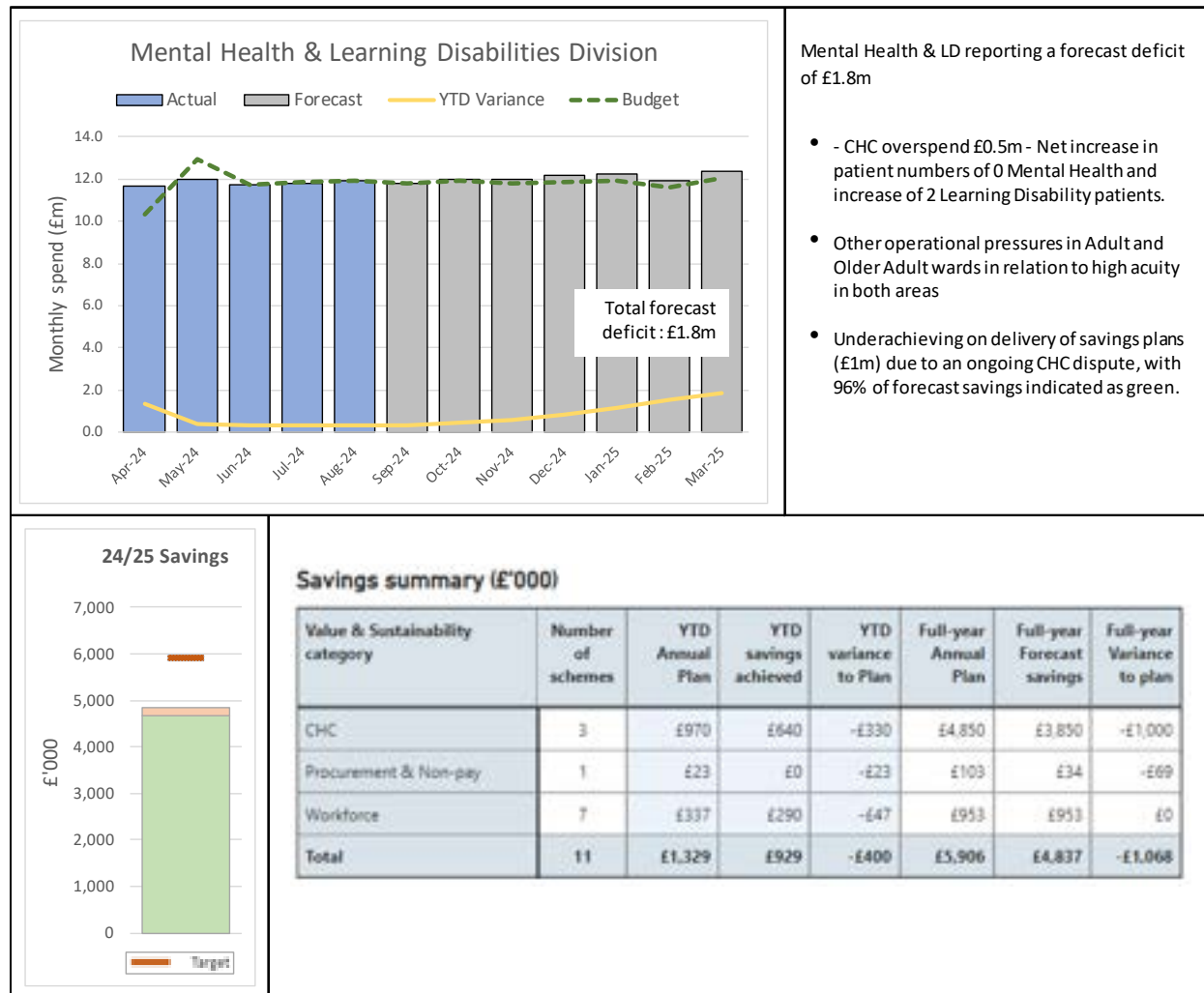


Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Med-01	Medicines Management review across Directorates. Horiz	NR	Month 1	Green	29	1	89	89
Med-02	Reconfiguration of beds across 3 wards with the net reduc	R	Month 1	Green	707	1,558	1,690	132
Med-03	No backfill for 0.40 band 7 sleep nurse wef	R	Month 1	Green	10	24	24	0
Med-04	Procurement of Medtronic pumps at reduced rate for a se	NR	Month 1	Green	17	27	17	(10)
Med-05	Reduced catalogue price for Medtronic sensors	NR	Month 1	Green	31	15	74	59
Med-06	Reconfiguration of beds Medicine	R	Month 1	Green	33	750	264	(486)
Med-07	Administration & Clerical review	R	Month 1	Red	0	158	0	(158)
Med-08	Cardiology backfill sessions	R	Month 1	Red	0	120	0	(120)
Med-09	Cardiology insourcing below plan	R	Month 1	Green	33	150	150	0
Med-10	Reduced catalogue price for Dexcom pumps and consuma	NR	In Year	Green	35	0	97	97
Med-15	Natalizumab - contract change	NR	In Year	Green	4	0	120	120

Medicine savings schemes continued...

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Med-17	Medical Rota - IMT Doctors (1 in 16 to 1 in 22 on call rota)	R	In Year	Green	9	0	70	70
Med-18	Respiratory CPAP purchase	NR	In Year	Green	18	0	80	80
Med-19	Gastroenterology Switch in product type Polyp Trap	R	In Year	Green	0	0	1	1
Med-20	Cardiology Reduction in Echo Insourcing reliance	R	In Year	Green	4	0	30	30
Med-21	Cardiology Recruitment Slippage CR/HF Hub	NR	In Year	Amber	0	0	45	45
Med-22	Gastroenterology Consent forms - Cessation of leaflet	R	In Year	Green	5	0	11	11
Med-23	Respiratory CPAP Mask Renewals	R	In Year	Green	25	0	60	60
Med-24	Respiratory CPAP Mask new set ups	R	In Year	Green	8	0	20	20
Med-25	Cardiology Mini comp tender Stents (Cath Lab)	R	In Year	Amber	0	0	9	9
Med-27	Gastroenterology Out of Area drug cost recovery for Ward	NR	In Year	Amber	0	0	50	50
Med-28	Neurology Out of Area drug cost recovery for Ward Attend	NR	In Year	Amber	0	0	50	50
Med-29	Acute Medicine Substantiate RNs in Line with Rosters	R	In Year	Green	0	0	240	240
Med-30	Diabetes Insulet Rebate	NR	In Year	Green	4	0	4	4
Med-31	GACU Giving Sets - Alternative Product with reduced Port	R	In Year	Amber	0	0	0	0
Med-32	Paracetamol IV to Oral Omnicell Implementation	R	In Year	Green	0	0	1	1
					971	2,801	3,195	394

Divisional analysis – Mental Health and Learning Disabilities

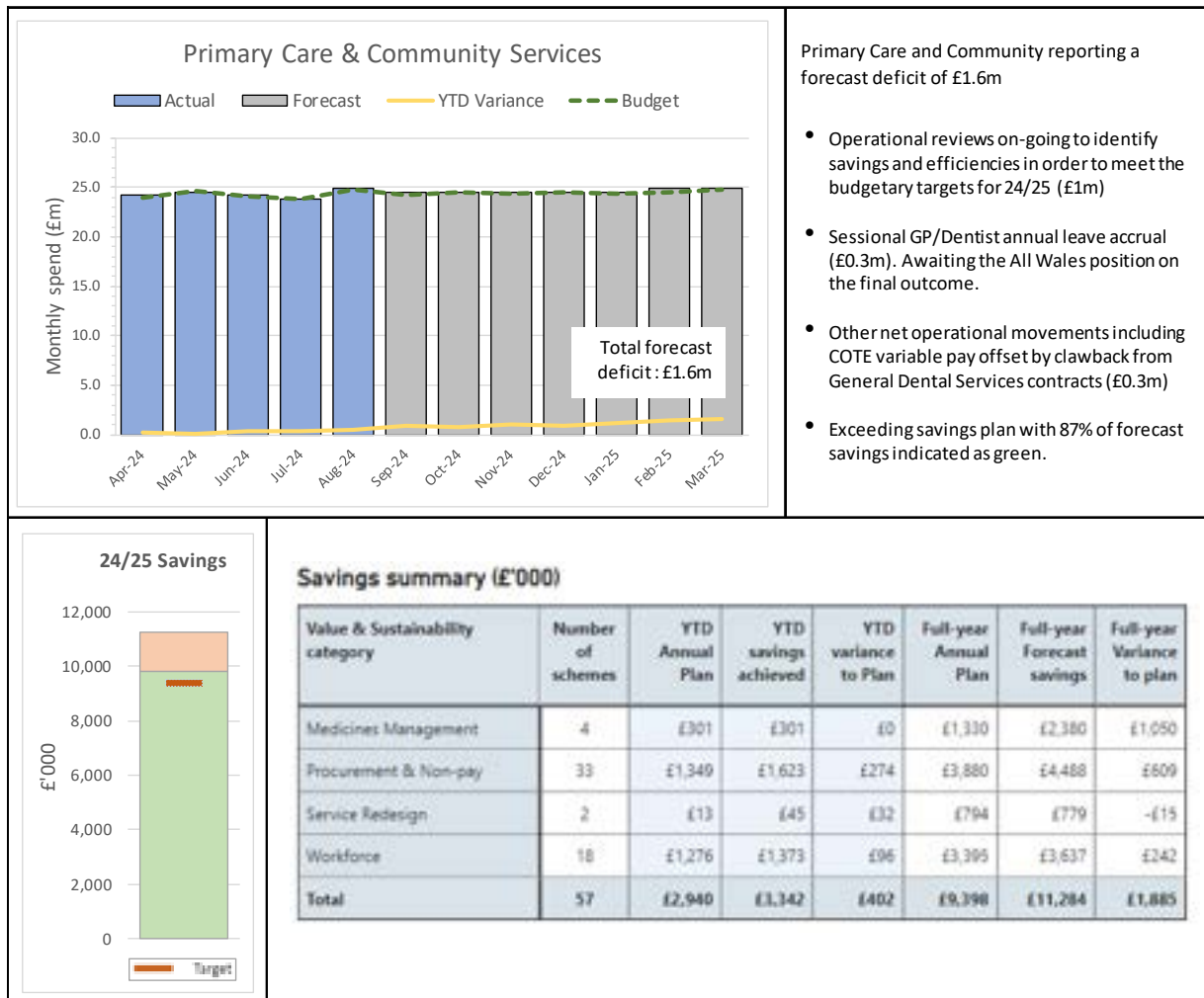


Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
MH-01	Reduction in variable pay agency premium B2 HCSW	R	Month 1	Green	101	192	192	0
MH-02	Ty Lafant ward LD reduction to VP	R	Month 1	Green	100	199	199	0
MH-03	Mitchell Close	R	Month 1	Amber	0	103	34	(69)
MH-04	Medical Agency Reduction	R	Month 1	Green	21	169	169	0
MH-05	Reduction in PHP Leadership PHPs	R	Month 1	Green	22	54	54	0
MH-06	MH&LD CHC reduction	R	Month 1	Green	506	3,250	3,250	0
MH-07	Administration & Clerical review	R	Month 1	Amber	0	140	115	(25)
MH-07a	Administration & Clerical review	NR	In Year	Amber	0	0	25	25
MH-08	MH&LD CHC further reductions	R	Month 1	Green	133	600	600	0
MH-09	MH&LD variable pay schemes	R	Month 1	Green	44	200	200	0
OPPS2-10	West Sussex	NR	Month 1	Red	0	1,000	0	(1,000)
					929	5,906	4,837	(1,068)

Red savings schemes (listed above) over £200k

Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
OPPS2-10	West Sussex	1,000	Currently with West Sussex Legal team for a response. If wish to progress likely with lead into a legal dispute which could be costly. Working towards full recovery of costs however current assumption that saving will not be achieved in the near future.

Divisional analysis – Primary Care and Community



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-02	Managed practices to independant status from 01/04/24	R	Month 1	Green	803	1,928	1,928	0
PCC-03	Revise Academy Offer	NR	Month 1	Green	178	426	426	0
PCC-04	Stoma Team Phase 2	NR	Month 1	Green	62	149	149	0
PCC-05	NHS wales reduction in enhanced mileage rate	R	Month 1	Green	25	60	60	0
PCC-06	Reduction in Medication/NonPay stock - Reduction in Drugs moving STW to RGH by using omniceII cabinets and bed side lockers, opportunity to introduce across other sites for bigger savings if found beneficial	R	Month 1	Green	13	30	30	0
PCC-07	Pharmacy Closures - Benefits within various fees & services (mainly establishment fee). Four community pharmacies due to close by April 24 along with one additional pharmacy following this. Saving of £35k each in the year though this would be a one-off saving	NR	Month 1	Green	73	175	175	0

Primary Care & Community savings schemes continued...

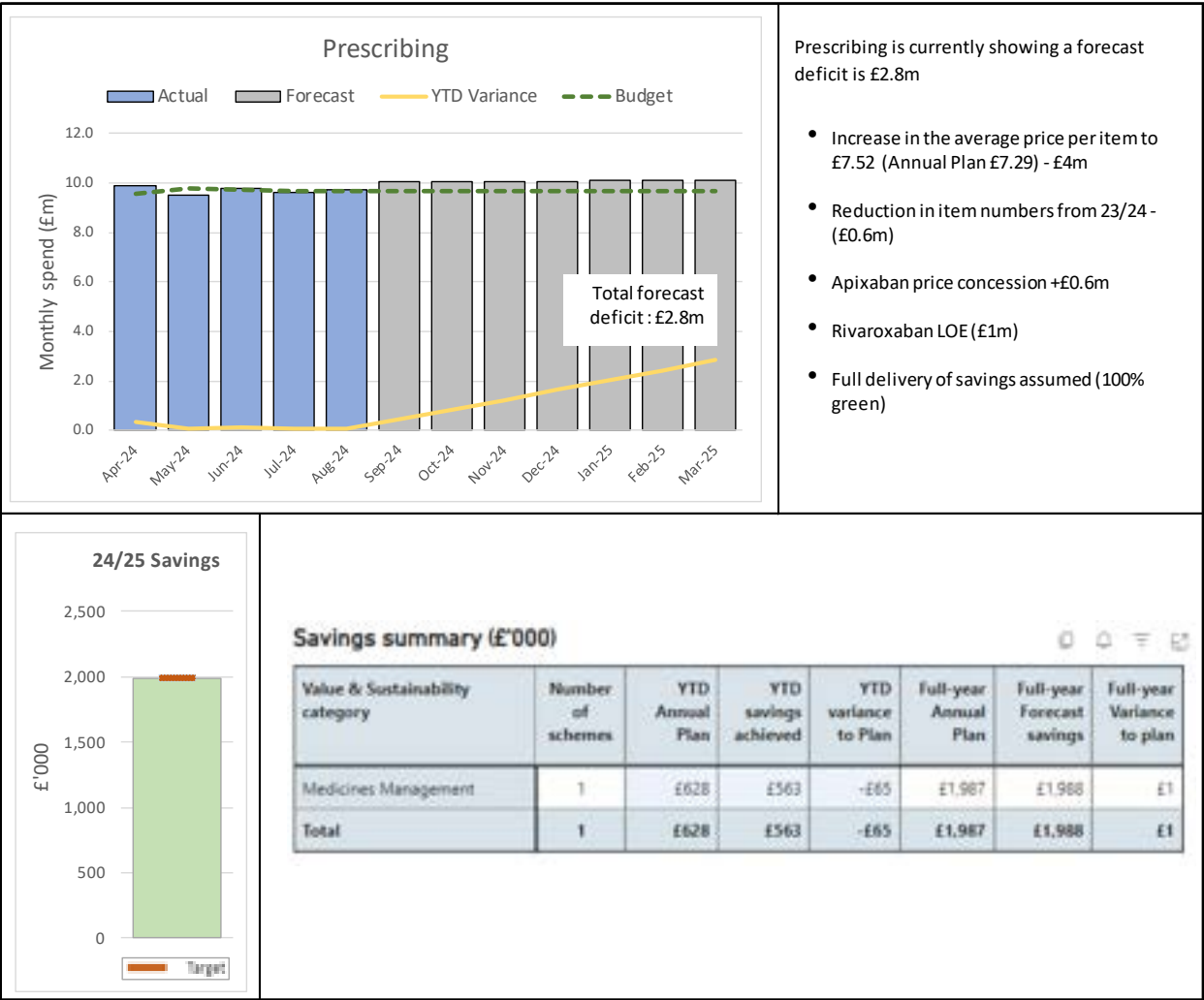
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-08	Staffing - Current B5 post holder reduction in hours	R	Month 1	Green	2	10	10	(0)
PCC-09	Staffing - Review of nursing rota and opportunities to decrease specialist nurse rate	R	Month 1	Green	1	5	5	0
PCC-10	Staffing - Currently have one agency GP, bring this person on substantive contract so cost of fees removed	R	Month 1	Amber	0	10	9	(1)
PCC-11	Reduction in Chepstow beds - 2 - Reducing 2 beds within Cas Gwent ward	R	Month 1	Green	45	204	204	(0)
PCC-12	E-rostering scrutiny and efficiency. Adopting additional scrutiny, process transparency and further/refresh training	R	Month 1	Green	4	10	10	0
PCC-13	Staffing structure review -Remove 8a role from structure	R	Month 1	Green	25	65	56	(8)
PCC-14	Redeployment of Business Administrator - Redeployment of B3 administrator following end of secondment. Role not required due to apprentice in post.	R	Month 1	Green	12	28	28	0
PCC-15	Business Intelligence / Data Analyst - If Data Analyst / Business Partner model continues to be provided by Information Services (current agreed via ACD/SPPC) there will be less requirement to backfill vacancy for a dedicated band 6 performance manager. Workplan/commitment needed from Corporate Information to reassure that work will be progressed on Division's behalf. May necessitate permanent recruitment of B6 business manager from within current structure, thereby releasing a band 5 role.	R	Month 1	Green	18	44	44	(0)
PCC-16	Review Management structure	R	Month 1	Green	32	76	66	(10)
PCC-17	Review Admin Structure	R	Month 1	Amber	0	32	27	(5)
PCC-18	Review Professional structure	R	Month 1	Green	10	76	76	0
PCC-19	Removal of vacant part time physio post	R	Month 1	Green	8	18	18	0
PCC-20	111 funding redistribution - Explore the opportunity for 111 funding to be redistributed based on previous years slippage / change of PDT process front end 111.	NR	Month 1	Amber	0	215	215	0
PCC-21	Non pay other - Look at opportunities including prescribing, Opex and Wireless Logic	R	Month 1	Green	2	10	10	0
PCC-22	Non pay premises rent - Explore accommodation opportunities. Currently UPC/GP OOH pick up costs for all P&CC care space within VPH which also includes SPA	R	Month 1	Red	0	30	0	(30)
PCC-23	Non-Pay reduction	R	Month 1	Green	16	22	29	6
PCC-24	Non-Pay reduction	R	Month 1	Green	3	10	10	0
PCC-25	Non-Pay reduction	R	Month 1	Green	5	10	10	0
PCC-26	Non-Pay reduction	R	Month 1	Green	2	10	10	0
PCC-27	Stock - Bring stock values in to balance sheet	NR	Month 1	Amber	0	66	66	0
PCC-28	Non pay review - Review stock, supplier usage, waste levels and training with a view to securing better prices / using less. Target 15% reduction.	R	Month 1	Green	45	109	109	0
PCC-29	Income opportunities - Increase charges to Llanarth Court to ensure costs are covered. Explore any other income generating opportunities	R	Month 1	Green	32	7	36	29
PCC-30	GDS contracts - Review service / number of sessions provided within the GDS contracts for OOHs, Blaenavon and Abertillery	R	Month 1	Green	25	60	60	0
PCC-31	Cessation of Hygiene Waste collection - Cessation of PHS contract and adoption of HB service supplier at saving of £2,000 per annum	R	Month 1	Green	1	2	2	0
PCC-32	Non Pay - Non Pay spend review to bring into line with budget for 24-25	R	Month 1	Green	5	5	5	0
PCC-33	Chase Project - Removal of this project	R	Month 1	Green	10	10	10	0
PCC-34	License Fees - No Longer needed	R	Month 1	Green	6	6	6	0
PCC-35	Reconfiguration of beds PCCS	R	Month 1	Green	45	750	750	0
PCC-36	Glyn Ebbw Closure	R	Month 1	Green	0	44	29	(15)
PCC-37	Staffing Structures in Community Dental Services	R	Month 1	Green	70	100	100	0
PCC-38	Additional clinical sessions LES	R	Month 1	Green	280	673	673	0
PCC-39	Reduction in NCN areas	R	Month 1	Amber	0	30	30	0

Primary Care & Community savings schemes continued...

Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-40	Relinquish Comms and Engagement agreement	R	Month 1	Amber	0	30	27	(3)
PCC-41	GDS clawback savings - Corporate assessment	R	Month 1	Green	83	200	200	0
PCC-42	Dental patient charges	R	Month 1	Green	667	1,600	1,600	0
PCC-43	Administration & Clerical review savings (2%)	R	Month 1	Green	71	254	81	(173)
PCC-44	Anti-viral cost mitigation / GP stock	R	Month 1	Red	0	1,300	0	(1,300)
PCC-44a	Anti-viral cost mitigation / GP stock	NR	In Year	Green	289	0	1,300	1,300
PCC-45	Optometry contract reduction	R	Month 1	Green	111	500	500	0
PCC-46	Nurse led Imms Team - under GMS Contract	R	In Year	Green	50	0	202	202
PCC-47	SLAs-Carers Collective Torfaen	NR	In Year	Green	19	0	45	45
PCC-48	SLAs-Carers Collective Monmouth	NR	In Year	Green	10	0	25	25
PCC-49	SLAs-British Red Cross Pan Gwent – Newport Hub	NR	In Year	Green	2	0	14	14
PCC-50	SLAs-Age Cymru Caerphilly	NR	In Year	Green	6	0	14	14
PCC-51	Llanarth House rates rebate	NR	In Year	Amber	0	0	44	44
PCC-52	Ruperra - RTG Ward - Bed reduction and revised model	R	In Year	Green	78	0	440	440
PCC-53	GMS-HB Improvement Grant funding	NR	In Year	Green	83	0	200	200
PCC-55	SLAs - National Exercise Referral Scheme	NR	In Year	Green	5	0	12	12
PCC-56	ODTC & WET AMD - Activity cap	NR	In Year	Green	11	0	50	50
PCC-57	Rivaroxaban LOE - Price reduction	R	In Year	Amber	0	0	1,050	1,050
PCC-58	Procurement saving for IV Giving Sets Switch	R	In Year	Amber	0	0	0	0
					3,342	9,398	11,284	1,885

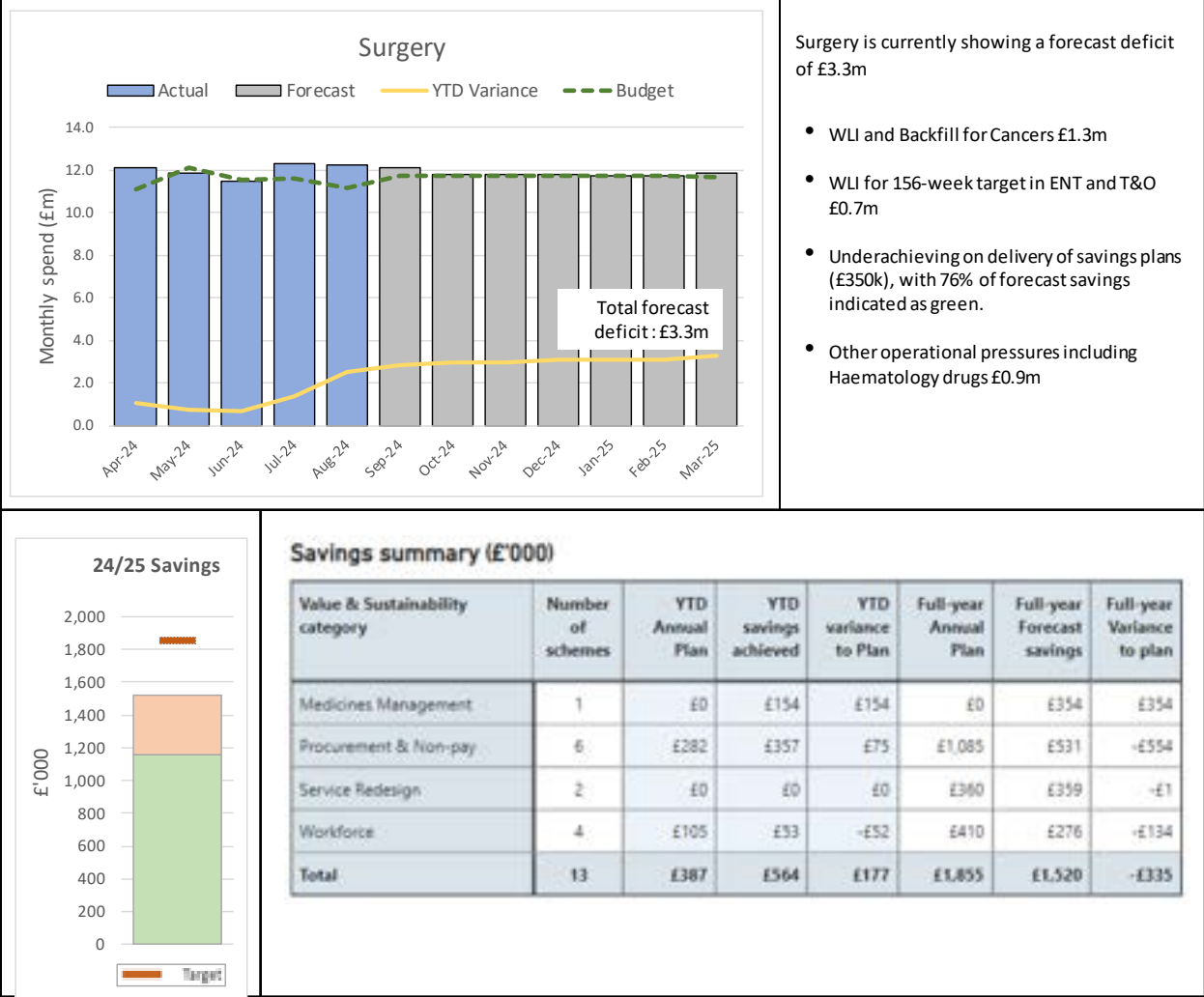
*Scheme PC-44 is replaced by PC-44a. The scheme was originally planned as recurrent but is now shown as non recurrent due to it being related to stock.

Divisional analysis – Prescribing



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
PCC-01	Prescribing savings options / opportunities	R	Month 1	Green	563	1,987	1,988	1
					563	1,987	1,988	1

Divisional analysis – Surgery



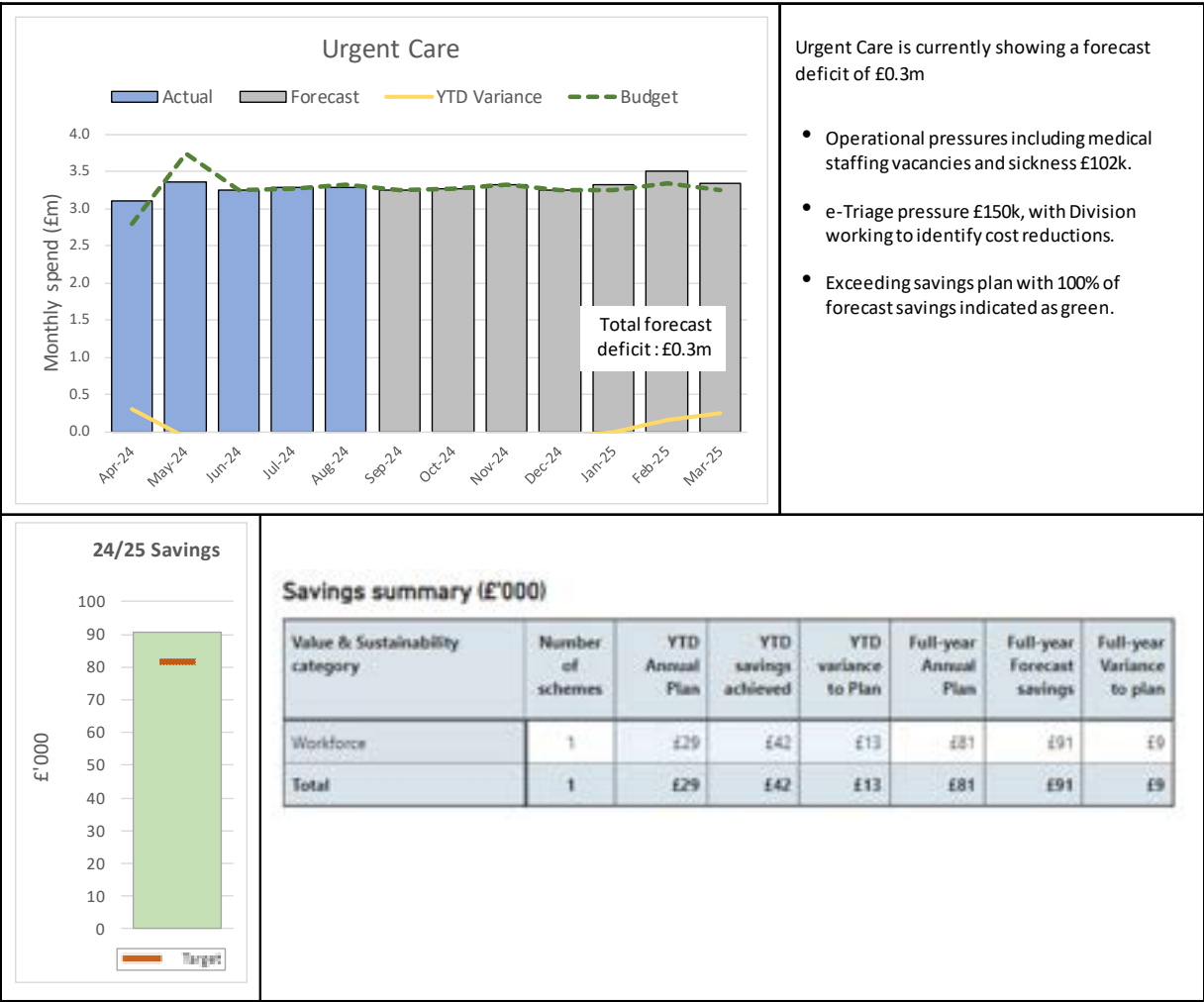
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
SUR-01	Ophthalmology Phaco Lenses and Procedure packs	R	Month 1	Green	33	79	79	0
SUR-02	Intensity Banding for On-call	R	Month 1	Green	5	44	39	(5)
SUR-03	Orthopaedics: Femoral Heads	R	Month 1	Green	22	45	51	6
SUR-04	Orthopaedics: rationalisation of suppliers for hips and knee	R	Month 1	Green	21	50	50	0
SUR-05	Trauma Contract	R	Month 1	Green	30	60	100	40
SUR-06	Bed Day Efficiencies	R	Month 1	Amber	0	205	205	0
SUR-07	Theatre Efficiencies	R	Month 1	Amber	0	155	154	(1)
SUR-08	Reduce Machen Ward Sat - Mon	R	Month 1	Green	8	179	112	(67)
SUR-10	Administration & Clerical Review	R	Month 1	Green	20	187	34	(153)
SUR-11	National priorities/best value biosimilars & Haematology	R	In Year	Green	154	0	354	354
SUR-12	Agency reduction with all junior clinical fellow posts now	NR	In Year	Green	20	0	90	90
OPPS2-11	WRP	R	Month 1	Green	251	251	251	(0)
OPPS2-12	Consignment / other M&SE disposables	R	Month 1	Red	0	600	0	(600)
					564	1,855	1,520	(335)

Surgery continued...

Red savings schemes (listed above) over £200k

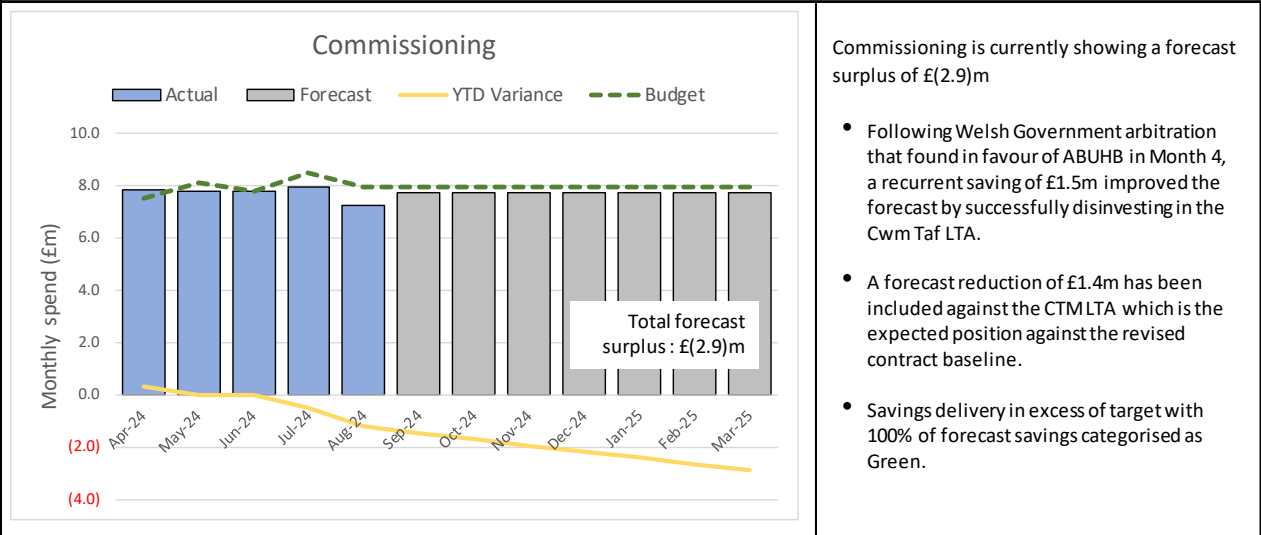
Savings Scheme Number	Scheme / Opportunity	Current Year Annual Plan £'000	Reason for unachievement
OPPS2-12	Consignment / other M&SE disposables	600	Original plan for Consignment Stock saving determined unachievable following technical advice

Divisional analysis – Urgent Care



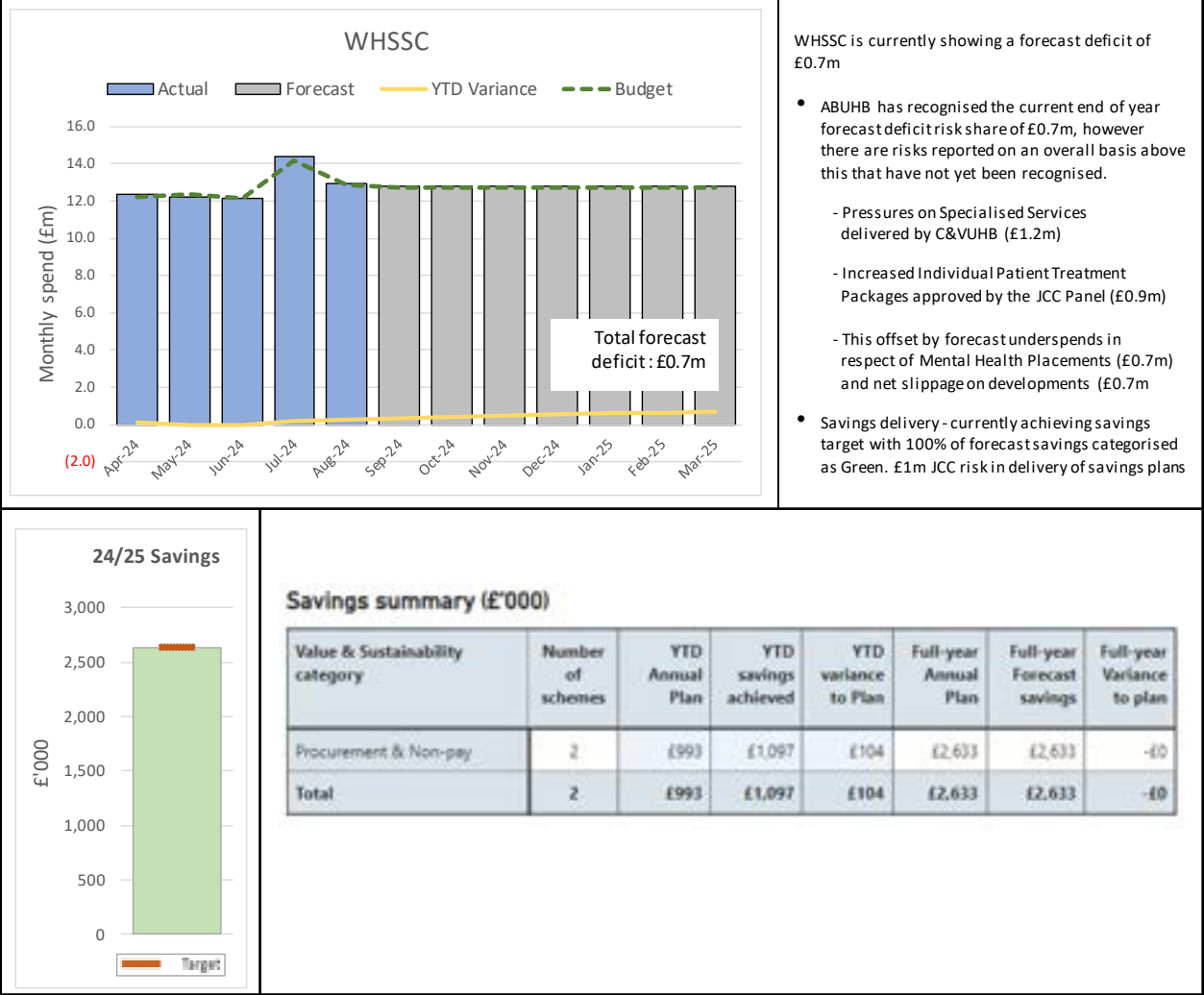
Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
URG-01	Administration & Clerical review	R	Month 1	Green	42	81	91	9
					42	81	91	9

Divisional analysis – External Commissioning



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
COMM-01	Reduction in expenditure for robotic surgery (repat)	R	Month 1	Green	90	406	406	0
COMM-02	LTA reviews	R	Month 1	Green	750	300	1,800	1,500
					840	706	2,206	1,500

Divisional analysis – WHSSC



Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
					Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
WHSSC-01	WHSSC Savings Schemes	R	Month 1	Green	875	2,099	2,099	(0)
WHSSC-02	WHSSC Savings Schemes	R	Month 1	Green	223	534	534	0
					1,097	2,633	2,633	(0)

Divisional analysis – EASC



Reserves

Reserves Delegation:

Following Board budget delegation undertaken in month 2 the reserves position at 31st of August 24 is (£38.239m). This consists of the revised recurrent deficit for 24/25 of £48.859m, specific commitment reserves of £7.577m, allocations to be delegated of £1.371m and items retained to support the deficit position of £0.063m.

The specific commitment reserves include targeted funding to support additional expenditure relating to RTT from August. An Innovation and Development reserve of £2m is being held within reserves of which £0.257m has been delegated for the expansion of the Multiple Sclerosis service, therefore £1.743m is remaining. A further £1.22m is maintained for pass through inflationary costs for other organisations and SLAs.

Funding will continue to be reviewed with further anticipated allocations being retained within reserves pending delegation.

7769-ALLOCATIONS TO BE DELEGATED

Description	24/25
Mental Health 111 Press 2 service funding 24-25	142,857
Real Living Wage (RLW) - 24/25	1,228,074
Confirmed / Anticipated Allocations to be apportioned	1,370,931

7788-COMMITMENTS TO BE DELEGATED

Description	24/25
Innovation and Development Fund	1,743,331
Innovation and Development Fund - RTT	1,000,000
Inflationary pressures reserve	1,220,000
Newport East HWBC (GDS contract increase)	48,000
Newport East HWBC (E&F costs)	66,000
GUH ED Extension	161,000
Prescribing price & volume growth 2024/25	1,800,000
Energy underspend at M4	1,657,000
Pay Matrix: Income via: PHW (core)	(118,000)
Total Commitments	7,577,331

7501-SUPPORTING FINANCIAL POSITION

Description	24/25
Previous balance	1,648,649
Pay Matrix: Income via: PHW (core)	22,639
Total Supporting financial position reserve	1,671,288

7515-IMTP 23/24 DEFICIT

Description	24/25
23/24 recurrent deficit	(112,848,200)
Underlying deficit	28,800,000
Inflationary uplift (conditional recurrent)	35,700,000
Energy	9,854,000
2024/25 budget-setting	(10,364,387)
Total IMTP 23/24 recurrent deficit	(48,858,587)

Totals **(38,239,037)**

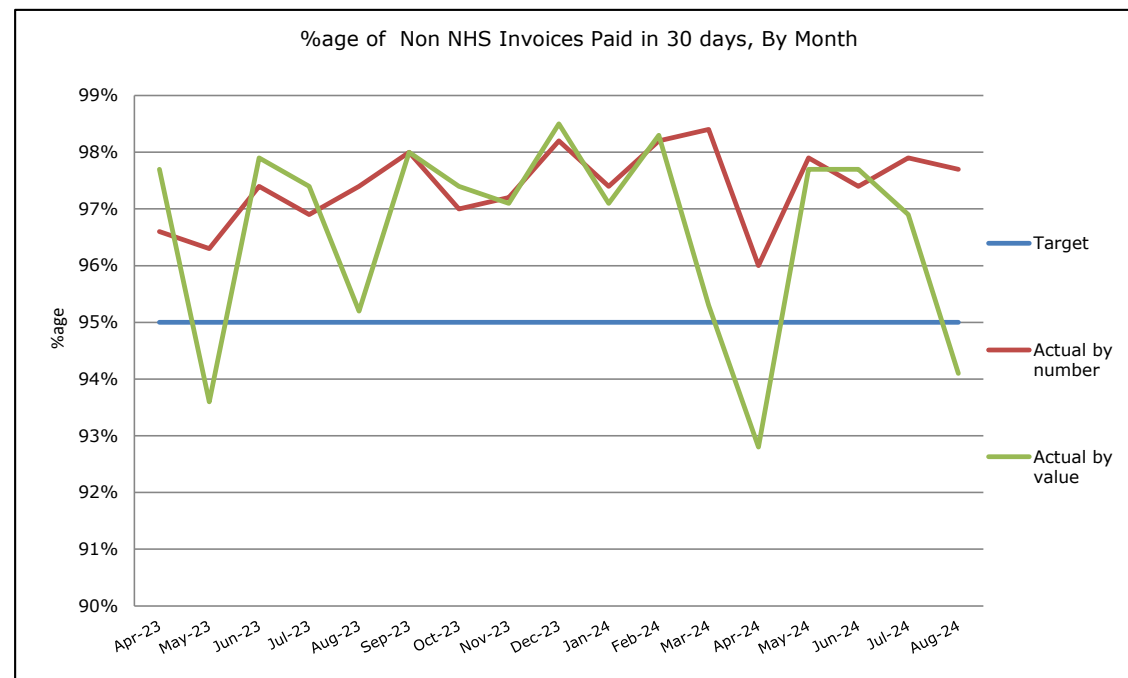
Cash Position

The cash balance at the 31st of August is £5.242m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in August and cumulatively. There has been a decrease in the number of NHS invoices paid within 30 days this month and this remains significantly below target level which is currently being investigated.

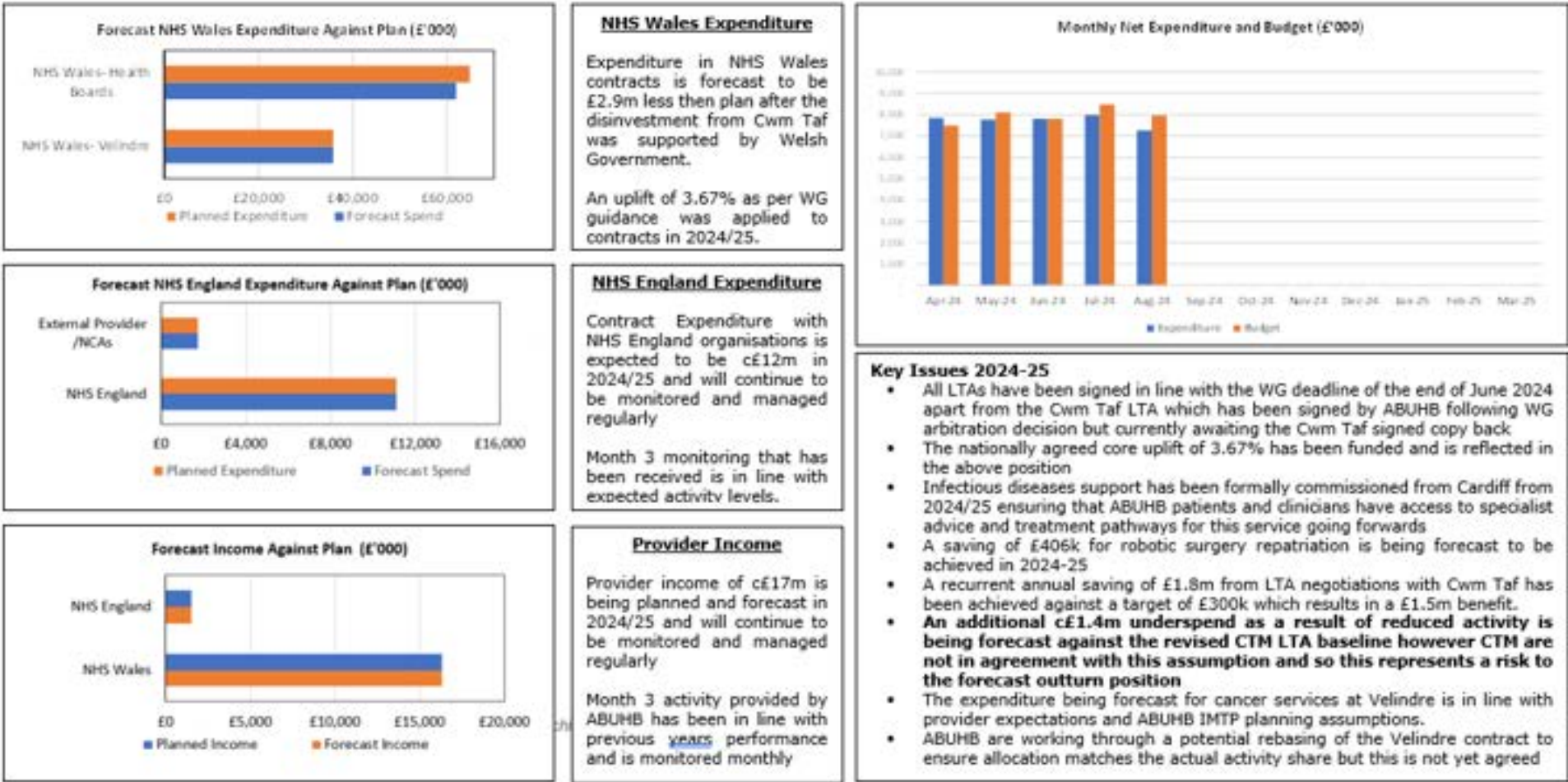
The Health Board performance for the number of NHS creditor invoices paid within 30 days of delivery of goods in August is 87.8% (YTD 91%). NHS Invoices in breach of the 30-day payment terms continue to be followed up with Divisional Managers as necessary.



Contracting & Commissioning – LTA Spend & Income

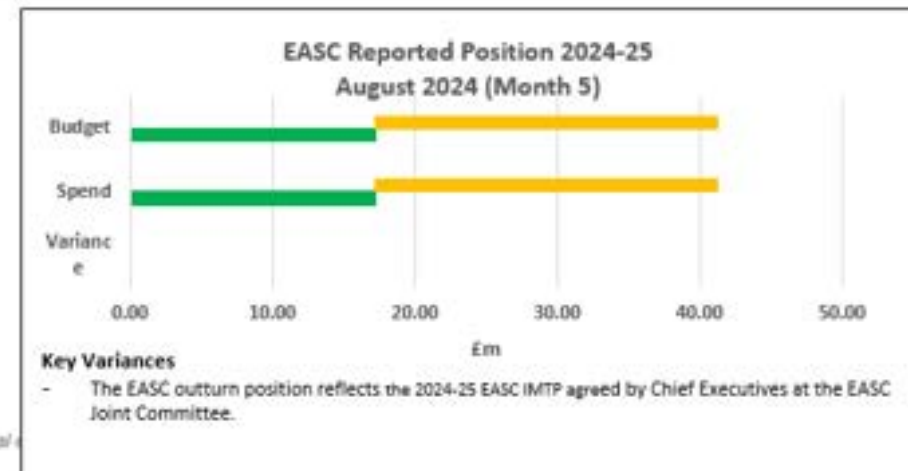
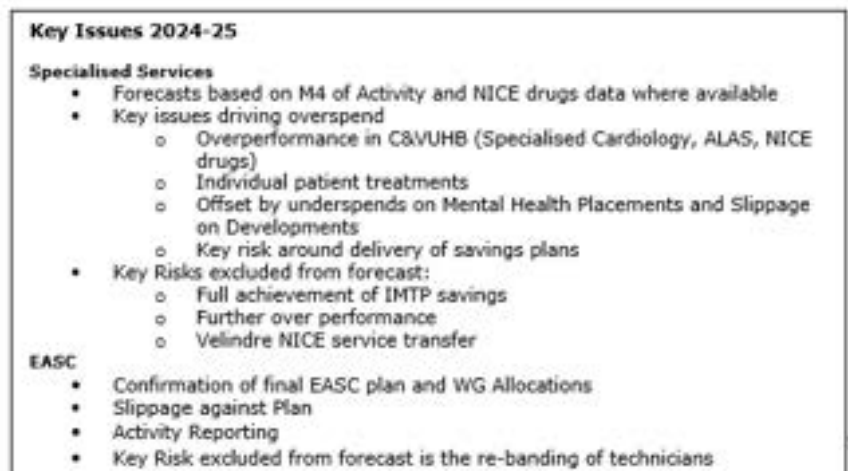
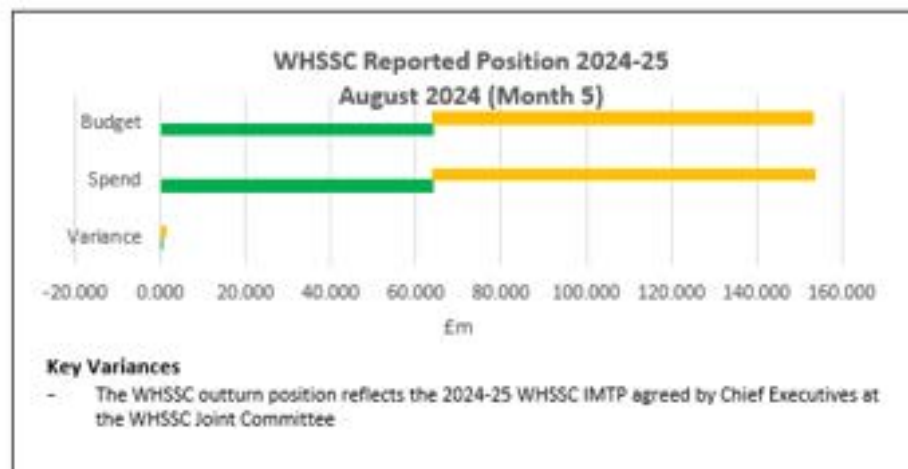
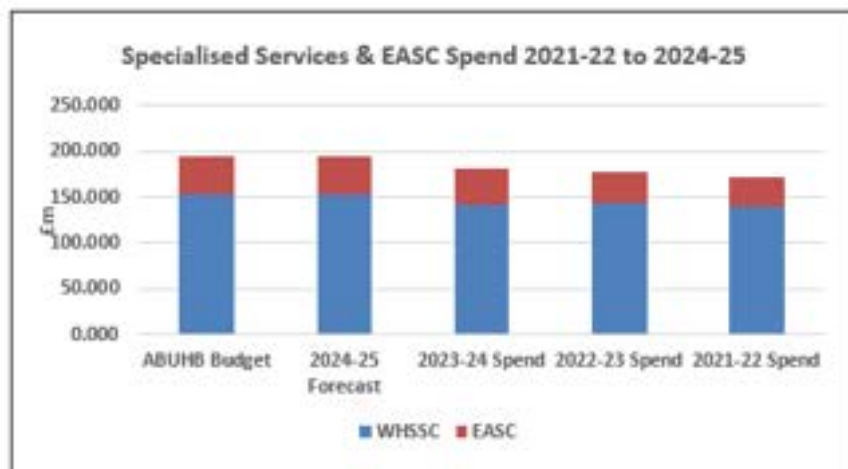
Month/Financial Year:- Month 5 (August) 2024-25

At Month 5 the year to date financial performance for Contracting and Commissioning is £1.208m underspend against the delegated budget, with a forecast year of £2.9m underspend. The key elements contributing to this position at Month 5 are as follows:



JOINT COMMISSIONING COMMITTEE (formerly WHSSC & EASC) Financial Position 2024-25

The Month 5 financial performance for the Joint Commissioning Committee is a forecast overspend of £0.720m. The Month 5 position reflects the agreed IMTP and budget delegation for the Specialised Services (WHSSC) and EASC elements.



Balance Sheet

Balance sheet as at 31st August 2024			
	2024/25 Opening balance £000s	31st August 2024 £000s	Movement £000s
Fixed Assets	910,187	947,342	37,155
Other Non current assets	149,418	153,525	4,107
Current Assets			
Inventories	9,844	10,138	294
Trade and other receivables	136,632	116,025	(20,607)
Cash	4,145	5,242	1,097
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	150,621	131,405	(19,216)
Liabilities			
Trade and other payables	218,038	190,005	(28,033)
Provisions	221,474	197,858	(23,616)
	439,512	387,863	(51,649)
	770,714	844,409	73,695
Financed by:-			
General Fund	581,390	643,756	62,366
Revaluation Reserve	189,324	200,653	11,329
	770,714	844,409	73,695

Fixed Assets

- An increase in net additions of £24.1m in relation to new 2024/25 capital expenditure incurred.
- A reduction of £14.2m for depreciation charges. An increase of £0.4m for IFRS16 related charges.
- An increase in indexation costs of £27.2m

Other Non-Current Assets: This relates to an increase in Welsh Risk Pool claims due in more than one year £4.7m, a decrease in intangible assets of £0.7m and an increase in ICR income due in more than one year of £0.1m since the end of 2023/24.

Inventories: The increase in year relates to changes in stock held within the divisions

Current Assets, Trade & Other Receivables: The main movements since the end of 2023/24 relate to:

- A decrease in the value of debts outstanding on the Accounts Receivable system since 2023/24 to the end of August £4.5m
- A decrease in the value of both NHS & Non-NHS accruals of £21.8m, of which £22.4m relates to a decrease of Welsh Risk Pool claims due in less than one year, £1.1m relates to an increase in NHS & Non NHS accruals and £0.5m relates to a decrease in VAT and other debtors since the end of 2023/24.
- An increase in the value of prepayments held £5.7m

Cash: The cash balance held at the end of August is £5.242m.

Liabilities, Provisions:

- The movement since the end of 2023/24 relates to a number of issues the most significant of which are:- An increase in Capital accruals (£0.1m), a decrease in NHS Creditor accruals (£3.2m), a decrease in the level of invoices held for payment from the year end (£10.2m), an increase in non NHS accruals (£2.5m), a decrease in Tax & Superannuation (£1.5m), a decrease in other creditors (£13.8m), an increase in the liability for lease payments (£0.5m), an increase in payments on account (£2.4m)
- Due to a decrease in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £21.3m and a decrease in other provisions of £2.3m.

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: £1.7bn

Confirmed Allocations as at August 2024 (M5 2023/24)

	£'000
HCHS	1,525,145
GMS	112,737
Pharmacy	34,917
Dental	34,643
Total Confirmed Allocations - August 2024	1,707,441

Plus Anticipated Allocation - August 2024	34,453

Total Allocations - August 2024	1,741,894

Other Income:

The HB receives income from a number of sources other than WG, based on the year-to-date income, this is forecast to be approximately £115m. (£114m for 23/24). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Estimated funding (allocations & income) for the UHB totals £1.86bn (£1.88bn for 23/24).

WG anticipated allocations: £34.5m

WG Revenue Resource Limit : Anticipated Allocations (August)			
Funding Type	Description	Value £'000	Recurrent / Non Recurrent
GMS	GMS Refresh	1,603	R
GMS	Primary Care Improvement Grant	142	R
HCHS	Capital - DEL Depreciation - Baseline Surplus/Shortfall	(1,521)	NR
HCHS	Capital - DEL Depreciation - Strategic	1,933	NR
HCHS	Capital - DEL Depreciation - Accelerated	190	NR
HCHS	Capital - DEL Depreciation - IFRS 16 Leases	3,829	NR
HCHS	Capital - AME Depreciation - IFRS 16 Leases (Peppercorn)	1	NR
HCHS	Capital - AME Depreciation - Donated Assets	333	NR
HCHS	Capital - AME Depreciation - Impairments	45,518	NR
HCHS	Capital - AME Depreciation - Impairment reversals	(19,406)	NR
HCHS	Capital - Removal of Donated assets / Gvnt grant receipts	(200)	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Equip)	(2,300)	NR
HCHS	Revenue Lease Payment Budget Reduction (IFRS16 Prop)	(1,340)	NR
HCHS	Real Living Wage 24/25	4,001	R
HCHS	Technology Enabled Care National Programme (ETTF)	598	R
HCHS	Informatics - Virtual Consultations	578	R
HCHS	Calman SPR's	125	R
HCHS	Clinical Excellence Awards (CDA's)	298	R
HCHS	National Clinical Lead for Falls & Frailty	30	R
HCHS	AHW:Prevention & Early Years allocation	1,114	R
HCHS	WHSSC - National Specialist CAMHS improvements (Tier 4)	234	R
HCHS	Same Day Emergency Care (SDEC)	725	R
HCHS	Urgent Primary Care	647	R
HCHS	VBH: Heart Failure and Rehab in the Community	506	R
HCHS	New Medical Training Posts 2017-2022 cohorts	1,400	R
HCHS	Welsh Risk Pool Risk Share agreement 23-24	(5,511)	NR
HCHS	RIF - Short breaks for Carers	247	NR
HCHS	Planned Care Transformation-3Ps funding	174	NR
HCHS	MCA and DoLs	189	NR
HCHS	MCA - IMCA service	217	NR
HCHS	Planned Care Transformation-Clinical Support SLAs	38	NR
HCHS	Planned Care Transformation-Pathway Alliance Editor Cost	63	NR
Total Anticipated: Per Ledger		34,453	

Capital Planning & Performance

Summary Capital Plan Month 5 2024/25	2024/25				
	Original Plan £000	Revised Plan £000	Spend to M5 £000	Forecast Outturn £000	Variance £000
Source:					
Discretionary Capital:					
Approved Discretionary Capital Funding Allocation	10,814	10,814		10,814	0
Less EFAB Contribution	-725	-725		-725	0
Less AWCP Brokerage 23/24	-230	-1,669		-1,669	0
Plus AWCP Brokerage 24/25	0	0		0	0
Less DCP Brokerage 23/24	0	350		350	0
NBV of Assets Disposed	0	3		3	0
Total Approved Discretionary Funding	9,859	8,773		8,773	0
All Wales Capital Programme Funding:					
AWCP Approved Funding	42,399	53,780		53,780	0
Anticipated AWCP Slippage to return to WG	0	0		-8	-8
Total Approved AWCP Funding	42,399	53,780		53,772	-8
IFRS16 Lease Funding:					
Approved IFRS16 Lease Funding	0	1,642		1,642	0
IFRS16 CRL Reduction for Leased Asset Disposals	0	0		0	0
NBV of IFRS16 Leased Assets Disposed	0	0		0	0
Total Approved IFRS16 Lease funding	0	1,642		1,642	0
Total Capital Funding / Capital Resource Limit (CRL)	52,258	64,195		64,187	-8
Applications:					
Discretionary Capital:					
Commitments B/f From 2023/24	284	382	229	394	12
Statutory Allocations	1,076	1,026	293	1,026	0
Divisional Priorities	3,414	2,640	855	2,640	0
Corporate Priorities	1,267	462	63	462	0
Informatics National Priority & Sustainability	2,257	2,645	1,589	2,645	0
Release of DCP Provision re: Tredegar H&WBC	0	-1,115	-1,115	-1,115	0
Remaining DCP Contingency	1,562	2,733	0	714	-2,019
Total Discretionary Capital	9,859	8,773	1,914	6,766	-2,007
All Wales Capital Programme:					
Grange University Hospital (VAT Recovery)	-3,517	-3,437	-1	-3,437	0
Tredegar Health & Wellbeing Centre Development	0	0	1,239	1,731	1,731
NHH Satellite Radiotherapy Centre	15,755	15,471	7,170	15,471	0
YYF Breast Centralisation Unit	0	111	-2	111	0
Newport East Health & Wellbeing Centre Development	12,754	12,119	8,292	12,247	128
RGH Endoscopy Unit	0	4	7	7	3
RGH – Block 1 and 2 Demolition and Car Park	230	279	-3	389	110
EFAB Schemes	2,612	2,889	814	2,889	0
ICF Schemes	0	8	-3	-3	-11
ED Waiting Area Funding	0	55	54	56	1
CAMHS Sanctuary Hub	1,202	1,226	532	1,226	0
GUH ED Extension	10,879	11,355	1,792	11,355	0
IRCF - Abervalley H&WBC	742	742	49	742	0
IRCF - Dixton H&WBC	742	742	52	742	0
Housing with Care Fund - 2023/24 Schemes	0	21	46	46	25
Digital Year End Funding 2023/24	0	73	45	73	0
Diagnostics Funding 2023/24	0	35	37	47	12
Ty Gwent	1,000	1,219	54	1,219	0
EOY Funding 2023/24	0	49	24	49	0
Head Lease for Chepstow Community Hospital	0	5,550	5,431	5,550	0
Diagnostic Equipment Funding 2024/25	0	497	0	497	0
DPIF - RISP	0	541	41	541	0
Backlog Maintenance 2024-25	0	4,231	0	4,231	0
Total AWCP Capital	42,399	53,780	25,669	55,779	1,999
Total IFRS16 Lease Expenditure	0	1,642	1,641	1,642	0
Total Programme Allocation and Expenditure	52,258	64,195	29,225	64,187	-8
Forecast Break Even against Overall Capital Resource Limit					0

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MONITORING RETURN FOR MONTH 5 2024/25

Director of Finance Commentary for the Period Ended 31st August 2024

Introduction

The purpose of this narrative is to provide a commentary on the financial monitoring returns being submitted to the Welsh Government (WG) by the Aneurin Bevan University Health Board (ABUHB) for the period to 31st August 2024 (Month 5, 2024/25). This commentary will provide an overview of the financial position and performance of the Health Board as at month five of the 2024/25 financial year. It will also provide a detailed narrative, where required, on each of the tables within the accompanying returns, in the format prescribed by WG.

This commentary will also respond, as far as is possible, to the issues highlighted in the WG response letter, the Health Board's response is recorded in the action log included as an Annex 1 to this commentary.

As at Month 05, ABUHB is reporting a year to date deficit of £22.193m with a forecast year end deficit of £47.9m which is £1m lower than the annual plan submission of £48.9m deficit as at 31st of May 2024. There remain risks associated with this forecast position, particularly full achievement of saving opportunities, prescribing / drug cost growth, receipt of anticipated allocations and operational demand & workforce pressures, more detail is provided in this report.

2024/25 pay award costs are not included or anticipated at this time, but it is expected that wage awards and any terms and conditions changes will be cost neutral to the Health Board.

Actual YTD

The month five reported financial position shows a **£22.193m overspend position**; this is presented on the face of **Table B – Monthly Positions**. The table below details the outturn financial position analysed across the Health Board's organisational structure of Divisions and Corporate Directorates. Funding has been delegated following Board approval and subsequent Chief Executive agreement, further delegation of reserve budgets to services is ongoing: -

Summary Reported position - August 2024 (M05)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	292,500	564	435	129
Prescribing	116,133	83	55	28
Community CHC & FNC	69,209	915	941	(26)
Mental Health	141,678	309	317	(8)
Total Primary Care, Community and Mental Health	619,519	1,872	1,748	124
Surgery	139,593	2,483	1,384	1,099
Clinical Support Services	125,980	296	190	106
Medicine	161,059	779	473	307
Urgent Care	39,276	(82)	(47)	(34)
Family & Therapies	133,550	1,012	839	172
Estates and Facilities	93,806	(21)	(159)	138
Director of Operations	10,754	(324)	(351)	27
Total Director of Operations	704,018	4,143	2,329	1,815
Total Operational Divisions	1,323,537	6,015	4,077	1,938
Corporate Divisions	103,974	(1,005)	(1,133)	128
Specialist Services	194,347	300	183	117
External Contracts	95,719	(1,208)	(500)	(708)
Capital Charges	74,749	(35)	(21)	(14)
Total Delegated Position	1,792,326	4,067	2,606	1,461
Total Reserves	(38,239)	18,126	15,558	2,568
Total Allocations	(1,741,894)	0	0	0
Other Corporate Income	(12,193)	0	(0)	0
Total Reported Position	0	22,193	18,164	4,029

Key messages for Month 5

The financial position at 31st of August 2024 shows a £22.193m deficit position, with the key issues in the month described below.

Expenditure in the Health Board for pay increased in comparison with July by £0.7m. Variable pay was £6.7m in-month which was a decrease of £0.1m compared with July. This increase was due to increased enhancement costs, medical substantive costs and overtime across most staff groups. Operational pressures including enhanced care, sickness and vacant posts contribute to this pressure. The focus remains on minimising variable pay with a range of operational actions and savings plans including service re-design and capacity reduction.

Non-Pay Spend (excluding capital adjustments) – has decreased by c.£2m compared with July due to decreased external commissioning and WHSSC spend (catch up pay matrix pass through in month 4) as well as decreased drugs costs in Neurology which is a timing issue with increased costs forecast in September. There is a focussed piece of work underway to review profiles and forecasting of secondary care drugs.

Enhanced care shifts / costs have slightly increased compared with July but remain at a similar level compared with previous months. This is significantly lower than the

2022/23 and early 2023/24 levels. Mental Health remains an area of concern with continued high levels of acuity and absence cover.

CHC costs for Adult Community Care, Mental Health & Learning Disabilities and Children continue to present an underlying financial pressure which shows as a variance in month 5 but is expected to improve in future months due to the profile of savings achievement. Fee uplifts had been assumed at around 7.7% for Adult and Mental Health packages however some uplifts have been agreed at a lower percentage. There remains a risk that Providers could approach the Health Board which could lead to revised uplifts. Additional high-cost packages within Learning Disabilities and Paediatrics may present a further pressure in future months. **The Real Living Wage impact for 2024/25 above National Living Wage has been anticipated (c.£4m). The Health Board is assuming this will be cost neutral (ie funded by WG).**

In January 2024 there was a very high-cost package of 'emergency' care for a paediatric patient which has been in place since April 2023 but only presented and discussed at the Children's CHC panel in January 2024. Legal advice has been sought, with a date being established for a dispute panel meeting (currently indicated as end of September 2024).

Prescribing costs present a financial pressure compared with IMTP financial forecasts, this is reflected in the year. The average cost per item for 2024/25 has increased from £7.29 (Annual Plan) to £7.52 (June PAR). Growth is assumed to be 0.8% for 2024/25 and will be reviewed further using future PAR data.

Energy costs reflect the latest forecast received on the 10th June as well as further local Divisional forecasts. The annual plan estimating growth of £2.069m has been reduced to c.£0.1m. The price and usage are being monitored. This forecast remains under review from the Estates & Facilities Division.

On-going acute secondary care drugs growth presents a significant pressure above planned levels. Previous NICE indications within Haematology and Dermatology along with continued activity growth in Ophthalmology, Gastroenterology and Neurology contribute to this pressure. The National V&SB procurement and Medicines Management savings opportunities are being reviewed and actions are being progressed to deliver any opportunities not within the current plan. Any further savings or mitigating actions deliverable for ABUHB in 24/25 will be progressed as soon as possible.

1. Actual YTD and Forecast Under / Overspend (Tables A, B, B2 & B3)

Table A – Movement of Opening Financial Plan to Outturn

The Board's identified aims for the 2024/25 financial plan are to achieve an improved revenue position compared with 2023/24, a positive movement towards achieving the WG control total and an improved underlying deficit, through achieving at least 2% savings.

As of month 5 the Health Board continues to reflect its revised year-end forecast deficit of £47.9m, which is £1m lower than the annual plan submission of £48.9m deficit as at 31st of May 2024. This is the result of:

- CTM arbitration on base LTA case £1.5m
- CTM month 5 under-delivery at marginal rates forecast £1.4m
- Additional prescribing costs above plan due to increased average price per item using quarter 1 24/25 PAR data and Apixaban NCSO (+£3.1m),
- Recognition of WHSSC current forecast over-performance (+£0.7m),
- Operational pressures in particular drugs (Surgery & Medicine), Gynae medical staff and Nursing maternity leave (+£2.1m)
- Increase in forecast savings (£1.2m)
- Assumed income for PADM's / Dispensing Dr's funding (£1.1m), Optometry contract funding (£0.8m), and International recruitment (£0.9m)

A reconciliation of the Annual Plan to the month 5 position is presented below:-

Category	March submission	May submission	Month 4	Month 5
Underlying deficit b/f (£m)	81.4	81.4	81.4	81.4
Cost pressures identified (£m)	59.8	59.8	59.8	59.8
WG discretionary funding (£m)	(51.8)	(51.8)	(51.8)	(51.8)
Identified savings (£m)	(29.1)	(34.4)	(40.5)	(40.5)
Pipeline opportunities (£m)	(11.4)	(6.1)	-	-
Sub-total deficit (£m)	48.9	48.9	48.9	48.9
CTM arbitration case benefit & revised performance	-	-	(1.5)	(1.5)
CTM under-delivery at marginal rates				(1.4)
Prescribing average price per item increase and NCSO				3.1
WHSSC forecast pressure (£m)			0.7	0.7
Operational pressures in particular Surgery drugs, Gynae medical and nursing maternity leave			0.9	2.1
Increase in forecast savings (Month 5 inc. Rivaroxaban)				(1.2)
PADMs & Dispensing Drs, International Recruitment and Optometry funding			(1.1)	(2.8)
Total deficit	48.9	48.9	47.9	47.9

As at month 5, the savings forecast is now £43.5m against the plan of £40.5m. This includes savings for the impact of the arbitration case above savings plan levels, with CTM (£1.5m) alongside several additional schemes. The savings off-set operational

pressures including the in-month performance pressures. In month 5, additional savings for the Primary Care drug Rivaroxaban off-set overall prescribing average price per item increases. CTM underperformance benefit of £1.4m is included in the forecast – this is required to maintain the forecast reported.

CTMUHB are continuing to ignore the arbitration decision made by WG and are refusing to sign the LTA agreement, this has been escalated to CEO level.

The carry forward underlying deficit for 2025/26 is determined as £55m. This is reflective of the 2024/25 recurrent forecast deficit, after accounting for non-recurrent savings, costs and funding including the benefits described above.

A high level 'route map' to recurrent financial recovery has been developed with the detail being worked up by Finance, Planning and Workforce business partners and the divisions.

The Executives and Board have allocated leads for the National Value & Sustainability themes as part of revised escalation arrangements as part of the ABUHB Value and Sustainability Board to progress savings, mitigations and delivery of core themes:-

- CHC – Executive Lead Leanne Watkins
- Medicines Management - Executive Lead Leanne Watkins
- Non-pay – Executive Lead Rob Holcombe
- Workforce – Executive Lead Sarah Simmonds
- Service reconfiguration – Executive Lead Hannah Evans
- Prevention - Executive Lead Tracy Daszkiewicz
- Digital – Executive Lead Paul Solloway

Updates are provided and discussed on a weekly basis.

Table B - Monthly Positions

The year to date reported position is a £22.193m deficit position (compared with the forecast MMR profile year to date deficit of £22.169m).

Material differences of actual expenditure compared to month 4 and the forecast are as follows:-

- *RRL* – The difference in-month relates to capital depreciation/impairment anticipated allocations. In month 6 additional allocations will be anticipated for PADM's / Dispensing Doctors, Optometry and International recruitment costs, these currently support the financial forecast.
- Primary Care Contractor – the in-month and forecast expenditure is slightly lower than forecast due to GMS costs below planned levels. This is likely related to coding between primary care and provider services pay for areas

such as GPOOH once this is confirmed the forecast expenditure will be reviewed to reflect the coding of the spend.

- *Primary Care – Drugs and Appliances* – forecast expenditure has significantly increased using PAR data received for quarter 1 2024/25. The average price per item increase is significantly above planned levels with no known further mitigating factors within prescribing (£2.5m). In addition, Apixaban NCSO forecast impact has been included (£0.6m).
- *Provider Services – Pay* – costs are higher than forecast due to the operational pressures linked to medical vacant posts, enhanced care, sickness and Health & Safety issues. The forecast costs continue to increase based trends and known additional costs in order to achieve 104 and 156-week targets. A review with Primary Care pay is pending which may impact this split by categories for future months.
- *Provider Services – Non-Pay* – expenditure is slightly higher than forecast in-month 5 due to additional non-pay consumables in areas such as theatres. The volatility of expenditure in various areas e.g. TEC Cymru will mean that the forecast will require further amendments given the impact of RPB/TEC Cymru expenditure which is under several categories.
- *Continuing Care and Funded Health Care* – forecast expenditure has decreased in line within Divisional plans due to lower growth than forecast.
- *Healthcare Services Provided by Other NHS Bodies* – in-month and forecast expenditure has decreased reflecting the LTA under delivery forecast benefit with CTM. There is continued concern with the forecast deficit being reported by JCC for specialised services.
- It should be noted that TEC Cymru is moving to the NHS Executive as of 1st September 2024. Income and expenditure is shown within table B pending confirmation of final figures. These will be adjusted once finalised.
- There are allocations to be anticipated for Dispensing Drs / PADMs, Optometry and International Recruitment. This will be reflected in the appropriate categories within income and expenditure at this point.

In response to Action point 4.3;

- The Revenue Resource Limit is phased in line with the expected use of the resource, effectively related to the delegated budgets to Divisions which are phased in accordance with expenditure plans. In addition some allocations are held in month 12, for example AME impairment costs are assumed to be incurred in Month 12 which is matched with the equivalent funding. The remaining reduction in expenditure forecast for the second half of the financial year relates to the impact of savings plans across most expenditure categories.

- Primary Care Contractor costs are forecast in line with expected spend profiles, they will increase in the second half of the financial year due to GMS, Pharmacy, Dental, Optometry contract.
- Provider services – Non-pay are forecast in line with expected spend profiles, there is an expected increase in the second half of the financial year due to increased activity linked to RTT and specific issues such as energy usage.

In response to Action point 4.4;

- Healthcare Services Provided by Other NHS Bodies forecast increased by £10.1m due to the pay award elements for other NHS bodies being included in forecast costs for 2024/25 (pay-matrix adjustments). The monthly forecast costs are now broadly the average of months 1-4.
- Secondary Care – Drugs forecast movement of £2.5m relates to the impact of growth in a number of specialities including Haematology (new NICE indications), Gastroenterology (activity growth), Dermatology and Ophthalmology (activity and new pathway treatments). There is a continued and further risk across these specialties given latest discussions on forecasts alongside further NICE pressures (e.g. Nephrology).
- Continuing Care and Funded Nursing Care forecast decreased by £2.4m due to a reduced forecast in Mental Health CHC growth numbers. This is under continual review and has been further updated for month 5 based on latest service discussions.

Table D shows the year-to-date and forecast depreciation position for the Health Board based on the final asset values for 2023/24 and the 2024/25 capital schemes approved in the CRL issued on 4th September 2024. The DEL and AME depreciation figures included in Month 5 are as per the August Non-Cash return submitted on 29th August 2024.

AME Impairment estimates have been updated as per the August Non-Cash return. These figures are estimates and may be subject to change when the final valuations are undertaken on scheme completion. The reversals of impairment funding requirement has been calculated using existing indexation rates and may be subject to change if revised rates are circulated by the Valuation Office Agency during the financial year. The anticipated allocations included at Month 5 are summarised in the table below:

	Forecast per M05-25 MMR / August Non-Cash return
Anticipated Allocations	£000
DEL - Baseline Depreciation Shortfall	(1,521)
DEL Strategic depreciation Support	1,933
DEL Accelerated Depreciation	190
DEL IFRS16 Leases Depreciation	3,721
DEL Impairment Funding	0
Total DEL Funding	4,323
AME Donated Asset Depreciation	333
AME Impairment Funding	45,518
AME Reversals of Impairment Funding	(19,406)
AME IFRS16 Leases Depreciation	109
Total AME Funding	26,554
Donated & Granted Assets Credit	(200)
Total Allocations (excluding DEL Baseline)	30,677

Section F describes the 2024/25 energy costs forecast, the breakdown of the full year energy cost forecast is as follows:-

- Shared service contract element - £17.305m
- Other gas and electricity costs - £0.396m
- Total forecast energy costs in section F - £17.701m

It should be noted that this forecast does not include energy management related contracts, water, sewage, staffing and other fuel costs which are part of the utilities directorate within the Health Board.

The reduction in the energy forecast has been shown as a distinct in year savings plan. It should be noted that there is some risk linked to non-commodity prices later in the year if they increase.

Table B2 – Pay & Agency (Section A)

This table has been completed in line with the guidance. Pay expenditure forecast costs have continued to increase due to continued operational pressures especially relating to maternity nursing (maternity leave pressures) and Gynaecology medical staffing (vacancies and other specific issues). Additional forecast costs for RTT performance (104 and 156-week waits) are also included in the forecast.

Table B3 – Covid-19

Total Covid-19 costs are shown as £12.4m for which funding has been received as part of the Health Board's allocation letter and is broken down as follows:-

- Health Protection and Immunisation (Mass Vaccination) - £10.080m
- PPE - £1.120m

- Adferiad (Long Covid) - £1.216m

The Health Board continues to have surge capacity open which is a legacy of Covid-19. The Health Board also continues to incur legacy costs which form part of the underlying deficit linked to estates & facilities costs. The list below is not exhaustive but includes: -

- Enhanced Cleaning
- Additional security and rental of portacabins

2. Underlying Position (Tables A1)

The Underlying (U/L) position is a brought forward value of £81.4m with a forecast carry forward deficit into 2025/26 of £55m.

This is reflective of the annual plan submission of £52m with a number of additional costs incurred outside of the submitted financial plan which result in recurrent expenditure. These include:-

- Additional cancer and urgent diagnostic activity requiring WLIs and mobile MRI capacity - £2.5m. The MRI capacity requirement is assumed to be recurrent and therefore the additional costs are required.
- Increased prescribing costs through increased average price per item alongside additional direct delivery vaccines - £1m. Average price per item costs continue to increase with some off-set due to lower volume growth rates. Rebates and savings plans are mitigating some of this pressure however NCSO and Category M prices are also presenting a recurrent pressure.
- Gynaecology and Maternity variable pay pressures through increased vacancies, sickness and increased maternity cover - £0.5m. Divisional assurance meetings will review the position and potential actions to mitigate where possible.
- CTM arbitration case benefit off-set by WHSSC pressures forecast as at month 4 reducing the underlying deficit by £1.0m

The underlying deficit position is under regular review and forms part of the draft 3-year 'route map' which will be discussed at the next ABUHB Board meeting.

As part of internal Divisional assurance, specific Divisional financial performance meetings and Executive Committee meetings; the elements and cost drivers making up the underlying deficit are under regular review in order to ensure an up to date picture and to review actions to address the growth/pressure.

3. Risk Management (Table A2)

The risks listed in table A2 which present a significant financial risk to the Health Board include:-

- Continuing Healthcare fee uplifts - £1m
- Prescribing average price per item (and number of items) growth above quarter 1 PAR data and associated forecast - £2m
- Additional operational and service pressures outside of the annual plan. This includes costs for Health & Safety issues, Diabetes, CAMHS, Winter and the infected blood inquiry. This has increased this month given the continued pressures relating to Acute NICE drugs - £3.4m
- Delivery of savings plans including mitigating actions against operational pressures – c.£0.8m
- Delivery of 6 goals target with resultant income clawback risk - £1.4m
- Risks of non receipt (full receipt) of all assumed (not yet anticipated) income in particular include funding for PADM's / Dispensing Drs, Optometry and overseas nurse recruitment - £2.9m
- CTM LTA not signed by CTM and under performance not recovered £1.4m

The following items are listed as opportunities pending further analysis and delivery via the Value & Sustainability Board and relevant Divisions / Departments:-

- Variable pay reduction linked to Administration & Clerical and Enhanced Care service reviews
- Service re-design – bed reductions
- Commissioning – LTAs and EASC

In addition, there are a number of further significant challenges to the financial forecast for 2024/25, which are currently assumed to be mitigated by the Health Board or require further information to enable an accurate financial value to be assigned. These include:

- Ensuring full delivery of savings plans identified in the annual plan including the pipeline opportunity values,
- Receipt of all anticipated allocations including performance requirements in order to secure full retention,
- Workforce absence / vacancies, availability of staff for safe service delivery,
- Delayed transfers of care due to LA service challenges,
- Funding for any wage award or change in terms and conditions,
- Impact on service delivery and performance on waiting times because of savings required,
- Establishment increases relating to patient safety issues,
- Inflationary impacts including provisions and supplies,
- Additional revenue costs due to IFRS 16,
- Specific economic factors such as supply chain issues and non-pay inflation including travel expense costs, and
- Health & Safety fines.

Opportunities for the Health Board include:

- VAT rebate opportunities,

- Other income / funding opportunities,
- Energy forecast changes,
- Work to identify new pipeline opportunities, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.

In response to Action points 4.1 & 4.2; the narrative has been updated accordingly.

4. Ring Fenced Allocations (Tables N, O & P)

Table P has been completed but will be subject to review and refinement for future months. With regards to Mental Health SIF, this funding has been delegated to the Mental Health / Family and Therapies divisions who are currently operating to deliver all service priorities and are over-committed in terms of budget variance.

Tables N (GMS) and O (Dental) will be completed from month 6.

5. Agency / Locum (Premium) Expenditure (Tables B2 Sections B & C)

Variable and agency expenditure continues at a high level, albeit reduced compared with 2023/24. Expenditure in month 5 of £7m was at a similar level compared with July. Medical cover for vacant posts and additional RTT activity continue which have increased the forecast for future months.

6. Savings (inc Accountancy Gains & Income Generation) (Tables C, C1, C2 & C3)

As part of the annual plan submitted by the Board to Welsh Government (March 2024), the financial plan for 2024/25 identified 2 elements to the savings plans for 2024/25:-

- Divisional plans alongside Corporate schemes and targets - £29.1m
- Pipeline opportunities - £11.4m

As at month 5 the pipeline opportunities of £11.4m have now been converted into savings schemes.

Category	March submission (Plan)	May submission (Plan)	Month 4	Month 5
Savings forecast (£m) - Green	(25.2)	(19.3)	(38.1)	(38.9)
Savings forecast (£m) - Amber	(3.9)	(15.1)	(4.2)	(4.6)
Pipeline opportunities (£m) - Red	(11.4)	(6.1)	-	-
Total Savings forecast	(40.5)	(40.5)	(42.3)	(43.5)
CTM under-performance				(1.4)
Total Savings improvement including CTM under-performance				(44.9)

The Health Board will continue to pursue further opportunities to mitigate / offset the risk to the planned savings and increases in new operational pressures.

The month 5 year to date delivery of savings plans is £13.3m. Planned (Month 1 and In Year) savings for this period were £12.2m. The additional savings above plan relate to a wide range of areas including CTM, Primary Care drugs off-patent (Rivaroxaban), energy forecast reduction, Welsh Risk Pool income as well as smaller workforce and medicines management savings.

CTM performance variance may be at risk if CTM do not sign the LTA in line with the WG arbitration direction.

The Health Board continue to operate a Bi-weekly Value & Sustainability Board to identify and monitor savings delivery & new opportunities.

7. Income Assumptions 2023/24 (Tables D, E & E1)

Table D – Welsh NHS Assumptions

This table has been completed in line with the guidance.

Table E - Revenue Resource Limit

This table has been completed in line with the guidance. The Month 05 financial position is based on total allocations of £1,741.9m, of which £1,707.4m are received and £34.5m are anticipated.

Allocations are anticipated on receipt of a notification from WG, including Policy Leads and finance colleagues.

In response to Action point 4.7a; this is noted and a review of the analysis of this anticipated funding has been undertaken. The revised analysis broadly assumes 75% of contractual forecast CHC expenditure in order to calculate the anticipated funding value. This is being reviewed with services to ensure only associated contractual expenditure is included. The anticipated funding value remains at c£4m.

The Health Board's forecast is reliant on the receipt of the following allocations:-

- Dispensing Drs / PADMs (c.£1.1m) discussions with WG have taken place and are awaiting finalised correspondence in order to anticipate funding.
- Optometry contract (c.£0.8m-£1.1m) – received WG correspondence on the 9th September which should result in additional income. Currently reviewing against forecast expenditure.
- International recruitment (c.£0.9m) – e-mail correspondence received however will need to be reviewed against forecast costs.

The Health Board has been made aware of additional targets that must be met in order to receive the full value of the local 6 Goals funding, this could be a risk to funding of c.£1.4m. At this stage the Health Board is assuming it will receive all of this funding.

A list of anticipated allocations is included in Table E.

The Capital MMR table shows the outturn capital charges position for the Health Board. The position confirms the DEL and AME outturn positions which includes the allocation adjustments agreed with WG colleagues. All figures are subject to change.

8. Healthcare Agreements and Major Contracts

LTAs have been agreed with all provider and commissioners with the exception of Velindre NHS Trust and CTMUHB.

Financial agreements have been reached with Velindre, however, there are some on-going discussions regarding activity delivery assumptions. This is being discussed and taken forward with the Velindre Director of Finance.

ABUHB sent a signed LTA document reflecting the Welsh Government arbitration outcome to CTMUHB on 31st July and we are awaiting the return of the document signed by the CTMUHB Chief Executive. The message the Health Board has received informally is that CTM do not accept the activity quantum but no information beyond that has been shared. The Chief Executives and Directors of Finance from each organisation are taking this forward.

In response to Action point 4.6: The arbitration outcome is fully reflected in the Health Boards Financial position, however, at month 4 CTM had not reflected this in their Income & Expenditure assumptions. CTM are correcting this for month 5.

In month 5 Aneurin Bevan is reflecting an element of in year underperformance against the contracted activity, this is £1.4m and this will be shown as a difference in the Income / Expenditure assumptions in table D between Aneurin Bevan and CTM.

ABUHB has recognised the JCC current end of year forecast deficit risk share of £0.72m, however there are risks reported, on an overall basis, above this that have not yet been recognised. Including:

- Savings achievement – overall plans to be found for £3m
- NHS England wage award – assumed funding from WG
- The transfer of Velindre non -specialist and drugs pass through, where funding will be transferred on a 23/24 basis – no variances against this are currently shown as it was not clarified in the JCC IMTP but could be c£1.2m pressure for ABUHB
- WAST - £3.2m risk for Technician re-bandings. Currently assumed WG funding available.
- Any over-performance as a result of meeting the Ministers KPI's – ie Plastics.

JCC have a work plan culminating in a committee meeting on the 17th September, where they will provide a full update on the forecast to the JCC and potential options required to break even overall, this may then result in a revised forecast for ABUHB.

9. Statement of Financial Position and Aged Welsh NHS Debtors (Tables F & M)

Table F – Statement of Financial Position

The main changes in the balance sheet between Month 5 and Month 4 relate to:

- A net reduction in trade and other receivables of £13m. This is mainly due to a decrease in Welsh Risk Pool income of £9m, a decrease in the value of invoiced debts outstanding of £4m and an increase of £2m for NHS Accruals and a further decrease in prepayments of £1m. The decrease in the income from the Welsh Risk Pool is offset by a reduction in the Clinical Negligence and Personal Injury provision.
- A net reduction in trade and other payables of £13m from Month 4. This is mainly due to a reduction in Non-NHS accruals of 11m, other payables £1m, payments on Account of £2m and an increase of £2m for accruals relating to goods received not invoiced with other small increases in CHC accruals and NHS creditor accruals.

Table M - AGED WELSH NHS DEBTORS

At the end of August 2024, the Health Board had 8 invoices outstanding with other Welsh Health Bodies totalling £188,319.

Digital Health & Care Wales – 1 invoice totalling £11,874. We have contacted DHCW to request an urgent payment date of the invoice.

Public Health Wales NHS Trust - 2 invoices totalling £72,904. One invoice for £63,000 has since been paid. We have contacted PHW to request a payment date of the remaining outstanding invoice.

Cardiff & Vale University Health Board – 1 invoice outstanding for £6,697, which has since been paid.

Powys Teaching Local Health Board – 4 invoices outstanding totalling £96,845. Three invoices totalling £92,374 have since been paid, and we have been notified that the remaining invoice has been sent for approval prior to payment.

10. Cash Flow Forecast (Table G)

The cash balance held at the end of August is £5.242m which is made up of £3.076m relating to revenue and £2.166m relating to Capital. The balance is within the advisory figure set by Welsh Government of £6m.

The Health Board is forecasting an overspend of £47.856m in 2024/25. This overspend has been reflected in the cash flow table and will require strategic cash support towards the end of the year.

Currently, the Cashflow is reflecting the following:

	P01-25	P05-25	P12-25
	Opening	Current	Closing
	£'000	£'000	£'000
Capital Balance	793	2,166	35
Revenue Balance	3,352	3,076	(46,056)
Total Balance	4,145	5,242	(46,021)

The cash flow table is showing a forecast overdrawn balance of £46.021m in March 2025, which is made up of the following and assumes a cash balance held at the end of 2024/25 of £1.835m (£1.8m revenue and £0.035m capital).

	Revenue	Capital	Total
	£'000	£'000	£'000
C/F Balance	1,800	35	1,835
Deficit/ Strategic Cash	(47,856)	0	(47,856)
Total	(46,056)	35	(46,021)

11. Public Sector Payment Compliance (Table H)

This table is not required for month 5.

12. Capital Schemes & Other Developments (Tables I, J & K)

Table I has been completed in line with the latest CRL issued on 4th September 2024.

The approved Capital Resource Limit (CRL) as at Month 5 totalled £64.192m. Forecast overspends totalling £1.993m against various All-Wales Capital Programme (AWCP) schemes (detailed further below) are being offset by a corresponding under spend against the Discretionary Capital Programme (DCP). The overall underspend of £0.008m shown relates to funding to be returned in relation to the ICF Pontllanfraith Feasibility scheme.

Table J indicates a validation error against the minimum in year forecast for the Grange University Hospital - Brokerage pending VAT reclaim scheme. This is due to the current YTD spend being more than the minimum spend forecast. The validation error

will be corrected when the expected VAT recovery credit is received and factored into the minimum spend validation calculation.

AWCP Schemes

Newport East HWBC

Construction of 19 Hills Health and Well-being Centre (Newport East) is progressing well. Phase 1 handover is forecast to be 6th December 2024. The overall project budget remains under pressure due to additional asbestos and utility costs with a forecast overspend of £172k which is currently being funded by DCP. A further funding bid is intended to be submitted via the Integration and Rebalancing Capital Fund (IRCF) route to mitigate the position.

NHH Satellite Radiotherapy Centre (including RAAC works)

Works at NHH Satellite Radiotherapy Centre are progressing well with completion forecast to be February 2025. The overall scheme is forecast to be £0.541m under budget largely because of VAT recovery savings. The 2024/25 resource limit was reduced during June by £0.500m to reflect the expected under spend in the current financial year. There is potential for further slippage if the contingency budget is not required in full in 2024/25, however, the project team are currently working through risks related to potential asbestos delays, PSBA installation delays and temperature control in relation to the linear accelerator installation. There is also a potential gainshare which could reduce 24/25 expenditure further as the contractor is currently forecasting a defined cost that is £644k plus VAT below the agreed revised contract prices. It is expected that a firmer gain share position will be available in October / November 2024.

EFAB – National Programmes: Infrastructure / Fire / Decarbonisation

Several of the larger EFAB schemes that commenced in 2023/24 continue into 2024/25 and are at various stages of progress. Glan Usk roof replacement, Ty Cyfannol windows replacement and other small projects are nearing completion, while St Cadoc's Duct safety works and the Fire alarm replacements at RGH and St Cadoc's are expected to continue to the end of March. Proposals for RGH Cordell Centre within the EFAB funding have now been revised. All EFAB schemes are anticipated to complete during 2024/25.

CAMHS – Sanctuary Hub (Plaid agreement and HCF Funding)

The CAMHS Sanctuary Hub scheme has been delayed due to asbestos removal with expected completion now anticipated for October 2024. The scheme is currently anticipated to be within budget.

Grange University Hospital – VAT Reclaim

The final VAT recovery claim for the main scheme was submitted to HMRC in September 2023. The Health Board are chasing an update from HMRC as there have been no further questions raised by HMRC since the last information was submitted in May 2024. It is currently anticipated that the final claim will be agreed in 2024/25, however, this assumption will need to be reviewed prior to fixing the CRL allocations

in October if the claim has still not been approved. As the final claim submitted (based on a recovery rate of 29.49%) is £3.690m higher than the agreed CRL budget, the minimum in year forecast assumes the claim is approved in full by HMRC. The maximum in year forecast estimate included in table J reflects the position if HMRC does not agree the claim in the current financial year and the agreement is pushed to 2025/26. The Health Board is aware of schemes in other organisations where the final claim is still not resolved 18 months after submission.

GUH Emergency Department Extension

A revised programme of works has been received for the Grange Emergency Department Extension scheme. The anticipated completion of Phase 1 is now April 2025 with Phase 2 estimated to be July 2025, however, the project team are looking at potential options to accelerate the programme. The overall scheme is currently anticipated to be within budget. Despite a revised cashflow being submitted with the new programme, year to date expenditure is £0.410m behind plan due to a further 2 weeks programme extension in relation to piling works and other ground issues impacting the programme.

Ty Gwent

The building lease was signed in early March following WG approval. The initial set up works and IT infrastructure requirements are being progressed with full spend expected to be achieved this financial year. Staff are expected to commence moving into the building in late October / November.

RGH Blocks 1 & 2 Demolition and Car Park

A forecast over spend of £0.110m is being reported against the RGH Blocks 1 & 2 Demolitions and Car Park scheme because of additional asbestos and delays due to nesting birds. This overspend is being funded via the DCP. Further survey works are required to be completed by the Civil Engineers before the programme can be confirmed.

YYF Unified Breast Unit

The final account is being agreed for the new Unified Breast Unit at YYF. Once agreed, the final VAT recovery claim can be made to HMRC. The allocation of £0.111m confirmed for 2024/25 is being used to support additional equipment and IT requirements for the unit.

RGH Endoscopy

Expenditure against this scheme is now complete and was £3k over the allocation carried-forward to 2024/25

DPIF – Digital Year End Funding – January 2024

The slippage amount of £20k is expected to be spent by the end of the financial year.

ICF – Pontllanfraith Feasibility

This scheme is now complete with a saving reported of £8k. The funding remaining will need to be repaid via the RPB process.

Emergency Department Improvements – 2023/24

Spend against the slippage amount of £55k is expected to be complete by quarter two of 2024/25.

Housing with Care Fund

Spend against the slippage amounts totalling £21k is now complete. Further allocations are awaited in relation to 2024/25 schemes.

DPIF – Digital Year End Funding – February 2024

The slippage amount of £53k is expected to be spent by quarter two of 2024/25.

Diagnostic Equipment

Spend against the slippage amount of £35k is now complete.

Year End funding – January 2024

Spend against the slippage amount of £49k has commenced and is expected to be completed during 2024/25.

IRCF - Monmouth Health and Wellbeing Centre and Dixon Surgery

The external teams have been appointed and work has begun on the OBC stage. The fee allocations are expected to be spent within the current financial year.

IRCF - Aber Valley Health and Wellbeing Centre and Aber Practice Development

The external teams have been appointed and work has begun on the OBC stage. The fee allocations are expected to be spent within the current financial year.

Purchase of Head Lease – Chepstow Hospital

The purchase of the head lease completed in June. The remaining funding relates to outstanding fees incurred in relation to the head lease purchase and works (£60k) which are likely to be completed after the building has been handed over by the PFI contractor.

Diagnostic Equipment Funding 2024/25

The equipment order has been placed. The works order is being urgently progressed so that the scheme can complete during 2024/25.

Bevan (Tredegar) H&WBC

Phase 2 of Bevan Health and Well-being Centre (demolition of the existing Health Centre and car-parking) is anticipated to complete in November 24. The scheme is forecasting an overspend of £1.731m in 2024/25 which includes the settlement agreement reached with the contractor in respect of two disputed compensation events (£1.115m). The overspend is being offset by the DCP, with the settlement agreement being offset by the release of the provision set up within the DCP in 2023/24. The overspend figure has increased in month by £0.064m due to the inclusion of new compensation events for asbestos and the grouting extension of time. An additional funding bid to WG is planned to be made in 2024/25 for unfunded

costs in relation to inflation allowances on works and fees, EV charging, disputed compensation events and other required changes. These currently unfunded costs total £2.2m plus VAT.

Tredegar H&WBC has been included as an AWCP scheme (despite there being no CRL funding allocated) as the current scheme funding ended in 2023/24. The reported expenditure incurred during 2024/25 is an overspend against the AWCP scheme which is being offset by a corresponding underspend against the DCP.

DPIF - RISP

Orders totalling £184k have been raised by the end of August. The remaining orders are being progressed to fully use this allocation during the current financial year.

Backlog Maintenance

This allocation was awarded in July. Orders are being urgently progressed across the fifteen identified schemes to ensure this allocation is fully spent during the current financial year. Works are expected to commence by September and conclude by 31st March 2025.

Discretionary Capital Programme

The Health Board Discretionary Capital Programme (DCP) funding available for 2024/25 is £8.773m made up of:

- 2024/25 DCP Funding – £10.814m
- Less 30% EFAB contribution – (£0.725m)
- Less 2023/24 AWCP scheme brokerage – (£1.669m)
- Plus 2023/24 DCP scheme brokerage – £0.350m
- Plus NBV of assets disposed – £0.003m

The current forecast spend for approved DCP schemes is £6.766m. This equates to an under spend of £2.007m which is required to offset the reported overspends on AWCP schemes and includes the release of the provision set up within the DCP in 2023/24 in relation to Bevan Health and Well-being Centre totalling £1.115m.

During August urgent schemes totalling £0.309m have been approved including the creation of the bus lane at GUH (£0.064m), changes to the HSDU steam system at GUH (£0.074m), a kitchen refurbishment at Twyn Glas (£0.041m) and other urgent works and replacement equipment. The contingency budget remaining at Month 5 is £0.714m.

13. IFRS 16 (Table Q)

The IFRS16 estimates for approved schemes at Month 5 include those schemes approved in Tranche 1 2024-25 and are as per the August Non-Cash return.

The unapproved section of the table reflects future potential leases included within the IFRS16 return submitted on the 31st July.

Other Issues

Risk Management

Claims submitted to the Welsh Risk Pool awaiting reimbursement at the end of August 2024 total £2.195m. £3.697m has been reimbursed up to the end of August 2024.

The total payments made by the HB equate to £34.206m of which we have submitted reimbursement claims for £2.195m leaving a balance of £32.011m relating to claims not yet reimbursed.

CREDITORS

Attached to the returns is a separate file containing the following information in relation to outstanding creditors: -

- All outstanding creditors we currently have identified with other Welsh Health bodies as at 9th September 2024.
- Response to the month 4 list of creditors circulated as part of the monthly reply letter.

14. Authorisation

Financial Performance is reported consistently in Board papers and external reporting including the MMR, however, internally these are presented in a more user-friendly way. The MMR Narrative and key tables are submitted for review to Finance and Performance Committee, as a sub-committee of the Board.

The dates for future Board meetings are as follows:-

- Wednesday 25th September 2024

The dates for future Finance and Performance Committee meetings are as follows:-

- Monday 16th December 2024
- Monday 17th February 2025

In accordance with the MMR guidance, the Health Board will endeavour to ensure that the MMR submission is agreed, and the narrative signed by two parties, by the Chief Executive and the Director of Finance. Where timescales and availability prevent this the Deputy Chief Executive will sign on behalf of the Chief Executive and the Deputy / Assistant Director of Finance (Financial Planning) will sign on behalf of the Director of Finance.



Robert Holcombe

Director of Finance, Procurement and Value
Cyfarwyddwr cyllid a chaffael



Nicola Prygodzicz

Chief Executive Officer
Prif Weithredwr

Submitted with this report are:

- Monthly Monitoring return Tables
- All outstanding creditors we currently have identified with other Welsh Health bodies as of 9th September 2024, and the
- Response to the month 4 list of creditors circulated as part of the monthly reply letter.

Appendix 1

Aneurin Bevan Health Board

Monthly Monitoring Returns – Current Period Action Points 2024/25

Month	Action Point	How responded to
2023/24 Month 12	No action-points	
2024/25		
Month 1		
1.1	The forecast outturn is phased unequally and is much higher in the first 6 months of the year. Please consider adjusting the opening plan section (e.g. using Line 7) to enable a straight-lined opening plan profile to be reported on Line 14.	See Commentary
1.2	We note that a number of future month expenditure profiles have been straight-lined. We trust expenditure profiles will be further refined at month 2.	See Commentary
1.3	Within future narratives, please ensure confirmation is provided where any unidentified savings/mitigating actions supporting the outturn position are being phased within the SoCNE (e.g. all against non pay).	See Commentary
1.4	Your narrative lists a number of challenges that the Health Board faces in the achievement of the 2024/25 financial forecast. However, these differ in terms of quantity and / or detail to those listed on table A2. Please improve the consistency between the two documents in your month 2 submission, noting the following extract of the MMR guidance:	See Commentary
1.5	The annual forecast pay savings in Table C of £10.682m are higher than the workforce savings reported in Table C2 (£9.443m). Please review the categorisation of savings in the tracker and if there remain differences between then categories in future months, provide a supporting explanation in your narrative.	See Commentary
1.6	The total Capital Cash Drawing Limit (£53.551m) does not agree with the Capital Cash Limit on the Master CRL (£52.231m). Please correct the variance in your next return.	Noted / See Commentary
1.8	Please ensure that the MMR template circulated with the MMR WHC is the version used to complete and submit your month 2 return.	Noted
Month 2		
2.1	While significant movements have been explained in your narrative, the phasing of expenditure for Healthcare Services provided by Other NHS Bodies and Other Private and Voluntary Sector that are c£0.7m above and c£0.7m below respectively that which a straight-line profile would result in, is not explained. Please provide this detail in your month 3 submission.	See Commentary
2.2	Your narrative states that "non pay expenditure has significantly reduced compared with April (£4m) mainly due to non-cash limited expenditure reductions linked to the Ophthalmic contract". Please provide further detail on this point, including describing any corresponding impacts on your income forecast.	See Commentary
2.3	Please ensure that all future narrative submissions include an explanation for each variance highlighted within this table.	Noted
2.4	Please provide supporting information in your month 3 narrative to explain the following seen in your month 2 return. Please also add narrative for any further variances occurring at month 3 - Decrease in Medical & Dental Agency/ Locum (Table B) forecast expenditure by £4.510m - Decrease in Nursing & Midwifery locum (Table B) forecast expenditure by £4.212m	See Commentary

	- Decrease in Estates & Ancillary (Table B) forecast expenditure by £0.875m. - Decrease in Vacancy (Table C) forecast expenditure by £5.772m. - Decrease in Additional Activity (Winter pressure) (Table C) expenditure forecast by £1.943m. - Decrease in sickness expenditure forecast (Table C) by £1.481m.	
2.5	Please provide further detail relating to the £0.723m increase in non-pay expenditure on table A2 (Covid-19 Vaccination programme).	See Commentary
2.6	The YTD Capital funding (£7.500m) is less than the value of capital payments (£8.029m) made by £0.629m. Please advise the source of the additional funding to enable these payments to have been made.	See Commentary
2.7	The capital scheme 'Tredegar H&WBC' has not yet been included in the latest CRL. Please provide detail in your next narrative submission as to the reasons for the inclusion of this scheme in the table.	See Commentary
Month 3		
3.1	There have been significant movements within the substantive pay position that are not explained in your narrative commentary. Please provide reasons for the following variances: - forecast expenditure for Nursing and Midwifery increase of £5.887m - forecast expenditure for Additional Clinical services increase of £3.876m - forecast expenditure for Medical and Dental increase of £1.9m.	See Commentary
3.2	We note that previous month savings have been reclassified, please ensure such changes are highlighted and explained in the narrative	Noted / See Commentary
3.3	There are savings included in 'other' categorisation with no explanation in the narrative. Please include this information in your month 4 narrative.	Noted
3.4	It is disappointing that there are unpaid 2023/24 invoices with no set payment date, which should have been paid by the 20th May. We trust that these invoices have since been resolved (paid or cancelled) as they must not be listed as outstanding within Table M at month 4.	See Commentary
Month 4		
4.1	The value of risk associated with delivery of pipeline opportunities and savings plan (£1.175m) does not agree with the value stated in the narrative (£0.8m). Please ensure the value stated on the MMR tables aligns with the narrative.	Noted
4.2	The only opportunity listed on the MMR table has not been discussed in the narrative, rather a wider list of unquantified opportunities available to the Health Board are listed in the narrative. Please ensure that as a minimum any opportunities listed in this table are discussed in the narrative.	Noted
4.3	At month 4, the following have been under phased, please explain in your narrative: - The Revenue resource limit is under phased by £35.4m; - Primary Care contractor (excluding drugs) is under phased by £2.491m; - Provider services – Non-pay is under phased by £2.526m	See Commentary
4.4	We also note that this month the forecast for the following has moved significantly. Please provide detailed explanations for these movements: - Healthcare Services Provided by Other NHS Bodies increase of £10.1m; - Secondary Care – Drugs movement of £2.5m; - Continuing Care and Funded Nursing Care movement of £2.4m.	See Commentary
4.5	There is an income variance of £1.155m with CTM. As requested under separate cover, please ensure that this variance is reviewed and eliminated by month 5.	See Commentary
4.6	We note from your commentary that "LTAs have been agreed with all provider and commissioners with the exception of Velindre NHS Trust and CTMUHB". Please provide confirmation in your month 5 submission that any outstanding steps to finalise these agreements have taken place and the documentation with each organisation has been signed.	See Commentary
4.7a	In your narrative you refer to a "real living wage impact for 2022/23, 2023/24 and 2024/25". We would expect that the anticipated RLW funding amount	See Commentary

	should be based on the current year impact (only) between and the NLW and RLW, ie: The Real Living wage is £12.00 per hour, The National Living wage is £11.44 per hour. Assuming 75% of CHC costs are staff on the National Living wage then this would imply that the organisation should be claiming 75% x (£0.56/£12.00) of the total spend on CHC. Please confirm that the value anticipated is in line with the above.	
4.7b	The Trade Receivables value has increased by £1.111m and Trade Payables has increased by £4.537m from last month. Your narrative discusses the net reduction in receivables and payables from year end. Please include in your monthly narrative commentaries the movement in values from the previous month.	Noted

Aneurin Bevan University Health Board
Finance Report – August (Month 5) 2024/25
Appendices

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Note: further detail available upon request

Table A – Movement of Opening Financial Plan to Forecast Outturn

	In Year Effect £'000	Non Recurring £'000	Recurring £'000	FYE of Recurring £'000		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	YTD £'000	In Year Effect £'000
Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-81,410	0	-81,410	-81,410	1	-6,784	-6,784	-6,784	-6,784	-6,784	-6,784	-6,784	-6,784	-6,784	-6,784	-6,784	-6,784	-33,921	-81,410
Cost Pressures (Non Covid-19) (Negative Value)	-47,382	0	-47,382	-60,022	2	-3,949	-3,949	-3,949	-3,949	-3,949	-3,949	-3,949	-3,949	-3,949	-3,949	-3,949	-3,949	-19,743	-47,382
Planned Expenditure For Covid-19 (Negative Value)	-12,416	0	-12,416	-12,416	3	-781	-701	-953	-969	-973	-924	-925	-927	-1,303	-1,308	-1,308	-1,344	-4,377	-12,416
Allocation Letter Revenue Funding Uplift / (Reduction) / WG RRL / WG Income Uplift / (Reduction) / Non-Covid)	39,414	0	39,414	51,830	4	3,285	3,285	3,285	3,285	3,285	3,285	3,285	3,285	3,285	3,285	3,285	3,285	16,423	39,414
Planned Welsh Government Funding for Covid-19 (Positive Value)	12,416	0	12,416	12,416	5	781	701	953	969	973	924	925	927	1,303	1,308	1,308	1,344	4,377	12,416
Other Income Uplift / (Reduction)	0	0	0	0	6													0	0
RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0	7	1,264	942	989	-190	-299	-371	-271	-315	-455	-394	-431	-470	2,706	0
Planned (Finalised) Green and Amber Savings Plan	34,466	3,828	30,638	31,627	8	1,221	1,521	1,475	2,654	2,763	2,834	3,515	3,559	3,698	3,637	3,675	3,914	9,633	34,466
Planned (Finalised) Net Income Generation	52	0	52	52	9	4	4	4	4	4	4	4	4	4	4	4	4	22	52
Planned Profit / (Loss) on Disposal of Assets	0	0	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0	0	0	11													0	0
	0	0	0	0	12													0	0
Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	6,000	10	5,990	5,990	13	0	0	0	0	0	0	1,000	1,000	1,000	1,000	1,000	1,000	0	6,000
Opening IMTP / Annual Operating Plan	-48,860	3,838	-52,698	-51,933	14	-4,959	-4,980	-4,980	-4,980	-4,980	-4,980	-3,200	-3,200	-3,200	-3,200	-3,200	-3,000	-24,880	-48,860
Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-6,000	-10	-5,990	-5,990	15	0	0	0	0	0	0	-1,000	-1,000	-1,000	-1,000	-1,000	-1,000	0	-6,000
Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0	0	0	16													0	0
Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0	0	0	17													0	0
Other Movement in Month 1 Planned & In Year Net Income Generation	150	0	150	150	18	0	-2	111	6	32	3	0	0	0	0	0	0	147	150
Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-1,637	293	-1,930	-661	19	1	-18	596	144	-253	-265	-433	-401	-361	-262	-268	-127	470	-1,637
Additional In Year Identified Savings - Forecast	10,424	5,196	5,228	6,453	20	0	52	1,204	939	821	1,013	1,041	1,041	1,126	1,076	973	1,139	3,016	10,424
Variance to Planned RRL & Other Income	0	0	0	0	21			48	-53	-60	-60	44	45	46	41	39	6	-161	0
Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional)	0	0	0	0	22	0	0	-85	-142	54	3	2	-2	-2	1	0	171	-173	0
Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0	0	0	23													0	0
Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Positive Value - reduction)	0	0	0	0	24	0	0	85	142	-54	-3	-2	2	2	-1	0	-171	173	0
In Year Accountancy Gains (Positive Value)	0	0	0	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0	0	0	26													0	0
Operational Pressures / benefits (- Deficit / + Surplus) - All inc. Prescribing / CHC / Acute drugs	-1,218	-1,218		-3,020	27			-1,373	177	411	300	-77	-101	-247	-267	-156	115	-785	-1,218
Operational Pressures / benefits (- Deficit / + Surplus) - WHSC performance pressure	-720	-720			28												-720	0	-720
	0	0	0	0	29													0	0
	0	0	0	0	30													0	0
	0	0	0	0	31													0	0
	0	0	0	0	32													0	0
	0	0	0	0	33													0	0
	0	0	0	0	34													0	0
	0	0	0	0	35													0	0
	0	0	0	0	36													0	0
	0	0	0	0	37													0	0
	0	0	0	0	38													0	0
	0	0	0	0	39													0	0
Forecast Outturn (- Deficit / + Surplus)	-47,860	7,379	-55,240	-55,000	40	-4,959	-4,948	-4,490	-3,767	-4,029	-3,989	-3,625	-3,616	-3,626	-3,612	-3,611	-3,588	-22,193	-47,860
Covid-19 - Forecast Outturn (- Deficit / + Surplus)	0				41	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operational - Forecast Outturn (- Deficit / + Surplus)	-47,860				42	-4,959	-4,948	-4,490	-3,767	-4,029	-3,989	-3,625	-3,616	-3,626	-3,612	-3,611	-3,588	-22,193	-47,860

Table A1 - Underlying Position

Section A - By Spend Area	IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated Pressures (-ve)	IMTP
	Underlying Position b/f	Recurring Savings (+ve)	Recurring Allocations / Income (+ve)	Subtotal		Underlying Position c/f
	£'000	£'000	£'000	£'000	£'000	£'000
Pay - Administrative, Clerical & Board Members	(0)		3,334	3,334	(3,498)	(164)
Pay - Medical & Dental	(24,293)		8,977	(15,316)	(1,772)	(17,088)
Pay - Nursing & Midwifery Registered	(15,638)	4,767		(10,871)	(375)	(11,246)
Pay - Prof Scientific & Technical	(807)		807	(0)		(0)
Pay - Additional Clinical Services	(6,776)	4,767	509	(1,500)	(250)	(1,750)
Pay - Allied Health Professionals	(0)		850	850	(850)	(0)
Pay - Healthcare Scientists	(115)		115	0		0
Pay - Estates & Ancillary	(2,841)			(2,841)	(45)	(2,886)
Pay - Students	0			0		0
Non Pay - Supplies and services - clinical	(15,001)	15,001	8,746	8,746	(14,742)	(5,996)
Non Pay - Supplies and services - general	(740)	740		(0)		(0)
Non Pay - Consultancy Services	0			0		0
Non Pay - Establishment	0			0		0
Non Pay - Transport	0			0		0
Non Pay - Premises	(5,088)	5,088		(0)		(0)
Non Pay - External Contractors	0			0	0	0
Health Care Provided by other Orgs – Welsh LHBs	(1,000)		7,000	6,000	(6,200)	(200)
Health Care Provided by other Orgs – Welsh Trusts	0			0		0
Health Care Provided by other Orgs – JCC	0		12,197	12,197	(17,026)	(4,829)
Health Care Provided by other Orgs – English	0			0		0
Health Care Provided by other Orgs – Private / Other	(9,110)	7,104	9,295	7,289	(18,129)	(10,840)
Total	(81,410)	37,467	51,830	7,887	(62,887)	(55,000)

Table A2 - Risks and Opportunities

Table A2 - Overview Of Key Risks & Opportunities		FORECAST YEAR END	
		£'000	Likelihood
1			
2			
3			
	Risks (negative values)		
4	Under delivery of Amber Schemes included in Outturn via Tracker		
5	Continuing Healthcare	(1,000)	Medium
6	Prescribing	(2,000)	Medium
7	Pharmacy Contract		
8	Joint Commissioning Committee Performance	TBC	Medium
9	Other Contract Performance		
10	GMS Ring Fenced Allocation Underspend Potential Claw back		
11	Dental Ring Fenced Allocation Underspend Potential Claw back		
12	Wage award / terms & conditions changes	0	Low
13	Further inflationary and unavoidable demand pressures	0	Medium
14	Additional operational and service pressures outside of annual plan (e.g. Diabetes, H&S, W	(3,366)	Medium
15	Delivery of pipeline opportunities and savings plans	(800)	Medium
16	Infected blood enquiry	TBC	Medium
17	Non Receipt / clawback of full allocations (ie 6 Goals)	(1,372)	Medium
18	Additional income risks assumed in forecast (overseas nursing, PADMs, Optometry contra	(2,862)	Medium
19	CTM LTA under-performance not recovered	(1,400)	Medium
20			
21			
22			
23			
24			
25			
26	Total Risks	(12,800)	
	Further Opportunities (positive values)		
27	Variable pay reduction / Service re-design / Commissioning	1,000	Medium
28			
29			
30			
31			
32			
33			
34	Total Further Opportunities	1,000	
35	Current Reported Forecast Outturn	(47,860)	
36		(47,860)	
37	Worst Case Outturn Scenario	(59,660)	
38	Best Case Outturn Scenario	(46,860)	

Table B– Monthly Summarised Statement of Comprehensive Net Expenditure/Statement of Comprehensive Net Income

A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue Resource Limit	Actual/F'cast	140,293	124,527	137,405	143,374	142,469	143,484	144,599	143,866	144,570	145,171	144,618	187,516	688,068	1,741,894
Capital Donation / Government Grant Income (Health Board only)	Actual/F'cast	0	0	17	0	0	48	0	0	60	0	0	75	17	200
Welsh NHS Local Health Boards & Trusts Income	Actual/F'cast	1,909	2,049	2,069	2,333	2,040	1,998	1,998	1,998	1,998	1,998	1,998	1,998	10,400	24,383
JCC Income	Actual/F'cast	981	1,019	1,098	1,887	1,121	1,079	1,079	1,079	1,079	1,079	1,079	1,079	6,106	13,660
Welsh Government Income (Non RRL)	Actual/F'cast	2,285	(1,198)	207	303	288	300	300	300	300	300	300	300	1,885	3,985
Other Income	Actual/F'cast	5,072	6,263	6,527	6,278	6,394	6,022	6,022	6,022	6,022	6,022	6,022	6,022	30,534	72,688
Income Total		150,540	132,660	147,323	154,175	152,312	152,931	153,998	153,265	154,029	154,570	154,017	196,990	737,010	1,856,810
Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/F'cast	18,815	15,396	16,871	16,550	17,413	17,456	17,842	17,842	17,842	17,842	17,842	17,842	85,045	209,553
Primary Care - Drugs & Appliances	Actual/F'cast	9,898	9,492	9,753	9,623	9,706	10,056	10,066	10,066	10,066	10,083	10,083	10,082	48,472	118,975
Provided Services - Pay	Actual/F'cast	62,289	64,288	63,043	64,093	64,712	63,957	63,332	63,332	63,332	63,332	64,065	63,399	318,425	763,174
Provider Services - Non Pay (excluding drugs & depreciation)	Actual/F'cast	13,292	12,402	11,888	12,319	12,920	12,927	13,071	13,135	13,761	13,768	13,859	14,212	62,821	157,553
Secondary Care - Drugs	Actual/F'cast	5,708	5,006	5,079	5,911	5,339	5,401	5,881	5,354	5,242	5,733	5,093	5,243	27,043	64,993
Healthcare Services Provided by Other NHS Bodies	Actual/F'cast	27,455	27,313	27,318	30,496	27,734	28,158	27,925	27,925	27,925	27,925	27,925	27,925	140,316	336,023
Non Healthcare Services Provided by Other NHS Bodies	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Continuing Care and Funded Nursing Care	Actual/F'cast	10,580	11,060	10,659	10,745	10,716	10,693	10,869	10,592	10,854	10,880	10,126	10,978	53,760	128,752
Other Private & Voluntary Sector	Actual/F'cast	813	1,183	1,090	1,004	1,315	1,100	1,100	1,100	1,100	1,100	1,100	1,100	5,405	13,105
Joint Financing and Other	Actual/F'cast	2,502	3,284	3,320	2,909	2,390	2,881	3,250	3,250	3,250	3,250	3,250	3,250	14,405	36,786
Losses, Special Payments and Irrecoverable Debts	Actual/F'cast	135	68	(1,226)	268	135	209	209	209	209	209	209	209	(620)	841
Exceptional (Income) / Costs - (Trust Only)	Actual/F'cast													0	0
Total Interest Receivable - (Trust Only)	Actual/F'cast													0	0
Total Interest Payable - (Trust Only)	Actual/F'cast													0	0
DEL Depreciation/Accelerated Depreciation/Impairments	Actual/F'cast	3,976	3,979	3,983	3,996	3,939	4,046	4,041	4,040	4,038	4,024	4,039	4,294	19,873	48,395
AME Donated Depreciation/Impairments	Actual/F'cast	37	(15,852)	36	36	36	36	36	36	36	37	37	42,043	(15,707)	26,554
Uncommitted Reserves & Contingencies	Actual/F'cast													0	0
Profit/Loss Disposal of Assets	Actual/F'cast	(0)	(12)	(1)	(8)	(14)	0	0	0	0	0	0	0	(35)	(35)
Cost - Total	Actual/F'cast	155,499	137,608	151,813	157,942	156,341	156,920	157,623	156,881	157,655	158,182	157,628	200,578	759,202	1,904,669
Net surplus/ (deficit)	Actual/F'cast	(4,959)	(4,948)	(4,490)	(3,767)	(4,029)	(3,989)	(3,625)	(3,616)	(3,626)	(3,612)	(3,611)	(3,588)	(22,193)	(47,860)

Table B2 - Pay Expenditure Analysis

A - Pay Expenditure		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
REF	TYPE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	9,760	9,935	9,712	9,661	9,747	9,685	9,680	9,680	9,680	9,680	9,740	9,680	48,815	116,640
2	Medical & Dental	15,120	15,270	15,175	15,670	15,993	15,800	15,585	15,575	15,575	15,575	15,550	15,550	77,228	186,438
3	Nursing & Midwifery Registered	18,828	19,771	19,292	19,635	19,765	19,375	19,200	19,200	19,200	19,200	19,588	19,285	97,291	232,339
4	Prof Scientific & Technical	2,757	2,816	2,776	2,768	2,750	2,775	2,775	2,775	2,775	2,775	2,775	2,770	13,867	33,287
5	Additional Clinical Services	9,372	10,039	9,640	9,794	9,907	9,800	9,641	9,629	9,629	9,629	9,950	9,641	48,752	116,671
6	Allied Health Professionals	3,794	3,816	3,818	3,787	3,808	3,802	3,800	3,790	3,790	3,790	3,800	3,790	19,023	45,585
7	Healthcare Scientists	1,157	1,194	1,195	1,220	1,210	1,200	1,200	1,200	1,200	1,200	1,200	1,200	5,976	14,376
8	Estates & Ancillary	3,431	3,586	3,387	3,489	3,592	3,450	3,367	3,367	3,367	3,367	3,392	3,367	17,485	41,160
9	Students	2	2	2	2	2	2	0	1	1	1	2	1	10	20
10	TOTAL PAY EXPENDITURE	64,221	66,429	64,997	66,026	66,774	65,889	65,248	65,217	65,217	65,217	65,997	65,284	328,447	786,516
Analysis of Pay Expenditure															
11	LHB Provided Services - Pay	62,289	64,288	63,043	64,093	64,712	63,957	63,332	63,332	63,332	63,332	64,065	63,399	318,425	763,174
12	Other Services (incl. Primary Care) - Pay	1,932	2,141	1,954	1,933	2,062	1,932	1,916	1,885	1,885	1,885	1,932	1,885	10,022	23,344
13	Total - Pay	64,221	66,429	64,997	66,026	66,774	65,889	65,248	65,217	65,217	65,217	65,997	65,284	328,447	786,519
B - Agency / Locum (premium) Expenditure															
- Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
REF	TYPE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	£'000	£'000
1	Administrative, Clerical & Board Members	28	8	19	(4)	6	39	37	36	35	35	35	35	57	309
2	Medical & Dental	1,124	932	937	1,232	1,258	1,200	1,175	1,175	1,175	1,175	1,175	1,175	5,483	13,733
3	Nursing & Midwifery Registered	1,034	1,064	1,011	1,169	1,150	1,097	1,016	976	936	936	936	936	5,428	12,262
4	Prof Scientific & Technical	27	68	40	38	25	38	36	35	34	34	34	34	198	440
5	Additional Clinical Services	26	39	38	63	37	36	34	33	32	32	32	32	203	436
6	Allied Health Professionals	102	105	162	132	128	143	135	131	127	127	127	127	629	1,545
7	Healthcare Scientists	27	26	37	65	57	38	36	35	34	34	34	34	212	454
8	Estates & Ancillary	205	138	77	188	176	140	140	140	140	140	140	140	784	1,764
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	2,573	2,381	2,321	2,883	2,837	2,731	2,609	2,560	2,512	2,512	2,512	2,512	12,994	30,943
11	Agency/Locum (premium) % of pay	4.0%	3.6%	3.6%	4.4%	4.2%	4.1%	4.0%	3.9%	3.9%	3.9%	3.8%	3.8%	4.0%	3.9%
C - Agency / Locum (premium) Expenditure															
- Analysed by Reason for Using Agency/Locum (premium)		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
REF	REASON	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	£'000	£'000
1	Vacancy	1,544	1,428	1,392	1,586	1,560	1,502	1,435	1,408	1,382	1,382	1,382	1,382	7,511	17,382
2	Maternity/Paternity/Adoption Leave	27	25	24	30	30	29	27	27	26	26	26	26	136	325
3	Special Leave (Paid) - inc. compassionate leave, interview	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Special Leave (Unpaid)	39	36	35	43	43	41	39	38	38	38	38	38	195	464
5	Study Leave/Examinations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	Additional Activity (Winter Pressures/Site Pressures)	520	481	469	726	715	688	657	645	633	633	633	633	2,911	7,434
7	Annual Leave	48	44	43	53	52	51	48	47	46	46	46	46	240	572
8	Sickness	396	367	357	444	437	421	402	394	387	387	387	387	2,001	4,765
9	Restricted Duties	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	Jury Service	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	WLI	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	Exclusion (Suspension)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	2,573	2,381	2,321	2,883	2,837	2,731	2,609	2,560	2,512	2,512	2,512	2,512	12,994	30,943

Table B3 - COVID-19

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
A1	Enter as positive values	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Overall Covid-19 Position															
108	Total Planned COVID-19 Expenditure	781	701	953	969	973	924	925	927	1,303	1,308	1,308	1,344	4,377	12,416
109	Total Actual/Forecast COVID-19 Expenditure	781	701	868	827	1,027	927	927	925	1,301	1,309	1,308	1,514	4,204	12,416
110	Movement from Planned Expenditure	0	0	85	142	(54)	(3)	(2)	2	2	(1)	(0)	(171)	173	(0)
111	Total Planned Funding	781	701	953	969	973	924	925	927	1,303	1,308	1,308	1,344	4,377	12,416
112	Total Actual/Forecast COVID-19 Funding excluding Virements	781	701	868	827	1,027	927	927	925	1,301	1,309	1,308	1,514	4,204	12,416
113	Total Actual/Forecast COVID-19 Virements	0	0	0	0	0	0	0	0	0	0	0	0	0	0
114	Total Actual/Forecast Funding	781	701	868	827	1,027	927	927	925	1,301	1,309	1,308	1,514	4,204	12,416
115	Movement from Planned Funding	0	0	(85)	(142)	54	3	2	(2)	(2)	1	0	171	(173)	0
116	Net Planned Position	0	0	0	0	0	0	0	0	0	0	0	0	0	0
117	Actual / Forecast Net Impact on overall Financial Position due to Covid-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0
118	Net Movement from Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation and Accountancy Gains)

		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast	
		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000			YTD variance as %age of YTD	Green £'000	Amber £'000	non recurring £'000	recurring £'000
Pay	Budget/Plan	621	514	536	784	810	810	1,207	1,210	1,210	1,210	1,210	1,210	3,265	11,332		0	940		
	Actual/F'cast	622	512	1,243	831	790	914	1,104	1,113	1,144	1,170	1,170	1,215	3,998	11,826	33.80%	11,247	580	1,035	10,791
	Variance	1	(2)	707	47	(20)	103	(103)	(97)	(66)	(40)	(40)	5	732	495	22.43%	11,247	-360		
Non-Pay	Budget/Plan	223	190	229	572	572	572	571	573	673	573	572	770	1,785	6,090		5,373	717		
	Actual/F'cast	223	165	1,151	1,047	1,045	906	972	972	1,072	1,034	936	1,332	3,631	10,854	33.45%	9,607	1,247	4,959	5,895
	Variance	0	(24)	922	475	473	334	401	399	398	460	364	562	1,845	4,764	103.37%	4,234	530		
Primary Care - Drugs & Appliances	Budget/Plan	121	134	144	301	312	324	335	346	358	369	381	394	1,011	3,517		2,217	1,300		
	Actual/F'cast	121	186	127	324	358	499	514	530	545	561	576	594	1,115	4,935	22.60%	3,885	1,050	1,300	3,635
	Variance	0	52	(17)	23	46	175	180	184	188	192	195	200	104	1,417	10.28%	1,667	-250		
Secondary Care Drugs	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	1		1	0		
	Actual/F'cast	0	9	12	9	16	29	29	29	29	29	29	29	46	249	18.54%	249	0	209	40
	Variance	0	9	12	9	16	29	29	29	29	29	29	29	46	248	22038.56%	248	0		
CHC/FNC	Budget/Plan	35	63	145	465	537	596	865	893	920	947	975	1,002	1,245	7,443		5,257	2,186		
	Actual/F'cast	35	63	87	378	410	469	788	840	917	942	954	988	973	6,871	14.16%	5,252	1,619	1,440	5,431
	Variance	0	0	(58)	(87)	(127)	(127)	(77)	(53)	(3)	(6)	(21)	(14)	(272)	(572)	(21.83%)	-5	-567		
Primary Care Contractor	Budget/Plan	221	221	221	287	287	287	292	292	292	292	292	292	1,237	3,278		3,248	30		
	Actual/F'cast	221	221	321	359	297	352	301	301	352	301	301	352	1,419	3,680	38.55%	3,650	30	375	3,305
	Variance	0	0	100	72	10	65	9	9	60	9	9	60	182	402	14.70%	402	0		
Healthcare Services Provided by Other Healthboards	Budget/Plan	0	400	200	245	245	245	245	245	245	245	245	245	1,090	2,805		2,805	0		
	Actual/F'cast	0	400	333	790	415	415	415	415	415	415	415	415	1,937	4,839	40.04%	4,839	0	0	4,839
	Variance	0	(0)	134	545	170	170	170	170	170	170	170	170	847	2,034	77.74%	2,034	0		
Non-healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
Other Private & Voluntary Sector	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
Joint Financing & Other	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
	Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0		
Total	Budget/Plan	1,221	1,521	1,475	2,654	2,763	2,834	3,515	3,559	3,698	3,637	3,675	3,914	9,633	34,466		18,901	0		
	Actual/F'cast	1,221	1,555	3,274	3,737	3,331	3,582	4,123	4,199	4,473	4,451	4,381	4,925	13,119	43,253	40.04%	38,727	4,526	9,318	33,936
	Variance	1	34	1,800	1,083	568	748	608	640	775	814	705	1,012	3,485	8,787	77.74%	19,826	4,526		
37	Variance in month	0.04%	2.24%	122.04%	40.82%	20.55%	26.40%	17.30%	17.99%	20.95%	22.38%	19.19%	25.85%	36.18%						
	In month achievement against FY forecast	2.82%	3.60%	7.57%	8.64%	7.70%	8.28%	9.53%	9.71%	10.34%	10.29%	10.13%	11.39%							

**Table D - Welsh NHS Assumptions – Income/Expenditure Assumptions
Annual Forecast**

	LHB/Trust	Contracted Income £'000	Non Contracted Income £'000	Total Income £'000	Contracted Expenditure £'000	Non Contracted Expenditure £'000	Total Expenditure £'000
1	Swansea Bay University	274	880	1,154	1,682	2,080	3,762
2	Aneurin Bevan University	0	0	0	0	0	0
3	Betsi Cadwaladr University	41	97	138	0	1,474	1,474
4	Cardiff & Vale University	1,585	1,614	3,199	37,976	6,327	44,303
5	Cwm Taf Morgannwg University	1,177	1,098	2,275	19,467	847	20,314
6	Hywel Dda University	321	25	346	403	820	1,223
7	Powys	11,348	3,310	14,658	168	205	373
8	Public Health Wales	0	4,253	4,253	0	1,588	1,588
9	Velindre	0	11,055	11,055	30,687	54,670	85,357
10	NWSSP			0			0
11	DHCW	0	761	761	0	6,031	6,031
12	Welsh Ambulance Services	0	182	182	0	512	512
13	JCC	12,854	0	12,854	216,425	779	217,204
14	HEIW	0	15,399	15,399	0	3	3
15	NHS Executive			0			0
16	Total	27,600	38,674	66,274	306,808	75,336	382,144

Table F - Statement of Financial Position

Table F - Statement of Financial Position For Monthly Period			
	Opening Balance Beginning of Apr 24 £'000	Closing Balance End of Aug 24 £'000	Forecast Closing Balance End of Mar 25 £'000
Non-Current Assets			
1 Property, plant and equipment	910,187	947,342	913,367
2 Intangible assets	4,685	3,997	3,421
3 Trade and other receivables	144,066	148,861	144,066
4 Other financial assets	667	667	667
5 Non-Current Assets sub total	1,059,605	1,100,867	1,061,521
Current Assets			
6 Inventories	9,844	10,138	9,844
7 Trade and other receivables	136,573	115,966	136,573
8 Other financial assets	59	59	59
9 Cash and cash equivalents	4,145	5,242	(46,021)
10 Non-current assets classified as held for sale	0	0	0
11 Current Assets sub total	150,621	131,405	100,455
12 TOTAL ASSETS	1,210,226	1,232,272	1,161,976
Current Liabilities			
13 Trade and other payables	202,150	173,018	203,177
14 Borrowings (Trust Only)	0	0	0
15 Other financial liabilities	0	0	0
16 Provisions	71,827	43,346	71,827
17 Current Liabilities sub total	273,977	216,364	275,004
18 NET ASSETS LESS CURRENT LIABILITIES	936,249	1,015,908	886,972
Non-Current Liabilities			
19 Trade and other payables	15,888	16,987	15,888
20 Borrowings (Trust Only)	0	0	0
21 Other financial liabilities	0	0	0
22 Provisions	149,647	154,512	149,647
23 Non-Current Liabilities sub total	165,535	171,499	165,535
24 TOTAL ASSETS EMPLOYED	770,714	844,409	721,437
FINANCED BY: Taxpayers' Equity			
25 General Fund	581,390	643,756	521,437
26 Revaluation Reserve	189,324	200,653	200,000
27 PDC (Trust only)			
28 Retained earnings (Trust Only)			
29 Other reserve			
30 Total Taxpayers' Equity	770,714	844,409	721,437
EXPLANATION OF ALL PROVISIONS			
	Opening Balance Beginning of Apr 24	Closing Balance End of Aug 24	Closing Balance End of Mar 25
31 Clinical Negligence	209,192	188,107	209,192
32 Personal Injury	3,231	2,987	3,231
33 Early Retirement	2,983	2,903	2,983
34 Continuing Healthcare	393	393	393
35 Other	5,675	3,468	5,675
36			
37			
38			
39			
40 Total Provisions	221,474	197,858	221,474
ANALYSIS OF WELSH NHS RECEIVABLES (current month)			
		£'000	
41 Welsh NHS Receivables Aged 0 - 10 weeks		3,572	
42 Welsh NHS Receivables Aged 11 - 16 weeks		35	
43 Welsh NHS Receivables Aged 17 weeks and over		154	
ANALYSIS OF TRADE & OTHER PAYABLES (opening, current & closing)			
	£'000	£'000	£'000
44 Capital	6,640	6,775	7,667
45 Revenue	211,398	183,230	211,398
ANALYSIS OF CASH (opening, current & closing)			
	£'000	£'000	£'000
46 Capital	793	2,166	35
47 Revenue	3,352	3,076	(46,056)

Table G - Monthly Cashflow Forecast

	April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
RECEIPTS													
WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA only	147,500	164,500	134,000	146,640	150,000	132,500	143,000	152,000	137,000	138,500	135,000	86,505	1,667,145
WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	0	0	0	250	0	250	0	400	0	400	0	435	1,735
WG Revenue Funding - Other (e.g. invoices)	774	184	167	1,756	194	300	303	351	767	269	733	535	6,333
WG Capital Funding - Cash Limit - LHB & SHA only	4,000	3,500	15,000	2,500	5,000	8,000	2,500	4,000	5,700	5,000	4,000	3,350	62,550
Income from other Welsh NHS Organisations	9,191	6,094	3,778	5,135	6,080	4,023	5,909	4,288	5,404	5,967	6,266	5,896	68,031
Short Term Loans - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Receivable - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
Sale of Assets	0	15	3	8	17	0	0	0	0	0	0	0	43
Other - (Specify in narrative)	3,051	5,187	6,439	4,319	6,785	3,905	3,698	4,207	5,243	4,529	8,490	7,476	63,329
TOTAL RECEIPTS	164,516	179,480	159,387	160,608	168,076	148,978	155,410	165,246	154,114	154,665	154,489	104,196	1,869,166
PAYMENTS													
Primary Care Services : General Medical Services	8,504	8,172	10,180	8,717	8,318	8,423	9,670	10,348	7,570	9,287	8,985	9,363	107,537
Primary Care Services : Pharmacy Services	2,809	6,711	1	2,683	5,410	1	2,910	5,745	2,827	2,916	2,918	2	34,933
Primary Care Services : Prescribed Drugs & Appliances	10,292	20,049	708	10,910	20,441	178	8,791	19,639	9,796	9,885	9,978	245	120,912
Primary Care Services : General Dental Services	2,639	2,504	2,620	2,629	2,796	2,726	2,695	2,883	2,388	3,878	2,602	2,637	32,997
Non Cash Limited Payments	143	(457)	812	71	(528)	796	161	(474)	146	(5)	173	857	1,695
Salaries and Wages	61,806	61,611	60,794	60,679	61,065	67,554	64,085	61,772	60,699	60,650	61,015	63,698	745,428
Non Pay Expenditure	75,420	76,170	68,161	71,900	67,561	62,338	64,748	61,103	65,004	63,113	64,415	72,548	812,481
Short Term Loan Repayment - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Repayment - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Payment	4,268	3,861	14,824	2,310	3,401	6,966	5,700	3,939	5,758	4,943	3,907	3,467	63,344
Other items (Specify in narrative)	0	2	0	0	3	0	0	0	0	0	0	0	6
TOTAL PAYMENTS	165,881	178,623	158,100	159,899	168,467	148,982	158,760	164,955	154,188	154,667	153,993	152,816	1,919,332
Net cash inflow/outflow	(1,365)	857	1,287	709	(391)	(4)	(3,350)	291	(74)	(2)	496	(48,620)	
Balance b/f	4,145	2,780	3,637	4,924	5,633	5,242	5,238	1,888	2,179	2,105	2,103	2,599	
Balance c/f	2,780	3,637	4,924	5,633	5,242	5,238	1,888	2,179	2,105	2,103	2,599	(46,021)	

Table H - Prompt Payment of Invoice Performance

30 DAY COMPLIANCE		ACTUAL Q1			ACTUAL Q2		ACTUAL Q3		ACTUAL Q4		YEAR TO DATE		FORECAST YEAR END	
		Target %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Forecast %	Variance %
PROMPT PAYMENT OF INVOICE PERFORMANCE														
1	% of NHS Invoices Paid Within 30 Days - By Value	95.0%	95.4%	0.4%		-95.0%		-95.0%		-95.0%	95.4%	0.4%	95.4%	0.4%
2	% of NHS Invoices Paid Within 30 Days - By Number	95.0%	92.0%	-3.0%		-95.0%		-95.0%		-95.0%	92.0%	-3.0%	95.0%	0.0%
3	% of Non NHS Invoices Paid Within 30 Days - By Value	95.0%	96.1%	1.1%		-95.0%		-95.0%		-95.0%	96.1%	1.1%	96.1%	1.1%
4	% of Non NHS Invoices Paid Within 30 Days - By Number	95.0%	97.2%	2.2%		-95.0%		-95.0%		-95.0%	97.2%	2.2%	97.2%	2.2%
10 DAY COMPLIANCE		ACTUAL Q1			ACTUAL Q2		ACTUAL Q3		ACTUAL Q4		YEAR TO DATE		FORECAST YEAR END	
		Actual %			Actual %		Actual %		Actual %		Actual %		Actual %	
PROMPT PAYMENT OF INVOICE PERFORMANCE														
5	% of NHS Invoices Paid Within 10 Days - By Value	81.5%									81.5%		81.5%	
6	% of NHS Invoices Paid Within 10 Days - By Number	26.5%									26.5%		26.5%	
7	% of Non NHS Invoices Paid Within 10 Days - By Value	58.8%									58.8%		58.8%	
8	% of Non NHS Invoices Paid Within 10 Days - By Number	36.5%									36.5%		36.5%	

Table I - Capital Resource/Expenditure Limit Management

Ref:	Performance against CRL / CEL	Year To Date			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	F'cast £'000	Variance £'000
	Gross expenditure						
	All Wales Capital Programme:						
	Schemes:						
1	Primary Care Fees - Newport East	8,501	8,292	(209)	12,119	12,247	128
2	Radiotherapy Satellite - Main Scheme	7,966	6,769	(1,197)	15,070	15,070	(0)
3	Efab - Infrastructure	1,049	662	(386)	2,129	2,129	(0)
4	Efab - Fire	0	3	3	592	592	0
5	Efab - Decarbonisation	162	148	(13)	168	168	0
6	Plaid Agreement - Mental Health Sanctuary Hubs	251	251	0	251	251	0
7	HCF - St Cadocs Mental Health Unit	400	281	(119)	975	975	0
8	Grange University Hospital - Brokerage pending VAT reclaim	0	(1)	(1)	(3,437)	(3,437)	(0)
9	Grange University Hospital - Emergency Department - Extension and Reconfiguration	2,202	1,792	(410)	11,355	11,355	(0)
10	Ty Gwent	100	54	(46)	1,219	1,219	0
11	RAAC Satellite Unit works	401	401	0	401	401	0
12	Royal Gwent Demolition	0	(3)	(3)	279	389	110
13	Breast Centralisation YF	33	(2)	(35)	111	111	0
14	RGH Endoscopy Unit	4	7	3	4	7	3
15	Digital Year End Funding - January 2024	11	1	(10)	20	20	(0)
16	ICF Pontllanfraith Feasibility	0	(3)	(3)	8	(3)	(11)
17	Emergency Department and Minor Injury Unit Improvements	55	54	(1)	55	56	1
18	HCF - Specialist Children's Beds	6	31	25	6	31	25
19	HCF - Exterior Lighting Serennu Centre	15	15	0	15	15	0
20	Digital Year End Funding - February 2024	34	45	11	53	53	0
21	Diagnostic Equipment	47	37	(10)	35	47	12
22	Year End Funding - January 2024	26	24	(2)	49	49	0
23	Head Lease for Chepstow Community Hospital	5,481	5,431	(50)	5,550	5,550	0
24	IRCF - Monmouth Health and Wellbeing Centre and Dixon Surgery	75	52	(23)	742	742	(0)
25	IRCF - Aber Valley Health and Wellbeing Centre and Aber Practice Development	75	49	(26)	742	742	0
26	Diagnostic Equipment 2024-25	0	0	0	497	497	0
27	DPIF - RISP	124	41	(83)	541	541	(0)
28	Backlog Maintenance 2024-25	30	0	(30)	4,231	4,231	0
29	Tredegar H&WBC	0	1,239	1,239	0	1,731	1,731
30				0			0
31				0			0
32				0			0
33				0			0
34				0			0
35				0			0
36				0			0
37				0			0
38				0			0
39				0			0
40				0			0
41				0			0
42	Sub Total	27,046	25,668	(1,378)	53,780	55,779	1,999
	Discretionary:						
43	IT.	1,832	1,761	(71)	2,971	2,974	3
44	Equipment	147	157	10	599	596	(3)
45	Statutory Compliance	269	294	25	1,094	1,094	(0)
46	Estates	892	818	(74)	4,510	2,504	(2,006)
47	Other	(1,115)	(1,115)	0	(401)	(401)	0
48	Sub Total	2,024	1,915	(110)	8,773	6,766	(2,007)

Table J - In Year Capital Scheme Profiles

Ref:	All Wales Capital Programme:	Project Manager	In Year Forecast		Capital Expenditure Monthly Profile															Risk Level
	Schemes:		Min. £'000	Max. £'000	April £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	YTD £'000	Total £'000		
1	Primary Care Fees - Newport East	Lorraine Morgan	12,200	12,350	2,416	536	2,245	1,606	1,490	1,474	700	400	400	350	350	281	8,292	12,247	Medium	
2	Radiotherapy Satellite - Main Scheme	Lorraine Morgan	14,370	15,070	919	1,503	1,677	1,873	796	1,701	1,733	1,415	1,212	834	603	803	6,769	15,070	Medium	
3	Efab - Infrastructure	Jamie Marchant	2,050	2,150	340	(284)	330	255	21	313	208	194	178	188	193	194	662	2,129	Medium	
4	Efab - Fire	Scott Taylor	560	620	2	(1)	3	(35)	34	70	50	60	120	95	100	94	3	592	Medium	
5	Efab - Decarbonisation	Jamie Marchant	160	180	0	0	87	61	(0)	7	13	0	0	0	0	0	148	168	Low	
6	Plaid Agreement - Mental Health Sanctuary Hubs	Kolade Gamel	251	251	128	123	(119)	119	0	0	0	0	0	0	0	0	251	251	Low	
7	HCF - St Cadocs Mental Health Unit	Kolade Gamel	875	975	0	34	(34)	50	231	375	200	119	0	0	0	0	281	975	Low	
8	Grange University Hospital - Brokerage pending VAT reclaim	Hannah Capel	(7,127)	5	5	0	(1)	(0)	(4)	0	0	(3,436)	0	0	0	0	(1)	(3,437)	High	
9	Grange University Hospital - Emergency Department - Extension	Hannah Capel	11,000	11,355	655	168	173	314	481	1,130	1,437	1,523	1,464	1,466	1,200	1,344	1,792	11,355	Medium	
10	Ty Gwent	Hannah Capel	1,219	1,219	1	2	15	23	13	300	300	370	194	0	0	0	54	1,219	Low	
11	RAAC Satellite Unit works	Lorraine Morgan	401	401	401	0	0	0	0	0	0	0	0	0	0	0	401	401	Low	
12	Royal Gwent Demolition	Jamie Marchant	389	389	0	(3)	3	(1)	(3)	25	50	50	50	50	100	67	(3)	389	Medium	
13	Breast Centralisation YF	Hannah Capel	111	111	4	1	1	1	(9)	15	20	20	20	20	18	0	(2)	111	Low	
14	RGH Endoscopy Unit	Lorraine Morgan	7	7	1	1	2	0	3	0	0	0	0	0	0	0	7	7	Low	
15	Digital Year End Funding - January 2024	Sarah Humphries	20	20	1	0	0	0	0	9	10	0	0	0	0	0	1	20	Low	
16	ICF Pontllanfraith Feasibility	David Powell	(3)	(3)	(3)	0	0	0	0	0	0	0	0	0	0	0	(3)	(3)	Low	
17	Emergency Department and Minor Injury Unit Improvements	Various	56	56	14	0	41	0	0	2	0	0	0	0	0	0	54	56	Low	
18	HCF - Specialist Children's Beds	Sara Garland	31	31	0	8	0	10	13	0	0	0	0	0	0	0	31	31	Low	
19	HCF - Exterior Lighting Serennu Centre	Sara Garland	15	15	0	0	7	8	0	0	0	0	0	0	0	0	15	15	Low	
20	Digital Year End Funding - February 2024	Sarah Humphries	53	53	0	0	10	13	21	9	0	0	0	0	0	0	45	53	Low	
21	Diagnostic Equipment	Various	47	47	13	0	24	0	0	10	0	0	0	0	0	0	37	47	Low	
22	Year End Funding - January 2024	Jamie Marchant	49	49	6	7	3	2	7	2	0	0	0	0	23	0	24	49	Low	
23	Head Lease for Chepstow Community Hospital	Jamie Marchant	5,490	5,550	0	0	5,430	1		50	9					60	5,431	5,550	Low	
24	RCF - Monmouth Health and Wellbeing Centre and Dixon Street	Hannah Capel	700	742	0	0	0	25	28	47	53	363	60	57	48	63	52	742	Low	
25	RCF - Aber Valley Health and Wellbeing Centre and Aberystwyth	Hannah Capel	700	742	0	0	0	25	23	42	353	100	100	44	28	26	49	742	Low	
26	Diagnostic Equipment 2024-25	Various	497	497			0	0	0	97	100	100	100	100	0	0	0	497	Low	
27	DPIF - RISP	Sarah Humphries	541	541			24	0	17	100	100	217	83	0	0	0	41	541	Low	
28	Backlog Maintenance 2024-25	Lorraine Morgan	4,000	4,231	0	0	0	0	0	241	509	680	669	833	782	516	0	4,231	Medium	
29	Tredegar H&WBC	Lorraine Morgan	1,731	2,544	102	20	1,434	(336)	19	89	89	87	87	87	42	12	1,239	1,731	Medium	
30																	0	0		
31																	0	0		
32																	0	0		
33																	0	0		
34	Sub Total		50,393	60,198	5,005	2,115	11,354	4,015	3,180	6,105	5,934	2,262	4,738	4,124	3,486	3,460	25,668	55,779		

	Discretionary:																		
35	I.T.	Various	2,950	3,050	48	54	140	1,488	30	84	143	137	134	279	164	274	1,761	2,974	Low
36	Equipment	Various	575	625	0	132	12	2	10	74	341	24	0	0	0	0	157	596	Low
37	Statutory Compliance	Various	1,050	1,150	9	70	79	23	112	115	140	143	122	105	81	93	294	1,094	Low
38	Estates	Various	2,400	2,600	53	(34)	105	556	138	291	214	274	267	379	129	132	818	2,504	Low
39	Other	Various	(501)	(301)	0	0	(1,115)	0	0	0	76	128	128	128	128	128	(1,115)	(401)	Low
40	Sub Total		6,474	7,124	111	223	(779)	2,069	291	565	914	705	650	890	501	627	1,915	6,766	
	Other Schemes (Including IFRS 16 Leases):																		
41	IFRS16 - Robotics	Leigh-Anne Challenge	1,320	1,320	0	0	0	1,320	0	0	0	0	0	0	0	0	1,320	1,320	Low
42	IFRS16 - Tranche 1	Various	322	322					322								322	322	Low
43	Charitable Funds Donated Assets	Various	100	200	0	0	17			48			60			75	17	200	Low
44																	0	0	
45																	0	0	
46																	0	0	
47																	0	0	
48																	0	0	
49																	0	0	
50																	0	0	
51																	0	0	
52																	0	0	
53																	0	0	
54																	0	0	
55																	0	0	
56																	0	0	
57																	0	0	
58																	0	0	
59																	0	0	
60																	0	0	
61	Sub Total		1,742	1,842	0	0	17	1,320	322	48	0	0	60	0	0	75	1,659	1,842	
62	Total Capital Expenditure		58,609	69,164	5,116	2,338	10,592	7,404	3,792	6,718	6,848	2,967	5,448	5,014	3,987	4,163	29,242	64,387	

Table K - Capital Disposals

A: In Year Disposal of Assets									
	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. Apr 24)	MM/YY (text format, e.g. Apr 24)	MM/YY (text format, e.g. Feb 25)	£'000	£'000	£'000	£'000	
1	Equipment Disposals	n/a	n/a	April 24	0	0	0	0	
2	Equipment Disposals	n/a	n/a	May 24	1	15	2	12	
3	Equipment Disposals	n/a	n/a	June 24	1	3	0	1	
4	Equipment Disposals	n/a	n/a	July 24	0	8	0	8	
5	Equipment Disposals	n/a	n/a	August 24	0	17	3	14	
6								0	
7	26 Clytha Square	n/a	n/a	March 25				0	Proposed property disposal - could be in next fy. Awaiting valuation and anticipated sales proceeds
8								0	
9								0	
10								0	
11								0	
12								0	
13								0	
14								0	
15								0	
16								0	
17								0	
18								0	
19								0	
	Total for in-year				2	43	6	35	

Table M - Debtors Schedule

Table M - Debtors Schedule						17 weeks before end of Aug 24 = 04 May 2024			
Debtor	Inv #	Inv Date	Orig Inv £	Outstand. Inv £	Valid Entry	>11 weeks but <17 weeks	Over 17 weeks	Arbitration Due Date	Comments
DIGITAL HEALTH & CARE WALES	227818	30 May 2024	11873.63	11,873.63	Yes, valid entry for period	11,873.63		26 September 2024	Chasing Urgent Payment of Invoice
PUBLIC HEALTH WALES NHS TRUST	227598	30 April 2024	63000.00	63,000.00	Yes, valid entry for period		63,000.00	27 August 2024	Paid 05.09.2024
PUBLIC HEALTH WALES NHS TRUST	228030	14 June 2024	9904.39	9,904.39	Yes, valid entry for period	9,904.39		11 October 2024	Chasing Urgent Payment of Invoice
CARDIFF & VALE UNIVERSITY LHB	227872	30 May 2024	6696.52	6,696.52	Yes, valid entry for period	6,696.52		26 September 2024	Paid 04.09.2024
POWYS HEALTH BOARD	227411	15 April 2024	36910.92	36,910.92	Yes, valid entry for period		36,910.92	12 August 2024	Paid 03.09.2024
POWYS HEALTH BOARD	227415	15 April 2024	53683.00	53,683.00	Yes, valid entry for period		53,683.00	12 August 2024	Paid 03.09.2024
POWYS HEALTH BOARD	228015	14 June 2024	4471.04	4,471.04	Yes, valid entry for period	4,471.04		11 October 2024	Powys have confirmed invoice has been sent for authorisation and will be paid asap.
POWYS HEALTH BOARD	228033	14 June 2024	1779.58	1,779.58	Yes, valid entry for period	1,779.58		11 October 2024	Paid 04.09.2024

Table N - General Medical Services Financial Position

Completed from month 6

Table O - Dental Services Financial Position

Completed from month 6

Table P - Ringfenced

This table needs to be completed from month 3																		
		WG Annual Allocation	Current Plan	Expenditure (£000s) - Variance (-deficit/+surplus)												Total	Total	Total
				April	May	June	July	August	September	October	November	December	January	February	March	YTD	Annual	Variance against WG Allocation (+over/-under spend)
Table A: Allocation Paper (24/25 New Ring Fenced)																		
Planned and Unscheduled Care Sustainability (£120m)	Plan	22,605	22,605	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	9,419	22,605	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	1,884	9,419	22,605	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Value Based Funding (£14m)	Plan	2,686	2,686	224	224	224	224	224	224	224	224	224	224	224	224	1,119	2,686	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			224	224	224	224	224	224	224	224	224	224	224	224	1,119	2,686	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Regional Integration Fund (£132.9m)	Plan	24,796	24,796	1,491	1,779	2,004	2,110	1,835	1,903	2,033	2,007	2,020	2,522	2,461	2,631	9,219	24,796	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			1,491	1,779	2,004	2,110	1,835	1,903	2,033	2,007	2,020	2,522	2,461	2,631	9,219	24,796	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Planned Care Recovery (£49.985m)	Plan	3,940	3,940	328	328	328	328	328	328	328	328	328	328	328	328	1,642	3,940	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			546	546	546	546	546	546	546	546	546	546	546	546	2,731	6,854	
	Variance against current plan			218	218	218	218	218	218	218	218	218	218	218	218	1,089	2,614	2,614
Mental Health Services (£730.957m)	Plan	117,753	117,753	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	49,064	117,753	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	9,813	49,064	117,753	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Palliative care/ Bereavement/ Hospice funding (£7.967m)	Plan	1,633	1,633	136	136	136	136	136	136	136	136	136	136	136	136	680	1,633	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			136	136	136	136	136	136	136	136	136	136	136	136	680	1,633	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Further Faster (£11.950m)	Plan	2,292	2,292	13	15	96	164	168	202	217	268	273	288	288	300	455	2,292	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			13	15	96	164	168	202	217	268	273	288	288	300	455	2,292	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Critical Care Funding (£18.7m)	Plan	2,753	2,753	229	229	229	229	229	229	229	229	229	229	229	229	1,147	2,753	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			229	229	229	229	229	229	229	229	229	229	229	229	1,147	2,753	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		WG Annual Allocation	Current Plan	Expenditure (£000s) - Variance (-deficit/+surplus)												Total	Total	Total
				April	May	June	July	August	September	October	November	December	January	February	March	YTD	Annual	Variance against WG Allocation (+over/-under spend)
Table B : Additional In-Year (24/25 Anticipated & Allocated)																		
Urgent Emergency Care Allocations	Plan	2,744	2,744	229	229	229	229	229	229	229	229	229	229	229	229	1,143	2,744	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			229	229	229	229	229	229	229	229	229	229	229	229	1,143	2,744	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Allocations	Plan	6,299	6,299	525	525	525	525	525	525	525	525	525	525	525	525	2,625	6,299	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			525	525	525	525	525	525	525	525	525	525	525	525	2,625	6,299	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Planned Care	Plan	525	525	44	44	44	44	44	44	44	44	44	44	44	44	219	525	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			44	44	44	44	44	44	44	44	44	44	44	44	219	525	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Value Based Health Care	Plan	506	506	42	42	42	42	42	42	42	42	42	42	42	42	211	506	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			42	42	42	42	42	42	42	42	42	42	42	42	211	506	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Regional Integration Fund	Plan	2,771	2,771	231	231	231	231	231	231	231	231	231	231	231	231	1,154	2,771	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed			231	231	231	231	231	231	231	231	231	231	231	231	1,154	2,771	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Spare	Plan															0	0	
	Actual/Forecast - not yet committed															0	0	
	Actual/Forecast - committed															0	0	
	Variance against current plan			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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

AGENDA		
Date and Time	Wednesday 11 th July 2024 at 9:30am	
Venue	Microsoft Teams	
PRESENT	Ann Lloyd Nicola Prygodzicz Sarah Simmonds Jennifer Winslade Hannah Evans Robert Holcombe Leanne Watkins Tracy Daszkiewicz Paul Deneen Dafydd Vaughan Iwan Jones Prof Helen Sweetland Penny Jones Pippa Britton Richard Clark Phil Robson Peter Carr	Chair Chief Executive Director of Workforce and OD Director of Nursing Director of Strategy, Planning and Partnerships Director of Finance & Procurement Chief Operating Officer Director of Public Health Independent Member (Community) Independent Member (Digital) Independent Member (Finance) Independent Member (University) Independent Member (Community) Vice Chair Independent Member (Local Authority) Special Advisor to the Board Director of Therapies and Health Science
ALSO IN ATTENDANCE	Rani Dash Bryony Codd Lisa Charles Julie Rees Stephen Edwards	Director of Corporate Governance Head of Corporate Governance Llais Cymru Audit Wales Assistant Medical Director
APOLOGIES	James Calvert Paul Solloway Neil Patrick Louise Wright	Medical Director Director of Digital Independent Member (Community) Independent Member (Trade Union)

ABUHB 1107/01	Welcome and Introductions The Chair welcomed members to the meeting to review and approve the annual accounts, performance and accountability reports for 2023/24. In particular, the Chair welcomed members of the public who were able to join the meeting on line. It was noted that the meeting would be recorded and published on the Health Board's website following the meeting.
ABUHB 1107/02	Declarations of Interest for Noting There were no declarations of interest.
ABUHB 1107/03	To RECEIVE Audit Wales' Audit of Accounts Report 2023/24 Julie Rees (JR), Audit Wales, presented the final Audit of Accounts for 2023/24 confirming an unqualified true and fair opinion would be issued. JR advised that the regularity opinion would be qualified as the Health Board had not achieved its first statutory financial duty to break even over a three-year period. JR highlighted that the substantive report referred to the fact that the Health Board had not met its financial duty to have an approved three-year integrated medium-term plan for the period 2023-26. The regularity opinion is not qualified for this. There were no uncorrected misstatements, and the Auditor General would sign the audit outcome on the 12th July 2024. The Board thanked Audit Wales for its audit work and RECEIVED the Audit Wales' Audit of Accounts Report 2023/24.
ABUHB 1107/04	To RECEIVE a recommendation from the Audit, Risk and Assurance Committee Iwan Jones (IJ), Chair of the Audit, Risk and Assurance Committee (ARAC), confirmed that the Committee had met on the 9th July 2024 to consider the Annual Report and Accounts, the Audit Wales' Audit of Accounts Report and the Letter of Representation for 2023/24. On behalf of the Committee, IJ thanked all those involved in preparing the documents which had demonstrated the significant work undertaken by the Health Board. IJ highlighted that the Financial Statements included a provision against the Tredegar (Bevan) Health and Wellbeing Centre. There had also been two limited audit reports on this project and the ARAC had requested that the Finance and Performance Committee undertake a review to identify lessons learned. Hannah Evans (HE), Director of Strategy, Planning and Partnerships, confirmed that the decision in

	relation to the provision in the Financial Statements was based on professional advice. A lessons learned exercise was also underway and would be reported as requested. The Audit, Risk and Assurance Committee RECOMMENDED to the Board that it: • RECEIVED the Audit of Accounts Report (2023/24) of External Audit (Audit Wales) • APPROVED the Annual Report and Accounts 2023/24, which includes: 1. The Performance Report (Part 1) 2. The Annual Accountability Report (Part 2) 3. The Financial Statements (Part 3) • APPROVED the Letter of Representation; and • AUTHORISED the Chair, Chief Executive Officer and Director of Finance and Procurement, to sign these documents where required.
ABUHB 1107/05	ABUHB Annual Report and Accounts 2023/24 Rani Dash (RD), Director of Corporate Governance, presented the Performance and Accountability Reports for 2023/24, confirming that these had been reviewed by the Audit, Risk and Assurance Committee, Welsh Government and Audit Wales and all comments had been incorporated within the final documents. Part One: Performance Report 2023/24 Hannah Evans (HE), Director of Strategy, Planning and Partnerships, confirmed that the Performance Report provided information on the Health Board, its main objectives and strategies. The report provided an analysis of the Health Board’s performance, in line with the End of Year report previously presented to Board. Part Two: Accountability Report 2023/24 RD explained that the Accountability Report comprised three sections – the Corporate Governance Report, Remuneration and Staff Report and the Senedd Cymru/Welsh Parliament Accountability and Audit Report. The report provided information on the governance arrangements, risks and ways of working of the Health Board and confirmed that the Health Board had continued to mature as an organisation and, whilst there were areas for strengthening, no significant internal control or governance issues had been identified. Part Three: Annual Financial Statements Rob Holcombe (RH), Director of Finance and Procurement, presented the Financial Statements for 2023/24. RH confirmed that the Health Board had not met its financial duty to breakeven against its Revenue Resource

	Limit over 3 years 2021-22 to 2023-24. The final position as at 31 March 2024 showed a year end deficit of £49.766m and combined with the outcomes for 2021-22 and 2022-23, a three-year deficit of £86.359m. RH noted that the Health Board had achieved the Capital Resource Limit, Public Sector Payment Policy and Cash balance held at the end of the year. The Board APPROVED the Annual Report and Accounts 2023/24, which included: • The Performance Report (Part 1) • The Annual Accountability Report (Part 2) • The Financial Statements (Part 3)
ABUHB 1107/06	To APPROVE for SIGNING the Letter of Representation, as included in Audit Wales' ISA260 2023/24 The Board APPROVED the signing of the Letter of Representation 2023/24.
ABUHB 1107/07	Date of the Next Meeting: • Wednesday 17th July 2024



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Governance Matters: Report on Sealed Documents and Chair's Actions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Michelle Jones, Head of Board Business

Pwrpas yr Adroddiad Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

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

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between the 1st July 2024 and 6th September 2024.

The Board is asked to note that there have been three (3) documents that required the use of the Health Board's seal during the above period.

Chair's Action in Standing Orders requires approval by the Chair, Chief Executive and two Independent Members, with advice from the Board Secretary (the Director of Corporate Governance). All Chair's Actions require ratification by the Board at its next meeting.

During the period 1st July 2024 and 6th September 2024 there were two (2) Chairs Actions agreed.

Cefndir / Background

1. Sealed Documents

The common seal of the Health Board is primarily used to seal legal documents such as transfers of land, lease agreements and other contracts. The seal may

only be affixed to a document if the Board or Committee of the Board has determined it should be sealed, or if the transaction has been approved by the Board, a Committee of the Board or under delegated authority.

2. Chair's Action

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

3. Key Issues

3.1 Sealed Documents

Under the provisions of Standing Orders, the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. Three documents were sealed between the 1st July 2024 and 6th September 2024, as outlined below.

Date	Title
04.07.24	Renewal lease for Mary Port Street, Usk (The Adult Education Centre Site, Maryport Street, Usk, Monmouthshire NP15 1AB)
08.07.24	Service Level Agreement, for Flying Start Health Visiting Services 2024-2025, between Aneurin Bevan University Health Board and Newport City Council.
21.08.24	ICF Funding Agreement: 216 Stow Hill, Newport, 47 Llanthwy Road (LAC 1 and LAC 2) between ABUHB and United Welsh Housing Association Ltd.

3.2 Chair's Action

The Chair's Actions approved between 1st July 2024 and 6th September 2024 are provided below:

Date	Title
09.07.24	A 3-year contract for the provision of outsourced radiology reporting services for the period 1 st November 2024 – 31 st October 2027 (All Wales Contract with an estimated annual value for ABUHB of £1,574,338.00).

05.08.24	On 24th May 2024, the Health Board was formally informed by Beaufort Park Dental Surgery, Chepstow, that they wish to terminate their existing NHS GDS contracts with effect from 31st August 2024. Consequently, contract awards for the period 1st September 2024 to 31st March 2025, totalling £700k (combined annual contract values) were made to invest additional funding into NHS dental services, specifically for patients affected by the contract termination. These were awarded to: • Paul John Jones Dental • 168 Dental Practice • St. Julians Dental Surgery
<u>Asesiad / Assessment</u> In endorsing this report the Health Board will comply with its own Standing Orders.	
<u>Argymhelliad / Recommendation</u> The Board is asked to NOTE the documents that have been sealed and to RATIFY the action taken by the Chair on behalf of the Board.	

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

**Gwybodaeth Ychwanegol:
Further Information:**

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Putting Things Right – Policy update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson Deputy Director of Nursing Gemma Couch Head of Quality Patient Safety Rhianon Price Senior Quality Patient Safety Manager

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

Ar Gyfer Penderfyniad/For Decision

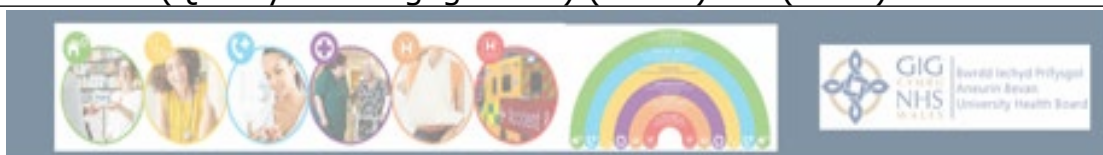
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Currently the Health Board policy for the management of concerns (PSOW inclusive) is comprised of three separate policies – these policies were issued between 2012 - 2016 and due for review between 2015-2019.

It has been recognised that the existing Putting Things Right (PTR) policies are now outdated and require refreshing to reflect changes to legislation, Health Board structures and processes and to lay the foundations for the upcoming Putting Things Right Guidance changes expected Spring/Summer 2025.

The three policies have been amended and amalgamated into one concise and current policy, to provide key stakeholders with clarity and the means to implement the organisation's expectations for the management of concerns within the parameters of the wider Welsh Government guidelines. There have been significant changes in national legislation and policy, including the introduction of The Health and Social Care (Quality and Engagement) (Wales) Act (2020).



Cefndir / Background

The current Health Board policies regarding the management of concerns comprise of three separate documents:

- Putting Things Right, Procedure on the Management of Concerns raised by patients and their representatives (Complaints)
- Policy for Putting Things Right, The Management of Concerns (Complaints, Claims and Patient Safety Incidents)
- Putting Things Right Policy, Procedure for the Management of Public Service Ombudsman for Wales Investigations

For context, the consolidation of the policies into one unambiguous document should be seen in the wider landscape of the current work underway at the Health Board to improve quality and safety processes. The number of concerns being received have increased significantly in complexity, making the management and life cycle of investigations more challenging. Therefore, clear guidance for staff managing investigations is critical.

The reconfiguration of QPS resources in February 2024 into a new central model and the inclusion of ABCi improvement colleagues May 2024 has been pivotal in ensuring that there is better cross organisational cross alignment in order to drive and embed learning and improvement and improved and more timely concerns responses.

Asesiad / Assessment

As a Health Board we must ensure that our processes and approach to this complex and sensitive area of healthcare are aligned to ensure that the quality of our concerns investigation processes are optimised, that our patients are at the heart of any investigation and to maximise learning and improvement opportunities for the benefit of patients, service users, their families/carers, our staff and other NHS organisations. In addition to conducting robust complaint investigations, it is also crucial to incorporate learning and improvement from our findings to prevent future occurrence.

The concerns team have already incorporated patient wishes/concerns/expectations at the point of contact directly into the 'Terms of Reference' (TOR) for the intended concern investigation and will confirm the draft TOR with the patient/representative, agreeing these at the outset wherever possible. This will ensure a more robust and focussed investigation from the outset.

The concerns team (s) will assist with the facilitation and implementation of the PTR regulations, quality assurance of concern responses and supporting Investigating Officers to update complainants on the progress of their concerns.

Each Division is responsible and accountable for the delivery of its investigation, any learning and actions and ongoing monitoring of these as well as any subsequent audits and assurance.

The aim of the policy is to give guidance on how concerns that are received as complaints should be investigated and responded to in order to facilitate resolution



of issues at a local level promptly and fairly for both users of the service, their families/carers and staff, recognising the individual needs of complainants (e.g., language, support, disabilities, etc). The policy has been designed to be used in conjunction with the Welsh Government's Putting Things Right – Guidance on Dealing with Concerns about the NHS from 1 April 2011 (Version 4 - May 2023).

4.6 The way that people are treated at the outset can set the tone for the whole investigation. It is also important that people do not develop unreasonable expectations about what the process might deliver. It is therefore essential that some of these issues are covered in the early stages following the receipt of any concern.

Timely engagement with complainants at the point of contact has been widely recognised by external stakeholders such as PSOW and more recently Welsh Risk Pool (WRP) at the time of their assessments as a very positive step in our ongoing concerns journey and are in agreement that the instigation of a concerns acknowledgement team by the Health Board is the right direction of travel for a person-centred approach to concerns management.

Following the implementation of the Duty of Candour in April 2023 and successful review and ratification of the Patient Safety Incident Reporting & Management Policy in November 2023 updated for ratification at the September 2024 Board, the Health Boards Putting Things Right policies have been reviewed and consolidated, with the vital and necessary elements of each policy, not captured elsewhere, collated in one comprehensive and current document.

2012-2016 Policies	2024 Policy
Referred to as a complaint	Referred to as a concern as per WG guidance
POVAs/Complaints raised by or about children	Amended to reflect changes to legislation and guidance – The Welsh Safeguarding Procedures (WSPs) Section amended to reflect legislative changes and include children <i>and</i> young people
Datix	Datix Cymru (All Wales system) has superseded Datix Main-frame, and the recording of complaints is now captured via the 'Feedback' module. Greater description of the recording and monitoring for concerns
Early Resolution & Managed Under PTR timeframes	Previously 24 hours for an Early Resolution and written acknowledgement within 2 working days. This has now been amended to reflect the 48 hours window for Early resolution and 5 working days in



	which to send a letter of acknowledgment if the concern is to be concluded under PTR
Community Health Council (CHC)	The CHC has been replaced by Llais an All-Wales advocacy service
Redress	Updates to the Redress process (virtual/LFERs)
Concerns raised by people with a disability	Amended to reflect Equality & Diversity and Welsh Government Equality Impact Assessment, along with Protected characteristics as defined with the Equality Act (2010), signposting to Diverse Cymru for further information.
Public Services Ombudsman for Wales (PSOW) Act (2005)	Amendments to legislative terminology and requirements updated to reflect PSOW Act (2019)

New components of 2024 policy:

Duty of Candour obligations explicit – Duty to be open.
Clarification of how to raise concerns and management upon initial receipt of concerns into the organisation (corresponding links included).
Aligned to latest legislation - Health and Social Care (Quality and Engagement) (Wales) Act 2020, The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023, Putting Things Right guidance document (v3, 2013), The Duty of Candour Procedure (Wales) Regulations 2023 and The Duty of Candour Statutory Guidance 2023.
Inclusion of definitions of terms
Cessation of the PTR procedure once litigation is engaged following the May 2023 PTR guidance update.
Public Services Ombudsman for Wales (PSOW) The Public Services Ombudsman (Wales) Act was updated in 2019, therefore the corresponding sections of the Act have been updated, along with the terminology used by PSOW in relation to investigations and outcomes.
The requirement for Grade 4/5 concerns not being managed as PSI's must be subject to a strategy meeting.



Importance of timely patient and family/carers engagement in setting and agreeing Terms of Reference.
Clarity of the recording process to new Datix Cymru system
Introduction of the Patient Advice and Liaison Service (PALS) as part of the Patient Experience portfolio and support for people raising concerns in an in-patient setting.
Presentation of Grade 4/5 concerns to weekly executive huddle.
Welsh Language requirements.
Notification where a Managed Under PTR matter has been resolved informally must be provided to the complainant and recorded for completeness and audit purposes
Withdrawal of concerns guidance incorporated.
More definitive guidance regarding Safeguarding requirements included (As per PTR Regs V4)
Confirmation of Annual report requirements
Dealing with people who make unreasonable demands – to be linked to H&S policy when finalised
Patient Advice and Liaison Service (PALS) - Inclusion of the PALS service in relation to early Resolution and support to staff
Training on the new components of the 2024 Policy will be provided to the concerns teams and Quality and Patient Safety Team through structured meetings, in order to ensure Divisional engagement the concerns teams have been aligned to Divisions
<u>Argymhelliad / Recommendation</u> The Board is asked to APPROVE the updated Putting Things Right Procedure for the Management of Concerns (Complaints) and to note the changes in system and process to ensure that there is more timely and high quality response to people who raise concerns.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A



Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 4.2 Patient Information 3.3 Quality Improvement, Research and Innovation
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk



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

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

Choose an item.
Choose an item.





Aneurin Bevan University Health Board

Putting Things Right Policy for the Management of Concerns (Complaints)

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document

Status: Issue 1
Approved by:
Owner: Putting Things Right Team

Issue date: TBC
Review by date: TBC
Number: TBC

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SECTION 1 – INTRODUCTION

1.1 Purpose of the Concerns Procedure

An effective concerns management system will make an important contribution to the improvement of the services we provide. The Health Board should take a proactive approach to dealing with concerns, by focusing on individuals' needs and not the concerns process itself.

The aim of Aneurin Bevan University Health Board (ABUHB) Concerns Procedure is to give guidance on how concerns should be managed, investigated and responded to in order to facilitate swift and fair resolution of issues at a local level for both users of the service, their carers, and staff, recognising the individual needs of complainants (e.g. language, support, disabilities, etc.).

The term "concern" is used throughout and should be taken to mean any complaint, claim or reported patient safety incident (about NHS treatment or services) to be handled under these arrangements. It also includes concerns which may trigger the candour procedure as set out in the Duty of Candour Procedure Regulations 2023.

1.2 Statutory Basis and Scope of the Policy and Guidance

This policy replaces the Procedure on the Management of Concerns raised by patients and their representatives (Complaints) policy and Policy for Putting Things Right the Management of Concerns. This policy applies to all permanent and temporary employed staff working within ABUHB, including primary care contractors, who have a responsibility to report and/or investigate and co-operate with complaints handling. This policy only applies to complaints which are to be reported, managed and investigated by ABUHB.

The Policy links to and may also need to be considered in conjunction with the following documents:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023
- Putting Things Right guidance document (v3, 2013)
- The Duty of Candour Procedure (Wales) Regulations 2023
- The Duty of Candour Statutory Guidance 2023

This complaints procedure complies fully with the Health Board's Welsh language duties and complainants should not be disadvantaged when they complain through the medium of Welsh.

SECTION 2 – STATEMENT

At the heart of the "Putting Things Right" (PTR) and Duty of Candour arrangements is the requirement to be open and honest when dealing with concerns. Most importantly to play a significant role in improving quality patient safety; endorse a person-centred approach to concerns management and reinforce a culture of Health Board learning and quality. This is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

The Health Board is committed to making it easy for people to raise concerns, feel that they are being listened to, and that their concerns are being taken seriously.

As a Health Board we aim to echo the NHS core values by putting Quality and Patient Safety first by providing high value evidence-based care for our communities at all times and delivering that in a Person-Centred approach.

SECTION 3 – AIM OF POLICY

Concerns are 'everybody's business'. The policy will play a significant role in improving patient safety and experience.

The policy aims to assist staff in interpreting the Regulations and providing practical advice on applying best practice at the various stages of handling and investigating a concern.

SECTION 4 – SCOPE

The policy applies to:

All Health Board staff involved in the delivery of services and provision of care to service users. It will apply to independent providers providing NHS funded care and primary care practitioners. The Redress elements of the regulations do not apply to primary care practitioners or independent providers.

SECTION 5 – ROLES AND RESPONSIBILITIES

5.1 Chief Executive

The Chief Executive Officer has overall responsibility for concerns. This responsibility has been delegated to the Executive Director of Nursing (EDoN).

5.2 Responsible Officer

The Executive Director of Nursing (EDoN) is the Responsible Officer who is charged with overseeing the day-to-day management of the PTR arrangements and ensuring that they operate in an integrated manner.

The Responsible Officer ensures arrangements are in place to:

- deal with concerns in line with the Regulations
- allow for the consideration of qualifying liabilities; and for incidents, complaints and claims to be dealt with under a single governance arrangement.

5.3 Head of QPS/Senior QPS/Concerns Manager

The handling and consideration of concerns in accordance with the Regulations will be the responsibility of the Head of QPS. The handling and consideration of concerns under the Regulations, will be part of the Senior Quality Patient Safety Manager (PTR) who will require the Concerns Manager and their team to undertake other functions in relation to dealing with concerns and to co-operate with other persons or responsible bodies, e.g. primary care providers, to facilitate the handling and investigation of concerns. This role will be supported by additional suitably trained staff as part of the integrated arrangements. The responsibilities of the Senior Quality Patient Safety Manager (PTR) can be delegated to an authorised person to act on their behalf.

5.4 Concerns Team

At a local level within the Health Board, the people involved in the handling of concerns may be referred to as 'concerns teams' or 'PTR'. This team will work with a range of other managers and administration staff throughout the Health Board.

The Senior Quality Patient Safety Manager (PTR) should ensure that staff throughout the Health Board know who to contact in the concerns team, as they will be a useful point of contact or support or advice when dealing with concerns, particularly those raised on the ward or in clinics, etc.

SECTION 6 – GENERAL PRINCIPLES AND REQUIREMENTS

6.1 What is a concern?

Policy Term	Applicable Definition
Concern	As defined in the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023, a concern is any complaint, claim or reported patient safety incident.
Patient or Service user	A person to whom healthcare is or has been provided Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/occupational health services.
Responsible Body	Defined as a Welsh NHS Body. A primary care provider or an independent provider.
PTR	Putting Things Right.
PSOW	Public Services Ombudsman for Wales.

Concerns which are excluded for consideration under these arrangements (Section 14) and do not fall within the scope of this policy are:

- Concerns notified by a primary care provider relating to a primary care provider's contract or arrangements under which they provide primary care services - these issues are dealt with through different mechanisms relating to the Regulations covering primary care.
- Concerns where a member of staff has an issue with their employment contract – these matters would be dealt with under the Health Board's HR policies and procedures.
- Where the concern is being or has been investigated by the Public Services Ombudsman for Wales; except where the Public Service Ombudsman for Wales recommends following their investigation that a Responsible Body considers the concern for redress.
- Where the Responsible Body has not complied with the Freedom of Information (FOI) Act 2000 – such concerns would be dealt with by the Information Commissioner's Office.
- Disciplinary proceedings identified as a result of the investigation – these would be managed under local HR processes.
- Any concern resolved to the satisfaction of the person who notified it by the end of the next working day after the day on which it was notified.
- Where someone tries to re-open the same concern that they have already agreed was dealt with satisfactorily under "early resolution"

- unless a Health Board considers it needs to look into the issue again and then it must follow the process for handling and investigation of concerns.
- Where the concern has already been investigated under the previous complaints procedure, that is, complaints that were reported pre-1 April 2011 and concerns that have already been considered under the Regulations.
- Concerns which are the subject of civil proceedings, including the pre-action stage of those proceedings. If court proceedings are issued when a concern is already under investigation in accordance with the Regulations, all further investigation of the concern must stop.
- Where a concern relates to an individual patient funding treatment request, that is, requests for funding of services not usually provided on the NHS in Wales – these concerns will be dealt with under a separate all-Wales process for decision and review.
- Where the responsible body is Health Education and Improvement Wales, a concern which does not relate to the provision of health care by that body.

6.2 Six principles for dealing with concerns

The following principles always apply when handling concerns. The process should be:

Person-Centred	▪ The person and those raising a concern on their behalf for example, their relative, should always be at the centre of the concerns process ▪ The support a person needs to raise a concern and engage in the complaint process must be determined at the outset. ▪ Service providers should assess and be flexible when responding to complainants’ differing needs
Simple	▪ Concerns processes should be well-publicised, have easy-to-follow instructions ▪ Concerns processes should embed the Accessible Communication Standards ▪ Concerns processes should be simple, flexible and focus on achieving the most appropriate outcomes for individuals and services. The Health Board should take a proactive approach to dealing with concerns, by focusing on individuals’ needs and not the concerns process itself. ▪ Information on advocacy services and support should be available. ▪ Concern responses should set out clearly the next stage and the right to approach the Ombudsman.

Fair & Objective	- Complainants should receive a complete and appropriate response to their concerns. - All parties associated with complaints including staff should be treated equally with dignity and respect.
Timely & Effective	- Concerns should be promptly addressed in a person-centred approach by actively listening, conducting a thorough investigation involving the individual keeping the complainant updated, and prioritising their needs and preferences are prioritised. - Listening meetings should be arranged when necessary
Accountable	Complainants should receive a clear and honest explanation of the investigation process, and where their complaint is upheld, they should be informed of any changes that will be implemented to promote continuous learning and improvement within the service
Committed to Continuous Improvement & Learning	The NHS is committed to learning from complaints, with data collated and analysed to drive continuous improvement, fostering learning both internally and with external partners to ensure the highest standards of care.

6.3 Providing Information widely and in accessible ways

To take account of the needs of individuals when handling and investigating concerns, Health Boards must publish and display information:

- In a variety of formats e.g. leaflets, posters, websites;
- Free of charge;
- In English and Welsh;
- In other languages as required;
- In other formats as required e.g. Braille, large print, audio, Easy Read, child-friendly, etc.

Concerns processes should be widely publicised by:

- Promoting the existence of the process, together with appropriate contact details, on a regular basis in any newsletters or other publications for service users.
- Making available bilingual complaints information as required.
- Ensuring information is available at all public reception areas, communal areas where service users may frequent and made widely available to the Health Board's staff.
- Circulating information to local offices of relevant advice and advocacy Health Boards operating in the service provider's area. Guidance for Public Service Providers on Implementing the Concerns and Complaints Policy.

- Publishing the complaints process at a prominent and easily accessed area of the Health Board's website (ideally via a link on the home page).

To ensure accessibility:

- Make concerns information available in alternative formats such as on CD, in large print, Braille, etc.
- Make concerns information available in other languages commonly used in the Health Board's area and publicise its existence. Bilingual (English and Welsh) posters and leaflets entitled Putting Things Right - Raising a concern about the NHS from 1 April 2011 must be displayed in public areas detailing how people can raise a concern. Leaflets should also be provided on request to individuals when they raise a concern.
- Accept verbal concerns.
- Be able to call upon translation/interpretation services (including British Sign Language).

The Health Board should keep a comprehensive list of relevant advice and advocacy Health Boards. Advice should be provided to complainants who require/request such support as to which Health Board is likely to be the most suitable to help them, in relation to their circumstances.

6.4 Equality & Diversity

Consideration must also be given to reaching other members of the community who may wish to raise a concern, but who might feel the process is not accessible to them. Staff should develop an understanding of why people might be reluctant to raise a concern, including some of the cultural, social, gender and other reasons, and look for ways to assure people that it is safe for them to do so.

Staff can access the Welsh Government's [Equality Impact Assessment](#) document, which highlights the sorts of issues that might act as barriers to people raising a concern, ensuring staff awareness of these potential issues.

There are many thousands of people in Wales who may have hearing or sight loss and the difficulties they often encounter in their dealings with the health service. One in five people in Wales have some form of sensory loss and these numbers are set to increase as people live longer. People with sensory loss may miss crucial information about their healthcare because information has not been communicated to them effectively and this can

lead to them being put at risk and concerns being raised. Much of this could be averted altogether by better communication and by making suitable adjustments to cater for the needs of people with sensory loss. Staff should be familiar with the barriers faced by people with sensory loss. When concerns are raised, then people should be provided with information in the format they need and should be offered support as appropriate.

In line with the Disability Discrimination Act (1995), the Health Board must make reasonable adjustments to ensure that the concerns process is accessible to service users who have a disability.

Staff should also be aware of people with protected characteristics to ensure the Health Board meets the needs of diverse groups of people in the management of concerns. The 9 protected characteristics to consider as defined within the Equality Act (2010) are:

- Age
- Belief and non-belief
- Disability
- Gender reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Sex (Gender)
- Sexual Orientation

More information can be found through Diverse Cymru.

6.5 Welsh Language

When dealing with concerns, the Health Board recognises the need to take account of our statutory duties in relation to the provision of services in Welsh.

In a health setting, concerns relating to the Welsh Language may be about the provision of health services (for example, that a particular service has not been provided through the medium of Welsh and therefore the person's needs have not been met) or about whether the Health Board has complied with its Welsh Language Scheme. Both can be handled under the Regulations.

It is important that in cases where the Welsh Language is a significant part of the concern that people are advised that as well as the Public Services Ombudsman for Wales, they can take their concern to the Welsh Language Commissioner if they remain unhappy.

When issuing a response to an individual regarding a concern about the Welsh Language, the following text should be included:

[Name of Health Board] has agreed on a statutory Welsh language scheme with the Welsh language Commissioner. If you are still dissatisfied following our enquiries and response, you can refer your concern to the attention of the Welsh Language Commissioner or the Public Services Ombudsman for Wales [insert address/e-mail].

Staff should be additionally sensitive to the requirements of first language Welsh speakers in the handling of their concerns and arrangements should be in place to ensure that they are able to raise their concerns, discuss them with Welsh speaking members of staff and receive a response in Welsh.

6.6 Accessing Advice and Support

When information is provided, it must include details about key sources of advice and support, such as:

- Advocacy assistance from Llais (Llais is independent of the NHS, local authorities and the Welsh Government). This is available to anyone over the age of 18 wishing to raise a concern
- Specialist advice and advocacy for people with mental health problems or who lack capacity – this is available for specific issues relating to services provided to people in these groups.
- Advocacy support for children and young people who wish to raise a concern – this is arranged by local health boards in accordance with the Welsh Government's 'Model for Delivering Advocacy Services to Children and Young People in Wales'. (Please see 7.4)

6.7 Safeguarding

The Wales Safeguarding Procedures for children and adults at risk of abuse and neglect detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect.

All practitioners should be aware of the definitions of abuse and neglect in the Social Services and Well-being Act (Wales) 2014.

There is a statutory duty to report to the local authority or police any concerns that a child under 18 or an adult-at-risk is, or is at risk of abuse, neglect or other kinds of harm. Managing immediate safety risks must also be included. Junior colleagues may seek advice from their managers or the corporate safeguarding teams. Safeguarding incidents occur out of hours and there must be a recognition of how to escalate safeguarding incidents within Health Boards and to emergency duty teams within local authorities.

The Social Services and Well-being (Wales) Act 2014 s.128, specifies the duty placed on 'relevant partners' under section 162 of that Act to report both adults and children, including unborn children, where they have reasonable cause to suspect they are at risk of abuse.

Agencies that are not included as 'relevant partners' above are still expected to report any safeguarding concerns in the same way as those with a specific duty to report.

It is important that practitioners do not ignore or dismiss suspicions about another practitioner or colleague who may be abusing, neglecting, or causing harm to a child or adult at risk.

<https://www.legislation.gov.uk/anaw/2014/4/section/197/enacted>

Every practitioner has a responsibility to safeguard adults and children at risk and that includes protection from abuse by a professional, paid carer or volunteer. Therefore, the duty to report any concerns about suspected abuse and neglect applies in these situations. This duty also covers situations when abuse is only suspected.

Practitioners are expected to report to the relevant local authority (social services) for both adults and children at risk. The relevant authority is the one in which the safeguarding concern is thought to have occurred. This may mean reporting to a local authority that is not in the same area as that in which the practitioner works.

The provision of training for Practitioners is crucial to determine the most effective way in which to safeguard an adult or child at risk. Practitioners should be aware of the different stages of the safeguarding process:

- identification of the concern

- gathering information
- assessment and analysis of early help, care and support or care and support protection needs
- decision-making and planning the most appropriate intervention
- actions and interventions
- evaluating effectiveness of the actions and interventions.

Practitioners are bound to follow the Wales Safeguarding Procedures which details the roles and responsibilities of practitioners and relevant bodies regarding planning and delivering interventions and escalation to meet the care and support, protection needs of an adult and child at risk.

Where there is any uncertainty as to whether a Putting Things Right investigation should be commenced, legal advice should be sought from Legal & Risk Services.

The Health Board has a legal duty to ensure that their functions are discharged having regard to safeguard and promote the welfare of children and adults-at risk. Detailed arrangements for protecting children and adults-at-risk are set out in the Wales Safeguarding Procedures and Working Together to Safeguard People.

SECTION 7 – RAISING A CONCERN

7.1 How can concerns be raised?

Concerns relating to the care or services received can be raised in the following ways:

- In writing by letter to the Chief Executive or by using the Concerns Form: [Aneurin Bevan University Health Board Concerns Form](#)
- By email using the Putting Things Right website which can be accessed via the following:

[NHS Wales complaints and concerns: Putting Things Right | GOV.WALES](#)

- Alternatively, directly on Aneurin Bevan's University Health Board website which can be accessed via the following:

[Complaints & Concerns - Aneurin Bevan University Health Board](#)

- Verbally (by telephone or in person) – a written record of concerns raised verbally must be made, a copy of which will be given to the person raising the concern. A template complaint form for recording verbal concerns is available at: [Aneurin Bevan University Health Board Concerns Form](#)

Where a concern is raised verbally, for example, because the person cannot or does not wish to put matters in writing, then the details of the concern must be recorded by a member of the concerns team or the person who deals with concerns before going on to being considered under the Regulations. If the person who raises the concern verbally does so in Welsh, the copy of the written record of the concern given to this individual should be provided in Welsh.

Record keeping and management of records should be adhered to all times. Record keeping is fundamental to the effective handling and investigation of concerns and where records exist, they must be accurate, complete, understandable and contemporaneous in accordance with professional standards and guidance.

Where the Duty of Candour applies in relation to a concern, regulation 9 the Duty of Candour Procedure (Wales) Regulations 2023 requires NHS bodies, to whom those regulations apply, to keep an accurate written record for each notifiable adverse outcome in respect of which the candour procedure is followed. The written record must include every document and piece of correspondence relating to the notifiable adverse outcome, including but not limited to:

- the notification of the duty
- attempts to contact the service user/person acting on their behalf.
- any decision by the service user/person acting on their behalf not to be contacted in relation to the duty of candour; and
- all documentation relating to the investigation of, and review of the notifiable adverse outcome, that is undertaken, giving rise to the triggering of the duty, including the response or interim report issued under regulations 24, 26 or 31 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Where it is decided that a concern does not trigger the Duty of Candour, it is considered good practice to record the reasons why that decision was taken on the requisite Datix Cymru file. It is important that accurate records are kept supporting quality assurance mechanisms that are needed to

identify areas for learning and improvement and also to enable NHS bodies to comply with their reporting requirements under the Act.

7.2 Who may put forward a concern?

Almost anyone can raise a concern, and the Health Board will be under a duty to consider whether it can be investigated. However, it might not always be possible to share the full details of the investigation with the person raising the concern, for instance, if they are not the patient or the patient's next of kin which would otherwise contravene the UK GDPR, unless consent has been provided to share the information, with somebody acting on behalf of the patient.

Concerns can be raised by:

- a service user/ patient who is receiving or has received services from a responsible body
- people affected or likely to be affected by the actions, errors or decisions of the Responsible Body
- staff members of responsible bodies
- independent member (non-executive director or non-officer) of an NHS body
- partners, e.g. a partner in a GP practice
- a representative acting on behalf of a person who is unable to raise a concern e.g. a young child or someone who lacks capacity to act on their own behalf; or because that person wants someone else to represent them
- a representative on behalf of a person who has died.

This procedure does not apply to members of staff raising employment issues. There are alternative internal mechanisms for these types of concerns, such as the All-Wales Respect and Resolution Policy and the Procedure for NHS staff to Raise Concerns procedures.

7.3 Concerns Raised by a Representative

Where a representative is acting on behalf of another e.g. a child or someone who lacks capacity, if there are reasonable grounds to conclude that they are not suitable to act on the behalf of the service user, for example because it does not appear to be in the patient's best interests, then they must be advised of this in writing. However, even where the Responsible Body has made a decision that the third party is not a suitable person to act on behalf of someone else, it may still choose to investigate

the concern – in particular, regard must be had to safeguarding issues as highlighted above. In this instance they are under no obligation to provide a detailed response to the person who raised the concern unless it is reasonable to do so, or where there is consent.

7.4 Concerns raised by or about children and young people

Where a concern is notified by a child or young person, they must be reasonably supported and assisted to pursue their concern. There may be a need for specialist advocacy to be offered to assist the child or young person and this should be arranged in accordance with the Welsh Government's 'Model for Delivering Advocacy Services to Children and Young People in Wales'.

In many cases, someone else (parent/carers/guardian) will raise a concern on behalf of a child or young person. This does not remove the right of the child or young person to take the concern forward themselves, with support. The Responsible Body should therefore satisfy itself as to whether the child or young person wishes to raise a concern themselves, with assistance or if they are happy for the person who raised the concern to represent them. If the child or young person is not willing to allow the concern to be investigated, then a decision will need to be taken about proceeding and specialist advice sought if appropriate. Once again, particular regard needs to be given to safeguarding issues, and it may be necessary to proceed with an investigation, even if a child appears unhappy to do so.

There may be a need for specialist advocacy to be offered to assist the child or young person and this should be arranged in accordance with the Welsh Government's 'Model for Delivery Advocacy Services to Children and Young People in Wales.' The Advocacy Service, MEIC Wales, can be contacted on <https://www.meiccymru.org> or by ringing a Freephone number, 0800880

23456. Alternatively, an online chat is accessible or a text service by using number:07943114449.

The investigation processes will be consistent with the principles of the Carlile Report (2002), with appropriate involvement of named advocates and others with nominated responsibility for children's health and welfare.

In all instances where a child protection issue arises, staff involved should seek advice from the Health Board's Head of Safeguarding.

The Putting Things Right Procedure for Handling Concerns (Complaints) should run independently of any child protection investigation. The concern should be investigated by the Investigation Lead; however, advice should always be sought from the Head of Safeguarding or Lead Nurse for Safeguarding.

Where the concern alleges child abuse or neglect by an employee, a multi-agency child protection referral must be made to the appropriate social services department in line with The Wales Safeguarding Procedures.

7.5 Concerns raised by prisoners

Prisoners have access to the same quality and range of healthcare services as the general public receives from the NHS in Wales. Where a prisoner raises a concern, the Responsible Body must handle and investigate the concern in the same way as it does for anyone else. Prisoners will also have access to the advocacy services provided by Llais (Citizen Voice Body) however this does not in any way affect the prisoner's right to raise a concern at any stage with the Independent Monitoring Board.

7.6 Concerns raised by staff

These arrangements may be used by members of staff who wish to report (e.g. via an incident report form) that something has gone wrong with care or treatment provided to a patient or patients, with a view to learning lessons. This is not the same as reporting concerns about another member of staff in terms of suspected wrongdoing, criminal activity or unprofessional behaviour which still need to be dealt with via appropriate HR Procedure for NHS Staff to Raise Concerns or via the speaking up safely framework policies and procedures. It is important that staff:

- Are fully supported to report concerns and safety issues;

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Number: ABUHB/Corporate/

- Are treated fairly and with empathy and consideration when raising concerns; and
- Have their concerns listened to and addressed when they have been involved in an incident or have raised a concern.

The Health Board aims to develop and maintain a culture across all parts of the Health Board that provides an environment where people feel able to raise concerns and are treated with respect and dignity when raising concerns.

Safety is at the heart of all care and must be underpinned by a culture which is open and transparent. This approach promotes increased reporting, learning and sharing of incidents and development of best practice. The Health Board recognises that this is the responsibility of everyone involved in the provision of health and social care services. The Health Board is committed to working towards ensuring that all individuals are treated in a service which is open to feedback and encourages as well as supports its staff to raise concerns.

The Health Board will ensure that individuals always feel free to raise concerns through local processes and are supported to do so directly, via their professional regulatory body, professional association, regulator or union.

The Health Board will facilitate an individual to raise an issue or concern in Welsh and they should be advised of this at the outset. Any subsequent proceedings should be conducted in Welsh, or a simultaneous translation service provided.

Where a concern is notified by a member of staff and initial investigation determines that there has been moderate or severe harm or death, the patient (or their representative) must be:

- Notified of the concern unless they have already been notified under the Duty of Candour Regulations; and
- Involved in the investigation of the concern unless it is not in their interests to be involved.

7.7 Concerns that have been referred to Coroner's Inquest

An investigation into a concern should continue regardless of the inquiries of the coroner, whose role is to determine the cause of death. However, in cases where there is a serious incident and/or statements are being taken from staff for the inquest, the person raising the concern will be informed that the investigation may not comply with the 30-day target.

Relatives who are concerned about the cause of death may be advised to contact the coroner for further information.

It may be possible for the Health Board to issue a formal response to the concern independent of the inquest. This is especially important if the coroner's inquest is delayed for a period of several months. However, where statements are being taken from the staff for an inquest, the concerns investigation should be based on these statements.

The Investigating Officer should discuss the case with the requisite Legal Services Manager and the Putting Things Right Manager (Concerns) to determine the most appropriate action of who will need to review the final response prior to signature by the Chief Executive.

7.8 Concerns from Solicitors / Intention to litigate /Requests for Compensation

People have a right to convey their concern through a solicitor. Provided that the solicitor is not engaged in "civil proceedings" (which explicitly includes the pre-action stage of those proceedings) the Putting Things Right process should proceed as normal.

The Legal Services Manager should be notified immediately of any concern which has the potential to be considered under Redress or develop into a legal claim over £25,000.

When pre-action stages are instigated, the Putting Things Right procedure is ended with the person raising the concern being appropriately advised in writing. If legal action is later withdrawn or fails, the concern can be investigated within the Putting Things Right process.

Where the Health Board accepts, in the absence of legal proceedings, that there is a qualifying liability in tort, then the Redress process as outlined in Section 8 below must be considered in writing. If legal action is later

withdrawn or fails, the concern can be investigated within the Putting Things Right process.

7.9 Concerns containing allegations against staff

Where concerns raised contain allegations against a staff member, they should receive a copy of the correspondence at the beginning of the investigation.

They should be given full opportunity to comment upon the concerns raised against them.

The Health Board is committed to providing support and advice for the member of staff during the investigation process, as appropriate.

Any staff member identified personally in the response letter should have a chance to see the draft response letter before issue.

Copies of final response letters will be sent to the relevant Division who will ensure that identified staff receive a copy.

7.10 Time limits for the notification of a complaint

A complaint can be notified no later than 12 months from:

- The date on which the concern occurred, or
- If later, 12 months from the date the person raising the concern realised they had a concern.

To investigate a concern after the 12-month deadline, the Health Board must consider whether the person raising the concern had good reason not to notify the concern earlier and whether, given the time lapse, it is still possible to investigate the concern thoroughly and fairly.

The discretion to consider a concern that has been notified outside the 12-month period is subject to the provisions of Regulation 15 which provides that a concern cannot be notified 3 or more years from the date the concern occurred or 3 or more years from the date the person became aware of the matter, for which the concern is about. This time limit is consistent with the limitation period, which is in place for clinical negligence claims, although there are exceptions to the rule such as:

- If the person who raised the concern is a child at the time of the injury the three-year period does not begin to run until the individual reaches the age of 18. In these cases, the period will expire on the eve of the person's 21st birthday.
- If the person who raised the concern lacks capacity under the Mental Capacity Act (2005), the three-year period may never begin to run, or it can start at the date of recovery.

In some cases where there is an exception to the rule, the Health Board must make it clear to the person raising a concern that the investigation may be limited in some respects, based upon the information available, particularly in situations where key staff have left the Health Board.

7.11 Withdrawal of concerns

A concern may be withdrawn at any time by the person who notified the concern. The withdrawal of the concern can be made:

- in writing;
- electronically; or
- verbally in person or by telephone.

If a concern is withdrawn verbally, confirmation of their decision should be provided in writing.

SECTION 8 – HANDLING AND INVESTIGATING CONCERNS

8.1 Grading of Concerns

All concerns will be graded on receipt in terms of severity, from 1(No Harm) to 5 (Catastrophic Harm) in accordance with the All-Wales Grading Framework (see Table One below). This will determine the level of investigation required in dealing with the issue(s) raised. Investigations should be proportionate to the level of harm and seriousness of the concern raised.

The grading of a concern should be kept under review throughout the investigation in case the level of investigation needs to change. For example, the seriousness of a concern may only become evident once an investigation has commenced or has been completed. The grading of a

concern may therefore be upgraded or downgraded by the Investigation Lead during the investigation.

When the Putting Things Right team is satisfied that they understand the complaint, they should:

- Grade the seriousness of the complaint to decide on the initial level of investigation.

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Grade	Harm	Examples of concerns	Potential for qualifying liability / Redress
1	None	a) Concerns which normally involve issues that can be easily / speedily addressed b) Potential to cause harm but impact resulted in no harm having arisen c) Outpatient appointment delayed, but no consequences in terms of health d) Difficulty in car parking e) Patient fall – no harm or time of work f) Concerns which have impacted on a positive patient experience.	Highly Unlikely
2	Low	a) Concerns regarding care and treatment which span a number of different aspects/specialities b) Increase in length of stay by 1 - 3 days c) Patient fall - requiring treatment d) Requiring time off work - 3 days e) Concern involves a single failure to meet internal standards but with minor implications for patient safety f) Return for minor treatment, e.g. local anaesthetic or extra investigations.	Unlikely

3	Moderate	a) Clinical / process issues that have resulted in avoidable, semi-permanent injury or impairment of health or damage that require intervention b) Additional interventions required, or treatment / appointments needed to be cancelled c) Readmission or return to surgery, e.g. general anaesthetic d) Necessity for transfer to another centre for treatment / care e) Increase in length of stay by 4 -15 days f) RIDDOR Reportable Incident g) Requiring time off work 4 -14 days h) Concerns that outline more than one failure to meet internal standards i) Moderate patient safety implications j) Concerns that involve more than one Health Board	Possible in some cases
4	Severe	a) Clinical process issues that have resulted in avoidable, permanent harm or impairment of health or damage leading to incapacity or disability b) Additional interventions required, or treatment needed to be cancelled c) Unexpected readmission or unplanned return to surgery d) Increase in length of stay by >15 days e) Necessity for transfer to another centre for treatment / care f) Requiring time of work >14 days	Likely in Many cases

		g) A concern, outlining non-compliance with national standards with significant risk to patient safety h) RIDDOR Reportable Incident	
5	Death	a) Concern leading to unexpected death, multiple harm or irreversible health effects b) Concern outlining gross failure to meet national standards c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being d) Clinical or process issues that have resulted in avoidable loss of life e) RIDDOR Reportable Incident	Very likely

8.2 Concerns Graded 4 or 5 – Serious Concerns Where correspondence raising a concern is received and it is graded as serious (severe or catastrophic/Grade 4 or 5) the complaints manager is required to check whether there is a serious incident investigation underway. If the concern is not appropriate for consideration as a PSI, a strategy meeting should be arranged by the Senior Concerns Manager with appropriate and relevant stakeholders to confirm roles and responsibilities, setting the scope of the investigation from the outset.

If necessary, the serious incident/concerns process will commence and again the person raising the concern will be informed that this is the case and of the likelihood that the 30-day target will not be achieved.

8.3 Contact with the Complainant

The Concerns teams should offer to discuss the concern with the complainant, including:

- Confirming the 'Terms of Reference' of the investigation and questions to be investigated and responded to.
- Helping the complainant to understand the process.
- Confirming their preferred method of communication.
- Discussing and confirming what the Health Board can do by way of resolution of the concerns they have raised.
- Providing advice of relevant advocacy and support services if they need help to raise their concerns.

Depending on the nature of the concern it may be necessary to obtain the complainant's permission to access their medical records. If the complainant refuses to give permission, it should be explained to them that this will influence the ability to conduct a thorough investigation. (Please see Appendix 1)

8.4 Recording and progress of the concern

All concerns are recorded on the Feedback section of Datix Cymru. This allows data from concerns to be analysed centrally and within Divisions.

The Concerns Team (s) will assume responsibility for completion of the Feedback form. The Concerns Co-ordinator should keep track of (and record) progress and take responsibility for monitoring the smooth running of the investigation, ensuring that timescales are met. The formal concerns process should normally be concluded within 30-working days. When this is not possible, complainants must be informed of the reasons and be

agreeable to any extension. The Health Board has up to 6 months to respond to a concern in exceptional circumstances. In any event, there should be regular contact with the complainant, updating them on the progress of the case.

Having formally received a concern, a formal acknowledgement should be issued in writing or, by email if the concern has been received electronically, within 5 working days of receipt.

If the concern is not from the patient, but a third party, consent must be sought from the patient.

The Concerns Co-ordinator utilises the necessary template documents to assist those involved in the concerns process. These include:

- An actioning memo that is sent to the Investigating Officer
- An acknowledgement letter (to be sent within 5 working days)
- A framework for 'update/holding' letters/calls to the complainant
- A template for response letters and investigation reports which includes the TOR.

A complainant may withdraw their concern at any time; however, the Health Board may continue to investigate if it feels that it is necessary to do so.

8.5 Stages in the Concerns Process

• Stage 1 - Early Resolution of Concerns

This stage offers the opportunity for informal engagement at the point of service delivery to seek to resolve concerns either at the time the concern arises or very shortly thereafter. This stage should be part of front-line service delivery and not viewed as separate from it. This first step will normally aim to be an explanation or other appropriate remedial action by frontline staff to remedy the complaint.

Staff should be empowered and trained to deal with concerns as they arise with the aim of resolving issues on the spot. This training can be provided during their induction period, with ongoing development.

Staff should be trained to recognise the seriousness of a concern and understand when it should be referred to more senior staff.

Staff may receive concerns that do not involve their own service, but that of another department. In large Health Boards, it can be challenging to identify the appropriate person to refer the complainant to. However, all staff should be able to direct the complainant to the Health Board's Putting Things Right concerns team or Patient Advice and Liaison Service (PALS), who will then be able to advise the complainant appropriately.

Staff may receive a concern that not only involves their own service, but also another department. It is recommended that, in such instances – since it is unlikely that the staff member will have the necessary authority to resolve a complaint on behalf of another service area – this matter should be escalated to a senior manager within the service for confirmation of best management.

Staff must advise complainants how to progress their complaint to the formal investigation stage if they are not satisfied with the outcome of the end of the informal stage.

Complainants may wish their concern to be 'fast tracked' straight through to the next stage (Stage 2 – Managed Under PTR). This should be discouraged, wherever possible. If the request stems from a breakdown in the relationship between the complainant and the service area staff, however, it may be wise to proceed directly to Stage 2. If approved by senior staff, this should be facilitated.

Frontline staff should be trained and encouraged to provide appropriate information on advice and advocacy support at Stage 1 of the concerns process. It is recognised that they may not be aware of all the types of help available, particularly when operating in a specialist field themselves. Nevertheless, they should certainly have knowledge of support that relates to their service area and should engage with PALS who can offer pastoral support to patients, families and carers.

The Putting Things Right concerns team and PALS should be a source of support for frontline staff in respect of informal resolution.

The early resolution stage should be completed as quickly as possible and certainly take no longer than 48 hours. If it is not possible to resolve the concern within the relevant timescale, then the matter should be escalated to the formal investigation stage.

Verbal concerns that can be dealt with as they arise (early resolution) should be recorded locally either on Datix Cymru, if accessible, or on a

verbal concern form. All early resolution concerns should be recorded on Datix Cymru.

- **Stage 2 – Managed under PTR**

Concerns that cannot be resolved in two working days/48hours must be dealt with as Managed under PTR. These concerns should be responded to within 30 working days wherever possible. More complex concerns and/or those that involve more than one division or Health Board may take longer than 30 days and in these instances the Health Board has up to 6 months to respond. It is important that the person raising the complaint should be made aware of this and be regularly kept up to date on the progress of the concern.

“Investigate once, investigate well” is the principle for this stage of the process. Emphasis is placed on one investigation to deal thoroughly with the concerns raised, rather than multiple investigations at various levels in the Health Board which can be protracted. However, the formal stage element of the concerns process is intended to be flexible to respond appropriately to the concern. “Investigating well” also means investigating in a manner that is proportionate to the degree of complexity of the concern.

In most instances a Managed under PTR concern will require a response signed by the Chief Executive Officer (CEO) or nominated Responsible Officer (RO).

8.6 Nomination of an Investigating Officer

The Division will nominate an investigating officer with sufficient seniority, credibility, and independence from the source of the concern to undertake the investigation.

Depending on the nature of the concern, this may still be someone within the service section/ department, but it may require someone independent from the section/department, including the concern handler themselves.

When deciding on an “investigator,” consideration should be given as to whether the investigation will need to span across more than one service and the level of seniority required to investigate across all those areas.

The Investigating Officer will be the named contact for the person raising the concern throughout the investigation.

In no circumstances should the Investigating Officer be the subject of the concern or directly involved in the incident

It is important that the Investigator(s) are appropriately selected according to their knowledge and experience and the nature of the concern.

8.7 The Concerns Investigation

A concern investigation should be a fact-finding exercise which is impartial, open, transparent, and proportionate to the seriousness of the concern. For serious complaints, a plan needs to be drawn up enabling the concern to be investigated systematically.

However, even when the concern reaches Stage 2, there may still be potential for resolving the concern to the complainant's satisfaction through an early resolution and without having to undertake a full and lengthy investigation. Consideration should be given to the possibility of this. However, notification of this outcome must be provided to the complainant for completeness and recorded on the concerns file. The PSOW welcomes attempts to resolve matters at all stages of a complaint, however this must be auditable.

Consideration should also be given to whether face to face meetings and/or mediation could be a means to resolving the complaint.

Evidence gathering can include:

- Correspondence (letters and emails)
- Notes of telephone conversations
- Health Board policies and procedures
- Good practice guidance
- Records (including those specifically relating to the complaint under consideration and training records of staff involved in the complaint)
- Interviews (including detailed notetaking)
- Site plans and visits
- Photographic evidence
- Recordings in various formats (e.g., phone, CCTV)
- Obtaining professional/expert advice
- Legislation

It is essential that the investigation addresses the concerns and underlying causes of the issue. Therefore, the Investigating Officer should, where possible, telephone the person raising the concern to seek a clear understanding of the nature of the concern and the expectations of the person raising the concern, to offer a meeting and to confirm that the investigation is underway and to explain the investigation process. If the person raising the concern has engaged with an advocate, then they should be kept informed of any decision made about how the concern will be handled.

On occasion, a meeting alone may be sufficient to resolve a concern. If the offer of a meeting is accepted and can resolve the concern, no further investigation is required. However, the meeting should be followed up in writing based on the discussions and should include confirmation that the concern is now resolved, unless expressly stated otherwise by the complainant, this must be explicitly recorded within the Feedback file. If any follow-up actions were agreed, then the person who raised the concern must be told when they can expect to receive information about the outcome of these actions. If a meeting is agreed, the person raising the concern should always be informed of their right to be accompanied by a relative/friend/advocate and/or a representative of Llais.

An apology, where this is appropriate, should be conveyed at the earliest opportunity, and recorded on the Datix Cymru file. This may be by telephone and should not await the formal response letter.

The level of investigation should be proportionate to the severity of the concern notified and will be determined by the initial assessment of the concern and the grading allocated to it. A variety of investigative tools are available on the Putting Things Right intranet page.

The Investigating Officer will ensure that any staff who are the subject of the concern receive a copy of the concern raised, and that any investigative interview is carried out impartially and fairly with due consideration of the potentially stressful nature of such interviews.

Consideration must be given to the level and type of support required by members of staff who are involved in matters raised in the concern

The Investigating Officer will interview relevant staff as necessary, and record key points from the discussion. Relevant written records and documentation will be used in the investigation to confirm and expand on the information obtained from staff.

The person who raised the concern should be kept updated in a timely manner about progress of the investigation in a format that meets any needs that have already been identified.

All contacts with the person raising the concern should be noted and recorded on the Datix Cymru file with date and time.

During the investigation, consideration should be given to inviting the persons raising the concern to attend meetings with staff. Timing should be carefully considered (e.g., it can do more harm for clinical staff to meet a patient too early; nor should things be left so long that the person raising the concern feels they have been forgotten about).

Where appropriate, the resolution of the concern through mediation or alternative dispute resolution should be considered. Llais can offer a mediation service.

Where the concern notified includes an allegation that harm has or may have been caused the likelihood of any qualifying liability arising should be considered.

If the investigation has identified that there is no qualifying liability, then a final response (under Regulation 24) will be issued. This should be within 30 working days.

If the investigation has identified that there is or may be a qualifying liability in tort worth less than £25,000, then presentation of the case at the Redress Panel should be arranged. (Please refer to Para 3.25 below)

If a final response, or in cases where there may be or is a qualifying liability, an interim report cannot be sent within 30 days, the person raising the concern must be notified of the delay.

As soon this is known, and before the agreed timescale has passed, the Investigating Officer must arrange, via the Concerns Co-ordinator, to issue a holding letter/call to the person raising the concern and, if appropriate, their advocate, explaining the delay and suggesting a revised timescale.

8.8 Duty to be open

Duty of Candour

The underpinning principles of these arrangements are openness and transparency. It is important to ensure that when incidents occur that the

patient or their representative is involved as much as possible in the investigation and is assured about lessons learned. This is also the same for any complaint received. Engagement and excellent communication are essential to the successful management of any concern, regardless of grade or complexity.

In addition to the Being Open principles, the Health and Social Care (Quality & Engagement) (Wales) Act 2020 (the "Act") places a legal duty of candour on NHS providers in Wales. The duty seeks to promote a culture of openness to improve the quality of care within the health service by encouraging Health Board learning.

Where a service user suffers an adverse outcome, which has or could result in unexpected or unintended harm that is more than minimal (i.e., moderate or severe harm or death), and the provision of health care was or may have been a factor, the Health Board must, in accordance with the Act and the regulations made there under the duty, notify the service user or their representative of the concern. This should be managed in accordance with the Health Board's Duty of Candour procedure and advice set out in the Duty of Candour Guidance.

It is intended that the requirements in the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations"), such as the requirement to undertake an investigation, will follow the candour procedure. The Health Board should, however, avoid duplicating any processes in complying with the candour procedure and the procedure required by the Regulations to avoid causing any unnecessary distress to the patient or their representative, and to ensure that the processes are properly streamlined.

For example,

Where a concern is notified by a member of staff, there remains a requirement in Regulation 12(7) of the Regulations to advise the patient to whom the concern relates, or their representative, of the notification of the concern where the Health Board's initial investigation determines that there has been moderate or severe harm or death. However, if the patient or their representative has already been notified of the concern in accordance with the Duty of Candour Regulations there is no requirement to inform the patient or their representative again.

However, there may be some necessary duplication in fulfilling other regulations such as regulation 24 which requires an apology to be given after the investigation has been completed.

Regulation 12(7) of the Regulations also requires that the Health Board involves the patient or their representative in the investigation of the concern unless Regulation 12(8) applies, and it is not in the interests of the patient to involve them in the investigation. This may be the case for example, if involving them could cause deterioration in their physical and/or mental health. In line with the general principles of the Duty of Candour, there, is still a need to inform a patient of the concern. Hence, where there has been moderate or severe harm or death, the investigation would commence straightaway and as part of this discussion, consent should then be sought to access medical records.

8.9 Investigating concerns which involve more than one Division

There will be situations where concerns are raised about services in more than one Division. The Division which has the more serious elements of the concern, or the highest number of concerns, will take the lead and the concern will be logged against this Division. The Investigating Officer will be responsible for liaising with other Divisions/areas to collate all relevant information to enable completion of a final response. Where the balance of concerns is equal between Divisions, agreement will be reached by the concerns teams, supported by the Senior Concerns Manager on where the concern should sit.

8.10 Investigating concerns which involve more than one Health Board

There will be situations where services provided by more than one Health Board form part of the concerns raised. In practice it is likely that the person has only raised the concern with one Health Board, however it is possible that they might have raised the concern with both. This must be checked carefully to ensure that there is no duplication of effort of the part of any Health Board.

If the concern is received by Aneurin Bevan University Health Board and it seems clear that the matters also involve another Health Board, then the Division involved must, within 5 working days of receipt of the concern:

- Inform the person raising the concern that another Health Board is or may be involved in their concern;
- Seek consent from the person raising the concern to contact and notify the other Health Board that they are involved in the concern raised.

Once consent has been received, the second Health Board must be informed within 2 working days of receiving consent, that a concern has been received. All Health Boards involved with the concern should then co-operate to agree:

- Which of the Health Boards will act as the lead in co-ordinating and investigating the concern;
- Who will directly communicate with the person raising the concern and keep them updated.
- A joint response to the concern, issued by the lead Health Board;
- The sharing of information relevant to the concern, subject to consent which should be obtained at the outset;
- Appropriate representation of the Health Boards at any relevant meetings.

7.11 Investigating concerns raised with the Health Board by a patient or their representative about services provided by a primary care provider

Under Putting Things Right, it is possible for people to raise concerns with Health Boards about the services provided by primary care providers.

When the Health Board receives a concern relating to care provided by a primary care provider, the correspondence should be forwarded to the Primary Care and Community Division aligned concerns team who must first decide whether it is more appropriate for the concern to be investigated by the Health Board, or whether the primary care provider should do so.

Before making this decision, the concerns team must, within 2 working days, contact the person raising the concern to:

Ask whether the concern has already been raised with the primary care provider and whether they have had a response

Seek consent for details of the concern to be sent to the primary care provider.

If the concern has already been dealt with by the primary care provider and a response issued, then the Health Board must not investigate it again. The person should be advised of this and be reminded of their right to take the matter to the PSOW.

If the concern has not been investigated by the primary care provider and it is considered that this is a concern that would be appropriate for the

Health Board to investigate, consent must be obtained from the person raising the concern to allow the Health Board to send details of the concern to the primary care provider.

If consent is not received from the person raising the concern, the Health Board cannot investigate the concern.

The only exception to this is if the Health Board is of the opinion that an issue is so serious that it would merit an investigation anyway, without direct involvement of the primary care provider, or the consent of the individual patient.

In terms of deciding whether it is appropriate for either the Health Board or the primary care provider to investigate the concern this will depend entirely on the issue raised. Whilst the Health Board can look at the matters regarding GP care, the Health Board cannot provide any comments on the clinical care. The Health Board may provide factual information to the person raising the concern, but no comments are to be made on the clinical care. The Health Board is not allowed to make any determination about the liability in tort of a primary care provider. If such matters are alleged by the patient or arise during the investigation, then the primary care provider will be advised to involve their medical defence organisation. The patient will need to be advised that the Health Board cannot become involved in those aspects of any concern about a primary care provider.

It may be in the interests of the Health Board to investigate the care provided by the primary care provider, but this investigation should not be included in the response if the concern is one about clinical care.

Where the concern relates to both the Health Board and the primary care provider, apart from issues relating to clinical care provided by the primary care provider, it would be appropriate for the Health Board to handle the entire concern.

The Health Board should make the decision on who should investigate the concern within 5 working days and inform the patient or their representative and the primary care provider who is the subject of the concern. Reasons for the decision reached must be provided.

If it is decided that the Health Board should investigate the concern, then the person who raised the concerns and the primary care provider will be notified.

Primary care providers are under an obligation to co-operate with investigations undertaken by the Health Board.

If it is decided that the primary care provider is best placed to investigate the concern, the Health Board must let the person, and the primary care provider know of the decision and why this has been made.

If the person raising the concern is unhappy with the above decision, then they must be informed of their right to take their concern to the PSOW.

The primary care provider must manage the concern in line with the investigation of concerns as outlined above.

Where the duty of candour applies, 'the day upon which it received notification of the concern' equates to the day upon which the NHS Body first became aware that the duty of candour has come into effect.

Where it is decided that the primary care provider should respond to the concerns raised, the appropriately aligned concerns team will facilitate this process and will:

- Provide a point of contact for the person raising the concern;
- Acknowledge the concern and obtain the necessary consent;
- Once consent is received, write to the Practitioner or practice concerned asking them to investigate and respond to the concern within working days;
- Monitor the provision of a response to the person raising the concern;
- Provide advice and guidance to primary care staff on the NHS Putting Things Right guidance on request;
- Offer to facilitate a meeting between the parties in an effort to resolve the concern;
- Record and monitor primary care concerns activity and prepare primary care concerns reports for the Head of QPS & Learning and Senior Quality Patient Safety Manager (PTR)
- Assist and advise individuals who do not wish to raise a concern directly with their practice.
- The Health Board should request a copy of the primary care provider's response to the concern raised.
- If the person raising the concern is unwilling or unable to deal directly with a primary care provider, then the Health Board can assist by providing an independent person to mediate between the person raising the concern and the practice. Typically, this will involve Llais.

8.12 Investigating concerns raised with the Health Board by a Primary Care Provider

Under the Putting Things Right regulations, a primary care provider can request that the Health Board investigates a concern that they have been notified of.

When a primary care provider asks the Health Board to investigate a concern about services provided by them, within 2 working days the Health Board must:

- check with the primary care provider that the person who has raised the concern consents to the Health Board considering their concern;
- establish whether the concern has been considered by the primary care provider and whether a response has already been issued.

If the person who raised the concern is unwilling to consent to the Health Board considering the concern, or if the primary care provider has already provided a response, then the Health Board cannot investigate the concern and must let the primary care provider know.

If the person who notified the concern is content for the Health Board to consider the concern, and they have not already received a response from the primary care provider, then the Health Board has 5 working days to make the decision about who should investigate the concern.

8.13 Dealing with people who make unreasonable demands

This policy acknowledges that some people may act out of character in times of trouble or distress. It is important to consider that there may have been upsetting or distressing circumstances leading up to a concern.

A complainant's behaviour should not be regarded as unacceptable just because they are forceful or determined. However, the actions of complainants who are angry, demanding, or persistent may result in unreasonable demands on a Health Board or unacceptable behaviour towards staff. It is these actions that are considered unacceptable. Please see Guidance when People Make Unnecessary Demands procedure available on the Putting Things Right intranet page.

7.14 The Final Response

Overall, the response should demonstrate throughout that the complaint has been taken seriously, that the investigation undertaken has been fair and, in accordance with the seriousness of the complaint, proportionately thorough.

Where it has been identified during an investigation that no qualifying liability exists then a final response/report needs to be issued under Regulation 24. In cases where a qualifying liability has been identified and Redress needs to be considered, the final response will also need to include the outcome of the Redress Panel. This response will be finalised by the Legal Services Managers. (Please refer to Section 5 below)

The response should include, as appropriate:

- The scope of the investigation
- A summary of the investigation:
 - Details of key issues, setting out a brief chronology of event leading to the complaint)
 - Those who were interviewed (including setting out to what degree the complainant, and if appropriate, any affected relatives, advocates, etc. were involved in the investigation)
- Conclusion
 - If the complaint is found to be justified/upheld
 - How it happened - i.e., what went wrong?
 - Why it happened - i.e., the root cause of the problem (e.g., human error, a systemic failure)
 - What impact did it have on the complainant?
 - If a systemic failing has been identified, an explanation of actions taken to put things right, with a view to ensuring the same problem does not occur again
 - If appropriate, an apology
 - If appropriate, an offer of redress
 - If the complaint has not been upheld, there should be an explanation of why this conclusion has been reached, demonstrating that it has been arrived at, based on the evidence gathered.

If the final response has not been able to be prepared within the agreed timescale, an apology and reason for the delay should also be provided in the response.

The letter will be written in clear, easily understandable language, avoiding medical or technical jargon. When such information needs to be included in the response a simpler explanation will also be given as to its meaning. Where there may be difficulties in understanding the response, the Health Board will make every effort to provide the appropriate support.

Where necessary, people raising concerns should be given the opportunity to receive their response in an appropriately accessible format.

In respect of a concern that alleges that harm has or may have been caused and this has been found not to be the case, the letter must also contain an explicit explanation of the reasons why there is no qualifying liability.

Even in cases where an investigation upholds the complaint and offers remedial action/redress, it may be that the complainant remains dissatisfied for some reason. Therefore, in all cases, the report should inform the complainant that, if they remain dissatisfied, they have the right to seek independent external consideration of their complaint. Information about making a complaint to the PSOW and other appropriate advocacy services such as LLais.

Consideration should be given to offering a meeting to a complainant at the time of closing a complaint investigation. Such a meeting may help the complainant to understand how the outcome was reached.

The response must be agreed both with the relevant senior professionals involved in the investigation and the Divisional Leads before it is sent to the Concerns Team (s). As a matter of good practice, it must also be shared with any staff involved in investigating the concern.

After the Divisional Triumvirate signs off and approves Grade 1 and 2 concerns, the concerns team will send the final approved response to the Chief Executive Officer (CEO) for quality assurance and approval. Grade 3, 4, and 5 concerns will be processed by the EDoN before being forwarded to the CEO for quality assurance, approval and signature.

The signed Chief Executive's letter is secured on the Datix Cymru System, and the concerns Co-ordinator will, on behalf of the Division, ensure that copies are distributed to staff directly involved in the investigation, and where appropriate to LLais and/or MS/MP.

The final response from the Chief Executive Officer (CEO) closes the PTR process; however, further correspondence may be received if the person raising the concern does not feel that all the issues in the original

correspondence have been addressed. Every effort will be made to address these further issues satisfactory at a local level including, where appropriate, the setting up of a meeting between the person raising the concern and relevant staff where this has not yet happened. Notes should be taken at meetings, and these will be shared with the person raising the concern.

Further letters received from the person raising the concern and dissatisfied with their final response will be acknowledged within 2-working days.

Any outstanding issues will need to be investigated, and a further response prepared, which will also be signed by the Chief Executive Officer and provided within 30-working days or sooner if possible.

Recommendations arising from investigations should be 'Specific, Measurable, Achievable, Realistic and Timed' ("SMART").

SECTION 8 - REDRESS AND REDRESS PANEL

During an investigation, it is identified that there is a possibility of a qualifying liability, then the matter must be presented to the Health Board's virtual Redress Panel. A Learning from Events Report (LFER) form and a draft concern response must be completed and forwarded to the Legal Services Administration team for "sifting" prior to presentation at a Redress Panel.

If the allocated Legal Services Manager confirms following a review that the relevant information is present and comprehensive for consideration this will be added to the agenda for the next available panel. In some instances, it may be necessary for a Clinical/Divisional representative to attend and speak to the findings of the investigation.

It is the duty of the Redress Panel to confirm whether there is a breach of duty and whether that breach caused or materially contributed to harm suffered by the patient. If a qualifying liability is proven it is the duty of the Panel to consider whether Redress should be offered, and which form of Redress is appropriate. Financial compensation is not necessarily an appropriate form of redress.

Redress cannot be offered where there is no qualifying liability in tort, nor can it be offered if the matter is or has been subject to civil proceedings. Under the regulations Redress does not extend to Primary Care providers or independent contractors.

Where the Panel determines there is no qualifying liability the Division will be notified and a response under Regulation 24 will be issued identifying the reasons why no qualifying liability exists. In some instances, it may not be possible to determine whether there has been a breach of duty and further investigation will be needed. In most instances the matter will be returned to the appropriate Division/Directorate for further investigation.

However, there may be occasions when it will be considered appropriate for an independent expert opinion to be sought. This will be commissioned by the Legal Services Manager with the appropriate Investigation Lead informing the person raising the concern of the delay in their response. It may be possible at this point to issue a letter to them giving the results of the investigation to date whilst explaining the need for further investigation. This response is not deemed to be a response under Regulation 24 or Regulation 26.

Once further investigations have been completed the matter will be re-presented to the Panel with an updated draft response and LFER form. The Panel will then consider whether it is now possible to confirm breach of duty and/or qualifying liability.

8.1 Confirmed Breach of Duty and Causation

The Legal Services Managers will have conduct of the file. It is the responsibility of the Legal Services Manager to finalise the draft response and ensure it is issued as a Regulation 33 response.

The Legal Services Managers will then need to undertake appropriate investigations to ascertain quantum if the Panel deem it appropriate to make an offer of financial compensation.

The response also needs to include the offer of free legal advice. The person raising the concern, or their representative must be advised that they have 6 months to respond to the offer of Redress or to the decision not to make an offer.

If they are unable to do so they must contact the Health Board and provide an explanation for the delay in responding. The time limit for response to the decision can then be extended to 9 months. If, however, no response is received within 9 months, the limitation period will restart, and the Redress arrangements will no longer apply.

Again, it may be necessary to seek an independent expert opinion on the patient's condition and prognosis and, if this is the case, the instruction of such an expert will be made jointly with the patient and/or their legal adviser if the offer of free legal advice has been taken up.

8.2 Quantum

Damages that may be payable under the Regulations should not exceed £25,000 (i.e., general damages plus special damages plus any repayments of benefits payable to the Department of Works and Pensions arising from the breach of duty of care i.e., CRU). If it is known that financial compensation would exceed £25,000 then the Redress regulations should not be engaged.

Awards for general damages (i.e., for pain and suffering and loss of amenity) will be made in line with the national tariff. Once quantum has been assessed approval for the making of such an offer should follow the lines of delegated authority as set out in Policy for the Management of Clinical Negligence and Personal Injury Litigation.

Evidence of the assessment of quantum and the investigation should be provided to the patient's legal adviser if the offer of free legal advice has been accepted.

8.3 Acceptance of Financial Redress

The offer to accept Redress will be made by formal agreement. By accepting the offer of Redress, the person or their representative must sign a waiver to any right to take the same concern for which they have accepted Redress to Court. There may be instances where a proposed Redress settlement will require approval by a Court e.g., for a person under 18 or where a person lacks mental capacity. In these instances, the Health Board will pay all reasonable legal costs to obtain the approval of the Court.

8.4 Suspension of Limitation Period

Under Civil Procedure Rules, the period in which a person can bring a claim is three years from the date of treatment or incident or within three years of the date of knowledge that something may be wrong. This is known as the date of limitation.

Under the Regulations and whilst the issue in question is the subject of consideration of Redress, the limitation period/date is suspended. This applies from the date on which the concern was first received by the Health

Board and continues until an offer of Redress has been made or refused. This is to ensure that person is disadvantaged or prevented from bringing legal action should they be unhappy with the outcome of the Redress investigation.

The person and/or legal representatives have up to nine months in which to accept an offer of financial compensation from the date of the offer. After nine months the limitation clock will start to run again. The same will apply if the offer of Redress is refused or where it has been decided not to make an offer of Redress.

In cases where Court approval for the settlement is needed, the Limitation period is suspended until a settlement is reached which receives the approval of the court.

8.5 An Independent Person

It may be that, for some investigations, it is considered appropriate to include the involvement of an independent person in the Stage 2 investigation. It will be the responsibility of the Putting Things Right Team to ensure that the Health Board has a pool of suitable people to call upon where necessary.

8.6 Concerns involving other legal or disciplinary proceedings

Occasionally, concerns received will involve legal or disciplinary proceedings. It may from time to time be necessary to put the investigation of a concern "on hold" until the conclusion of those other proceedings. However, it should not automatically be assumed that this is necessary in every case. An assessment should be made (with legal advice sought, if appropriate) to identify whether it is possible to address the subject of the concern, without impacting unfairly on the other proceedings underway. It is important that, if a complainant is in a continued state of disadvantage as a result of poor service delivery, every step is taken to conclude this part of their complaint. This will mean that, if the concern is upheld, it has been demonstrated that the Health Board is doing everything it can to return them as soon as possible to the position they would have been in if that failure had not occurred.

SECTION 9 – LEARNING AND IMPROVING FROM CONCERNS

9.1 Learning from concerns/continuous improvement

Concerns information should be used to improve Health Board service delivery and increase its Quality Patient Safety and Experience.

To support this, the Health Board should:

- Ensure that the concerns team periodically reviews all concern outcomes and their recommendations to identify whether there are any themes to concerns/wider lessons to be learned that may not be apparent from individual concerns.
- When considering the lessons that can be learned from a concern, an assessment should be made as to whether:
 - These are limited to the section/department in question
 - They have a Health Board-wide implication
 - They are ones that should be shared across the sector of the public service or even more widely.
- Ensure that concerns reports are considered on a regular basis by Divisional Triumvirate Teams, including an analysis of the data gathered and information on recommendations that have been made for improving service delivery.
- Ensure that concerns data is shared with the Ombudsman to support improvement in concerns handling and in service delivery.
- Ensure that the information received by Divisional Triumvirate Teams is used to target any problem areas and consider if there is potential to improve policies, procedures, and services.
- Ensure that the Executive Board receives reports giving an overview of concerns received, setting out what changes have been made as a result of concerns information and, following monitoring of their implementation, what results have been received.
- Ensure that an annual report on concerns is produced, drawing out lessons learned over this period and demonstrating how they have contributed to improved service delivery. **See Section 13**

SECTION 10 - RECORDING AND MONITORING CONCERNS AND THE PROCESS FOR DEALING WITH CONCERNS

10.1 Data collection for concerns dealt with under the Regulations

Effective concerns management includes collecting specific data and identifying recurring or system-wide problems. All feedback and concerns

received should be recorded to ensure that a comprehensive evaluation of data can be made.

To support this, Health Boards should:

- Have a system to collect Health Board-wide concerns data.
- Use the system to help track concerns and compliance with timescales.
- Enable the numbers, types, outcomes, and trends of concerns to be captured, to facilitate comparisons with previous periods and identify system wide or recurring concerns.
- Enable key points from lessons learned to be captured.
- Write to the complainant detailing the findings of the investigation, providing an apology for any shortfalls, and describing what action will be taken to prevent recurrence.
- Inform the NHS Executive of the data collated on a quarterly basis.

To also identify outcome trends of concerns, definitions and subjects as outlined, Datix Cymru will be used.

SECTION 11 – THE PUBLIC SERVICES OMBUDSMAN FOR WALES (PSOW)

11.1 Remit of PSOW

The Public Services Ombudsman (Wales) Act 2019 (PSOW Act 2019) allows the investigation of complaints made by members of the public who believe they have suffered hardship or injustice through maladministration or service failure on the part of a body in their jurisdiction, which essentially includes all Health Boards that deliver public services devolved to Wales.

The 'own initiative' powers PSOW have been granted under the Public Services Ombudsman (Wales) Act 2019 (PSOW Act 2019) allow them to investigate where evidence suggests there may be systemic failings, even if service users themselves are not raising complaints.

The Act also established the Complaints Standards Authority (CSA) to drive improvement in public services by supporting effective complaint handling through model procedures, training and collecting and publishing complaints data.

11.2 PSOW Investigations

The Public Service Ombudsman (Wales) Act 2019 enables persons raising a concern to request an investigation into their concern about the service

received from a public body once the concern has gone through local resolution stage.

The Ombudsman's jurisdiction enables an investigation into actions taken in connection with the exercise of clinical judgment by health service professionals and concerns about health services.

Once an investigation has been completed the Ombudsman can issue two types of report:

- *A report issued under Section 23 (public) of the Public Services Ombudsman (Wales) Act 2019 ("the Act")*

Where a concern is upheld and has a public interest the Ombudsman can issue a Section 23 Report. The ABHB has a duty under Section 23 of the Act to publicise the report and make it available to the public at its offices and via its website. The Health Board has a duty to accept the recommendations within the Report.

In accordance with normal practice the ombudsman's office will send a copy of the report to MS/MPs and media one week after the date of the report. In addition, the report will be on the ombudsman's website two weeks after the date of the report.

- *A report issued under Section 21 of the Public Services Ombudsman (Wales) Act 2019 ("the Act")*

Where a concern is upheld and has limited public interest, the Ombudsman is empowered to issue a Section 27 Report as long as the Health Board has agreed to implement the recommendations before the end of the permitted period.

The person raising the concern (patient or their representative) needs to approach the PSOW and request an investigation. The PSOW will contact the person raising the concern and provide information about the type of investigation the PSOW will undertake.

Early Resolution

If it appears from an initial review of a complaint that something has gone wrong and that there is an obvious solution, the PSOW caseworker will often contact the Health Board and ask it to carry out one or more actions to resolve the matter. If the Health Board agrees, then the case will be

closed without an investigation. PSOW expect the Health Board to provide evidence that we have done what we said we would do, and PSOW will follow up the actions agreed.

Investigations

When PSOW investigate a complaint, they will usually conclude the investigation by issuing a report, or by discontinuing it because of the action agreed by the Health Board. In both these cases PSOW will ask the Health Board to give evidence that we have carried out any recommendations made, or actions agreed.

Draft report / settlement proposal

Before issuing a final report or discontinuing an investigation, PSOW will always offer the complainant and the Health Board the opportunity to comment on any proposed recommendations.

This is the Health Board's opportunity to provide any comments on the proposed actions and the timescales for carrying them out, and it is therefore important that the Health Board considers them carefully. It is important that the proposed recommendations are shared with the staff or teams who will be responsible for putting them into action to decide whether the recommendations are likely to be useful and practical. The Health Board should also notify PSOW if proposed recommendations duplicate actions that have already been taken or are in the process of being taken.

If the Health Board agrees with the recommendations, it should let the PSOW caseworker know within the deadline set. PSOW will then issue the final decision.

If the Health Board does not agree with one or more of the recommendations, it should give reasons as to why. PSOW will consider these carefully, together with any comments from the complainant. If the recommendations change substantially as a result of comments, it is likely that PSOW will issue a further draft report to both parties to allow another opportunity to comment. If, however, after considering the comments, PSOW believe that the recommendations should stand and if the Health Board still does not agree, then they will consider issuing a public report.

Final report / decision

Once the recommendations have been agreed upon, PSOW will issue a final report or decision letter to the complainant and to the Health Board. This will set out the agreed recommendations/actions and the timescales for the Health Board carrying out the actions.

Recommendations complete

Once the Health Board has given PSOW evidence relating to each of the recommendations, the caseworker will consider it. If PSOW are satisfied that the recommendations have been met, they will send a letter or email to the complainant and the Health Board (CEO) confirming that the action taken meets the recommendations and that the matter is now closed.

SECTION 12 - STAFF AND TRAINING

12.1 Staff Involved in Concerns

Whilst it is common for people to look for someone to blame when things go wrong, staff should be assured that this is not the aim of an investigation. It should be made clear that any interview that may take place is to establish facts as part of the investigation of a concern, and that it does not form part of a disciplinary procedure. (However, a separate disciplinary process could take place, if appropriate.)

When requiring staff to attend for interview, they should be told the purpose of the interview, what to expect and what preparation they need to do. They should be advised that they can bring someone (such as a colleague) for support although the position of confidentiality and their role should be made clear. They should also be advised as to what will happen after the interview.

Being the subject of a concern is in any event a stressful situation and, depending on the circumstances of the concern and the issues involved, it may be prudent to inform the interviewee of any staff support/counselling available.

In the same way that it is important to keep complainants informed on progress in the investigation and its outcome, the same is true in respect of staff.

As well as informing staff involved of the outcomes of concerns and any recommendations that arise, there should also be a means (staff newsletters, making the annual report available on the intranet) of disseminating to staff how the way they deal with complaints can contribute to better public services. Health Board culture should see that reporting a concern and taking action is positive, as it assists Health Board learning. If many individuals across different locations manage similar concerns without sharing this information, a deep-rooted systemic problem within the Health Board may remain hidden. When frontline staff inform complainants about the (intended) actions being taken, it is likely to positively impact customer relations

12.2 Training

Staff at all levels across the Health Board and across all relevant areas of work should receive appropriate training to enable them to comply with the Regulations.

This will require staffing levels and skills suitable to both conduct and oversee robust and appropriate investigations as well as to be able to consider issues such as liability and settlement of claims in appropriate cases where the Redress arrangements are engaged. Training should be provided following local training needs analysis and in accordance with training strategies. The level of training required by individual staff will need to be arranged according to their specific roles and responsibilities. Refresher training needs of staff will be determined at a local level and based on local training needs analysis.

It is envisaged that the delivery of training for the arrangements will be approached locally and through a selection of national training resources, where applicable.

These include:

- PowerPoint presentations
- digital stories
- use of digital training material and
- classroom and e-learning methods.

Examples of training which are of relevance to the Putting Things Right arrangements include:

- Customer Care
- Communication

- Duty of Candour training
- Records Management
- Root Cause Analysis Training – (which includes tools for proportionate investigations as well as comprehensive investigation)
- Mental Capacity Training
- Dementia Training
- Legal training/awareness - L&RS presentation
- Sensory awareness - Links to RNIB or Action Hearing Loss
- Equality and Diversity.

The training is graded: ranging from all staff undertaking fundamental training to more detailed training for staff who manage formal concerns.

The concerns team needs to be adequately resourced by appropriately trained staff.

Training in concerns handling and Investigating Officer skills is provided by the Health Board. Please see training available on the Putting Things Right intranet page.

SECTION 13 - ANNUAL REPORT

The Health Board must prepare an annual report for each year. The report must contain, as a minimum:

- Number of concerns received (including, in the case of Welsh NHS bodies, concerns reported under Part 7 of the Regulations related to cross border services)
- The number of concerns deemed well founded; and
- Number of concerns referred to the Public Services Ombudsman for Wales.

In accordance with regulation 51(1)(d) the annual report should also summarise:

- The nature and substance of concerns received
- Any matters of general importance arising out of these concerns or the way that they were handled including areas of concern within particular departments, staff groups, treatments or services provided, that is reporting on trends:
- Actions taken to improve services as a result of a concern/s being notified.

The report is aimed at providing assurance and evidence to the Public, Welsh Government, Regulators and other stakeholders that the Health

Board is dealing and learning from concerns in accordance with the Regulations and that concerns are being 'investigated once and investigated well'.

It is important for the Health Board to communicate the actions taken in response to concerns received and the lessons learned.

At all times the Health Board must ensure that the annual report does not identify individuals or any related sensitive information.

SECTION 14 – REVIEW

This policy will be reviewed every three years or in light of new guidance, legislative or Health Board change.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Communication Standards when Conversing with a Person Raising a Formal Concern

INITIAL CONTACT – Before starting a complaint investigation

- Contact should be made with the complainant before starting an investigation.
- Assure the complainer that their complaint/concern has been taken seriously.
- Offer opportunity for a face-to-face discussion before appointing an IO. This may prevent the need for a formal investigation.
- Date of initial contact to be recorded and indicate the staff member holding that discussion.
- Determine how they wish to be addressed (e.g. Mr, Mrs by first name etc).
- Ask whether they require an advocate (consider referral to Llais or member of the PALS Team)
- Determine with complainant the specific questions they wish to be answered.
- Confirm with the complainant whether they want a formal investigation with written response or if they would prefer a face-to-face meeting to discuss the concern.
- Consider with the complainant what could resolve the concerns right now. That might be an apology, confirmation that you will improve a practice, clearer explanations, early resolution etc.
- Set out any resolution proposals clearly, making any conditions and dates for acceptance very clear.
- Action any resolution agreements promptly
- If you don't think that resolution is appropriate, explain why, keeping the language neutral and respectful.
- If formal written, ensure complainant questions are included in the investigation brief.
- Consider any additional support that the complainant may need immediately e.g., bereavement support.

INITIATION OF FORMAL INVESTIGATION

- Advise complainant of name and role of investigation officer.
- Assure of impartiality.
- Consider preferred method of communication.
- Consider reasonable adjustments e.g., interpreter, large font email etc.

- Record communication method.
- Provide point of contact of IO should they have further queries. Mobile and Email where possible, landline not ideal.
- Be clear about what may or may not be possible e.g., if the person who could inform the complaint has left employment.

DURING THE INVESTIGATION – how often will contact be made?

- Agree with complainant timings of contact e.g., monthly, 6 weekly etc.
- Be clear on what this communication may entail e.g., updates on the investigation method of communications.
- Diarise contact dates so that agreed communication dates are met.
- Record summary of contact with complainant after each discussion.
- **NOTE:** Make sure any critical findings or events are communicated to the complainant outside of agreed contact dates if appropriate.

ON COMPLETION OF INVESTIGATION – outlining the findings of the investigation

- Offer complainant a face to face or telephone discussion to go through investigation findings before receiving hard copy (make sure all complainant questions have been answered).
- Explain the findings in clear, neutral and respectful language. The complainer might not have understood the original correspondence, so it can help to paraphrase or explain any quotations that you include.
- Outline the actions that have/will be taken as a result of the findings.
- Consider reasonable adjustments to engage in these discussions e.g. support from interpreter, large font complaint response, having a family member with them etc.
- Offer follow up discussions e.g., meeting with clinical teams, meeting with Patient Experience Lead etc.
- Provide point of contact within the complaint letter should they wish to discuss the outcome further.
- Consider whether complainant would speak about their experience to support learning e.g., face to face meeting with staff, make reference to contact in the letter, joining an existing collaborative (e.g. People Participation Panel), film etc

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Aneurin Bevan University Health Board Patient Safety Incident Reporting & Management Policy (Duty of Candour: Moderate/Severe Harm)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Garvin Jones – Head of Legal Services

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

The Board is asked to APPROVE the Health Board's Patient Safety Incident Reporting & Management Policy.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Health Board's Policy & Procedure for the Management of Serious Concerns (Severe or Catastrophic) was issued in 2012 and due for review in 2015 and is therefore now significantly outdated. There have been numerous developments and changes of focus over the intervening period:

- Significant changes in national legislation and policy, including the introduction of Duty of Quality and Duty of Candour.
- Changes to the methodology for National Reportable Incidents (NRI's), moving away from prescriptive 'trigger lists' to 'judgement' and 'analysis'.
- An embracing of new concepts, including 'Safety 11 culture' and 'Just culture'.
- Alongside 'good' incident investigations, ever important need to embed learning & improvement from our investigation findings, to reduce patient safety incidents and prevention of future occurrence.
- 'Rich stream' of learning/improvement/actions now formally submitted and assessed for assurance via the Welsh Risk Pool (WRP).
- Increased recognition of the ever important need to ensure our systems put patients, families and staff at the heart of our process.



The Health Board's policy has been updated and refreshed to reflect the changing landscape. As a Health Board we must ensure that our processes and approaches to this complex and sensitive area of healthcare are aligned, to ensure the quality of our Patient Safety investigations, that our patients are at the heart of that process, and to maximise learning opportunities for the benefit of patients, service users, their families, our staff and other NHS organisations.

In addition to Patient Safety Incident investigations which focus on an adverse event causing moderate or severe harm, the Health Board will invoke other types of investigations as determined, including thematic reviews, look back reviews, joint investigations, concise reviews and rapid learning. These will be discussed and taken forward via the Executive Huddle.

Going forward, the Health Board will look to incorporate patient wishes/ concerns/ expectations from the outset directly into the Terms of Reference for the intended investigation. The Health Board will share the draft TOR with the patient/ representative and look to agree these wherever possible.

Accountability for tracking and implementing learning and actions

The central Patient Safety Incident Team will monitor and track identified Divisional actions and learning from incident investigations. Whilst the central team will assist with this quality assurance, ultimately each Division will be responsible and accountable for the delivery of its learning, actions and ongoing monitoring, audits and assurance around compliance. Accountability Agreements will be developed for each Division. An Escalation process will be invoked if required.

Actions arising from moderate/severe investigations to be shared with Executives and Divisional Triumvirate.

The Health Board strives to be an all-encompassing learning organisation where people continually expand their capacity to improve.

Cefndir / Background

On 11th May 2023 the NHS Wales Executive published NHS Wales National Policy on Patient Safety Incident Reporting & Management. The purpose of this Policy is to set out clear expectations and standards for patient safety incident reporting and management across NHS Wales, superseding the previous guidance on Serious Incidents within the 2013 Putting Things Right guidance document. The Health Board's policy, and processes going forward, have been updated to reflect the National policy and approach.

For context, this updating of our policy should be seen in the wider landscape of current works underway at the Health Board. Patient Safety Incidents are increasing. We currently have a high number of significant/severe harm investigations underway. We are seeing repeated incidences and themes. Whilst these are being managed and local learning occurs, this does not appear to translate into organisational learning.



With this in mind, a significant piece of work is underway to realign QPS resources in a new central model, to include ABCi improvement colleagues, and so better align our ability to drive and embed learning and improvement. The central Patient Safety Incident team, alongside a new alignment to the legal services team, will see increased specialism, to include dedicated Investigating Officers, ensuring the required skills and independency for our most complex and sensitive patient safety incident investigations.

Through these combined, cost-neutral changes, we hope to make more effective use of our available resources and skilled staff, reduce variation in practices, achieve a more unified consistent approach, being more adaptable and responsive to our most sensitive and complex incidents, promoting the Health Board’s reputation as a truly learning organisation.

Asesiad / Assessment

The Health Board’s Patient Safety Incident Reporting & Management Policy supports the NHS Wales National Policy which endeavours to empower all NHS organisations in Wales to take more ownership and accountability for incident reporting and management, and thereby learning & improvement from our investigation findings, to reduce patient safety incidents and prevention of future occurrence.

A summary of key changes outlined in the chart below:

2012 Policy	2023 Policy
Referred to as a Serious Incident	Redefined as Patient Safety Incident
Severe and Catastrophic harm considered	Moderate and severe harms considered in addition to thematic reviews of lower harm incidents
Safety I culture	Safety II culture
Focusing on ‘What went wrong’	Examining ‘what went right’ in addition to ‘what went wrong’
Focus on incident in isolation	Focus on themes and wider learning from these.
Incidents categorised as Red 1 (Corporate led) and Red 2 (Divisional led) investigations	Incidents categorised as Moderate and Severe investigations



New components of 2023 policy:

Duty of Candour obligations explicit
Aligns to the All-Wales National policy on patient safety incident reporting and management – previously local arrangement responsibility.
Harm is due to healthcare exposure ('but for')
Just Culture introduction
Outlines National Reporting process
Aligned to new legislation - Health and Social Care (Quality and Engagement) (Wales) Act 2020, The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023, Putting Things Right guidance document (v3, 2013), The Duty of Candour Procedure (Wales) Regulations 2023 and The Duty of Candour Statutory Guidance 2023.
Inclusion of definitions of terms
Removal of Health & Safety and child protection sections (links to supporting policies)
Removal of Coronial reporting categories
Importance of timely patient and family engagement in setting and agreeing Terms of Reference
Clarity of Executive sign off process.
Clarity upon lead divisional/organisational responsibility for action plan production and dissemination of organisational learning.
Introduction of incident review by Division within 2 working days.
Presentation of incident to weekly pre- executive huddle.
Recognised importance of securing CCTV / other evidence where relevant

Training on the new components of 2023 Policy will be provided to the Divisions and Quality and Patient Safety Team through structured meetings and ongoing OCP process.

New components of Policy version 3

Section 9.4 – Corporate Responsibilities

- Consider the need, in highly complex or sensitive Patient Safety Incidents (PSI), to hold a Strategy Meeting, overseen by a senior member of the



Corporate team; to give early and considered determination of best management, identifying any early challenges or resource issues to address.

Section 11.1 – Guidance for Investigating a Concern

- Interviews/or information gained from the staff involved in the concern/witnesses. These should be identified at the earliest opportunity.

Argymhelliad / Recommendation

The Board is asked to APPROVE the updated Health Board Patient Safety Incident Reporting & Management Policy 2023 (Duty of Candour: Moderate/Severe Harm).

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 6. Individual care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	N/A

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	NHS Wales National Policy on Patient Safety Incident Reporting & Management.
Rhestr Termiau: Glossary of Terms:	Within Policy
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	Executive Committee



Parties / Committees consulted
prior to University Health Board:

Effaith: (rhaid cwblhau)
Impact: (must be completed)

	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No, not needed
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.





Aneurin Bevan University Health Board

Patient Safety Incident Reporting & Management Policy (Duty of Candour: Moderate/Severe Harm)

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1 Introduction and Background

Patient Safety Incidents have the potential to cause harm to those in receipt of healthcare. It is inevitable that healthcare systems and processes will have weaknesses and that sometimes, these may result in errors or near misses. Patient Safety Incidents not only impact upon patients, services users, their families, and Health Board staff but can affect the reputation of the organisation, eroding public trust. Therefore, being able to respond effectively and appropriately when things go wrong is fundamental to improving patient safety and the quality-of-service provision. In an increasingly complex health care system, it is impossible to prevent all risks associated with healthcare. Aneurin Bevan University Health Board (ABUHB) is committed to the health and safety of its patients, service users, staff, visitors and contractors by promoting a culture of openness and honesty, focusing on improving practice and creating a safer environment. It thereby aims to proactively report and manage all patient safety incidents to reduce future risks and mitigate further recurrence.

This Patient Safety Incident Reporting & Management Policy forms part of the Health Board's governance and risk management process for managing, reporting, analysing and learning from patient safety incidents.

Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. Incident reports can be a valuable source of data about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. Patient safety incident reporting has changed across NHS Wales as our understanding of how to best use intelligence from incident data continues to evolve. This includes triangulation with other data sources (for example, patient experience and compliance data) and moving from a Safety I to a Safety-II approach will help organisations to shift the narrative from focusing purely on "what went wrong?" and balance this with learning from "what goes right".

Applying these new approaches will enable the Health Board to think differently about this complex and sensitive area of healthcare and ensure that these maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, and ABUHB staff. Incident reporting and management can highlight specific weaknesses in our healthcare system or processes that need to be addressed to prevent future incidents leading to avoidable death or serious harm.

The Patient Safety Incident Reporting & Management Policy seeks to promote an open reporting culture which encourages staff to look critically at their own actions and those of their teams, with an emphasis on learning and not blame, and where Health Board staff feel supported to identify, report, manage and learn from patient safety incidents, without the fear of punitive response or action. The Health Board are fully committed to embedding Speaking Up Safely as part of our culture. [Speaking up Safely: A Framework for the NHS in Wales \(gov.wales\)](#)

ABUHB's Patient Safety Incident Reporting & Management Policy supports the NHS Wales National Policy (effective from 11 May 2023) which endeavours to empower all NHS organisations in Wales to take more ownership and accountability for incident reporting and management.

2 Policy Statement

This Patient Safety Incident Reporting & Management Policy covers the reporting, management and investigation of patient safety incidents. These will be facilitated by the Patient Safety Incidents Team, in conjunction with and support from, the Executive team, Divisions and Directorates, the Health & Safety Team, and Health Board staff

While many patient safety incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- Highlighting existing risks so that early safety actions can be implemented to reduce the likelihood of recurrence.
- Reviewing of current measures, the Health Board has in place to prevent incidents.
- Fulfilling the Health Board's legal and statutory obligations to record and report certain defined incidents as set forth by NHS Wales Executive.
- Acting as a mechanism for oversight and assurance particularly where significant harm has occurred in the delivery of healthcare, in line with The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 - also known as 'Putting Things Right' (referred to forthwith as 'the Regulations').
- Enabling the monitoring of trends, themes and patterns of incident types or in certain areas, departments or hospital sites and helps to facilitate thematic review for wider learning.

- Learning from what has gone wrong and what could have been done differently, ensuring the sharing of lessons learnt from appropriate levels of investigation and providing a springboard for onward system improvements for the safety of patients.
- Ensuring that all learning is disseminated among key members of the Health Board to inform and improve future practice.
- Providing assurance to patients, service users, their families that lessons have been learned.

There are several routes within the Health Board for learning opportunities to ensure an open and positive learning culture. These include, but are not limited to, patient safety incident investigations, patient experience and complaints alongside established Health Board panels such as Medical Examiner, Falls Review, and Redress. These should be managed collaboratively and thoroughly to determine root causes, contributory factors and actions where appropriate to improve services. ABUHB is committed to ensuring that all actions for learning and improvement from patient safety incidents should be disseminated across the whole organisation to ensure the safety of patients, service users and staff.

3 Aims

ABUHB aims to ensure that all staff can identify Patient Safety Incidents, take appropriate actions and mitigate risks of avoidable harm to patients, staff and service users. Integral to this is the development of an organisational culture which supports incident reporting in an open and fair environment in line with a 'just culture.' Efforts to resolve system failures to support staff in delivering a quality service will be prioritised to improve service delivery. Analysis and learning from incidents are a critical part of patient safety including learning from when things go well. ABUHB is committed to the development of a positive learning culture throughout the organisation.

4 Objectives

- Ensure a clear and consistent Health Board approach to incident reporting, management and investigation aligned to the All-Wales National Policy.
- Provide support and guidance regarding the reporting and investigation of patient safety incidents within ABUHB.
- Provide clear guidance on what types of incidents should be nationally reported to the NHS Executive, and how this should occur.

- To ensure that all incidents (including incidents of near miss) are appropriately reported, and recorded, and an appropriate and proportionate level of investigation is undertaken.

5 Scope

This policy replaces the ABUHB Serious Incident Policy (2012). This policy applies to all permanent and temporary employed staff working within ABUHB, including primary care contractors, who have a responsibility to report and/or investigate and co-operate with Patient Safety Incidents. This policy only applies to patient safety incidents which are to be reported, managed and investigated by ABUHB.

The Policy links and may also need to be considered in conjunction with the following documents:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023
- Putting Things Right guidance document (v3, 2013)
- The Duty of Candour Procedure (Wales) Regulations 2023
- The Duty of Candour Statutory Guidance 2023

6 Definitions

6.1 Patient Safety Incident

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

This also extends to;

“A situation in which one or more patients or staff are involved, has or could result in significant harm or death; is likely to produce significant legal, or media interest; could damage the Health Board’s (HB) reputation or assets and may have significant HB wide implications for practice and delivery of care”.

Policy Term	Applicable Definition
Concern	As defined in the <i>NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011</i> , a concern is any complaint, claim or reported patient safety incident.
Patient Safety Incident	Refers to an incident occurring during the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.
Patient or Service user	A person to whom healthcare is or has been provided Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/occupational health services.
Action	Something done intentionally or unintentionally.
Inaction	Something not done intentionally or unintentionally including because of indecision, unnecessary delay, failure to act.
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy.
"Must report"	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy.

6.2 Harm definitions

The following definitions align with the definitions set out in the [Duty of Candour Statutory Guidance](#).

No harm	Any patient safety incident that had the potential to cause harm, but impact resulted in no harm having arisen.
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care.
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care.
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition.
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition.

A near miss is an incident that did not result in harm, loss or damage, but could have.

7 Roles and Responsibilities

7.1 Chief Executive

The Chief Executive has overall responsibility and accountability to ensure that effective reporting and management of the risks associated with Patient Safety Incidents within ABUHB and is consistent with good practice throughout the Health Board.

The Chief Executive is responsible for ensuring that ABUHB meets its mandatory reporting obligations to external bodies including the NHS

Executive, Wales and Health and Safety Executive (HSE). This is achieved through the development of robust incident reporting and investigation mechanisms. The Chief Executive and the Executive Team are committed to improving patient outcomes and patient safety and increasing patient satisfaction as well as workplace health and safety of staff. Timely and effective reporting, investigation and analysis of incidents are important constituent parts in achieving this commitment.

7.2 Responsible Officer

The Executive Director of Nursing has day to day responsibility for quality and patient safety. They are responsible for and overseeing the day-to-day management of these arrangements and will provide leadership and support in achieving the aims of this policy and procedures.

The Responsible Officer ensures arrangements are in place to:

- Ensure that concerns (patient safety incidents, complaints and claims) are dealt with under a single arrangement.
- Manage concerns in line with the Putting Things Right (PTR) Regulations (2013).

The responsibilities of the Executive Director of Nursing are delegated to the Head of Patient Safety Incidents but remain under the direct control and supervision of the Executive Lead.

7.3 Head of Patient Safety Incidents

The Head of Patient Safety Incidents, with the support of the central Patient Safety Incident team, is responsible for the handling and consideration of patient safety incident investigations (Duty of Candour: Moderate/ Severe/ Death) and their role requires them to undertake other functions in relation to dealing and cooperating with other persons or organisations, e.g., primary care providers. The Head of Patient Safety Incidents provides leadership and advice to the Executive Board, clinicians and managers on the handling and management of Patient Safety Incident investigations. This includes implementing a system across the Health Board to ensure the remedial actions of Divisions and Directorates are tracked and implemented, with escalation if required, to avoid recurrence of incidents and the sharing of lessons learnt across the organisation and beyond.

All Patient Safety Incidents raised will be discussed via the weekly Executive Safety Huddle. Details of the subject and nature of the incident together with the outcome of the investigation must be recorded. Compliance with

the stated time periods for response are monitored and reported. The Board are made aware of Patient Safety Incidents which may adversely affect the reputation of Board.

7.4 Patient Safety Incidents Team

The central Patient Safety Incident team will provide an Annual Report to the Board. This report will include the number of Patient Safety Incidents. The report will focus on providing assurance to the Board that lessons identified during the investigation of an incident are actioned and that appropriate remedial action is implemented, monitored and evaluated for effectiveness.

7.5 Divisional Directors

Are responsible for establishing structures to ensure that Patient Safety Incidents are reported in a timely manner and appropriately investigated within their division. This includes establishing reporting and monitoring arrangements within the Division with a focus on lessons learnt.

7.6 Divisions

Each Division will establish a Quality and Patient Safety forum which includes in its terms of reference the need to review monitor and audit its management of Patient Safety Incidents.

7.7 Redress

If the investigation identifies that there is a possibility that the Health Board may have breached its duty of care to the patient, and that as a result this has caused harm to the patient, and assessed to be within the financial threshold for Redress, the division/locality will need to submit their investigation findings to the Health Board's Redress Panel. In addition to the investigation papers, clinical opinions on harm, and a draft CEO response, the Division will need to complete an LFER to summarise the case and submit to the Redress Panel – Learning from Events Report.

Further information on the required process can be obtained from the Legal Intranet pages: [Legal Services - Home \(sharepoint.com\)](#)

The Redress Panel will formally review the information provided and make a determination as to whether a breach of duty and harm has occurred – a 'Qualifying Liability'

It is possible that the Panel will require further information before a determination can be made. Once the further information has been gathered the case will be represented to the Panel.

The findings of the Redress Panel will be layered into the draft CEO response and send to the CEO for final approval and sign off.

Each division will produce a robust and measurable action plan related to Patient Safety Investigations that occur within their division.

7.8 Investigating Officers

Investigating officers are required to:

- Undertake all patient safety incident investigations and produce written reports in accordance with this policy when appointed by the Divisional Management/QPS team or on occasions the corporate team to do so.
- Seek and undertake the Health Board Investigating Officer training to perform this role.
- Communicate with other key staff involved in the investigation and ensure confidentiality, integrity, sensitivity, courtesy and professionalism throughout their investigation.
- Act in the best interests of patients and their families in the course of their patient safety incident investigation. Seek advice from specialist departments where necessary.
- In cases where information is provided by a member of staff or employee (e.g., from their statement) is referenced in the report, the member of staff or employee must be shown a copy of the report before it is approved.

7.9 Responsibility of All Staff

- Work to the principles and aims outlined in this policy and the All-Wales National Policy.
- To identify, report and review all patient safety incidents (regardless of harm).
- To learn from Patient Safety Incidents and use opportunities to share learning among colleagues.
- To fully co-operate in an investigation to ensure that there is no unreasonable delay in providing information to the investigating officer. Where appropriate to provide statements and attend meetings to give information. Employees are encouraged to seek assistance or advice from their employee's representative. Staff with

any literacy issues, must be supported to complete statements from their line manager.

7.10 Responsibility of the Patient Quality Safety Outcome Committee

- PQSOC to receive assurance of data, learning and actions
- PQSOC to provide assurance to the Board.

7.11 Primary Care (General Medical Services) contractors in NHS Wales

- Accountable for the quality and safety of care and services provided to their respective populations.
- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. (The Health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting).
- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.
- Establishing mechanisms to extract and share learning from incidents and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

8 Nationally Reportable Incidents

8.1 Governance and Assurance Requirements

Aneurin Bevan University Health Board must ensure that it has robust systems and processes in place in relation to local and national incident reporting, including:

- Systems and processes to enact this policy in all areas of the organisation.
- All incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirements.
- Being responsible and accountable for their judgements and decisions in line with the policy.

- Integration with other relevant clinical and corporate governance processes e.g., management of complaints and claims, mortality review processes etc.
- Internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms.
- Clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board.
- Mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate.
- Systems for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. Organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes.
- Capturing and demonstrating shared learning.
- Ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

8.2 Types of Incidents

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident, and the Health Board will need to apply judgment when considering what should be reported, both at a local and a national level.

Examples of incidents which must be reported include but not limited to:

- Unexpected death
- Clinical error
- Equipment failure
- Unexpected outcome of clinical intervention
- Absence of records
- Self-harm/suicide/overdose
- Delays in diagnosis or treatment
- Slips, trips and falls (patients, public & Staff)
- Information Governance issues
- Staffing/resource related
- Medication errors (prescribing, administration, anaphylaxis)

- Never Events (see Appendix for further guidance)

Incident Reporting should not be used as a means for staff to register a point of view, highlight a situation they were unhappy with or raise a 'political' issue. There are other, more appropriate, means of raising and dealing these within ABUHB. The Health Board also has other policies that may be the more appropriate avenue for raising a concern.

8.3 Complaints as Patient Safety Incidents

The Health Board may be alerted to a Patient Safety Incident raised via the Complaints process. On receipt of a concern raised by a patient, their carer or representative, the Complaints Manager will conduct an initial review and grade the incident in terms of level of harm to the patient. It is acknowledged that the complaint letter is based on the perspective of the patient/family and facts will need to be verified. Therefore, for concerns graded as serious (severe or catastrophic) the complaints manager will check whether there is a serious incident investigation underway and send the concern to the Locality/Divisional Director to arrange for a rapid review (within 3 working days) to verify the grading. If grading is verified the complaint will be managed via the serious concerns process.

8.4 Datix Cymru

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees should have access to report directly into the system. Relevant clinicians should register on the Datix Cymru system to access and review incidents within it also assign and be assigned actions as well as being able to send and receive e-mails out of Datix Cymru thereby creating an audit trail.

The use of Datix Cymru ensures a consistent approach to data collection and analysis. This should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

- Secondary and acute care settings
- Primary and community care, including community pharmacy, optometry, dentistry services urgent and emergency services including emergency departments & ambulance services

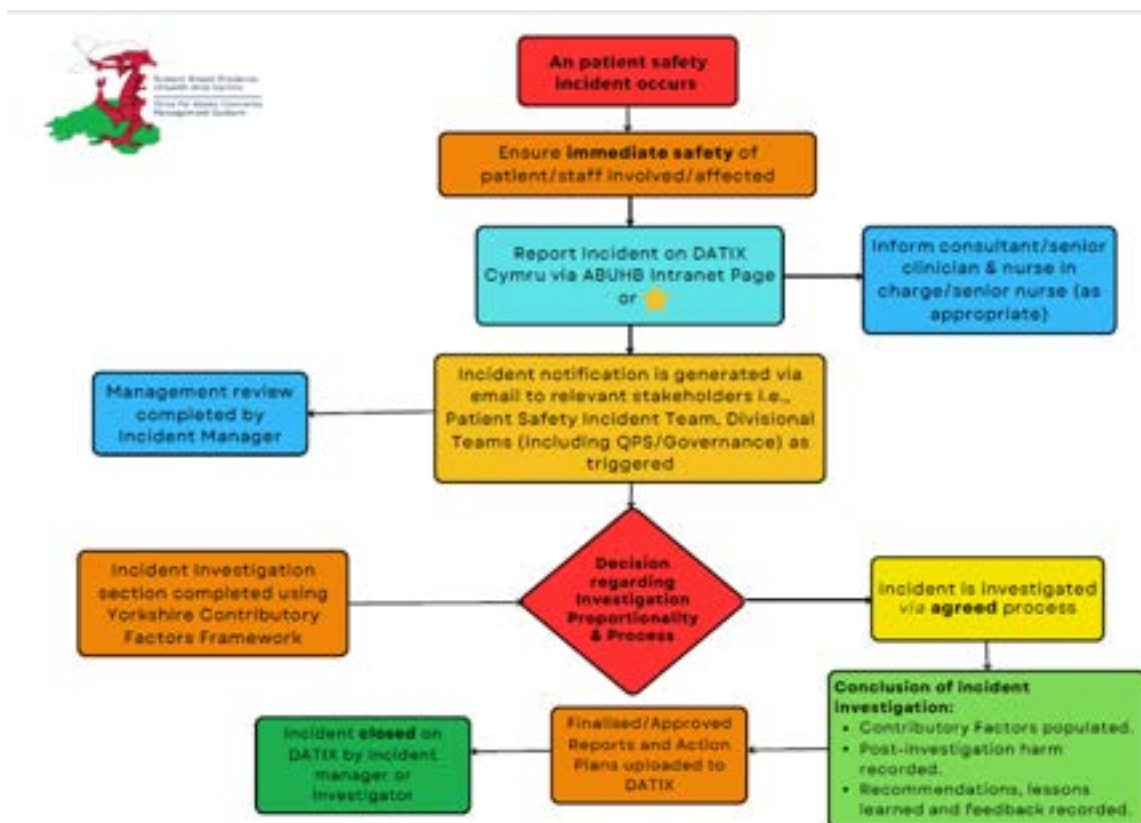
- Out of hours' services
- Public health services
- Relevant IT services
- Prisons
- Commissioned services, and
- Incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the Health Boards' governance and assurance mechanisms, ensuring clear reporting of relevant information.

The Health Board will ensure that local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

Guidance for Reporting an Incident can be found in the Appendices.

Figure 1: Process for reporting and investigation of a Patient Safety Incident within ABUHB



9 Review of Patient Safety Incidents to ascertain if they are Nationally Reportable Incidents (NRIs)

As part of the initial assessment process the Health Board will need to consider whether an incident requires reporting nationally, taking the following principles into account:

Principle 1 - 'Must reports'

Incidents related to the following are always nationally reportable:

- Never Events, as specified within this Policy, even where no harm has occurred. (The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy);
- Suspected mental health homicides;
- Suspected suicide or self-inflicted death
 - in any clinical setting; or
 - during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge
- maternal, perinatal and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** during a patient or service user's treatment or care, in any healthcare setting, **has**, or **could have caused or contributed** to their **severe harm or death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded later.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- Screening services
- IT failures
- Data breaches
- National system failures, and/or
- Service disruptions

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- Near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or
- Incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources to inform the discussion.

9.1 Reporting Process for Patient Safety Incidents as NRIs

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in **Appendices**.

9.1.1 Welsh Government Early Warning Notifications (EWN)

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function to provide rapid information to Welsh Government

on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems which are overseen and managed by the NHS Wales Executive.

AN EWN should be considered with regards to incidents which may or may not have resulted in direct harm to patients, but may have an impact on service provision, organisational reputation, adverse media coverage or political embarrassment.

An EWN will be submitted to Welsh government via PTR only and requires Executive sign off prior to submission.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, both processes must be followed.

9.2 Initial assessment to determine risk management and next steps

All patient safety incidents will require an initial assessment to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident (within first 72 hours) has occurred or otherwise been identified by the Health Board.

This initial assessment must include:

- Review of known information about the incident and consideration of further information to be obtained to inform the next steps;
- Assessment of risk and determination of make safe actions in relation to:
 - All patient(s) or service user(s) affected by the incident; and
 - The organisation, or other safety systems, to prevent recurrence in similar circumstances;
 - Consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.

The initial assessment must be undertaken by a member of staff of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. This should ideally be undertaken by the incident manager or an ABUHB appointed member of staff identified to complete an incident investigation.

The incident will be presented to a pre-executive huddle panel made up of Assistant Director level representatives from Nursing, Medicine and Therapies and Health Sciences.

9.3 Just Culture and Staff Wellbeing

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive and fair way. ABUHB in conjunction with NHS Wales endorses the use of the NHS England Just Culture guide as a tool to support the fair treatment of staff who have been involved in an incident. It supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should not be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The Just Culture guide, along with supporting reference materials, can be found on the NHS England website - www.england.nhs.uk/patient-safety/a-just-culture-guide/.

If staff are involved in an incident, the investigating officer assigned to undertake an investigation might want to talk to all staff involved about what happened. Staff may be asked to provide a formal statement of their involvement or what they witnessed. This helps to understand the events leading to and during the incident. Staff who are asked for this type of information should receive support from their clinical supervisor/line manager and should be kept informed of what is happening with any investigation.

Being involved in a patient safety incident can be upsetting for any member of staff.

Staff who are worried or distressed by what has happened or need someone to talk to can access support via their clinical supervisor, or local education centre. They can also self-refer to [Employee Wellbeing Service](#).

9.4 Corporate Responsibilities

The ABUHB Patient Safety Incidents Team will escalate patient safety incidents of potential concern, and which meet the criteria of national reportable incidents to the Executive team via the weekly Executive Safety huddle to:

- Determine the depth and parameters of an appropriate investigation;
- Consider, where required, escalation e.g.: as a Nationally Reported Incident (NRI) or Early Warning Notification
- Determine reporting to relevant national frameworks (e.g., multiagency safeguarding processes); Reporting to relevant external bodies (MBRACE/HSE/RIDDOR/SHOT);
- Any relevant communications handling required;
- Consider the need, in highly complex/sensitive/involved Patient Safety Incidents (PSI), to hold a Strategy Meeting, overseen by a senior member of the Corporate team; to give early and considered determination of best management, identifying any early challenges or resource issues to address.
- Next steps in terms of incident management.

10 Duty of Candour

The provisions of the statutory Duty of Candour, as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the statutory guidance, can be found on the Welsh Government website.

Incident reporting, management and investigation is intertwined with the principles of Being open: communicating patient safety incidents with patients and their carers and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and

management to ensure that they are aligned as far as possible, to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- An adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is:
 - Unintended or unexpected, and
 - More than minimal e.g., moderate, severe or death, and
 - The provision of healthcare was or could have been a factor in that harm occurring.

At the point the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 occur after the date on which Section 3 was brought into force (i.e., 1 April 2023). In practical terms, this means that the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

- The Duty of Candour Statutory Guidance 2023 – see **Appendices**
- Duty of Candour Datix Process – see **Appendices**

11 Investigation

All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2023.

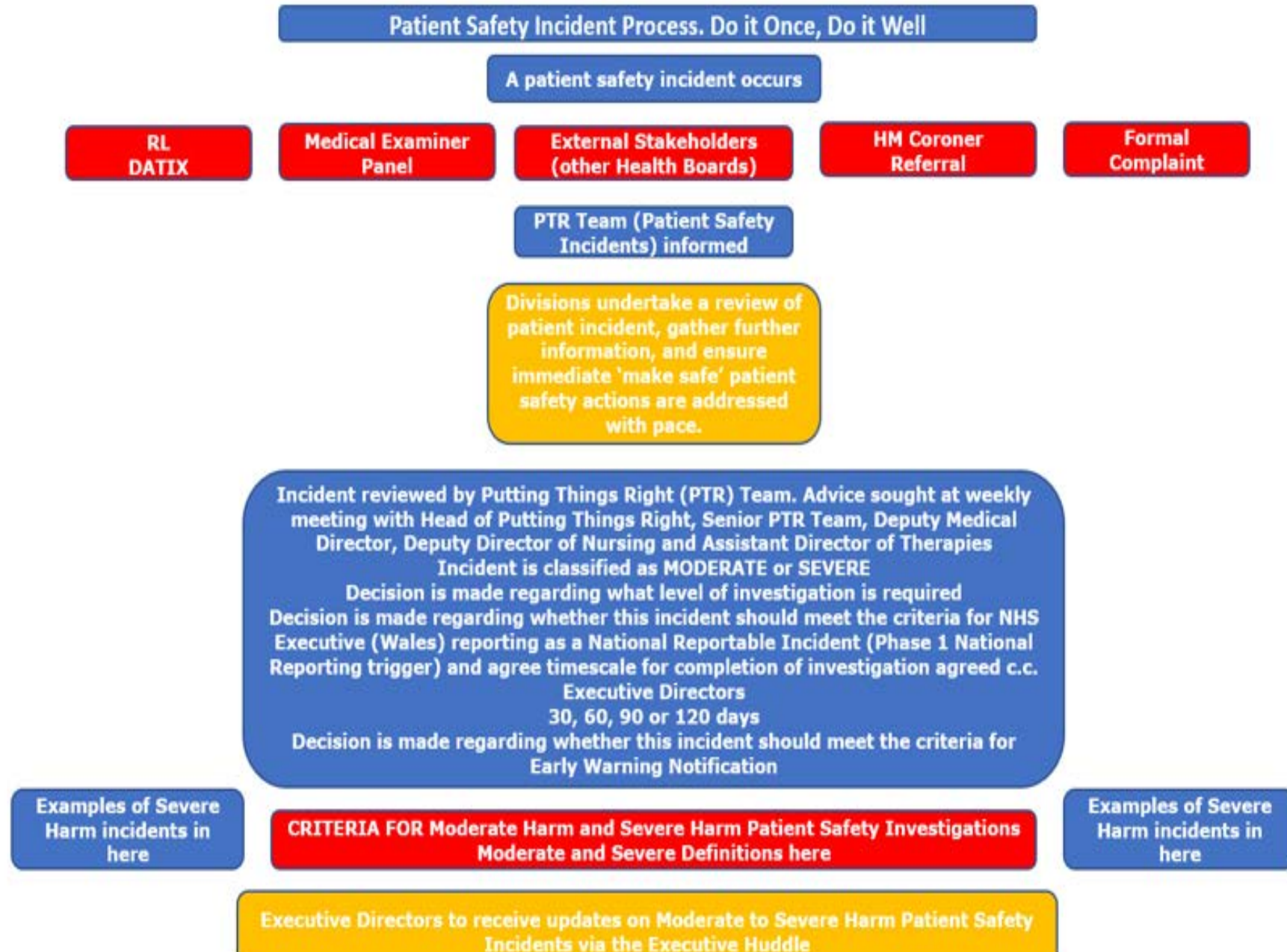
Regulation 23 outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in

the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

In addition to Patient Safety Incident investigations, focussed on an adverse event causing moderate or severe harm, the Health Board will invoke other types of investigations as determined, including thematic reviews, look back reviews, joint investigations, concise reviews and rapid learning. These will be discussed and taken forward via the Executive Huddle.

Patients and/or their representatives/family will be engaged from the beginning of the investigation. If the Duty of Candour has been triggered this will commence at that point. Patients must be contacted to ascertain any concerns, explain the intended investigation and its purpose, to ascertain the patient's wishes and expectations. The Health Board will incorporate this input from the patient directly into the Terms of Reference (TOR) for the intended investigation. The Health Board will share the draft TOR with the patient/representative and look to agree these wherever possible. The ultimate determination of the TOR will rest with the Health Board to ensure investigations progress and wider opportunities for learning/prevention of future harm are not lost through delay.

Appendix 1



Appendix 2

<u>Moderate to Severe Harm Patient Safety Incident Process</u> • Appointment of Chair of Investigation process (list as appendix) • A trained Investigating Officer (IO) is appointed by the Division in advance of the initial meeting (consideration of multiple IOs if cross-divisional) • Timeline of events completed by the Division and clinical notes secured. • List of key stakeholders to attend is agreed (including any external). • Dates for initial and outcome meetings are arranged. • Standard PTR Incident Agendas are used.
Initial Meeting 1 week <i>Purpose of meeting (Initial meeting agenda used):</i> • Division present overview/timeline of patient safety incident. • Agree Terms of Reference and Scope of Investigation. • Nominate a Patient/Family Liaison Officer for Patient/family. <i>Need discussion about minutes</i> • Appoint an Action Plan Lead. • Consider if incident meets the criteria for National Reporting. • Gain assurance that immediate patient safety actions undertaken. • Identify support for staff. • Assurance of immediate Patient Safety actions undertaken and added to Action Plan • Any early learning for sharing to be presented.
Family Liaison Officer Contacts Patient/Family and asks if they have any questions/concerns to be investigated as part of the process.
Investigation Period 6 weeks • Investigating Officer undertakes investigation based on Terms of Reference and Scope, including any additional Patient/Family questions and drafts investigation report (+/- Fishbone Diagram) • Investigating Officer meets with PTR Incidents Team and the draft investigation report is reviewed against Terms of Reference. Consider if any other areas of investigation need to be explored. • The Investigating Officer meets with Action Plan Lead, shared key areas of learning and improvement and the draft action plan is developed. • The Investigating Officer considers any Breach of Duty and if Learning from Events (LFER)/Redress required.
Investigating Officer shares Investigation Report and Action Plan (+/- Fishbone Diagram) and sends to Divisional Management for Divisional Approval.
Outcome Investigation Meeting 10 weeks • Divisionally Approved Investigation Report and Action Plan is presented and Chair Approval is completed. • Agree monitoring of Actions and ABUHB learning. • Consider if Incident meets the criteria for National Reporting (if reported, an NHS Executive Outcomes Form is completed by PTR (Incidents) Team. • Confirm arrangements for sharing report with relevant staff and family/patient. • Confirm arrangements for sharing report and action plan with Legal Services (for HM Coroner)
Approved Investigation Report and Action Plan (+/- Fishbone Diagram) are formatted and saved in Word and PDF. PDF copies are uploaded to RL DATIX as Approved and PTR (Incidents) Team will email Divisional QPS out of RL DATIX to request closure of the incident. Investigating Officer emailed final Exec Approved Report as copy.
Sharing of Approved Reports with Patient/Family

11.1 Guidance for Investigating a Concern

The investigating officer will undertake several steps in the thorough investigation of a Patient safety Incident.

Purpose of the Investigation

1. **To find out the full facts** with respect to sequence of events that led to concern
2. To determine **what, if anything, went wrong** – and what went well
3. To find out **why it went wrong**
4. To Identify what actions are required to **prevent it happening again**

Planning the Investigation

Take time to plan your investigation

- Be clear of the issues
- Make a list of the people you will need to speak to/contact and what information you need from them
- Remember other people may emerge as you gather information
- Identify the documentation you will need to look at, e.g.
 - Medical and nursing records
 - Incident form
 - CWS / Myrddyn
 - Staff rotas, etc
- Remember time scales
- Factor in:
 - Availability of medical records
 - Availability of key staff
 - Time to draft the report
 - Time for the corporate review

Finding out the Facts

Gather the information - this is the lifeblood of any investigation and will take 60% of your time. Facts will be obtained from:

- Documentation

- Interviews/or information gained from the staff involved in the concern/witnesses. These should be identified at the earliest opportunity.
- Examination of equipment records, where necessary
- Examination of the location of the incident may relevant
- A review of appropriate policies and procedures
- **Consider whether CCTV exists and if it aids the investigation**
N.B. it will require securing within 28 days

Determine what, if anything, went wrong

- What service/care should have been provided?
- What was provided and what happened?
- Map and analyse the information gathered by using relevant tools (e.g., timeline, tabular timeline, narrative chronology, time person grid)
- Compare sequence of events with relevant standards, protocols and guidelines

Determining why it went wrong

- Were suitable standards in place to control what went wrong?
- If standards in place, were they appropriate or sufficient?
- If standards were good enough, were they applied in practice?
- Look at the influencing factors, such as:
 - Staff factors
 - Patient factors
 - Environmental factors
 - Task factors
 - Equipment factors
 - Team factors
 - Organisational and Management factors

Use appropriate tools dependent on severity and complexity of concern. Remember, some tools help gather information, some help to analyse information and some help to draw conclusion. (ABUHB Patient Safety Incident Toolkit).

More information on the ABHB Toolkit can be found on: Putting Things Right - Web Page Tool Kit.pdf - All Documents (sharepoint.com) and within the Appendices.

Preventing it happening again

- What lessons can be learnt?
- Are there any recommendations?
- Think about failures that have led to concern, e.g.
 - Human error or inappropriate behaviour by staff
 - Procedural or administration problems
 - Communication problems
 - Recommendations to be practical, proportionate and constructive

Witness statements from staff involved should include:

- Name and job title at the time of the index events.
- Qualifications and relevant training/experience to the issues at hand.
- How the witness was involved in the care.
- Whether the information provided is based on the contemporaneous medical notes, normal medical practice and/or recollection of the events.
- A chronological description of involvement in the case giving dates and places and the identity of others involved. Distinguish between what is in the notes and what is recollection or your usual practice.
- The diagnosis and treatment plan where applicable.
- Try to avoid medical jargon.
- If results are included, it is helpful to explain the normal ranges for the particular test.
- Clinical reasoning for the decisions made.
- Any discussions with the patient and/or family about the issues of concern that were raised.
- Set out anything that would have been done differently in retrospect, and/or now do differently as a matter of practice and/or details of any additional training, protocols, guidance which have come into force since.
- Include only facts and not assumptions.
- Sign and date the statement once completed.

Involving patients, families, service users and carers

Involvement begins with a genuine apology. The principles of honesty, openness, and transparency (Being Open) must be used. All ABUHB staff involved in liaising with patients, families, service users and carers must have the necessary skills, expertise, and knowledge to explain what

occurred comprehensively and compassionately. The appropriate person must be identified for each incident in accordance with the Duty of Candour.

- Patients and/or their representatives will be engaged from the beginning of the investigation. They must be contacted to ascertain any concerns and to help inform the Terms of Reference for the investigation.
- Patients and their families will know what they can expect from the investigation. They will be informed of realistic and achievable timescales and outcomes, including predicted timescales for investigation.
- Patients and their families will be made aware of the rationale and purpose of the investigation.
- Patients and their families will be provided with the opportunity to express any concerns and questions.
- Patients and their families will be provided with a draft final patient safety incident report inclusive of the findings. The Health Board will consider any further comments or questions before finalisation of the report.
- Patients and their families will be signposted to any identified appropriate support services.
- Patients and their families will be provided with the opportunity to meet with representatives from the Health Board to discuss the findings and explore any further concerns.

11.2 Methodologies

Methodologies used should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are several focussed review tools built into Datix Cymru which should be used where they are available. This includes safety incidents relating to:

- Falls
- Pressure damage (All Wales Pressure Ulcer/PU tool)
- Extravasation

Use of Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents,

including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents (see Appendices).

11.3 Joint investigations

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;
- where patients have been moved between organisations, including patient handovers at emergency departments; and
- where services have been commissioned, including relating to social care.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Appendices.

The Health Board currently holds weekly joint investigation meetings with Welsh Ambulance Service Trust (WAST) to review collaboratively cross organisational incidences.

Commissioned Services

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a 'Welsh NHS body' (Health Board or Trust) through NHS funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:
 - NHS England; or
 - NHS Scotland; or

- NHS Northern Ireland; and
- 2. NHS Wales funded healthcare provided by an 'independent provider', either:
 - Provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or
 - Provided outside of Wales.

NHS Wales funded healthcare provided by another UK NHS provider

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does or may** exist. However, there is no requirement on other UK NHS organisations to inform an NHS Wales commissioning organisation where they **do not** consider a QL exists.

NHS Wales funded healthcare provided by an 'independent provider'

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare (CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

Responsibility to Investigate

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

- The investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and
- There is no requirement on the provider to consider a QL as part of the investigation process.

Joint investigations in relation to commissioned services

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

Post discharge

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

11.4 Investigation outcomes

Learning from incident investigations

A fundamental part of undertaking incident investigations is to learn from previous experience to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

Completing an incident investigation

The accountability for supporting and engaging with an incident investigation sits within the Division who undertook the investigation.

To allow the Executive Board to be assured that incidents within the organisation have been dealt with appropriately, the Health Board must ensure robust processes are in place to inform and assure their Boards that:

- The quality of their investigation processes is of a high standard;
- Investigations are being undertaken and completed in a timely manner;
- Patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- Appropriate actions are being taken and learning is being shared across the organisation.

All Patient Safety incident investigations and their accompanying action plan, resulting in Moderate and above harm, in addition to all Never Events will receive Senior Executive sign off.

Learning, and ongoing monitoring and assurance of actions, will be presented at the Quality and Patient Safety Operational Group by Divisions and Directorates through to Patient Quality Safety Outcome Committee.

Accountability for tracking and implementing learning and actions

The central Patient Safety Incident Team will monitor and track identified Divisional actions and learning from incident investigations. Whilst the central team will assist with this quality assurance, ultimately each Division will be responsible and accountable for the delivery of its learning, actions and ongoing monitoring, audits and assurance around compliance. Accountability Agreements will be developed for each Division. An Escalation process will be invoked if required.

Actions arising from moderate/severe investigations to be shared with Executives and Divisional Triumvirate.

The Health Board strives to be an all-encompassing learning organisation where people continually expand their capacity to improve.

12 Process for reporting outcomes of a National Reportable Incident investigation

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Appendices.

This function will be undertaken by the Patient Safety Incident SI team.

13 Training

Staff undertaking the Investigating Officer Role Should attend the Putting Things Right Serious Incident Investigation and Complaints Training. This workshop is held over a full day and should be attended by Senior Health Board staff involved in the handling and response to Complaints and Serious Incidents received within the Health Board.

The workshop focuses upon developing an understanding of Serious Incident and Complaints investigation and response in line with the Putting Things Right regulations and provides:

- An understanding of the PTR process and the framework for investigating concerns.
- Roles and responsibilities of the IO.
- An overview of the necessary tools and knowledge required in the execution of an investigation.
- Signposts to the resources used to support investigations.

14 Review

This Policy will be reviewed every 3 years or in line with any National or Local Policy change.

15 References

Health and Social Care (Quality and Engagement) (Wales) Act 2020

The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023

Putting Things Right guidance document (v3, 2013)

The Duty of Candour Procedure (Wales) Regulations 2023

The Duty of Candour Statutory Guidance 2023

16 Appendices/Supporting information

1. [NHS Wales Never Events list](#)
2. [Nationally Reportable Incident \(NRI\) reporting processes & flow chart](#)
3. [Guidance on nationally reporting specific incident types](#)
4. [Joint investigation process](#)
5. [Guidance on Safety-II principles](#)
6. [Commissioned Services flowchart](#)
7. [Cause and effect diagram \(fishbone diagram\)](#)
8. [Yorkshire Contributory Factors Framework - Improvement Academy](#)
9. [Systems Engineering Initiative for Patient Safety \(SEIPS\)](#)
10. [Guidance for Reporting an Incident](#)
11. [Datix Cymru Incidents Module User Guide](#)
12. [Health and Safety Intranet pages](#)
13. [Safeguarding Intranet pages](#)
14. [Putting Things Right Intranet pages](#)
15. [Duty of Candour Datix Process](#)
16. [The Duty of Candour Statutory Guidance 2023](#)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Standards of Business Conduct Policy
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report presents, for approval, the revised Standards of Business Conduct Policy.

The Health Board's Standing Orders state that:

"The Board must adopt a set of values and standards of behaviour for the LHB that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the LHB, including Board members, LHB officers and others, as appropriate. The framework adopted by the Board including the Health Boards Values and Standards of Behaviour Framework and Policy for Standards of Business Conduct will form part of these SOs."

Cefndir / Background

Aneurin Bevan University Health Board expects a high standard of behaviour treating patients, their families, the public and colleagues with dignity and respect at all times. All staff are expected to carry out their roles with dedication and a commitment to the NHS and its core values. The Standards of Business Conduct Policy compliments the Health Board's Values and Behaviours Framework, which

details the Behaviours and attitudes required by all employees, in support of the delivery of our Business Plan, values and culture.

The Standards of Business Conduct Policy enables Aneurin Bevan University Health Board (ABUHB) to ensure that its Employees and Independent Members practice the highest standards of conduct and behaviour. The policy sets out the expectations required and provides supporting guidance so that all Employees and Independent Members are supported in delivering that requirement.

The “Seven Principles of Public Life”, or the “Nolan Principles”, form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

- **Selflessness** – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends.
- **Integrity** – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.
- **Accountability** – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.
- **Openness** – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
- **Honesty** – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership** – Individuals should promote and support these principles by leadership and example.

In support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day-to-day functions. They must remain beyond suspicion at all times. They can achieve the “Seven Principles” above by:

- Ensuring that the interests of patients remain paramount.
- Being impartial and honest in the conduct of their official business.
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money.
- Not abusing their official position for personal gain or to benefit family or friends.
- Not seeking advantage or to further private business or other interests in the course of their official duties.
- Not seeking or knowingly accepting, preferential rates or benefits in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board.

The Standards of Business Conduct Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the Health Board’s Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it

operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made.

The Policy is supported by a short guide on the Standards of Behaviour Framework that provides a summary of expected conduct. This Framework is intended to compliment the various Professional Codes of Conduct relevant to Employees of the Health Board.

Asesiad / Assessment

The Health Board's current Standards for Business Conduct Policy was approved by the Audit Committee in October 2019 and, although is now overdue for a review, remains the extant policy for the organisation.

A key corporate governance priority within the IMTP is to further strengthen mechanisms for recording and reporting declarations of interest, gifts, hospitality and sponsorship. The revised policy (Attachment One) is based on that adopted by a number of Health Board's and expands of the current policy, providing more explicit guidance on declaring interests, gifts and hospitality, and now includes honoraria and sponsorship.

In support of the revised policy, work has been undertaken to develop a new sharepoint site which includes support and guidance for implementing the policy, and utilises Microsoft forms for completing declarations, which will automatically populate the relevant register. This site will go live once the policy is approved. (note the links to sharepoint in the attached policy are therefore not yet active)

In line with Standing Orders, the Audit, Risk and Assurance Committee will continue to review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, and for gifts, hospitality and sponsorship. This will be undertaken bi-annually.

The Policy has been presented to the Audit, Risk and Assurance Committee (ARAC) and the Workforce and OD Policy Group for review as part of the consultation process prior to submission to the Board for approval. Following discussion with the Workforce and OD Policy Group, although the content of the policy was agreed, it was requested that the policy be provided in a more interactive and user friendly format. The content is therefore the same as that considered by ARAC, but the format has changed.

Argymhelliad / Recommendation

The Board is asked to APPROVE the Standards of Business Conduct Policy for the Health Board.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg

Corfforaethol a Sgôr Cyfredol:

N/A

Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

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

Equality Impact Assessment (EIA) completed	In consideration of the EQIA guidance and the criteria outlined in the developing screening tool, the proposals are unlikely to have equality impacts and the Equality, Diversity and Inclusion Specialist is satisfied that a full EQIA is not required. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.



GIG
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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Standards of Business Conduct

(incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria)

Lead Author (S)	Head of Corporate Governance
Lead Executive	Director of Corporate Governance
Division/Department	Corporate Governance
Reference	ABUHB/Corporate/0258
Applies to	Health Board Wide
Approving Forum	Board
Date Approved	
Review Date	

Version Control		
Version No	Approved	Author
5		Head of Corporate Governance

Policy on a Page: Key Messages

Aim

This policy outlines the arrangements in ABUHB to ensure that staff comply with the requirements for recording and declaring potential conflicts of interest and handling of gifts, hospitality, honoraria and sponsorship (even if these are declined).

Summary of key changes

This is a re-write and expansion of the former Standards of Business Conduct Policy, to provide more explicit guidance on declaring interests, gifts and hospitality, and now includes honoraria and sponsorship.

Training:

No specific training requirements however, awareness raising sessions will be held with managers.

Key Requirements

How to declare and record potential conflicts of interest.

Ensure you are not in a position where you (or your close family's) private interests and NHS duties may conflict.

Seek your managers permission before taking any outside work, in accordance with employment terms and conditions.

Declare any offers of gifts, hospitality or sponsorship using the appropriate forms

Obtain permission before accepting any commercial sponsorship or hospitality.

If in doubt declare it!

Target Audience

All employees and Board members



Click on this icon to
return to the contents
page



Click on this icon to
access the sharepoint site
and forms



Click on this icon for
further guidance

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1. Introduction/Overview

The Standards of Business Conduct Policy enables Aneurin Bevan University Health Board (ABUHB) to ensure that its Employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out the expectations required and provides supporting guidance so that all Employees and Independent Members are supported in delivering that requirement.

2. Scope

This Policy is applicable across the whole of the Health Board. It applies to all Employees and Independent Board Members. The term "Employees" includes all those who have a contract of employment or honorary contract with the Health Board, or are workers within the Health Board.

3. Aim

The aim of this Policy is to ensure that arrangements are in place to support employees to act in a manner that upholds the Standards of Behaviour Framework as well as setting out specific arrangements for the appropriate declarations of interests and acceptance/refusal and record of offers of Gifts, Hospitality or Sponsorship. The Policy also aims to capture public acceptability of behaviours of those working in the public sector so that the Health Board can be seen to have exemplary practice in this regard.

ABUHB is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported to deliver this requirement.

4. Background

The Welsh Government's Citizen-Centred Governance Principles apply to all public bodies in Wales. These principles integrate all aspects of governance and embody the values and standards of behaviour expected at all levels of public services in Wales.

"Public service values and associated behaviours are and must be at the heart of the NHS in Wales"

ABUHB is strongly committed to being value-driven, rooted in the Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.

The Board expects all Independent Board Members and Employees to practice high standards of corporate and personal conduct, based on the recognition that the needs of patients must come first.



4. Background cont.

The “Seven Principles of Public Life”, or the “Nolan Principles”, form the basis of the Standards of Behaviour requirements for Health Board employees and Independent Board Members. These are:

- Selflessness – Individuals should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or friends.
- Integrity – Individuals should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- Objectivity – In carrying out public business, including making public appointments, awarding contracts, recommending individuals for rewards and benefits, choices should be made on merit.
- Accountability – Individuals are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate for their position.
- Openness – Individuals should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
- Honesty – Individuals have a duty to declare any private interests relating to their duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- Leadership – Individuals should promote and support these principles by leadership and example.

In support of these principles, Independent Board Members and all employees must be impartial and honest in the way that they go about their day-to-day functions. They must remain beyond suspicion at all times. They can achieve the “Seven Principles” above by:

- Ensuring that the interests of patients remain paramount.
- Being impartial and honest in the conduct of their official business.
- Using public funds to the best advantage of the service and the patients, always seeking to ensure value for money.
- Not abusing their official position for personal gain or to benefit family or friends.
- Not seeking advantage or to further private business or other interests in the course of their official duties.
- Not seeking or knowingly accepting, preferential rates or benefits -in kind for private transactions carried out with companies, with which they have had, or may have, official dealings on behalf of the Health Board

This Policy re-states and builds on the provisions of Section 7, Values and Standards of Behaviour, of the Health Board’s Standing Orders. It re-emphasises the commitment of the Health Board to ensure that it operates to the highest standards, the roles and responsibilities of those employed by the Health Board and the arrangements for ensuring that declarations of interests, gifts, hospitality, honoraria and sponsorship can be made.

The Policy is supported by a short guide on the Standards of Behaviour Framework that provides a summary of expected conduct. This Framework is intended to compliment the various Professional Codes of Conduct relevant to Employees of the Health Board.

The impact of other Health Board policies which should be considered by staff include:

- The Counter Fraud Bribery and Corruption policy
- Charitable Funds Financial Control Procedure
- Counter Fraud, Bribery and Corruption Policy
- Raising Concerns (Whistleblowing)
- Personal Relationships at Work Policy



5. The Bribery Act 2010

The Bribery Act 2010 came into force on 1st July 2011.

It reformed the criminal law of bribery, making it easier to tackle this offence proactively in both the public and private sectors. It is intended to respond to the extremely broad range of ways in which bribery can be committed by providing robust offences, enhanced sentencing powers, and wide jurisdictional powers.

Broadly, the Act defines bribery as:

"Giving or receiving a financial or other advantage in connection with the 'improper performance' of a position of trust, or a function that is expected to be performed impartially or in good faith"

The Bribery Act 2010 abolished all existing UK Anti-Bribery Laws and replaced them with a suite of new offences markedly different to what has gone before.

The Bribery Act 2010 made it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". The maximum penalty for bribery is up to 10 years imprisonment, with an unlimited fine. In addition, the Act introduced a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event.

- Some simple examples follow:
- Bribery in order to secure or keep a contract.
 - Bribery to secure an order.
 - Bribery to gain any advantage over a competitor.
 - Bribery of a local, national or foreign official to secure a contract.
 - Bribery to turn a blind eye to a health and safety issue or poor performance or substitution of materials or false labour charges.
 - Bribery to falsify an inspection report or obtain a certificate.



6. Roles and Responsibilities

Chief Executive

The Chief Executive is the “Accountable Officer” with overall responsibility for ensuring that the Health Board operates efficiently, economically and with probity. The Chief Executive will ensure a policy framework is set and that arrangements are in place to support the delivery of that framework.

Director of Corporate Governance

The Director of Corporate Governance has delegated responsibility for ensuring that the Health Board is provided with competent advice and support regarding the contents and application of this Policy and the Standards of Behaviour Framework. They will ensure that:-

(i) A Register of Interests is established and maintained as a formal record of interests declared by Employees and Independent Board Members. The Register will include details of Directorships, pecuniary (financial) and non-pecuniary interests in organisations that may have dealings with the NHS and membership of professional committees and third sector bodies. Where relevant it will also include details of interests of close family members or civil partners.

(ii) In addition, all staff employed in areas deemed specific ‘high risk’, as per Table 1, will be asked to complete a Declaration of Interest form. For the purpose of defining high risk, the Health Board considers this to include those whose role necessarily brings them into contact with external companies, contractors or suppliers, those who are able to initiate orders or those who are budget holders and strategic decision makers.

This includes any interests that may influence, or be perceived to influence, the member of staff’s judgement in the course of undertaking their duties whilst working for ABUHB.

Table One

Independent Members	Annually
Executive Directors	Annually
Associate Members	Annually
Staff in specified ‘high risk’ areas	
Staff at Band 8a and above	Annually
Research and Development Staff*	Annually
Procurement Staff*	Annually
Pharmacy Staff*	Annually
Informatics Staff*	Annually
Estates and Facilities Staff*	Annually

*whose role necessarily brings them into contact with external companies, contractors or suppliers, those who are able to initiate orders or those who are budget holders

Note: It is the individual employee’s responsibility to make a declaration should their circumstances change within these timescales.

(iii) A Register of Gifts, Hospitality, Honoraria and Sponsorship, whether accepted or declined, is maintained.

(iv) Appropriate information from the Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship is published on the Health Board Website in accordance with the requirements of the Freedom of Information Act.



6. Roles and Responsibilities cont.

(v) Reports detailing the content of the Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship and the effectiveness and adequacy of the arrangements in place will be provided to the Audit, Risk and Assurance Committee on an annual basis.

(vi) The form that Employees should complete when making a Declaration of Interest or when advising if gifts, hospitality, sponsorship or honoraria have been accepted or declined are available on the following [link](#).

Chair

The Chair should:

- -Ensure that Independent Board Members are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.
- -Ensure that the Audit, Risk and Assurance Committee review the adequacy of arrangements for managing Declarations of Interest and Gifts and Hospitality.
- -Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- -Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered to Independent Board Members PRIOR to the event.

Executive, Assistant and Divisional Directors

Directors must ensure that:

- Employees are aware of the requirements contained within this Policy and the Standards of Behaviour Framework.

- Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- -They review the contents of the Registers of Declarations of Interest and Gifts, Hospitality and Sponsorship on an annual basis to assist with the verification of the accuracy of the information contained within it.
- During periods of annual leave and prolonged absence they will ensure that they delegate the responsibilities to their relevant deputy.

Line Managers / Departmental Managers

Line/Departmental Managers (with budget management responsibilities) will:

- Lead by example and ensure that they personally declare any relevant interest or the offer of gifts, hospitality or sponsorship.
- -Ensure that Employees are aware of the requirement to follow and comply with the Policy and Standards of Behaviour Framework. The Standards of Business Conduct Policy will be discussed at Individual Performance Reviews, Consultant Appraisals and as part of the Consultant Job Plan Reviews as appropriate.
- -Approve (or not) the acceptance of gifts, hospitality and sponsorship that have been offered within their Directorate PRIOR to the event.
- Support their Employees in the application of the Policy and the Standards of Behaviour Framework, seeking advice from the Director of Corporate Governance if required.



6. Roles and Responsibilities cont.

Employees and Independent Board Members

All Employees and Independent Members, including those on Honorary Contracts, will ensure that they:

- Understand this Policy and the Standards of Behaviour Framework, consulting their line manager if they require clarification.
- Declare to the Health Board for recording in the Register of Interests any relevant interests:
 - At the commencement of employment
 - Whenever a new interest arises, and
 - If asked to do so at periodic intervals by the Health Board.
- Inform patients and their relatives as appropriate, when referring them for treatment, investigation, or any aspect of their care if they have a material interest in an organisation to which they plan to refer a patient. The fact that the patient has been informed must be recorded appropriately.
- Verbally declare any relevant interest when a potential for conflict arises e.g. at Board and committee meetings, during procurement processes.
- Observe the Standing Orders, Standing Financial Instructions and procurement policies and procedures of the Health Board.
- Where employees or Independent Members wish to engage in any outside employment which may affect their contractual obligation to ABUHB, they must first discuss it with their Line Manager. This will ensure that their position in ABUHB is not compromised. Agreement to such outside employment will not be unreasonably refused.

It is the responsibility of all Employees and Independent Members to ensure they are not placed in a position that risks, or appears to risk, conflict between their private interest and their ABUHB duties. This responsibility applies to all ABUHB staff, including those who commit resources directly, by ordering goods or services, and those who do so indirectly.





6. Roles and Responsibilities cont.

Procurement Department

Where an Employee is requested to participate in an ABUHB procurement process and has not previously completed a Declaration of Interest Form, they will be asked to do so prior to participating, or asked to reaffirm their interests and to confirm that there are no other relevant interests that should be declared.

The procurement lead will scrutinise such individual Declarations of Interest to ensure that there is no opportunity for any conflicts of interest.

The NHS Wales Shared Services Partnership (NWSSP) will ensure that all procurement staff complete declaration of interest forms in line with their procedures. NWSSP will advise ABUHB, through the Director of Corporate Governance, of any such interests impacting on ABUHB services.

Whilst individual staff must not seek or accept preferential rates or benefits in kind for private transactions carried out with which they have, or may have, official dealings with on behalf of ABUHB, this does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests on behalf of all staff, for example, NHS staff benefits schemes.

All staff in contact with suppliers and contractors, particularly if authorised to sign purchase orders or place contracts for goods, materials or services, shall adhere to accepted professional standards i.e. the NHS Wales Shared Services Partnership Procurement Policy and the Standing Orders and Standing Financial Instructions of ABUHB.

Directors and Senior Managers should ensure that no special favour is shown to current or former staff or their close relatives or associates in awarding contracts to private or other businesses operated by them or employing them in a senior or relevant managerial capacity.

Contracts may be awarded to such business where they are won in fair competition against other tenderers, but care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

7. Register of Interests

The Director of Corporate Governance will maintain Registers of Declarations of Interests and Gifts, Hospitality, Honoraria and Sponsorship. Appropriate information from these Registers is available on the Health Board website.

The master copy of the Register, together with the forms which are used to inform its contents will be retained by the Corporate Governance Team.

The Register is available for public inspection. Enquiries should be made to the Director of Corporate Governance via the following email: ABB.BoardSecretary@wales.nhs.uk



8. Declarations of Interest at Meetings

It is a requirement that at the beginning of every Health Board, Committee or decision making / formal Health Board meeting that members and those in attendance be invited to declare their interests in relation to any items on the agenda. Where a potential conflict is material or the member has a financial / pecuniary interest in the matter under discussion, that person shall withdraw from discussions pertaining to that agenda item and shall not vote upon it. The potential conflict and the action will be recorded in the minutes of the meeting and the Register of Interests will be updated if required.

Where it becomes evident part way through a meeting that there may be a potential conflict the individual must declare their interest immediately. Under certain circumstances the Chair may choose to waive the need for the individual to leave the meeting. The advice of the Director of Corporate Governance should always be sought prior to such a decision being made. From time to time, employees may need to declare interests at other Health Board or Partnership meetings. Such declarations will be recorded as if it were a Board or committee meeting and the individual will be asked to withdraw from discussions pertaining to that agenda item.

9. Gifts, Hospitality, Honoraria and Sponsorship

Employees and Independent Members have a personal responsibility to volunteer information regarding offers and acceptance of gifts, hospitality, honoraria and sponsorship, including those offers that have been declined. Employees should seek approval from their line manager prior to accepting any gifts, hospitality, honoraria or sponsorship. These details must be recorded on the Gifts, Hospitality, Honoraria and Sponsorship Form and submitted to the Director of Corporate Governance for inclusion on the register.

In determining whether to accept gifts, hospitality, honoraria and sponsorship, it is not always possible to make explicit a situation in which these may be considered acceptable as each offer should be considered independently. In determining whether any offer of a gift, hospitality, honoraria or sponsorship should be accepted, the following principles should be considered:

- **Openness:** It has been openly offered and the offer will not be construed as any form of inducement and will not put the individual under any obligation to those offering it.
- **Legitimate interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Health Board i.e. further the aims of the organisation.
- **Relationship:** Consideration given as to Health Board is likely to enter into a contractual relationship with the organisation/ individual making the offer.
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/ calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct.
- **Reputation:** If the body concerned is known to be under investigation by, or has been publicly criticised by, a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations. As such it should always be declined.



9. Gifts, Hospitality, Honoraria and Sponsorship cont.

Gifts

A gift is an item of personal value, given by a third party e.g. a patient or a supplier. The definition includes prizes in draws and raffles at sponsored events /conferences.

It is a criminal offence under the Bribery Act 2010 to accept any money, gift or consideration as an inducement or reward from a person or organisation holding or seeking to hold a contract with the Health Board. Such gifts should be refused and if they have already been received they should be returned clearly advising why they cannot be accepted. The appropriate Director, Director of Corporate Governance and Head of Counter Fraud should be advised immediately.

Click on the icon for further guidance on the types of gifts.



Gifts by way of inducement or reward

The Bribery Act 2010 prohibits staff from soliciting or receiving any gift or consideration of any kind from contractors or their agents, or from any organisations, firms or individuals with whom they are brought into contact by reason of their official duties, as an inducement or reward for:

- a) Doing or refraining from doing anything in their official capacity; or
- b) Showing favour or disfavour to any person in their official capacity.

It should be understood that a breach of the provisions of this Act renders staff liable not only to dismissal but to prosecution under the Act, and it is expected that the Health Board would deal severely with any such breaches. Any instances would be referred to Counter Fraud for investigation, with a view to prosecution by the Crown Prosecution Service.

Staff should be aware that the Health Board is required in accordance with its Standing Orders to insert in every formal contract a clause entitling them to cancel the contract and recover any losses if any inducement or gifts are offered by the contractor or by his employees, whether with or without his knowledge. Any such offer of an inducement or gift should accordingly be reported by the person to whom it is made to the Director of Corporate Governance.

Any acceptance of a gift or hospitality needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the gift or hospitality likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of hospitality or a gift will not be misconstrued.





9. Gifts, Hospitality, Honoraria and Sponsorship cont.

Hospitality

Hospitality is where there is an offer of food, drink, accommodation, entertainment or entry into an event or function by a third party, regardless of whether provided during or outside normal working hours. Employees in contact with contractors should be particularly mindful of accepting any hospitality that might later be misconstrued as impacting on strict independence and impartiality.



Click the icon for guidance on acceptable / unacceptable hospitality

Sponsorship

Sponsorship is sometimes provided by organisations to allow employees to attend conferences or working visits to view equipment. It may also include sponsorship of posts.

No sponsorship should be accepted without the prior agreement of the appropriate Line Manager. A Gifts, Hospitality, Sponsorship and Honoraria Form should also be completed prior to the acceptance of any sponsorship. If sponsorship is inappropriately offered and/or declined this should also be declared.



Click on the icon for further guidance on the many forms that sponsorship may take

Any acceptance of sponsorship needs to be justified. Think about the context in which the offer has been made, and the effect on your position. For example, is the sponsorship likely, or could it be seen as likely, to influence you? The onus is on you to make sure that the acceptance of any sponsorship will not be misconstrued.



Honoraria and Miscellaneous Payments

An honorarium is an ex gratia payment i.e. one which would not usually be expected to be provided.

Employees may be invited to give presentations at conferences, provide responses to surveys or attend professional meetings where a one-off payment or honorarium is offered. If this activity is to be undertaken during hours when the Employee is contracted to work for ABUHB, the payment should be made to ABUHB. Individuals may accept payment for activities that they undertake in their own time, subject to the provisions regarding outside employment contained within the various Employee Contracts and Terms of Service. The activity should be reported using a Gifts, Hospitality, Honoraria and Sponsorship Form.



Click the icon for further guidance on how to handle honoraria for work undertaken during Health Board hours and work undertaken in an individual's own time.



10. Secondary Employment and Private Practice

Secondary Employment (Paid, Unpaid or Self-Employed)

Throughout their employment with ABUHB employees should not engage in any outside employment which may adversely affect their ability to perform their work or which may involve the use of any confidential or commercially sensitive information obtained in the course of their employment with the Health Board.

Employees should inform their line manager of any secondary employment and ensure that this does not affect their ABUHB employment. Declarations should be made using the Staff Declaration of Interests Form. There should be no conflict with their normal contractual employment obligations to ABUHB, and such work should not involve the use of any confidential or commercial information obtained in the course of their employment with ABUHB.

Where Employees have or are contemplating other employment, they must ensure this does not compromise their availability or physical or mental fitness to perform their duties as an Employee of ABUHB. Employees must also ensure this does not place them in a position where their judgement or actions might be influenced by considerations arising from their other employment.

Employees have a responsibility to ensure that their line manager is made aware of any hours worked in order that the Health Board fulfils its statutory requirement of the Working Time Directive.

An Employee, absent because of sickness, is regarded as unfit to work and should not undertake any paid or unpaid work in any capacity during a period of sickness absence from the organisation, unless it is deemed jointly by their manager and the Occupational Health Department to be therapeutically beneficial to their recovery. Express written permission must be granted by the manager in advance in all such cases.

An employee found to be undertaking other work during sickness absence without the prior written consent of the manager, may be considered in breach of contract and will be subject to disciplinary action, which may result in the involvement of the Counter Fraud Department, the possibility of criminal investigation and/or dismissal.

Private Practice

There are codes for good private patient practice which clearly include the fact that private practice should not adversely affect NHS duties.

The Health Board has a Private Practice Policy which provides medical staff with appropriate governance in understanding their contractual obligations and organisational expectations in relation to the undertaking of private practice.

Whilst the Policy is primarily directed at Consultants undertaking private patient activity, it equally applies to any other medical staff employed by the Health Board who may privately charge for their services whilst using NHS facilities, equipment or staff, or who may undertake such activities during NHS time, including private patients travelling from outside of the UK. [Link to policy once approved](#)



11. Research and Development

Before undertaking any research, the Health Board Research and Development Department must be contacted to ensure the appropriate approvals are in place. Research should always be fully costed and supported by either a Commercial or Non-Commercial Grant. This includes post marketing product evaluations. Research is governed by a number of frameworks and regulations including:

- The UK Policy Framework for Health and Social Care (UK Policy Framework)
- Medicines for Human Use (Clinical Trials) Regulations 2004 (as amended)

Anyone wishing to undertake or be part of research project will be required to hold a current ICH GCP certificate, registered with the Research and Development Department.

The Research and Development Department should always be contacted in these circumstances to offer advice and support in this area.

Rewards for Initiative

Potential intellectual property rights (IPR) should be identified, as and when they arise, in order to protect and ensure that the ABUHB receives any rewards or benefits (such as royalties) in respect of work commissioned from third parties, or work carried out by its Employees in the course of their duties.

Most intellectual property is protected by statute e.g. patents are protected under the Patents Act 1977, and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. Appropriate specifications and provisions should be built into contractual arrangements before they are entered into or before work is commissioned or begins. Legal advice or advice provided via the Research & Development Department should be sought if in doubt in any specific cases.

With regard to patents and inventions, in certain defined circumstances the Patents Act 1977 gives Employees a right to obtain reward for their efforts, and the Health Board should agree a suitable reward for individual circumstances as appropriate. Other rewards may be given voluntarily to Employees who within the course of their employment have produced innovative work of outstanding benefit to the NHS. Similar rewards should be voluntarily applied to other activities such as giving lectures and publishing books and articles.

In the case of collaborative research and evaluative exercises with manufacturers, the Health Board should obtain a fair reward for the input its Employees provide. If such an exercise involves additional work for an Employee outside that paid for by the Health Board under their contract of employment, arrangements should be made for a share of any rewards or benefits to be passed on to the Employee(s) concerned from the collaborating parties.

Care should be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from them.

Employees are reminded that all information generated during the course of their employment with ABUHB is the property of the Health Board and remains so, irrespective of origin or authorship.

Conflicts of interest can arise when a member of staff who hold patents and other intellectual property rights is involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from the organisation, this can also create risks of conflicts of interest, and it is important that the Health Board is aware of this in order to manage it appropriately.



11. Research and Development cont.

Employees are responsible for:

- Declaring patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might reasonably be expected to be, related to items to be procured or used by the organisation.
- Seeking prior permission from ABUHB before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest, then the management actions outlined in this policy should be considered and applied to mitigate risks.
- Members of staff are also reminded of their responsibilities to ensure the correct use of copyrighted information.

12. Charitable Funds

There may be occasions when commercial organisations offer to make a donation into the ABUHB Charitable Funds. Monies paid into charitable funds from commercial companies must only be accepted as donations. Any offers where there is a benefit in return should be considered under the policy section relating to Sponsorship for Events Hosted Wholly or Partly by ABUHB. Where donations are received, they should only be used to fund expenditure which is in line with the terms of the charitable fund's use.

Expenditure from Charitable Funds and charitable fundraising within the workplace does not fall within the remit of this policy, however there may be a close association. Further guidance is available from the Charitable Funds Manager.

13. Failure to Adhere to Standards of Business Conduct Policy

If any Employee or Independent Member fails to declare an interest or gift, hospitality, honoraria or sponsorship as defined within this policy or the Standards of Behaviour Framework, and then:

- participates in a decision-making process where special favour is shown to unfairly award a contract; or
- abuses their official position or knowledge for the purpose of benefit to themselves, their family or friends

disciplinary action may follow. The action taken will depend on the individual circumstances and will be in accordance with the Health Board's Disciplinary Policy. Under some circumstances, failure to follow this policy could be considered gross misconduct.

In addition to any potential disciplinary action being taken, if there is any suspicion that fraud, corruption and/ or bribery has been or is being committed, then all such cases must be reported at the earliest possible opportunity to the Local Counter Fraud Specialist (LCFS) within ABUHB. This is also extended to include the inappropriate acceptance of any gifts, hospitality, honoraria or sponsorship.

Furthermore, if an employee breaches the Standards of Behaviour Policy or Framework, this could in certain circumstances result in notification/ reporting to the appropriate professional codes of conducts/ registration/ memberships i.e. Health Professions Council (HPC), General Medical Council (GMC), Nursing and Midwifery Council (NMC), etc. This could incur registrations being revoked and Employees no longer continuing to be employed in their current position within the Health Board.



13. Failure to Adhere to Standards of Business Conduct Policy cont.

Failure to declare a relevant interest by an Independent Member of the Board will be reported by the Chair to the Minister for Health and Social Services

14. Consultation, EQIA and Training Requirements

Consultation

The following groups were consulted with during the development of this policy:

- Workforce and OD Policy Group
- Audit, Risk and Assurance Committee
- Executive Committee

Equality Impact Assessment

An EQIA screening tool is currently in development to help staff to identify the relevance of each policy, project, function or major development/planning application to equality, and whether an EQIA should be undertaken.

In consideration of the EQIA guidance and the criteria outlined in the developing screening tool, the proposals are unlikely to have equality impacts and the Equality, Diversity and Inclusion Specialist is satisfied that a full EQIA is not required.

Training Requirements

There are no training implications arising from this Policy and the Standards of Behaviour Framework. However, awareness sessions will be held with managers. The importance of continued compliance will require reference in induction programmes, during Individual Performance Reviews, Consultant Appraisals, Consultant Job Plan Reviews and at times when Employees are invited to make declarations.

15. Audit and Review

The Director of Corporate Governance is responsible for the monitoring of this policy and its formal review every three years.

The Director of Corporate Governance will arrange for the Declarations of Interest Register and an overview of the gifts, hospitality, honoraria and sponsorship activities within ABUHB to be presented to the Audit, Risk and Assurance Committee at the end of each financial year.

The Audit, Risk and Assurance Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests, gifts, hospitality, honoraria and sponsorship at least annually.

Audit Wales and the Health Board's Internal Audit Service may also review the arrangements from time to time and their findings are also reported to the Audit, Risk and Assurance Committee.

Staff should note that following implementation of the Freedom of Information Act 2000 the information contained within the Health Board Register will be subject to disclosure to any member of the public on request.



Legislative and NHS Requirements

This policy aims to ensure that the Health Board complies with the requirements set out in: -

- (DGM(93)84) Standards of Business Conduct for NHS Staff
- WHC(2005)016 – The NHS and Sponsorship by the Pharmaceutical Industry
- WHC(2006)090 - The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006
- Director General, Health and Social Services, Chief Executive NHS Wales, Shared Values and Reinforcing Behaviour in NHS Wales (January 2011)
- Commercial Sponsorship - Ethical Standards for the NHS, Department of Health(November 2000)
- Code of Practice for NHS Wales Employers, Welsh Assembly Government (January 2011)
- Code of Conduct for Healthcare Support Workers in Wales,Welsh Assembly Government (January 2011)
- General Medical Council– Conflicts of Interest (September 2008)
- Health Board Standing Orders, Reservation and Delegation of Powers
- Nursing and Midwifery Council, The code - Standards of conduct, performance and ethics of nurses and midwives (May 2008)
- Royal College of Psychiatrists, Good Psychiatric Practice,Relationships with Pharmaceutical and Other Commercial Organisations (2008)

- Association of the Pharmaceutical Industry(ABPI), Code of Practice for the Pharmaceutical Industry (November 2011)
- The Institute of Chartered Secretaries and Administrators (ICSA), Model Conflicts of Interest Policy for NHS Trust Board Members (June 2010)
- The Bribery Act 2010
- NHS Counter Fraud Authority.
- Health Board Policy on Intellectual Property

Acknowledgements

This policy has been reviewed and developed against the following Health Board policies:

- Hywel Dda University Health Board Standards of Behaviour Policy (October 2022)
- Cwm Taf Morgannwg University Health Board Standards of Behaviour Policy (January 2023)
- Cardiff and Vale University Health Board Standards of Behaviour Policy (November 2022)



In this section you will find further guidance referenced throughout the policy





Examples of Relevant Interests

“Relevant interests” will include:-

- (a) Directorships, including Non-Executive Directorships held in private companies or PLCs, with the exception of dormant companies.
- (b) Ownership or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the Health Board. This includes shareholdings, debentures or rights where the total nominal value is £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less.
- (c) A personal or departmental interest in any part of the pharmaceutical / healthcare industry that could be perceived as having an influence on decision making or on the provision of advice to members of the team.
- (d) Sponsorship or funding from a known NHS supplier or associated company/subsidiary.
- (e) A position of authority in a charity or voluntary body in the field of health and social care.
- (f) Any other connection with a voluntary, statutory, charitable or private body that could create a potential opportunity for conflicting interests.
- (g) Employment by any other body where there could be a perceived or actual conflict with NHS duties. This includes the undertaking of private practice.



It is recommended that where there is doubt, a declaration of interest should be made.

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Types of Gifts

Gifts from Patients/Service Users or their Relatives

Employees may accept, subject to it not contravening their professional Codes of Conduct, gifts up to the value of £25 from patients /service users and relatives as a mark of their appreciation for the care that has been provided. This can include items such as chocolates, flowers, cards. There is no requirement to declare such gifts.

Where a gift is offered by patients or their relatives that is likely to be over £25 in value it should be politely declined. In some cases the gift may have been delivered and it may be difficult to return it or it may be felt that the bearer may be offended by the refusal. Under such circumstances the gift can be accepted, and the bearer advised that it will be utilised for the benefit of the Charitable Funds e.g. used as a prize in a raffle. A Gifts, Hospitality, Sponsorship and Honoraria Form declaring that the gift has been received must be completed. Employees should seek approval from their line manager prior to accepting any gifts.

Personal gifts of cash or gift vouchers/cards from patients or their relatives are not acceptable. It may only be accepted as a donation to an appropriate Charitable Fund and recorded as such.

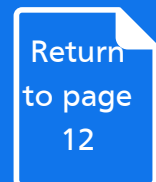
Gifts from Suppliers/Commercial Organisations

No gifts, unless they are of low intrinsic value e.g. diaries, calendars, etc. are allowable from suppliers, contractors and other commercial organisations. All such offers of gifts should be politely declined.

Whilst it is not necessary to declare gifts of low intrinsic value, where other items are offered and declined a Gifts, Hospitality, Sponsorship and Honoraria Form should be completed. This will allow the Health Board to monitor when such organisations are inappropriately offering gifts or potential inducements.

Under some circumstances suppliers may send gifts to all of its clients as custom and practice e.g. hampers at Christmas. Whilst such practices should be discouraged and it is not acceptable for staff to personally accept these gifts, following discussion with the supplier/commercial organisation and line manager it may be considered appropriate to accept the gift and utilise it for the benefit of Charitable Funds.

Gifts of cash (including gift vouchers/cards) from suppliers/commercial organisations are not acceptable in any circumstances.





Types of Gifts

Gifts from Dignitaries / Overseas Organisations

There may be occasions when visits are made by dignitaries or overseas organisations who consider it “culturally custom and practice” to exchange gifts. In such cases Employees should seek guidance from their line manager initially and declare these gifts on a Gifts, Hospitality, Sponsorship and Honoraria Form. Further guidance may also be sought from the Director of Corporate Governance. A decision will then be jointly made as to the most appropriate way to manage the gift. This will depend on the nature of the “gift culture” and may include decisions to keep and display in public, donate to an internal user group, auction for charity etc.

Gifts to Groups of Staff, Service/Department or Organisation-Wide

Non-monetary gifts are sometimes made to show appreciation to the NHS from a patient/service user and/or their relatives, the general public, community groups, local business, suppliers, contractors or commercial organisations. Staff may accept non-monetary gifts that are voluntarily donated by a third party to a group of staff (e.g. whole ward or department), a service/department, or the whole organisation rather than to an individual, where there is no expectation of the donor receiving anything in return and where there are no conditions attached to the gift. Employees should seek approval from their line manager prior to accepting any gifts.

Where these gifts represent tangible items such as IT equipment, medical devices or electrical items, consideration should be given prior to accepting the gift to matters such as their compatibility with Health Board systems, their ongoing maintenance to comply with any warranties involved,

storage, and any infection prevention issues with appropriate advice sought. Such gifts over the value of £25 should be declared on the Gifts, Hospitality, Honoraria and Sponsorship Form and registered to the group of staff or service/department receiving them. In addition, donated items over £5,000 must be recognised in the Health Board’s Asset Register.



Bequests/Legacies/Wills

Employees are not permitted to accept bequests left to them by a deceased patient or service user who became known to them through providing care or treatment as part of their ABUHB employment. Accepting a gift of this nature, particularly where a patient is considered vulnerable, could leave the staff member open to accusations of financial abuse, fraud (by abuse of position) or misconduct. If an Employee is made aware that they may be a beneficiary in a patient’s or service user’s will e.g. by a deceased’s legal representative, they must declare this to their line manager, with any complex cases escalated to the Director of Corporate Governance. In such a scenario, the Health Board will send a letter, endorsed by the employee, to those acting for the deceased’s estate, advising that whilst the bequest cannot be accepted by the individual employee, the estate may, should they so wish, deposit the bequest in a designated charitable fund associated with the staff member involved, to benefit from a range of expenditure as per the charitable objectives of ABUHB’s registered charity, Aneurin Bevan Health Charities, with the objective to “provide those additional amenities that will improve the conditions under which patients are cared for and treated or staff work”.



Hospitality

Acceptable hospitality includes:



Offers of food and non-alcoholic drink, provided it is equivalent to that offered in similar circumstances by the NHS, can be accepted during working visits and does not need to be recorded in the Gifts, Hospitality and Sponsorship Register.

Other hospitality that may be accepted includes instances where:

- There is a genuine need to impart information, or represent the Organisation at Stakeholder Community Events e.g. Local Authority or Charitable organisations which have an association with the Health Board.
- An employee has been invited to receive an award or prize in connection with the work of the organisation or their role .
- An employee is invited to a Society or Institute Dinner or Function which is to be funded by a commercial organisation and where there is a genuine benefit to the professional standing of the individual or the Health Board.

These types of hospitality must be authorised prior to their acceptance by their line manager and a Gifts, Hospitality, Sponsorship and Honoraria Form must be completed. The hospitality should be proportionate i.e. it should not be of significant value and only the minimum number of Employees to achieve the purpose of representing the Health Board should attend.

Unacceptable hospitality includes the following examples as general guidance:

- A holiday or weekend/overnight break.
- Offers of hotel accommodation when this is not associated with a sponsored course or conference (see below).
- Use of a company flat or hotel suite.
- Attendance at a function or event restricted to Employees which is not for the purposes of training or organisational development.
- Lunch or dinner provided by a private company or their representative which does not form part of a training or development event.
- Entertainment and/or tickets/hospitality at sporting and other corporate entertainment events.

If employees are not clear whether an offer falls into one of these categories advice should be sought from their line manager in the first instance or if complex from the Director of Corporate Governance.

Employees should report any case where an offer of hospitality is pressed which might be open to objection. They should also declare on the appropriate form any offers of hospitality which are declined.

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Types of Sponsorship

Sponsorship for Research Projects

Sponsorship of a research project has specific legal responsibilities under the Clinical Trials Regulations. Before initiating a trial, the sponsor should define, establish and allocate all trial-related duties and functions. The NHS Research and Development (R&D) Forum [Sponsorship Principles document](#) provides a comprehensive summary of requirements, including various models of sponsorship and guidance on the allocation of responsibilities, duties or functions. If you wish the Health Board to Sponsor a research study you should contact the R&D Director prior to applying for a grant to ensure the Health Board is able to support the study or offer advice about alternative Sponsors.

Commercial Sponsorship for Attendance at Courses/Conferences

Employees may accept commercial sponsorship for attendance at relevant conferences and courses, but only where the employee seeks permission in advance from their Line Manager. The sponsorship should only be extended to the number of Employees who would have normally attended if funded by the Health Board. The Line Manager must be satisfied that acceptance will not compromise purchasing decisions in any way.



Commercial Sponsorship to attend Demonstrations/Technical Evaluations

Employees may be invited to view products or equipment at another location. There may be occasions when it is appropriate as part of a procurement exercise to visit a suppliers' reference site to observe equipment in operation in a medical or laboratory setting. Such sponsorship is not usually considered appropriate and the Health Board will normally meet the costs of such a visit so as to protect the integrity of subsequent purchasing decisions.

Arrangements whereby the company meets all or part of the cost of such a visit must be approved by the appropriate Line Manager following consideration of the implications for the integrity of subsequent purchasing decisions.

Commercial Sponsorship for Sponsored Posts ('Linked Deals')

Pharmaceutical companies and other suppliers may offer to sponsor, wholly or partially, a post or equipment for ABUHB. The Health Board will not enter into such arrangements, unless it has been made clear to the company concerned that the sponsorship will have no effect on purchasing decisions within ABUHB.





Types of Sponsorship

Sponsored posts must be approved and managed in order that appropriate monitoring arrangements are established to ensure that purchasing decisions are not being influenced by the sponsorship agreement. Under no circumstances may 'linked deals' be agreed, whereby sponsorship is linked to the purchase of particular products, or to supplies from particular sources.

Sponsored posts are posts that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

The following should be considered when sponsored posts are offered:

- External sponsorship of a post requires prior approval from the relevant Executive Director.
- Rolling sponsorship of posts should be avoided unless appropriate put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements should conflicts of interest which cannot be managed arise.

- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

The relevant Line Manager should declare any posts sponsored by external organisations on a Gifts, Hospitality, Sponsorship and Honoraria form and submit it to Director of Corporate Governance for recording on the register.

Sponsorship of Events in the Context of Partnership Arrangements with the Pharmaceutical Industry or other Commercial Organisations

The pharmaceutical industry and allied commercial sector representatives may organise meetings in support of specific functions or specialties within the healthcare sector. Under such arrangements they are permitted to fund the hiring of accommodation, meet any reasonable actual costs which may have been incurred and to provide appropriate hospitality. If no hospitality is required, there is no obligation or right to provide it, or indeed any benefit of equivalent value. An example of hospitality which would not be acceptable under these circumstances is where a company takes the attendees, on the conclusion of a course, for a meal in a restaurant.

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Types of Sponsorship

The Pharmaceutical Industry is expected to adhere to the ABPI Code of Practice for the Pharmaceutical Industry which clearly specifies what is and what is not acceptable; this is available via the following link:

[2021 Interactive ABPI Code of Practice - Comes into operation 1 July 2021 \(pmcpa.org.uk\)](https://pmcpa.org.uk)

Sponsorship for Events Hosted Wholly or Partly by ABUHB

Where the ABUHB receives or invites offers of sponsorship for events which are hosted wholly or partly by the Health Board, the relevant Line Manager must consider whether it is appropriate to accept the offer. For all offers, whether accepted or declined, a Gifts, Hospitality, Sponsorship and Honoraria form must be completed and sent to the Director of Corporate Governance for recording on the register.

The following guiding principles should apply:

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit for ABUHB and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- The organisation's discretion, sponsors or their representatives may attend or take part in the event, but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.

- Members of staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Members of staff arranging sponsored events must declare this to the organisation.

Whilst it is recognised that sponsorship can provide a useful source of funding for particular events or activities, it can also present risks and in considering whether to accept sponsorship, the following principles should be adhered to:

- Sponsorship should be sought in an open and even-handed manner with opportunities being offered as widely as possible.
- Benefits should be for the Health Board (not an individual) and should be proportionate.
- Arrangements must not compromise the standing or image of ABUHB i.e. they must be ethical.
- Sponsorship should be for a specific activity or event and not a general endorsement of the Health Board.
- The sponsorship must not imply that ABUHB endorses particular products, services or companies and organisations.
- Sponsorship should not be accepted from inappropriate sources, such as companies with dubious or doubtful backgrounds or who have poor financial or business practices.
- Arrangements must not bring adverse publicity to the event or the Health Board.





Types of Sponsorship

Particular care should be taken when considering sponsorship from companies or organisations for which the Health Board has, or could have, contractual business arrangements. The above principles should be adhered to and a renewal or an award of a contract should not be influenced by any sponsorship arrangements.

A sponsor would normally expect to receive a reciprocal benefit which may be beyond a modest acknowledgement, and companies may seek sponsorship for a number of legitimate business reasons. These include:

- To raise the company's image and profile.
- To improve public/ community relations.
- To generate public exposure and media coverage.
- To differentiate the company from its competitors.
- To increase profit/market share.

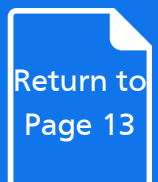
Careful consideration should always be given to understanding what a sponsor might gain from the arrangement and these should be in keeping with the principles listed above.

Employees and Independent Members may, on occasion, be asked to provide an endorsement of an event, conference or training course that they have attended which was organised by a third party.

Caution should be exercised in these circumstances as it may not be appropriate to cite such an endorsement. It is also important to consider any potential future conflict, for example, where the third party may be in the process of re-tendering for the work or be seeking commercial gain from the endorsement.

ABUHB may also receive unsolicited proposals for sponsorship which is not in response to any action that the Health Board has taken. The Health Board should carefully consider such offers and ensure that the proposal meets the Health Board's requirements, standards and principles. ABUHB will need to ensure there are no conflicts of interest or that better value for money cannot be obtained by testing wider market interest.

All sponsorship arrangements should be approved by the appropriate Line Manager.



C



Honoraria

Honoraria received for work undertaken during Health Board hours:

When appropriate authorisation has been granted to permit an employee to be involved in activity outside their normal contract during Health Board hours, any honoraria must be paid directly to the Health Board revenue budget to reimburse the Health Board for the Employee's time.

To ensure good governance, the honoraria must be paid into a revenue budget that is not managed by the Employee who has provided their services during Health Board time.



Honoraria received for work undertaken in an individual's own time (out of normal working hours or on authorised annual leave):

Individuals are personally liable for the payment of both tax and NICs on any honoraria payments received for work undertaken in their own time.

Where an Employee wishes, a donation may be made to Aneurin Bevan University Health Board Charitable Funds in lieu of an honoraria. This must be received into the Charity's general fund and it is then for the Charity Trustees to determine how the donated funds should be used. The basic principle being that the employee giving their own time should have no influence over how the donation is then used and therefore lessens the risk of this being interpreted as being of any benefit to them as 'income' in any sense.

In cases of doubt, staff should seek advice from the Director of Corporate Governance and should report any case where an offer of sponsorship or honoraria is pressed which might be open to objection. Instances where honoraria has been offered and declined should still be declared on the Gifts, Hospitality, Honoraria and Sponsorship Declaration Form.





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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Policy Management Framework (including all Written Control Documents)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

**Pwrrpas yr Adroddiad
Purpose of the Report**

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The report presents, for approval, the revised Policy Management Framework (including all Written Control Documents).

Aneurin Bevan University Health Board has a legal duty to ensure that policies, procedures, protocols and guidelines are in place. Together, these are referred to as Written Control Documents (WCDs).

A strong policy framework is vital to give staff the information they need to underpin all clinical and non-clinical process and practices within the organisation. This in turn ensures consistent, effective and safe care.

Cefndir / Background

Internal Audit conducted a review of the effectiveness and adherence of the Health Board's policy management arrangements, at the end of 2022, which resulted in a Limited Assurance rating.

An improvement plan was subsequently developed to respond to the recommendations within this review. However, it is apparent that the overarching policy framework required

review in order to strengthen the governance processes relating to the development and approval of Written Control Documents (WCD) and supporting the implementation of the improvements required.

The following groups have been consulted with in the development of this Policy Management Framework:

- Executive Committee
- Clinical Standards and Policy Group
- Workforce and OD Policy Group

A summary of the comments and responses is provided at Attachment One.

Asesiad / Assessment

A robust and clear governance framework for the management of policies is essential to minimise the risk to patients, employees, and the organisation itself whilst ensuring policies remain legally compliant. A review has therefore been undertaken to strengthen the current Policy Management Framework ('Policy on Policies').

The two objectives within the Internal Audit review which received limited assurance were:

- Appropriate measures in place to ensure policies are published in a consistent format, maintained on a central database and updated in sufficient time for the scheduled review.
- Policies are subject to quality review, formal approval and suitable engagement before they are issued, to ensure alignment with Health Board requirements where required.

The revised Policy Management Framework aims to address these issues, in particular the definitions of WCDs and the approval process.

1) Definition of Written Control Documents

As at the 25th July 2024, there were 914 documents within the Health Board's central policy register. Of these, 52.5% are compliant with the scheduled review dates. These include all forms of WCD and contains both Health board wide and local documents.

In order to be able to understand the number of Health Board wide WCDs that are in the database, and to be able to effectively monitor compliance, there needs to be clarity on definition. The following is proposed in the Policy Framework:

Health Board Wide documents are applicable to staff across the Health Board and are subject to approval via the Policy Governance and Approval Group, or relevant committee. All Health Board wide documents require an Executive sponsor.

Health Board wide documents will be captured in the Health Board's central policy register, held by the Corporate Governance Team and compliance monitored and report on centrally.

Local documents apply to a single department, profession or staff group and there is no wider impact on the Health Board. These documents are subject to approval via local approval mechanisms. Such documents should follow the principles contained in the Policy Framework and must not conflict with relevant Health Board policies or Health Board wide procedures. All local WCDs require a divisional sponsor (divisional director/assistant director).

Determining Health Board wide documents will enable the corporate governance team to refine and focus the policy register to ensure that key WCDs are updated and reviewed in a

timely manner. Since the audit, the current register of policies has been transferred to share point and automated email notifications are in place to improve reminders to policy owners when policies are due for review.

The revised policy also aims to provide clarity on the definitions of written control documents, as follows:

Health Board Policy

A policy mandates, specifies, or prohibits conduct in order to enhance the organisation's mission, ensure coordinated compliance with applicable laws and regulations, promote operational efficiency, and/or reduce institutional risk.

The formulation of policies allows the Health Board to produce formal agreements, which clearly define the commitment of the organisation and the obligations of individual staff.

Health Board-wide policies are binding and breach of them may lead to disciplinary action.

Division/departmental Policy

Many policies within the Health Board are Departmental documents: these set out a course of action which is to be followed by specific members of staff, particularly those employed within the department to which the policy applies. Failure to apply departmental policy may result in disciplinary action.

Charter

A charter is a formal document describing the rights, aims, or principles of an organisation or group of people.

Procedure/Control Procedure

A procedure is a description of the operational processes necessary to implement policy.

It provides a standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures set out the operational processes to be followed to meet objectives, usually the objectives required by a strategy or policy.

Standard Operating Procedure

Standard Operating Procedures (SOPs), are designed to provide accurate and detailed instructions on how to perform a defined process or procedure to ensure consistency and standardisation. The purpose is to eliminate variations in processes which need to be completed the same way every time.

Protocol

Protocols are an agreed framework that provide step by step guidance. They are different from policies and procedures as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competencies can play a role as they are flexible working documents. Within a protocol it must be clear by whose authority it is being implemented, and what the scope of the protocol is. If a protocol is not to be followed it is necessary to record the alternative action that is to be taken and the rationale for this.

Guideline

Guidelines give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with the knowledge and expertise of the individual

using them. Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed and the rationale for this has not been recorded or justified.

2) Approval of Written Control Documents

The Board is responsible for the approval of policy documents. This responsibility can be delegated to an appropriate Committee, Group or Forum in the Health Board in accordance with the Standing Orders, Reservation and Delegation of Powers.

There are a number of groups/committees currently endorsing or approving WCDs and it can be unclear which is the most appropriate forum for approval.

It is therefore proposed that a Policy Governance and Approval Group be established to review and approve Health Board wide policies which are not reserved for Board decision. In support of this, Policy Reference Groups, comprising experts in the field will review new policies within their remit, and major revisions, prior to submission to the approving group.

- Clinical Standards and Policy Group (can also approve certain clinical WCDs, as determined by Clinical Executive Lead)*
- Workforce and OD Policy Group
- Information Governance Sub Group
- Health and Safety Committee
- Statutory Compliance Group

* For **Health Board wide clinical WCDs**, the Clinical Executive (Medical Director, Director of Nursing, Director of Therapies and Health Science) will determine the appropriate approval forum (either the Clinical Standards and Policy Group or Policy Governance and Advisory Group).

Classification	Sub Theme	Reference	Approval	Responsible Board Committee
Clinical – relate to patient care and treatment of patients	Clinical services (health board wide)	Clinical Standards and Policy Group	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
	Pharmacy / Medicines Management	Clinical Standards and Policy Group	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
	Infection Prevention and Control	Clinical Standards and Policy Group	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
Corporate – relate to the management of the organisation and formulate the organisation's response to situations and circumstances	Statutory/legislative eg Standing Orders, Standing Financial Instructions	Audit, Risk and Assurance Committee	Board	Board
	Putting Things Right	Policy Governance and Assurance Group	Board	Board
	Corporate Governance (Policy Management, Standards of Business Conduct)	Policy Governance and Assurance Group	Board	Board

Classification	Sub Theme	Reference	Approval	Responsible Board Committee
Corporate – relate to the management of the organisation and formulate the organisation's response to situations and circumstances	Risk Management	Audit, Risk and Assurance Committee	Board	Board
	Digital (Information Governance, Health Records)	Information Governance Sub Group	Policy Governance and Assurance Group	Finance and Performance Committee
	Health and Safety	Health and Safety Committee	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
	Mental Health Act	Mental Health Act Monitoring Committee	Mental Health Act Monitoring Committee	Mental Health Act Monitoring Committee
	Facilities and Estates	Statutory Compliance Group	Policy Governance and Assurance Group	
Employment - relate specifically to the management of employees (however defined) within the organisation.	Workforce Matters (including all-Wales human resource policies)	Workforce and OD Policy Group	Policy Governance and Assurance Group	People and Culture Committee
Financial - relate specifically to the financial controls within the organisation	Financial Management	Policy Governance and Assurance Group	Audit, Risk and Assurance Committee	Audit, Risk and Assurance Committee
	Counter Fraud	Policy Governance and Assurance Group	Audit, Risk and Assurance Committee	Audit, Risk and Assurance Committee
	Charitable Funds	Charitable Funds Committee	Charitable Funds Committee	Board (as Trustees)

In addition, in order to strengthen the Board’s oversight of policy compliance, it is proposed that Health Board wide WCDs be assigned to a Board or delegated Committee of the Board in accordance with their Terms of Reference. Committees will receive regular reports on compliance rates for WCDs within their remit.

Argymhelliad / Recommendation

The Board is asked to APPROVE the revised Policy Management Framework for the Health Board.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA screening tool is currently in development to help staff to identify the relevance of each policy, project, function or major development/planning application to equality, and whether an EQIA should be undertaken. In consideration of the EQIA guidance and the criteria outlined in the developing screening tool, the proposals are unlikely to have equality impacts and the Equality, Diversity and Inclusion Specialist is satisfied that a full EQIA is not required.

	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Policy Framework Consultation Responses

Section	Comment	Response
General	I feel this is straying into the Quality Management System field of controlled documents which we need to be aware of. controlled documents could be massive – I collect nursing documentation all the time that's been 'created' which should be controlled and ratified.	Section added to the scope: <i>For the purposes of this framework, a Written Control Document refers specifically to a policy, charter, procedure, standard operating procedure, protocol or guideline (refer to section 5.1 for definitions).</i>
General	There are a few areas within the document which reference applicability of the wider HB policies etc. to staff but no words which are reflective of others who would be required to adhere to policies e.g. Students who are on placement in ABUHB.	Scope amended to include: This policy applies to all Health Board employees in all locations. <i>This includes students and trainees, those with whom we contract, those who are seconded to work in the organisation and any volunteers who work in partnership with the organisation.</i>
General	Policy could potentially be shorter as there is some duplication in narrative which is repeated in the flowcharts(FC).There may be opportunities to direct staff directly to the FC's which provide the detail in an easy-to-follow format.	Policy narrative is required to support the flowcharts. However, flowcharts will be extracted into a toolkit on the policy sharepoint site for ease of reference.
Corporate Corporate WCDs relate to the management of the organisation and formulate the organisation's response to situations and circumstances. This would include Health and Safety and Information Governance WCDs.	Where it states 'This would include Health and Safety and Information Governance WCDs'. It may be advantageous to use these as examples as there are many other corporate documents which need to be considered. There is the potential that the readers/users will only consider those that are referenced.	Section amended: Corporate WCDs relate to the management of the organisation and formulate the organisation's response to situations and circumstances. <i>For example Corporate Governance, Health and Safety and Information Governance WCDs.</i>

Section	Comment	Response
5.3.1 Identify the need to adopt, develop or review.	This section includes several reasons for the above, but the one that it does not include is to ensure a WCD is compliant with the specified review date.	Added WCD has reached review date
5.3.3 Consultation All WCDs should be developed in consultation with their target audience involving appropriate managerial, clinical and staff representation. All new or significantly revised policies should be the subject of consultation within the divisional structure and with relevant professional groups and/or individuals. Where the WCD is relevant to patient care it must also be sent for consultation to relevant members of the public and/or stakeholders where required.	For clinical polices we would expect this to happen before it comes to CSPG What we are lacking is the process for public involvement. I think we may also need to highlight the WCDs are not patient information leaflets, and there is a different process for this. I have discussed to ensure that we have a governance structure and SOP for this within the patient experience and involvement team	This is what the policy states - consultation to be undertaken prior to submission to approval group. Added para to consultation section: Where a change in clinical policy constitutes a change in service provision, discussion should be held with the planning team regarding statutory consultation and engagement. Section added to the scope - see earlier comments
5.3.5 – Approval Approval delegated to the Clinical Standards and Policy Group	What is the process for this being delegated down and then escalated up...? Just need an awareness of the relationship between CSPG and Executive leads.	For Health Board wide clinical WCDs, the Clinical Executive (Medical Director, Director of Nursing, Director of Therapies and Health Science) will determine the appropriate approval forum (either the Clinical Standards and Policy Group or Policy Governance and Advisory Group). The Corporate Governance Officer will liaise with the Clinical Executives to agree approval route.

Section	Comment	Response
No changes should be made to Health Board WCD after it has been ratified and approved	Should or must? Are there times when they could?	Must – sentence amended
5.4 Review All other WCDs must be reviewed no later than three years after initial approval and regularly reviewed on the same basis thereafter.	Last year we looked to review all the Policies that sat under the Clinical Exec team to get up to date. We probably need to complete this exercise gain for good housekeeping	The Corporate Governance Team issue reminders when policies are due for review within 6 and 3 months. Regular updates on compliance will be reported to the Exec and relevant committee to support compliance with reviews.
Appendix One: Flow chart for approval	Assuming local WCD are approved internally for department – local agreements in place. *I we have multiple local WCD for departments – how will be know if this needs to be more widespread to ensure consistency for the same process between departments?	Where it is perceived that the same processes are in place across departments it would be expected that discussions be held at a divisional level to ensure uniform process.
Authorisation matrix	I think there needs to be clarity provided for CSPG. This means the Group will not be able to sign off any approval but recommend approval to the next layer up. Does this mean the Policy has to be presented again? This would be time consuming, so need to look at how much extra time this takes up and the relationship between these two groups. Also currently there is no policy digest to show what has been approved and escalated to PQSOC, so need to be clear on the ask as so much is already done to prep for PQSOC. Need to know who's responsible for these actions Also ned to build this into the wiring diagram for clinical execs for quality governance assurance	CPSG will approve those WCDs deemed appropriate by Clinical Execs. For those policies requiring approval by the Policy Governance and Advisory Group, if the policy has been previously considered by a reference group, including CSPG, the policy would be recommended for approval by the reference group, rather than the policy being presented again. Policy digest has been re-implemented. Corporate Governance Team would compile reports for committees on compliance with policies within their remit.

Policy Management Framework (including all Written Control Documents)

Lead Author (s)	Bryony Codd, Head of Corporate Governance
Lead Executive	Rani Dash, Director of Corporate Governance
Division/Department	Corporate Governance
Reference	ABUHB/corporate/001
Applies to (delete as appropriate)	Health Board Wide
Approving Forum	Board
Date Approved	Insert date in full dd/mm/yyyy
Review Date	Insert date in full dd/mm/yyyy

Version Control (latest version number to be listed first):

Version No	Approved	Author
5	DATE	Head of Corporate Governance

Policy on a Page: Key Messages

Aim:

This document details the process to be used when developing/reviewing and approving Health Board wide written control documents.

The aim is for all health board wide written control documents to be accurate, up to date with current best practice and legislation and in a format which is easy for staff to use and access.

Summary of key changes (for revised documents only)

Re-write of existing document to simplify the process.

Renamed - formerly Policy for the Management of Policies and Other Written Control Documents

Inclusion of authorisation matrix

Key Requirements:

Identify need to adopt, develop or review Written Control Document



Confirm Author and Executive Lead



Draft document in line with current legislation and best practice, using template provided



Circulate for comment and consultation



Undertake EQIA (facilitated by EQIA Group)



Submit for Approval in line with Authorisation Matrix



Publish Written Control Document

Target Audience:

All Staff

Training:

No specific training required. Staff need to be aware of this policy and how to implement it. The Corporate Governance Directorate will provide support to staff where required.

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1. Introduction/Overview

Aneurin Bevan University Health Board (the Health Board) has a legal duty to ensure that policies, procedures, protocols and guidelines are in place. Together, these are referred to as Written Control Documents (WCDs).

A strong policy framework is vital to give staff the information they need to underpin all clinical and non-clinical process and practices within the organisation. This in turn ensures consistent, effective and safe care. This is referenced in the 'Three Lines of Defence Model, (Institute of Internal Auditors, 2013), which the Health Board has adopted as part of its Risk Management and Assurance Framework. *The second line of defence provides the policies, frameworks, tools, techniques, and support to enable risk and compliance to be managed in the first line, conducts monitoring to judge how effectively they are doing it and helps ensure consistency of definitions and measurement of risk.*

2. Scope

This policy applies to all Health Board employees in all locations. This includes students and trainees, those with whom we contract, those who are seconded to work in the organisation and any volunteers who work in partnership with the organisation. It applies to the development and review of Written Control Documents (WCDs) and includes any joint WCDs developed in partnership with other organisations.

For the purposes of this framework, a Written Control Document refers specifically to a policy, charter, procedure, standard operating procedure, protocol or guideline (refer to section 5.1 for definitions).

This policy applies to Health Board wide documents however, it should be used to inform local processes for the development, review and approval of local Written Control Documents.

Health Board Wide documents are applicable to staff across the Health Board and are subject to approval via the Policy Governance and Approval Group, or relevant committee. All Health Board wide documents require an Executive sponsor.

Local documents apply to a single department, profession or staff group and there is no wider impact on the Health Board. These documents are subject to approval via local approval mechanisms. Such documents should follow the principles contained in the Policy Framework and must not conflict with relevant Health Board policies or Health Board wide procedures. All local WCDs require a divisional sponsor (divisional director/assistant director).

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3. Statement/Background

In order to ensure a consistent, high quality level of service provision across the whole organisation, it is essential for the Health Board to set standards that are evidence based and developed in conjunction with relevant stakeholders. These need to be compliant with statutory, regulatory and mandatory requirements and consistent with the Health Board's strategic objectives.

To achieve this, it is important to have WCDs that are developed and managed in a systematic way within the Health Board. The Health Board has a responsibility to ensure that written control documents;

- Meet the Health Board's needs and fit with its values and culture.
- Enable the Health Board to deliver its strategic objectives.
- Provide a framework for safe, effective and acceptable practice and which comply with statutory, regulatory and mandatory requirements.
- Are standardised in the Health Board format and style and give clarity on the appropriate route for approval.
- Are easy to understand and accessible.
- Promote diversity and are non-discriminatory.
- Are formally reviewed and revised at specified intervals.
- Are subject to consultation with stakeholders.

4. Aim

The aim is for all WCDs to be accurate, up to date with current best practice and legislation, and in a format which is easy for staff to use and access and for people using services and stakeholders to reference.

This document outlines the definitions, roles and responsibilities and process for the development, review and approval of WCDs.

5. Development of Written Control Document

5.1 Definitions

Health Board Policy

A policy mandates, specifies, or prohibits conduct in order to enhance the organisation's mission, ensure coordinated compliance with applicable laws and regulations, promote operational efficiency, and/or reduce institutional risk.

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The formulation of policies allows the Health Board to produce formal agreements, which clearly define the commitment of the organisation and the obligations of individual staff.

Health Board-wide policies are binding and breach of them may lead to disciplinary action.

Division/departmental Policy

Many policies within the Health Board are Departmental documents: these set out a course of action which is to be followed by specific members of staff, particularly those employed within the department to which the policy applies. Failure to apply departmental policy may result in disciplinary action.

Charter

A charter is a formal document describing the rights, aims, or principles of an organisation or group of people.

Procedure/Control Procedure

A procedure is a description of the operational processes necessary to implement policy.

It provides a standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. Procedures set out the operational processes to be followed to meet objectives, usually the objectives required by a strategy or policy.

Standard Operating Procedure

Standard Operating Procedures (SOPs), are designed to provide accurate and detailed instructions on how to perform a defined process or procedure to ensure consistency and standardisation. The purpose is to eliminate variations in processes which need to be completed the same way every time.

Protocol

Protocols are an agreed framework that provide step by step guidance. They are different from policies and procedures as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competencies can play a role as they are flexible working documents. Within a protocol it must be clear by whose authority it is being implemented, and what the scope of the protocol is. If a protocol is not to be followed it is necessary to record the alternative action that is to be taken and the rationale for this.

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Guideline

Guidelines give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with the knowledge and expertise of the individual using them. Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed and the rationale for this has not been recorded or justified.

5.2 Classification of Documents

Clinical

Clinical WCDs relate to patient care and treatment of patients and offer an evidence-based approach to clinical decisions for patients with a given condition.

Corporate

Corporate WCDs relate to the management of the organisation and formulate the organisation's response to situations and circumstances. For Example, Corporate Governance, Health and Safety and Information Governance WCDs.

Employment

Employment WCDs relate specifically to the management of employees (however defined) within the organisation. They include guidance on how a wide range of issues should be handled, incorporating a description of principles, rights and responsibilities for managers and employees.

Financial

Financial WCDs relate specifically to the financial controls within the organisation. They are a written source of guidance and incorporate a description of controls, processes and responsibilities for all managers and employees. These need to align to the Health Board's Standing Orders and Standing Financial Instructions.

5.3 Process for the Development of New Written Control Documents

5.3.1 Identify the need to adopt, develop or review

The reason to develop or adopt a new WCD, or to review an existing WCD, can come from a number of sources, including:

- Changes to legislation or national guidance
- External reviews
- Audits
- Standardisation
- Clarify or improve working practices

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- To mitigate an identified risk
- To adopt an all Wales WCD
- WCD has reached review date

All Wales WCDs are subject to approval by the Health Board. Although the contents of these documents cannot be amended, it is for the Health Board to determine how they will be implemented and monitored. If more specific local information and guidance is required to implement the All Wales document this will be contained within a local WCD.

A WCD cannot be developed or revised in isolation, the document must be owned and overseen by the correct approval and reference groups. These groups must contain the expertise to advise on current legislation, guidance and evidence which affects the WCD.

Please refer to Appendix 1 for the 'Process for the Development of New Policy Documents' flowchart.

5.3.2 Format

WCDs should be as concise as possible and incorporate processes into flowcharts where relevant to facilitate understanding.

The language used should be plain English, using short sentences and where possible avoiding technical terms. If technical terms are used, they should be explained in a glossary.

A checklist is provided as Appendix 4 outlining the areas that should be included within a Policy. Templates are also available in the Policy Management Toolkit ([link to be added once sharepoint live](#)).

5.3.3 Consultation

All WCDs should be developed in consultation with their target audience involving appropriate managerial, clinical and staff representation. All new or significantly revised policies should be the subject of consultation within the divisional structure and with relevant professional groups and/or individuals.

Where the WCD is relevant to patient care it must also be sent for consultation to relevant members of the public and/or stakeholders where required.

Where a change in clinical policy constitutes a change in service provision, discussion should be held with the planning team regarding statutory consultation and engagement.

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All consultation will be led by the author and must be completed before the WCD begins the approval process.

The author must identify and document consultation and provide assurance to the approving group that this has been conducted thoroughly and that comments have been incorporated into the WCD.

5.3.4 Equality Impact Assessment

The Health Board is committed to equality, diversity and inclusion and meeting its statutory obligations under the Equality Act (2010), so it employs a comprehensive system of Equality Analysis, also referred to as Equality Impact Assessments (EQIAs).

The EQIA process will identify what effect, or likely effect, the WCD may have on the people who come in to contact with the organisation, such as service users and staff. The EQIA will examine the policy to see if it could have a negative, or potentially negative, impact on an of the protected characteristics.

NOTE: A revised EQIA Screening tool is being developed for an online assessment - a link will be added to this once available.

5.3.5 Approval

The Board is responsible for the approval of policy documents. This responsibility can be delegated to an appropriate Committee, Group or Forum in the Health Board in accordance with the Standing Orders, Reservation and Delegation of Powers, and will be one of the following:

- Approval reserved for the Board
- Approval delegated to a Board-level Committee
- Approval delegated to the Health Board's Policy Governance and Advisory Group
- Approval delegated to the Clinical Standards and Policy Group

The Scheme of Delegation for the authorisation of WCDs is provided at Appendix Three.

For **Health Board wide clinical WCDs**, the Clinical Executive (Medical Director, Director of Nursing, Director of Therapies and Health Science) will determine the appropriate approval forum (either the Clinical Standards and Policy Group or Policy Governance and Advisory Group).

No changes must be made to Health Board WCD after it has been ratified and approved.

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Where policies are created as a joint policy on an All-Wales basis or with partners and require formal adoption by the Health Board, the Board will delegate approval to the relevant Health Board Committee, as required.

Where policies relate to the functions of the NHS Wales Joint Commissioning Committee, the Board will delegate approval to the Joint Committee (JCC).

Policy Reference Groups

Policy Reference Groups comprise of experts in the field and should review new policies within their remit and major revisions prior to submission to the approving group.

- Clinical Standards and Policy Group (can also approve certain clinical WCDs, as determined by Clinical Executive Lead)
- Workforce and OD Policy Group
- Information Governance Sub Group
- Health and Safety Committee

Policy Governance and Assurance Group

The Policy Governance and Approval Group will review and approve Health Board wide policies which are not reserved for Board decision (refer to authorisation matrix).

5.4 Process for the Review of Written Control Documents

Certain WCDs must be reviewed annually and this will be explicitly noted within the document. These include:

- Risk Management Strategy and Policy
- Major Incident Plan

All other WCDs must be reviewed no later than three years after initial approval and regularly reviewed on the same basis thereafter. Documents will be reviewed more frequently if changes in legislation or the service requires it. Until a document is reviewed, it will remain the extant WCD of the organisation until replaced. It is the responsibility of the policy author to ensure that documents are reviewed in line with their review dates.

To ensure the timely review of Health Board wide documents, reminder notices will be initiated by the Corporate Governance Officer 6 months prior to the review date and subsequent months thereafter. Executive Directors will be notified one month prior to the review date of any Health Board wide WCD under their area of responsibility that is due for review.

The flowchart at Appendix 2 outlines the process to be undertaken for the review of Health Board wide WCDs (this can be adapted for local approval of local WCDs).

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Prior to embarking on a full review of an existing WCD, the Author must determine the type of change required:

- **Minor Changes** - these are changes which do not impact on the practice / staff responsibilities. These normally relate to changes to staff titles, committee names or review dates (where a review has highlighted no major changes are required);
- **Major changes** - these are changes which impact on the practice being used or staff responsibilities (e.g., new responsibilities, changes to forms used etc).

Please refer to Appendix 2 for the review of WCD flowchart.

6. Roles and Responsibilities

Chief Executive Officer

As Accountable Officer, the Chief Executive has overall responsibility for ensuring the Health Board has appropriate WCDs in place. These WCDs must comply with legislation, meet mandatory requirements and provide services that are safe, evidence-based and sustainable.

Executive Directors

Executive Directors are responsible for ensuring that all Health Board WCDs within their remit are maintained and updated by liaising with the appropriate policy author/lead.

They are responsible for ensuring that the appropriate advice and assistance is provided to the author/lead and that consideration is given to any training/resource implications that are identified.

Director of Corporate Governance

The Director of Corporate Governance is responsible for providing a robust and clear governance framework for the effective management of all WCDs, and compliance with this policy. Specifically ensuring that:

- A consistent approach and process for the development, approval, publication, implementation and management of WCDs, which meets statutory requirements, is in place.
- There is an appropriate scheme of delegation in place for the approval of WCDs.
- There is a system in place for registering and managing WCDs.
- WCDs are available to the public to improve transparency and in accordance with the requirements of the Freedom of Information Act.

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Head of Corporate Governance

The Head of Corporate Governance will act as the Health Board's 'Policy Manager' with responsibility for ensuring that the policies and procedures are followed, providing appropriate training and advice to support the process. The Head of Corporate Governance, supported by the Corporate Governance Officer, will:

- Manage the development and maintenance of a central Health Board wide WCD database.
- Notify Policy Leads three months in advance of review dates.
- Escalate non-compliance through the escalation process outlined in section 5.4 (Review of WCDs) of this policy.
- Cascade approved/amended WCDs in line with the Health Board's communication systems, including publication on the Health Board's website and Sharepoint sites as appropriate.
- Maintain an archive of previous versions of any revised or reviewed WCDs.
- Monitor and report to the Executive Committee and Audit, Risk & Assurance Committee on compliance with this policy.

Policy Author

Policy Authors are employees who have been given the task of writing or reviewing a WCD.

Authors are responsible for the review of their documents. If an author leaves the Health Board or takes up a non-related post, the responsibility for the ongoing maintenance of the document is taken on by their replacement. Where no direct role replacement is appointed, responsibility reverts to the postholder's line manager. Changes to authors must be relayed to the Corporate Governance Team in order to update the database.

Authors must:

- Liaise with Executive lead/delegated person to ensure that WCDs are implemented appropriately and, where necessary, compliance is formally monitored;
- Ensure that documents are reviewed in line with the review date or amended as a result of changes to practice, organisational structure or legislation;
- Ensure appropriate engagement and consultation with the relevant individuals and groups;
- Ensure that any learning, education, development or resource issues are clearly identified;
- Undertake the necessary impact assessments, including EQIA, prior to approval;
- Ensure that documents follow the correct approval process;
- Submit the final, approved WCD for publication.

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Divisional/Departmental Policy Leads

Policy leads should be established for each division/directorate/specialty, as appropriate (it is recommended that this responsibility is assigned to Patient Quality and Safety Leads in clinical settings).

Policy Leads will:

- Serve as the gatekeeper and coordinator of organisational wide policies relevant to their area; liaising with the Corporate Governance Team on the development, review, approval and publication of Health Board wide WCDs.
- Establish a process for the approval and monitoring of departmental Written Control Documents, including responsibility for uploading local WCDs onto share point and maintaining and archive of historic local documentation.

All staff with Management Responsibilities

Staff with management responsibilities must:

- Ensure that any new members of staff within their department are made aware of the policy control system at local induction, and how to access Health Board wide and local WCDs specific to their area;
- Ensure that information is disseminated on a regular basis, to ensure employees have read and understood the relevant documents and are aware of any new documents or revisions to existing ones.
- Support staff to undertake training requirements outlined within WCDs within their area of work.
- Ensure that local systems are in place to enable the review, audit and compliance testing of all relevant departmental and Health Board wide WCDs as required.

All Staff are responsible for ensuring that:

- They keep updated with WCDs relevant to their employment and area of work;
- Their practice is in line with policies and WCDs in use across the Health Board and specific to their area of work;
- Information regarding failure to comply with a policy, for example, lack of training, inadequate equipment, is reported to their Line Manager and the incident reporting system (DATIX) used where appropriate.

7. Consultation

The following groups have been consulted with in the development of this Policy Management Framework:

- Executive Committee
- Clinical Standards and Policy Group
- Workforce and OD Policy Group

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8. Equality Impact Assessment

An EQIA screening tool is currently in development to help staff to identify the relevance of each policy, project, function or major development/planning application to equality, and whether an EQIA should be undertaken.

In consideration of the EQIA guidance and the criteria outlined in the developing screening tool, the proposals are unlikely to have equality impacts and the Equality, Diversity and Inclusion Specialist is satisfied that a full EQIA is not required.

9. Training Requirements

There are no specific training requirements. Staff should be aware of this policy and how to implement it.

10. Audit and Review

All policies will form part of formal auditing process to ensure that they are fit for purpose, have been implemented effectively and to assess compliance.

It will be necessary to ensure that all documents are being produced, vetted, approved and disseminated in accordance with this policy. Periodical 'spot checks' will be carried out to ensure that all policies and written control documents comply with this policy.

Compliance will also be monitored as part of the Health and Care Standards for Wales Annual Review process.

11. References

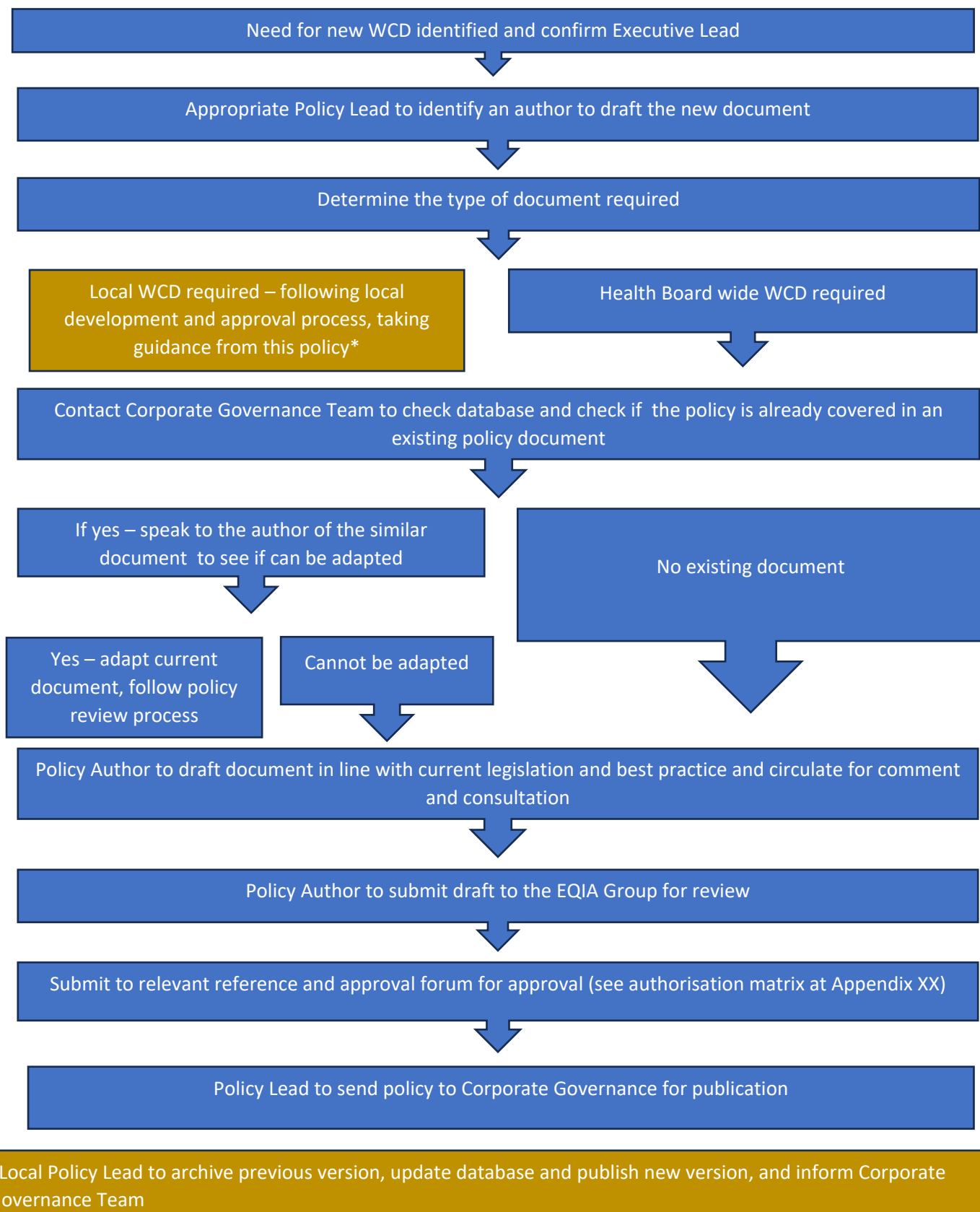
- Hywel Dda University Health Board, Written Control Documentation Policy
- Swansea Bay University Health Board, Policy for the Management of Health Board wide policies, procedures and other Written Control Documents
- Devon Partnership NHS Trust, Policy, Procedures and Approved Documentation Development and Management
- East London NHS Foundation Trust, Policy and Procedure for the Development, Review and Control of Trust Approved Procedural Documents
- Mersey Care NHS Foundation Trust, Policy Management Framework
- Northern Care Alliance NHS Foundation Trust, Policy Template

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12. Appendices

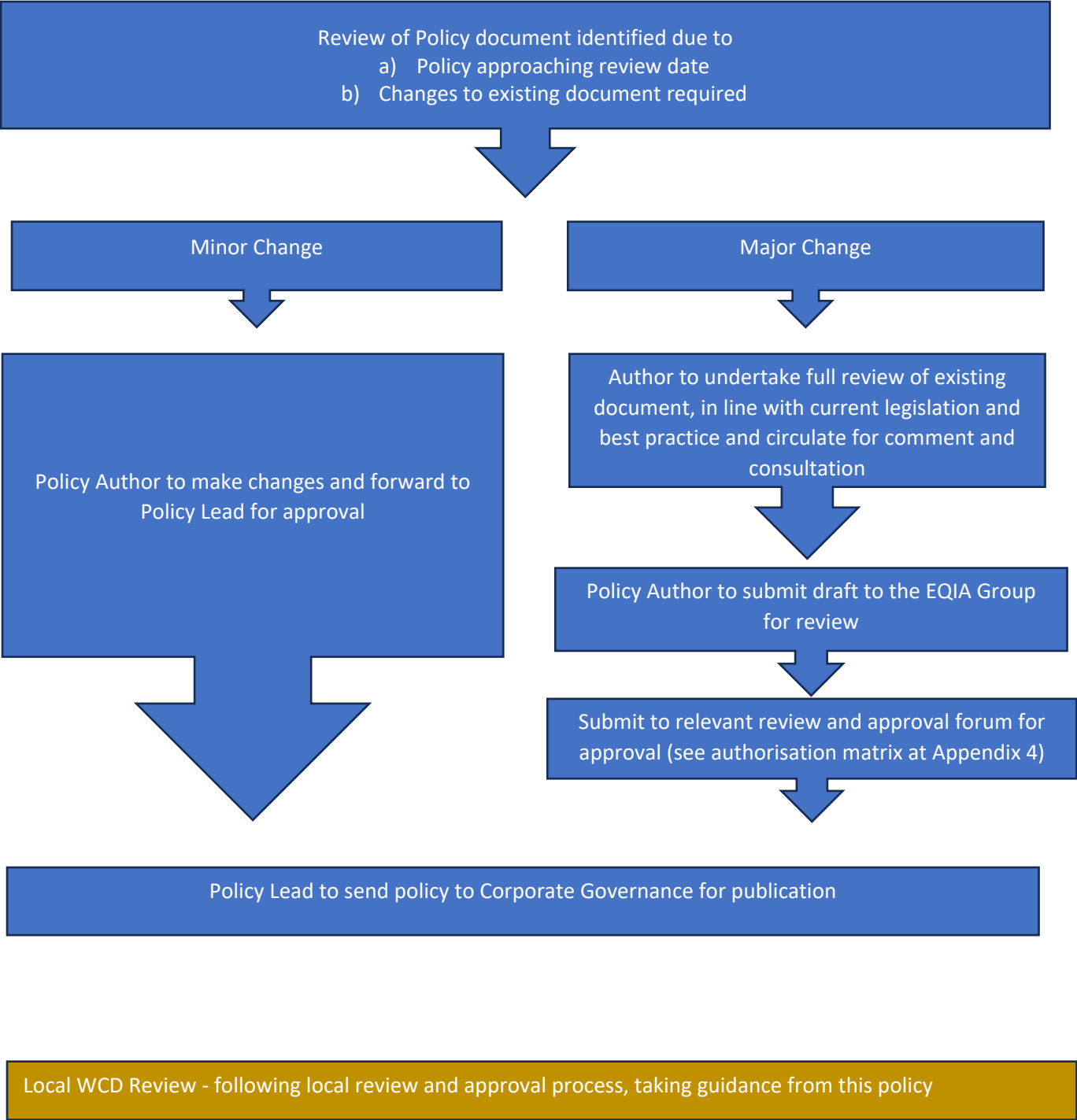
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Appendix 1. Process for the Development of New Health Board wide Written Control Documents flowchart



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Appendix 2. Review of Health Board wide Written Control Document flowchart



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Appendix 3: Authorisation Matrix

This authorisation matrix outlines the approval routes for **Health Board wide** Written Control Documents.

Health Board Wide documents are applicable to staff across the Health Board and are subject to approval via the Policy Governance and Approval Group. All Health Board wide documents require an Executive sponsor.

Local documents apply to a single department, profession or staff group and there is no wider impact on the Health Board. These documents are subject to approval via local approval mechanisms. Such documents should follow the principles contained in the Policy Framework and must not conflict with relevant Health Board policies or Health Board wide procedures. All local WCDs require a divisional sponsor (divisional director/assistant director)

Classification	Sub Theme	Reference	Approval	Responsible Board Committee
Clinical – relate to patient care and treatment of patients	Clinical services (health board wide)	Clinical Standards and Policy Group	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
	Pharmacy / Medicines Management	Clinical Standards and Policy Group	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
	Infection Prevention and Control	Clinical Standards and Policy Group	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
	For Health Board wide clinical WCDs , the Clinical Executive Lead (Medical Director, Director of Nursing, Director of Therapies and Health Science) will determine the appropriate approval forum (either the Clinical Standards and Policy Group or Policy Governance and Advisory Group).			
Corporate – relate to the management of the organisation and formulate the organisation's response to	Statutory/legislative eg Standing Orders, Standing Financial Instructions	Audit, Risk and Assurance Committee	Board	Board
	Putting Things Right	Policy Governance and Assurance Group	Board	Board
	Corporate Governance (Policy Management, Standards of Business Conduct)	Policy Governance and Assurance Group	Board	Board

Classification	Sub Theme	Reference	Approval	Responsible Board Committee
situations and circumstances	Risk Management	Audit, Risk and Assurance Committee	Board	Board
	Digital (Information Governance, Health Records)	Information Governance Sub Group	Policy Governance and Assurance Group	Finance and Performance Committee
	Health and Safety	Health and Safety Committee	Policy Governance and Assurance Group	Patient Quality, Safety and Outcomes Committee
	Mental Health Act	Mental Health Act Monitoring Committee	Mental Health Act Monitoring Committee	Mental Health Act Monitoring Committee
	Facilities and Estates	Statutory Compliance Group	Policy Governance and Assurance Group	Finance and Performance Committee
Employment - relate specifically to the management of employees (however defined) within the organisation.	Workforce Matters (including all-Wales human resource policies)	Workforce and OD Policy Group	Policy Governance and Assurance Group	People and Culture Committee
Financial - relate specifically to the financial controls within the organisation	Financial Management	Policy Governance and Assurance Group	Audit, Risk and Assurance Committee	Audit, Risk and Assurance Committee
	Counter Fraud	Policy Governance and Assurance Group	Audit, Risk and Assurance Committee	Audit, Risk and Assurance Committee
	Charitable Funds	Charitable Funds Committee	Charitable Funds Committee	Board

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Appendix Four

Written Control Document Checklist (policies, procedures, guidelines)

There is no prescribed format for documents, however, the following checklist identifies areas which must be included.

Front Page		✓
Title	Title of the WCD	
Logo	Health Board logo	
Lead Author (s)	Name(s) and job title (s)	
Lead Executive	Name and job title	
Division/Department	Name of Department/division responsible for the document	
Reference	Health Board wide: (reference to be provided by Corporate Governance) Local: ABUHB/directorate/001 (digits in sequence with other documents in the directorate)	
Applies to	Health Board Wide Local (state which department/service)	
Approving Forum	Name of committee/group	
Date Approved	Date in full dd/mm/yyyy	
Review Date	Date in full dd/mm/yyyy	
Version	Version number	
Main Document		
Key messages	If you only had two minutes to inform staff about the practice covered in this document – what key messages do you need them to remember?	
Contents page	List of contents and page numbers	
Introduction/Overview	A summary of what the document is about and why it is needed.	
Scope	Clearly state who the document applies to and where it will be used –local or Health Board wide? For clinical documents – does this apply to children as well as adults? Is it relevant to community services as well as hospital services?	
Background/Aim	Outline the Health Board's commitment and why the document is important or necessary? What is the purpose of this document?	
Main Body	Information can be broken down in to sub sections to aid clarity. Provide the information in a way that most clearly and concisely conveys the information – consider using pictures, tables, diagrams or flow charts. All text should be Verdana 12 point (point 14 for headings). Other fonts, sizes and colours can be used for charts,	

	diagrams and tables as long as the information is clear, adds clarity and is easy to read. Keep the content as concise as possible – do not duplicate information that is already available in other documents – provide links or reference to other documents. This also ensures that information is up to date if any source documents change.	
Roles and Responsibilities	State those teams, groups or individuals who have specific roles and/or responsibilities relating to this policy, including the Accountable Officer for the policy.	
Consultation	All new or significantly revised policies should be the subject of consultation within the divisional structure and with relevant professional groups and/or individuals. Identify those who have been consulted with in the development of the policy.	
Equality Impact Assessment	Confirm that an EQIA has been undertaken and the outcome.	
Training Requirements	Identify any training needs required to implement the policy, and how to access this training.	
Audit and Review	The time period for review is generally three (3) years unless legislation requires differently. Policies contain 'must do' information and evidence of compliance will be required. Outline how compliance will be monitored.	
References	List all reference material in full.	
Appendices	Include any procedures or templates to support the policy.	

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Proposed Amendments to the Scheme of Delegation
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Bryony Codd, Head of Corporate Governance

Pwrpas yr Adroddiad Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

The purpose of this report is to propose amendments to the Scheme of Delegation for Aneurin Bevan University Health Board, specifically, the delegated general financial limits, delegated limits for clinical negligence/personal injury claims and RPB limits at Executive Director level and above.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

NHS Organisations are required to keep Standing Orders (SO's) and Standing Financial Instructions (SFIs) under review to ensure that they remain current.

The current Scheme of Delegation was approved by Board in in September 2023, as part of the Model Standing Orders and Standing Financial Instructions annual review. However, a review of the delegated financial limits was subsequently requested as the Health Board was considered to be an outlier when compared with other Health Boards. A clear Scheme of Delegation is a key component of the Health Board's Financial Control Environment.

This report recognises the challenging financial position faced by the Health Board, and the NHS in Wales. However, delegated limits which are proportionate to the Health Board's overall budget of £1.6 billion are required in order to enable agile and flexible decision making and reduce bureaucracy whilst maintaining effective financial control.

Learning has also been undertaken from the COVID-19 pandemic, during which the Strategic Group, comprising the CEO, Deputy CEO and Executive Team members, were able to make spend decisions up to/including £250k, exceeding the current Scheme of Delegation (£100k), in order to facilitate timely decision making.

A review of the current Scheme of Delegation has been undertaken, focussing on general financial limits and delegated limits for clinical negligence/personal injury claims. The Executive Committee is requested to consider the proposed revised financial limits. If supported, there will be a requirement to present the revised SoD to the Board, for approval, outside of the routine annual review.

This is in line with Section 2.3.2 of the Local Standing Orders, which state: *The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.*

Cefndir / Background

Standing Orders are designed to translate the statutory requirements set out in the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (S.I. 2009/779 (W.67)) into day to day operating practice, and, together with the adoption of a Scheme of Decisions reserved to the Board; a Scheme of Delegations to officers and others and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Local Health Board.

The current Scheme of Delegation is provided as Appendix One.

Asesiad / Assessment

The general financial limits within the current Scheme of Delegation, for Executive Directors and above, have not changed since they were approved by the Board in July 2010.

A comparison has been undertaken for general financial limits and clinical negligence/personal injury limits and this demonstrates that Aneurin Bevan University Health Board has significantly lower delegated limits than other Health Boards of a similar size.

General Financial Limits

A summary of the general financial limits, at Executive Director level and above, is outlined below (noting all expenditure over £1m requires WG approval):

General Financial Limits						
	ABUHB	HDUHB	SBUHB	CTMUHB	CVUHB	BCUHB
Revenue Allocation (as set out in WHC (2023)048	£1,636.590b	£1,106.231b	£1,160.658b	£1,310.255b	£1,237.056b	£2,015.650b
Board	Up to £1m	Up to £1m	Up to £1m	Up to £1m	Up to £1m	Up to £1m
Chief Executive	£100k*	Up to £500k	Up to £750k	Over £500k	Up to £500k	£500k-£1m**

Chief Exec & Chair	Up to £500k*					
Chief Exec & DoF		£500k - £1m**				
Chief Exec & Exec Team		£500k - £1m				
Deputy CEO			Up to £500k			
Director of Finance		Up to £500k		Up to £500k		£500k-£1m
Executive Directors	£75k	Up to £100k	£250k	Up to £250k	Up to £125k	Up to £300k
Any 2 of CEO, DoF, Exec of Integrated Clinical Delivery (must incl DoF)						Up to £500k

*or deputies **or deputy CEO

Up to £1m	Up to £750k	Up to £500k	Up to £300k	Up to £250k	Up to £125k	Up to £100k	Up to £75k

It can be seen from the table above that the general delegated limits for the Chief Executive and Executive Directors in ABUHB are substantially lower than in other Health Boards. In addition, ABUHB is the only Health Board to specify the Chair in the delegated limits.

Of the 5 Health Boards compared, 3 are able to approve up to £1m through the Chief Executive/Executive structure, one can approve up to £750k and one up to £500k.

As a result of the lower delegated limits in place, ABUHB is required to undertake additional chairs actions and seek additional approvals for any spend over £100k.

General expenditure between £100k and £500k is reviewed and signed off by the Chair, Chief Executive and Director of Corporate Governance. In 2022 67 approvals were required, with 54 in 2023 and 40 in 2024 to date. In addition, all spend between £500k and £1m, which is not able to be discussed by the Board in a timely manner, requires a Chairs Action, involving the Chair, Chief Executive and two Independent Members. A summary of Chair’s Actions undertaken during 2022 and 2023 is provided at Appendix Two, and shows that during 2022 and 2023, 18 chair’s actions were taken with a value of £500k to £1m.

Proposed limits:

The proposed revised delegated limits are outlined in the table below:

	ABUHB
Board	Over £500k
Chief Executive*	Up to £250k
Executive Directors	Up to £125k

*or deputy

It should be noted that the current delegated limit for Divisional Directors/General Managers/Assistant Directors is £50k and it is not proposed that these are changed at the current time.

Individual Patient Placements (including Continuing Health Care)

The general financial limits also specify delegation in relation to Individual Patient Placements, set at £500k for the CEO/Deputy and £250k for the Director of Primary, Community & Mental Health Services (DPCMHS) and Director of Operations (DoO).

This requires update to reflect the revised Executive Team roles, removing the DPCMHS and DoO and replacing with the Chief Operating Officer.

However, it is also proposed that the Delegated limit for approval of Individual Patient Placements (Including CHC) is amended to require approval by the CEO, COO and 1 Clinical Executive for packages of care between £250k to £500k. Over the past 12 months there were 3 placements over £250K, as follows:

- £343k
- £259k
- £346k

Packages of care over £500k will require Chairs Action, in line with Standing Orders.

Proposed limits:

The proposed revised delegated limits are outlined in the table below:

	ABUHB
Board	Over £500k
CEO, COO and 1 Clinical Executive	£250-£500k
Chief Operating Officer	Up to £250k

Clinical Negligence/Personal Injury

A further area requiring review within the current Scheme of Delegation is that of clinical negligence/personal injury claims. A summary of the delegated limits in relation to clinical negligence/personal injury claims, at Executive Director level and above, is outlined below.

All Health Boards in Wales have delegated authority to settle cases up to £1 million. Above £1million, authority has to be sought from Welsh Government, with a process in place through Shared Services Legal & Risk and the Welsh Risk Pool.

Clinical Negligence/Personal Injury						
	ABUHB	HDUHB	SBUHB	CTMUHB	CVUHB	BCUHB
Board	£100k-£1m		Up to £1m			
Chief Executive	£25k-£100k			£500k-£1m		£500k-£1m
CEO and DoF		£100k-£1m				
Chief Exec/Deputy Chair			Up to £750k			
Deputy Chief Exec			Up to £500k			
Executive Directors			Up to £250k			

Director of Finance						£500k-£1m
Nurse Director					Up to £1m	Up to £150k
Chief Executive & Director of Nursing, Quality and Patient Experience		Up to £100k				
Director of Corporate Governance				£75k-£500k		
Director of Therapies and Health Science						Up to £150k

Up to £1m	Up to £750k	Up to £500k	Up to £250k	Up to £150k	Up to £100k

Again, the table above shows that the delegated limits within ABUHB are significantly lower than other Health Boards. All claims between £25k to £100k require approval by the Chief Executive, supported by detailed briefing notes and accompanying legal advice. All cases above £100k require approval by the Health Board's Litigation Group. It is understood that ABUHB is the only Health Board to approve claims in this way, with all other Health Boards being able to approve up to £1m through the Chief Executive and Executive Structure, (except SBUHB where the limit is £750k) as outlined in the table above.

A review of the current level of medical negligence and personal injury claims settled over the past 3 years, in line with current financial limits, is provided below:

Year	2020/21	2021/22	2022/23
Up to £25k	60	64	66
£25k-£100k	21	23	19
Over £100k	15	10	18

A further breakdown of settlement is provided below:

Year	2020/21	2021/22	2022/23
Up to £50k	68	75	73
£50k to £500k	23	17	3
£500k to £750k	0	1	3
£750k to £1m	2	0	0
Over £1m	3	4	4

As stated earlier in this report, the delegated limits have remained unchanged since 2010 and are now set too low for the management of cases on current valuations.

Proposal:

The proposed revised delegated limits are outlined in the table below:

	ABUHB
Board	Over £1m
Chief Executive with 2 Clinical Executive Directors**	£500k-£1m
2 Clinical Executive Directors**	Up to £500k

* Or Deputy

** Medical Director, Director of Nursing, Director of Therapies and Health Science, or their nominated deputy

In line with the general delegated limits, it is also proposed that the Deputy Director of Nursing can approve clinical negligence/personal injury claims up to £50k, noting that the Head of Legal Services is able to approve up to £25k, in line with the current Scheme of Delegation.

If the proposals are accepted, the need for the Health Board's Litigation Group to be a Board level committee, chaired by the Chair of the Health Board, would no longer be required. All settlements over £1m would be submitted to the Board for review and approval. It is proposed that a management group is established to review learning from such claims.

Regional Partnership Board

The CEO approval limit is also set at £100k for RPB related payments, in line with the general delegated limits. The Specific Approval Limits in the current Scheme of Delegation include payments to *Local Authorities for their Share of Integrated Care Funding*. The ICF was the predecessor to the current RPB allocations from WG which currently includes the Regional Integration Fund (RIF), Housing with Care Fund (HCF), Integrated Rebalancing Capital Fund (IRCF), ND Improvement Fund (NDIP) and Further Faster.

The historical Specific Approval Limits for Chief Executive reflected an outdated cost centre structure and was not refreshed following the transition from ICF to RIF. However, given that these transactions would receive RPB approval prior to the purchase orders are raised an exercise was carried out in June 2023 to review this to minimise the need of chair's action/approval on RPB purchase orders that exceed £100k. In addition, the exercise looked to extend the arrangement from just local authorities to include RPB approved payments to Housing Association and Third Sector organisations.

These changes were not reflected in the Health Board's Scheme of Delegation

The exercise has been reviewed again for 2024/25 following an update to the cost centre structure for the new financial year.

The proposed revised RPB limits, for processing payments within the contract limits awarded by the RPB are provided in Appendix Three.

To support these changes and to provide the appropriate assurance of the agreed allocations from the RPB, the monthly RPB finance update which documents the agreed annual allocation by scheme and organisation is provided as Appendix Three.

Next Steps

The full financial scheme of delegation document will be updated, in partnership with the financial governance team. This will include the specific provisions, outlined in the current Scheme of Delegation, where regular payments which exceed delegated limits have been delegated and the specific provisions made for the GUH Project which are no longer relevant.

Argymhelliad / Recommendation

The Board is requested to approve the proposed revised financial limits as set out.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

Gwybodaeth Ychwanegol: Further Information:	
Ar sail dystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	None
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

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

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

Appendix One

Aneurin Bevan University Health Board

Scheme of Delegation – April 2021

The Scheme of Delegation, in line with the Health Board’s Standing Orders and Standing Financial Instructions provides a framework of appropriate arrangements for certain functions to be carried out and financial approvals to be made on behalf of the Board by designated Committees or Officers within the organisation. The Scheme of Delegation is designed to enable the day to day business of the Health Board to be carried out effectively, and in a manner that secures the achievement of the organisation’s aims and objectives. It also reflects the general consent required from Welsh Ministers for individual contracts and agreements over to the value of £1m in each case.

For further advice on the Scheme of Delegation, please contact Rani Dash, Director of Corporate Governance on 01633 435938 or via e-mail at rani.dash@wales.nhs.uk

General Delegated Financial Approval Limits:

Table 1

Body / Committee / Post	General Financial Limit £’000	Individual Patient Placements (Including CHC)

		Annual Contract Limit £'000
Welsh Government	>1,000	N/A
Board	1,000 (note 1)	N/A
Chief Executive and Chairman / (Deputy Chief Executive/ Vice Chairman in their absence)	500	N/A
Chief Executive / Deputy Chief Executive	100	500
Executive Team Members	75	250 (note 2)
Divisional Directors/General Managers / Assistant Directors	50	50
Other Delegated Budget Holders	25 and below	N/A

Note (1) above: urgent issues between scheduled Board meetings should be referred to the Board Secretary to seek approval via Chair's action.

Note (2) above: this relates specifically to the Director of Primary, Community and Mental Health Services and the Director of Operations

Specific Approval Limits:

The following provides specific provisions for delegation to identified roles within the Health Board structure, where regular payments exceed approval limits in Table 1 above:

Table 2

Company	Description	Approver
Abbott Laboratories Ltd	Pathology biochemistry managed service contract for analysers and consumables.	Pathology Directorate Manager
Baywater Healthcare Ltd formerly Air Products Ltd.	Home oxygen supplies	Director of Primary, Community and Mental Health Services
Department for Energy & Climate Change (DECC)	Annual Purchase of Carbon Reduction allowances.	Divisional Director of Facilities
Fujifilm UK Ltd	PACS managed service contract	Radiology Directorate Manager
Honeywell Control Systems Ltd	Energy PFI Contract	Divisional Director of Facilities

Kintra	Chepstow PFI	Divisional Director of Facilities
Local Authorities	Section 28a agreements	Divisional Director of Primary Care and Community Services
Local Authorities	Payment to Local Authorities for their Share of Integrated Care Funding.	Chief Executive
NHS Dental Services	Reimbursement to NHS Dental Services of the payments they have made to Dental Contractors on behalf of ABUHB	Assistant Director of Finance (Financial Systems and Services)
Monmouth Facilities Ltd.	Monnow Vale PFI	Divisional Director of Primary Care and Community Services
Utilities	Invoices for gas, electricity, rates and water.	Divisional Director of Facilities
Retinue	Medical agency management service	Associate Director of Operations
SLA's agreements with NHS bodies		Relevant Divisional Director
Audit Wales	Annual audit fees	Assistant Director of Finance (Financial Systems and Services)
LTA Agreements with NHS Bodies		Chief Executive
Velindre NHS Trust (NWSSP)	Invoices for stock issued from NWSSP stores for ABUHB	Director of Operations
Velindre NHS Trust (NWSSP)	Annual Charge for Oracle Finance and iProcurement System	Assistant Director of Finance (Financial Systems and Services)
Velindre NHS Trust (NWSSP)	Annual Charge for the procurement and maintenance of GPICT systems for GP practices.	Chief Executive

Government Bodies & Private Contractors	Description	Approver
HM Revenue & Customs	PAYE and NI	Payroll Services (NWSSP)
Various charities and trades unions	Union & other deductions	Corporate Finance
HM Revenue & Customs	Superannuation	Payroll Services (NWSSP)
General Practitioners, Dentists, Opticians and Pharmacists	Payments made over to private contractors under Primary Care	Contractor Services (NWSSP)

LOSSES & SPECIAL PAYMENTS

Table 3

Losses & Special Payments:

	Clinical Negligence/Personal Injury		Redress	
	Settlements	Legal Fees	Settlements	Legal Fees
>£1,000,000	Welsh Government and Board	Welsh Government and Board	N/A	N/A
>£100,000<£1,000,000	Board	Board	N/A	N/A
>£25,000<£100,000	CEO	CEO	CEO	N/A
>£10,000<£25,000	Head of Legal Services	Senior Head of Legal Services	Head of Legal Services	Head of Legal Services
<£10,000	Head of Legal Services	Claims Manager	Head of Legal Services	Claims Manager

Ombudsman Claims	Per normal Scheme of Delegation approval limits.
Special Payments	Per normal Scheme of Delegation approval limits.

Capital Scheme of Delegation

(i) Capital Project Approval Limits

Table 5

Value of proposal	Documentation required	Scrutiny	Approval
Less than £75,000	Project Proposal Document	Head of Capital Planning /Head of Capital Finance	Director of Planning, Digital and IT
£75,000-£500,000	Project Proposal Document for low risk items such as replacement equipment/ICT or Business Justification Case depending on complexity of proposal	Capital Group, Pre-Investment Panel (if appropriate), Executive Team	Chief Executive and Chair (Deputy Chief Executive/ Vice Chair in their absence)
£500,000 - £1,000,000	Business Justification Case	Capital Group, Pre-Investment Panel (if appropriate), Executive Team	Board
Over £1,000,000	Scoping Document to be agreed with WG prior to development of Business Justification Case following Welsh Government requirements	Capital Group, Pre-Investment Panel (if appropriate), Executive Team	Board Welsh Government

(ii) Approving Expenditure against Approved Capital Contracts

The previous table shows the process for approving capital projects, whereas this section shows the approval process for payments, where projects have:

- been authorised to proceed;
- the contract has been approved;
- the contract has been let.

The authorisation of expenditure against those contracts will differ depending on whether or not the project is:

- (a) An all-Wales Capital Programme Project
- (b) The Grange University Hospital Project

(a) All-Wales Capital Programme Projects

Where schemes are part of the all-Wales procurement framework, in order for them to accommodate the processing of payments in a timely manner and to comply with the contractual obligations for these major construction contracts, the following process is to be applied where payments exceeding £100K are delegated to the Director of Planning, Digital and IT for approval:

- The External Cost Advisor (Quantity Surveyor representing the Health Board) shall advise the Health Board that a stage payment to the Supply Chain Partner (SCP) can be made and of the amount.
- The Project Director will have authority to approve payments of less than £50K.
- The Director of Planning, Digital and IT will have delegated authority to approve any payments exceeding £50K.

(b) The Grange University Hospital Project

Where the scheme is part the Grange University Hospital capital project it is proposed that the following delegations and process apply to ensure tight contractual payment terms are met:

1. The Director of Planning, Digital and IT will have delegated authority to approve annual expenditure commitments by approving a Purchase Order equal in value to the Welsh Government and Board approved capital budget for the financial year.
2. The External Cost Advisor (Quantity Surveyor representing the Health Board) shall advise the Health Board that a stage payment to the Supply Chain Partner (SCP) can be made and of the amount.
3. The Project Director, based on the advice of the External Cost Advisor, will have authority to approve payments not exceeding the value advised by the External Cost Advisor, provided it falls within the total approved budget for the financial year. The payment approval must be counted against the approved Purchase Order referred to in (1) above.
4. The Capital Group, chaired by the Director of Planning, Digital and IT, will formally review project payments against the approved budget and outturn forecast on a monthly basis in a report provided by the Head of Capital Finance. This report

should also be periodically provided to the Board. Any variance to the forecast outturn and approved budget will require additional approvals in line with the normal scheme of delegation shown in Table 1.

(c)Discretionary Capital Schemes

Where projects with an expected value of less than £1M have been authorised to proceed and the contract has been approved and let, then the authorisation of expenditure against those contracts is as follows:

Nominated project manager to certify stage payments where approvals are within delegated limits set out in Table 1 above. If approvals exceed limits the normal approval hierarchy must be followed.

Appendix Two

Review of chairs Actions

>£500k <£1m	(18)	>£1m	(11)

Date	Title	Cost
2022		
25/01/2022	Endoscopy Equipment, Nevill Hall Hospital	£953,500
16/02/2022	Outpatient Transthoracic Echo's (TTE)	£624,000
16/02/2022	Replacement of Stacks and Scopes – NHH - Endoscopy	£746,309.52
11/03/2022	Insourcing of Endoscopy Procedures	£2,071,650
17/03/2022	'Careflow' Contract Extension	£559,020

24/03/2022	Support Services for Voice Network	£863,975.84
28/03/2022	Robotic Process Automation Platform	£763,920
06/04/2022	Endoscopy and MRI Outsourcing	£958,800
09/06/2022	Provision of Childcare Vouchers	£928,027.20
29/06/2022	Microsoft Server Licensing Renewal	£800,000
12/10/2022	Pathology Testing	£954,503
31/10/2022	Cabling Works	£2,250,000
03/11/2022	SIP and DEL Lines Tender	£618,818.40
09/11/2022	DELL Laptops and PCs	£833,000
21/11/2022	Cardiology mini-competition	£2,815,672.80
21/11/2022	Postal Services	£556,078.28
8/12/2022	Nevill Hall Hospital – Satellite Radiotherapy Unit	£700,000
14/12/2022	Blood Transfusion Laboratory Information Management System (LIMS) - Pathology	£1,622,912
2023		
25/01/2023	Video Consultation Service – Attend Anywhere	£3,260,000
08/02/2023	HSG Facilities Management – Provision of a manned security service (GUH, NHH, St Cadoc's, Hospital, RGH)	£1,800,000
23/02/2023	2023/24 Delivery Plan for Mass Vaccination Programme	£3,731,729
06/03/2023	Energy and Ancillary Services	£22,955,496
06/04/2023	Access to NHS Dentistry: Contract Reform (Detail not included due to commercial sensitivities)	
06/04/2023	Remedy Healthcare Solutions – Endoscopy Insourcing	£1,550,620
26/04/2023	Postal Services	£583,424.13
31/05/23	Block E Flood Damage - Equipment Replacement RGH	£752,500
30/06/23	Medical E-Systems	£943,870
27/07/23	Approval of funding for design fees for stages 3 & 4, following completion of stages 1 & 2, in respect of developing a Business Case for an Extension to	£515,688.00

	Emergency Department Waiting Area – Grange University Hospital.	
03/10/2023	To award a Bed Services & Maintenance Contract via the SBS Framework to Drive Devillbiss for a period of 5years with option to extend for 5 years.	£9,212,190

						22/23 Hierarchy and Approval Limits										23/24 Hierarchy & Approval Limits										24/25 Hierarchy & Approval Limits (Requested)									
Q Level	Cost Code	Cost Code Description	Maximum PD value Expected	External Organisation	Scheme	£	1,000	£	75,000	£	100,000	£	600,000	£	2,000,000	£	1,000	£	50,000	£	75,000	£	100,000	£	250,000	£	500,000	£	750,000	£	2,000,000				
Q827-CARERS	8268	SP01 SUPPORT FOR UNPAID CARERS	£376,000	Third Sector	Hub & Spoke													Chris D-Morris	Hannah Evans																
	8269	SP02 CHILDREN'S EARLY INTERVENTION & RESILIENCE	£324,551	Local Authority	Enhanced Edge Of Care (Caer)													Chris D-Morris	Hannah Evans																
Q828-CHILDREN & FAMILIES	8263	SP03 SAFE ACCOMMODATION	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8261	SP04 CHILDREN'S EMOTIONAL HEALTH & DEVELOPMENT	£691,967	Third Sector	Family Intervention Team													Chris D-Morris	Hannah Evans																
Q829-CHILDREN & FAMILIES	8264	SP05 WORKFORCE DEVELOPMENT/PROFESSIONAL SUPPORT	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8272	SP06 DEMENTIA: ASSESSMENT & DIAGNOSTICS	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
Q831-DEMENTIA BOARD	8273	SP07 DEMENTIA: LIVING WELL WITH DEMENTIA	£136,337	Local Authority	Early Intervention Dementia Reablement Services													Chris D-Morris	Hannah Evans																
	8265	SP08 PREVENTION & WELLBEING	£353,146	Local Authority	Community Connectors - Caerphilly													Chris D-Morris	Hannah Evans																
Q832-PMO	8274	SP09 ASSISTIVE TECHNOLOGY	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8267	SP10 PLACE BASED GRADUATED CARE	£395,468	Local Authority	Step Up/Down Beds													Chris D-Morris	Hannah Evans																
Q829-GASP	8266	SP11 IMPROVING SYSTEM FLOW	£1,799,410	Local Authority	Home First													Chris D-Morris	Hannah Evans																
	8268	SP12 ND & LD IMPROVEMENT PROGRAMME	£160,960	Local Authority	My Mate													Chris D-Morris	Hannah Evans																
QNEW - RLG	8275	SP13 INTEGRATED DATA	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8267	SP10 PLACE BASED GRADUATED CARE	£395,468	Local Authority	Step Up/Down Beds													Chris D-Morris	Hannah Evans																
Q889-ICF Other Funding	8991	SMALL GRANTS FUND	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8276	REGIONAL DEVELOPMENT	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
Q832-PARTNERSHIP REVENUE - CENTRAL	8983	REGIONAL SYSTEM PRESSURES	£174,422	Third Sector - GAVO	2324 Stepage allocation													Chris D-Morris	Hannah Evans																
	8981	RPB ADDITIONAL FUNDS	£364,708	Local Authority	2324 FF Allocation for Regional Telecom													Chris D-Morris	Hannah Evans																
Q832-PARTNERSHIP REVENUE - CENTRAL	8994	REVENUE RECLAIMED FUNDS	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8997	RIC	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
Q891-PARTNERSHIP CAPITAL	8347	ICF CAPITAL: MCP	£750,000	Local Authority	Childrens Residential Home - complex needs													Chris D-Morris	Hannah Evans																
	8348	ICF CAPITAL: DCP	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
Q891-PARTNERSHIP CAPITAL	8967	HOUSING WITH CARE FUND (HCF)	£112,080	Local Authority	2324 DFG grant funding													Chris D-Morris	Hannah Evans																
	8958	INTEGRATION & REBALANCING CAPITAL FUND (RCF)	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
Q891-PARTNERSHIP CAPITAL	8990	CAPITAL RECLAIMED FUNDS	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8975	NATIONAL PROJECTS	£445,000	Third Sector - Age Cymru	2425 National Dementia Project													Chris D-Morris	Hannah Evans																
Q837-Director of Planning	8385	RPB PMO	Standard	Standard	Standard													Chris D-Morris	Hannah Evans																
	8576	RPB PMO Non-Pay	Standard	Standard	Standard																														
Q833- RPB 2024-25	8913	RIF Revenue 24-25	£1,799,410	Local Authority	2425 Home First																														
	8914	RIF Dementia 24-25	£219,967	Local Authority	2425 Dementia Connect																														
Q833- RPB 2024-25	8915	RIF Memory Assessment Service 24-25	Standard	Standard	Standard																														
	8916	RIF Unpaid Carers 24-25	Standard	Standard	Standard																														
Q833- RPB 24-25	8917	RIF IAS 24-25	Standard	Standard	Standard																														
	8918	RIF Carers Short Breaks 24-25	£247,269	Local Authority	2425 Bridging the Gap																														
Q833- RPB 2024-25	8919	ND Improvement Programme 24-25	Standard	Standard	Standard																														
	8920	Further Faster 24-25	Standard	Standard	Standard																														
Q833- RPB 2024-25	8921	ICRF REVENUE 24-25	Standard	Standard	Standard																														
	8922	ICF Capital Legacy 24-25	£750,000	Local Authority	2425 ICF Legacy Children's Residential Home																														
Q833- RPB 2024-25	8923	HCF Capital Minor 24-25	Standard	Standard	Standard																														
	8924	HCF Capital DFG 24-25	£112,080	Local Authority	2425 DFG Grant Funding																														
Q833- RPB 24-25	8925	HCF Capital Programme Resource 24-25	Standard	Standard	Standard																														
	8926	Gwent RPB Other Funds 24-25	£445,000	Third Sector - Age Cymru	2425 National Dementia Project																														

GWENT REGIONAL PARTNERSHIP BOARD (RPB)

CAPITAL FINANCIAL UPDATE

Month 1 (End of April 2024/25)

Report Author: Bethan Vong, Partnership PMO

Accountable Officer: Chris Commins, ABUHB

EXECUTIVE SUMMARY

CURRENT POSITION

- **Capital funding available to the Partnership for 2024/25 is £27.183m. This includes the following funding streams:**
 - £11.208m Housing with Care Fund (HCF)
 - £ 1.266m Integrated Capital Fund Legacy Programme Managed (ICF Legacy PM),
 - £14.009m Integrated Rebalancing Capital Fund (IRCF), and
 - £ 0.700m IRCF Revenue funding.
 - £27.183m Total RPB Capital Funding for 24/25**
- **As of Month 1, the overall capital programme is £731k over-programmed.** This is a favourable position to be in for the start of the new financial year and is also a reflection of all the effort across the whole partnership to develop and deliver the programme over the last few years.
- There are some variations to highlight across the different funding streams:

£1.279m Over programmed in HCF Major Schemes – The majority of schemes are awaiting a revised award letter from Welsh Government for 24/25 as deliverability is being reviewed. Being overprogrammed at this stage is preferential and will support the backfilling of schemes should any slip as they progress, as seen in previous years.

(£61k) Under programmed in HCF Minor Schemes – The RPB is currently awaiting the Minor Project award letter from the Welsh Government (WG). These schemes are also awaiting an update on partner deliverability for this financial year prior to awards being issued. Confirmation early in the year will provide an indication of opportunities to progress pipeline schemes.

(£560k) Under programmed in HCF Disables Facilities Grant (DFG) Funding – Award letters have been issued to delivery partners. A forecast spend against this funding stream is predicated on applications received by Local Authorities during the year. Given the increase in demand for DFG over recent years there is minimal risk to underspending on this funding stream.

(£47k) Under programmed in ICF Legacy PM Funding – This underspend is in relation to funding carried forward for the Strategic Needs Assessments – Gwent, of which there is currently no spend plan in place.

£406k Overspend is forecasted in the IRCF Capital Programme – This is in relation to the Newport East Health & Wellbeing Centre. This risk will continue to be monitored and reviewed with ABUHB and opportunities to seek further funding WG are in progress.

(£68k) Under programmed in IRCF Revenue – Capital Resource Funding – This underspend is currently unallocated and will be lost as a region if no spend plan is considered for this financial year.

(£219k) Under programmed in IRCF Revenue – Strategic Capital Funding – This forecast currently reflects the commitments that were awarded in the plan for 2024/25. However, there are certain schemes that did not progress in 23/24 which may affect the 24/25 allocations and will be reviewed for Month 2.

Similarly to the IRCF Capital Resource Funding, there is also an element of underspend that is currently unallocated which will be lost as a region if no spend plan is considered for this financial year.

DECISIONS REQUIRED

None

RECOMMENDATIONS

The Regional Partnership Board is asked to note the spend plans required to maximise funding utilisation in 2024/25.

These include spend plans for ICF Legacy PM funding and IRCF Revenue funding for Capital Resource and Strategic Capital.

1.0 2024/25 CAPITAL PROGRAMME OVERVIEW

- 1.1 Capital funding available to the Partnership for 2024/25 is £27.18m. This includes £11.208m Housing with Care Fund (HCF), £1.266m of Integrated Capital Fund Legacy Programme Managed

(ICF Legacy PM), £14.009m Integrated Rebalancing Capital Fund (IRCF) and £0.7m of IRCF Revenue funding.

Going in to 2024/25, the overall capital programme is £731k over-programmed, which is a favourable position to be in for the start of the new financial year and is also a reflection of all the effort across the whole partnership to develop and deliver the programme over the last few years.

Table 1. 2024/25 Gwent RPB Capital Programme by Funding Stream

FUNDING STREAM	24/25 FUNDING AVAILABLE £	24/25 FUND UTILISATION FORECAST £	24/25 FULL YEAR (SURPLUS) / SHORTFALL £
Housing with Care Fund (HCF) – Major Schemes	9,350,405	10,629,270	1,278,865
Housing with Care Fund (HCF) – Minor Schemes	1,120,800	1,059,574	(61,226)
Housing with Care Fund (HCF) – DFG	560,400	0	(560,400)
Housing with Care Fund (HCF) – Capital Resource	176,395	176,395	0
Integrated Rebalancing Capital Fund (IRCF)	14,009,000	14,009,000	406,000
ICF Legacy Programme Managed Fund (PM)	1,266,205	1,219,560	(46,645)
TOTAL GWENT CAPITAL PROGRAMME	26,483,205	27,09,799	1016,594
IRCF CAPITAL RESOURCE (Revenue)	200,000	132,469	(67,531)
IRCF STRATEGIC CAPITAL FUNDING (Revenue)	500,000	281,486	(218,514)
TOTAL GWENT CAPITAL PROGRAMME	27,183,205	27,507,754	730,549

However, there are some variations to highlight across the different funding streams:

- **£1.279m Over programmed in HCF Major Schemes** – The majority of schemes are awaiting a revised award letter from Welsh Government for 24/25 as deliverability is being reviewed. Being overprogrammed at this stage is preferential and will support the backfilling of schemes should any slip as they progress, as seen in previous years.
- **(£61k) Under programmed in HCF Minor Schemes** – The RPB is currently awaiting the Minor Project award letter from the Welsh Government (WG). These schemes are also awaiting an update on partner deliverability for this financial year prior to awards being issued. Confirmation early in the year will provide an indication of opportunities to progress pipeline schemes.
- **(£560k) Under programmed in HCF Disables Facilities Grant (DFG) Funding** – Award letters have been issued to delivery partners. A forecast spend against this funding stream is predicated on applications received by Local Authorities during the year. Given the increase in demand for DFG over recent years there is minimal risk to underspending on this funding stream.
- **(£47k) Under programmed in ICF Legacy PM Funding** – This underspend is in relation to funding carried forward for the Strategic Needs Assessments – Gwent, of which there is currently no spend plan in place.

- **£406k Overspend is forecasted in the IRCF Capital Programme** – This is in relation to the Newport East Health & Wellbeing Centre. This risk will continue to be monitored and reviewed with ABUHB and opportunities to seek further funding WG are in progress.
- **(£68k) Under programmed in IRCF Revenue – Capital Resource Funding** – This underspend is currently unallocated and will be lost as a region if no spend plan is considered for this financial year.
- **(£219k) Under programmed in IRCF Revenue – Strategic Capital Funding** – This forecast currently reflects the commitments that were awarded in the plan for 2024/25. However, there are certain schemes that did not progress in 23/24 which may affect the 24/25 allocations and will be reviewed for Month 2.

Similarly to the IRCF Capital Resource Funding, there is also an element of underspend that is currently unallocated which will be lost as a region if no spend plan is considered for this financial year.

Table 2. 2024/25 Housing with Care Fund (HCF) – Major Schemes

Project Name	Delivery Org.	Locality	Strategic Partner	ICPG Approval Date	Strategic Partnership Approval Date	RPB Approval Date	WG Award Date	2024/25 HCF Forecast £	Comments
Crisis Sanctuary Accommodation, Children, NCC, Caerleon	ABUHB	CCBC	C&F	16/06/2022	12/09/2022	15/11/2022	18/05/2023	975,000	Healthboard CRL uplifted with the allocation. Due to be completed in the Autumn 2024.
MH Supported Housing, Mental Health, MCC,	MHA	MCC	MH&LD	16/06/2022	14/02/2023	14/03/2023	pending	666,614	MCC currently progressing with an alternative site.
Rhymney LD Scheme, Learning Disabilities, CBCC, Rhymney	FCHA	CCBC	MH&LD	16/08/2022	23/02/2023	14/03/2023	pending	361,000	This scheme was undeliverable in 23/24 due to delays with the SAB approval. Still awaiting approval.
30 Stow Park Avenue, Children, NCC, Newport	Action For Children	NCC	C&F	20/10/2022	01/03/2023	11/03/2023	pending	1,071,620	Application has been submitted to WG and technical scrutiny has been obtained. Awaiting WG approval.
Childrens Residential Home - complex needs BGCBC	BGCBC	BGCBC	C&F	16/08/2022	12/09/2022	15/11/2022	pending	867,455	Tenders have been received and additional funding is required. An NOE is due to be submitted prior to seeking further RPB and WG approval.
Dual Diagnosis Ty Rhos, Mental Health, CCBC	UWHA	CCBC	MH&LD	15/09/2022	23/02/2023	17/07/2023	pending	725,000	Delivery partner currently in discussions with landowner for acquisition of site.
Solo Placement The Firs & Ty Heulog, Children, CBCC, Cefn Fforest	CCBC	CCBC	C&F	17/11/2022	01/03/2023	14/03/2023	pending	603,338	Awaiting an award letter from WG for phase 2 of the project in 24/25
Homeleigh, Childrens, CCBC, Newbridge	CCBC	CCBC	C&F	17/11/2022	01/03/2023	17/07/2023	pending	1,310,000	Purchase of the property was unable to complete in 23/24 due to complications with legal ownership. The full £1.31m was re-profiled into 24/25 whilst discussions are still on-going.
Caerphilly Children's Home - Rhymney College site	CCBC	CCBC	C&F	01/02/2023	01/03/2023	17/07/2023	pending	618,963	This project was not deliverable in 23/24 and was re-profiled into 24/25. Discussions are still on-going between the asset owner and planning.

Bungalows Crick Road, Complex Needs, MCC, Portskewett	Melin Homes	MCC	GASP	16/08/2022	20/10/2022	15/11/2022	pending	251,494	This scheme was unable to enter into contract in 23/24 and was re-profiled into 24/25. Due to enter into contract by the end of June 2024.
Cambridge House, Children, NCC, Newport	FCHA	NCC	C&F	16/08/2022	12/09/2022	15/11/2022	pending	958,182	Delays to the commencement date in 23/24 led to £958k to be re-profiled into 24/25.
Transitional Accommodation Stanley Road, Children, NCC, Newport	POBL	NCC	C&F	N/A	05/02/2024	12/02/2024	pending	648,030	This scheme was awarded by WG in 23/24, however planning permission was not obtainable by the end of the financial year, therefore the full £648k was re-profiled into 24/25
LAC 1 - 216 Stow Hill, Children, NCC, Newport	UWHA	NCC	C&F	N/A	05/02/2024	12/02/2024	pending	508,293	Property was acquired in 23/24. Invitations to tenders for the refurbishment is due to take place by the end June 24.
LAC 2 - 47 Llanthewy Road, Children, NCC, Newport	UWHA	NCC	C&F	N/A	05/02/2024	12/02/2024	pending	508,293	Property was acquired in 23/24. Invitations to tenders for the refurbishment is due to take place by the end June 24.
Step down accommodation, Mental Health, CBCC/NCC, Newport/Caerphilly	POBL	NCC	MH&LD	29/01/2024	09/02/2024	12/02/2024	pending	86,000	Further engagement needed with WG on the utilisation of the remaining funding.
Pre 16 Childrens Residential Home, Children, MCC, Llanfoist	MCC	MCC	C&F	29/01/2024	09/02/2024	12/02/2024	pending	300,000	Awaiting update on tender timescales.
Independent Living Pod, Children, TCBC, Abersychan	TCBC	TCBC	MH&LD	15/06/2023	31/01/2024	19/04/2024	pending	169,988	An NOE for further funding was received and approved by RPB. Further engagement needed with Myst and WG
Total Forecast for Major Schemes Approved by RPB								10,629,270	
24/25 HCF Major Funding								9,350,405	
24/25 HCF Major – (Surplus Funding)/Overprogrammed								1,278,865	

Table 3. 2024/25 Housing with Care Fund (HCF) – Minor Schemes

Project Name	Delivery Organisation	Strategic Partnership	ICPG Approval Date	Strategic Partnership Approval Date	RPB Approval Date	Award Letter Issued	2024/25 Funding Utilisation Forecast £	Comments
Minor Adaptations (EMAS) Care & Repair - Gwent	Care and Repair	GASP	16/06/2022	20/10/2022	15/11/2022	pending	100,000	Awaiting confirmation of deliverability and funding availability.
Mardy Park Pavilion, Complex Needs, MCC, Abergavenny	MCC	GASP	19/08/2022	20/10/2022	15/11/2022	pending	90,050	Awaiting confirmation of deliverability and funding availability.
Building Extension, Older Adults, MCC, Wyesham	Melin Homes	GASP	19/08/2022	20/10/2022	14/03/2023	pending	100,000	Awaiting confirmation of deliverability and funding availability.
Pilmawr Gardens, Mental Health, NCC, St Cadocs	ABUHB	MH&LD	15/09/2022	23/02/2023	30/01/2024	pending	100,000	NOE requesting additional funding was approved in Jan 24. Awaiting confirmation of deliverability and funding availability.
Annwylfan, Mental Health, CCBC, Ystrad Mynach	ABUHB	MH&LD	20/10/2022	06/12/2023	30/01/2014	pending	100,000	NOE requesting additional funding was approved in Jan 24. Awaiting confirmation of deliverability and funding availability.
Cedar Parc, Mental Health, BGCBC, Ebbw Vale	ABUHB	MH&LD	20/10/2022	23/02/2023	17/07/2023	pending	50,000	Awaiting confirmation of deliverability and funding availability.
Specialist Childrens Beds, Children, Gwent, All	ABUHB	C&F	01/02/2023	01/03/2023	14/03/2023	pending	50,000	Awaiting confirmation of deliverability and funding availability.
Ty Clarence 111 Call Centre, Mental Health, TCBC, Pontypool	Melin Homes	MH&LD	01/02/2023	07/12/2023	30/01/2024	pending	20,000	NOE requesting additional funding was approved in Jan 24. Awaiting confirmation of deliverability and funding availability.
In2change, Children, NCC, Newport	Pobl	C&F	01/02/2023	26/07/2023	09/10/2023	pending	50,000	Awaiting confirmation of deliverability and funding availability.
Energlyn Childrens Centre, Childrens, CCBC, Energlyn	Action For Children	C&F	15/06/2023	13/11/2023	29/11/2023	pending	44,812	Awaiting confirmation of deliverability and funding availability.
Ty Ni & Ty Isaf, Children, CCBC, Penyrheol	CCBC	C&F	27/09/2023	13/11/2023	29/11/2023	pending	66,362	Awaiting confirmation of deliverability and funding availability.
ADL Bathroom Conversion, Children, NCC, Rogerstone	Action For Children	C&F	15/12/2024	05/02/2024	12/02/2024	pending	18,650	Awaiting confirmation of deliverability and funding availability.
Wesley Street Family Centre, Children, TCBC, Old Cwmbran	TCBC	C&F	27/09/2024	13/11/2023	29/11/2023	pending	95,000	Awaiting confirmation of deliverability and funding availability.
Llys-Y-Brenin, Learning Disabilities, MCC, Abergavenny	Melin Homes	GASP	27/09/2024	25/10/2023	29/11/2023	pending	64,700	Awaiting confirmation of deliverability and funding availability.
Project Name	Delivery Organisation	Strategic Partnership	ICPG Approval Date	Strategic Partnership Approval Date	RPB Approval Date	Award Letter Issued	2024/25 Funding Utilisation	Comments

							Forecast £	
Bron Afon Adaptations, Mixed Population, TCBC, All	Bron Afon Housing	C&F	27/09/2023	13/11/2023	29/11/2023	pending	20,000	Awarded in 23/24 but was unable to deliver. Awaiting confirmation of deliverability and funding availability.
SRP Care & Repair, Complex Needs, Gwent, All	Care and Repair	GASP	N/A	07/09/2024	09/10/2024	pending	90,000	Awaiting confirmation of deliverability and funding availability.
Total							1,059,574	
24/25 HCF Minor Funding							1,120,800	
24/25 HCF Minor - (Surplus Funding)/Overprogrammed							(61,226)	

Table 4. 2024/25 Disabled Facilities Grant (DFG) Funding Summary

DISABILITIES FUNDING GRANT (DFG) - By Local Authority	FUNDING AVAILABLE £	FUND UTILISATION FORECAST £	YEAR END (SURPLUS) / SHORTFALL £
Blaenau Gwent	112,080	0	(112,080)
Caerphilly	112,080	0	(112,080)
Monmouth	112,080	0	(112,080)
Newport	112,080	0	(112,080)
Torfaen	112,080	0	(112,080)
TOTAL GWENT CAPTIAL PROGRAMME	560,400	0	(560,400)

Table 5 – 2024/25 Integration Rebalancing Capital Fund

Integrated Capital and Rebalancing Fund Scheme	2022/23 ACTUAL £	2023/24 ACTUAL £	2024/25 FORECAST £	TOTAL FORECAST £	TOTAL FUNDING ALLOCATED £	FORECAST D (SURPLUS)/ SHORTFALL £
Newport East Health & Wellbeing Centre	6,035,000	10,046,000	12,525,000	28,606,000	28,200,000	406,000
Monmouth Health and Wellbeing centre and Dixon Surgery	0	0	742,000	742,000	742,000	0
Aber Valley Health and Wellbeing Centre and Aber Practice	0	0	742,000	742,000	742,000	0
Total IRCF Capital Schemes	6,035,000	10,046,000	14,009,000	30,090,000	29,684,000	406,000

Given the limited uptake of IRCF funding nationally, WG have agreed to fully fund the Newport East Integrated Health & Wellbeing Centre to the total value of £28.200m, as profiled in Table 5 below.

The current completion date for this project is the 13th January 2025 and it currently is reporting an expected overspend of £406k. This risk will continue to be monitored and reviewed with ABUHB and opportunities to seek further funding WG are in progress.

In addition, funding has been awarded to for the Monmouth Health and Wellbeing Centre and Dixon Surgery and Aber Valley Health and Wellbeing Centre and Aber Practice as shown below.

Table 6 – 2024/45 ICF Legacy Programme Managed Fund Summary

Project Name	Delivery Organisation	Award Date	2024/25 ICF LEGACY PM FUNDS £	2024/25 FUNDING UTILISATION FORECAST £	YEAR END (SURPLUS)/ SHORTFALL £	COMMENTS
Childrens Residential Home - complex needs Rhymney	Caerphilly	17/10/2020	750,000	750,000	0	Planning application has been submitted and awaiting outcome before commencing the tender process.
Strategic Needs Assessments - Gwent	PMO	01/01/2022	46,645	0	(46,645)	No spend plan
Transitional Accommodation	POBL	17/10/2020	469,560	469,560	0	Delays due to accessibility to the existing property meant there were delays to the project in 23/24.
TOTAL LEGACY ICF CAPTIAL PROGRAMME MANAGED FUNDS (PM)			1,266,205	1,219,560	(46,645)	

GWENT REGIONAL PARTNERSHIP BOARD (RPB)

REVENUE FINANCIAL UPDATE

Month 1 (End of April 2024/25)

Report Author: Bethan Vong, Partnership PMO

Accountable Officer: Chris Commings, ABUHB

EXECUTIVE SUMMARY

CURRENT POSITION

- **As at the end of Month 1, there is a funding surplus of £3.38m identified, £3.24m of funding is awaiting confirmation of approved spend plans, whilst £91k has been reported as slippage.**
- £58k of the slippage is driven by an OT vacancy forecasted for Hospital Discharge Co-ordination in Monmouthshire, £19k from D2RA in Monmouthshire, £7k from Enhanced intermediate Care and £7k from the System Resilience Plan (SRP).
- The following spend plans are needed to support the schemes included within the £3.24m:
 - **£674k RIF Revenue Programme** – RPB have agreed to focus this funding on support initiatives within the Children and Families programme and the Welsh Community Care Information System (WCCIS). The Children and Families Strategic Partnership Board Strategic Partnership Board is currently exploring potential opportunities and are next meeting on 15th July 2024, whilst further details relating to WCCIS is being collated and reviewed by the Health Board and Local Authorities, with a view to providing an update in Month 2.
 - **£165k Dementia** – A potential spend plan has been submitted to the Dementia Board and are due to review the business case on the 5th June 2024.
 - **£247k Short Breaks for Unpaid Carers** – The Carers Strategic Partnership Board will be conducting a virtual review of the Bridging the Gap spend plan for 2024/25 in June 2024.
 - **£191k Unpaid Carers Hospital Discharge Engagement** – The Carers Strategic Partnership Board will be conducting a virtual review of the pilot schemes in June 2024.
 - **£1.05m Further Faster** - The Nursing Task and Finish Group are currently finalising spend plans for the nursing elements whilst the PMO team are facilitating plans for the Third Sector Fund. Further information will be available within the Month 2 update.
- **£2.294m of RIF Revenue funding was delegated to the Gwent Adult Strategic Partnership Board (GASP) to support the delivery of the 2024-25 System Resilience.** GASP will continue to review and monitor the SRP with potential spend plans ready to off-set any slippage identified.

DECISIONS REQUIRED

- None

RECOMMENDATIONS.

- The Regional Partnership Board is asked to note the **£3.24m of spend plans required above to maximise funding utilisation in 2024/25.**

1.0 24/25 RPB Revenue Programme Financial Position

- 1.1 The Regional Partnership Board has a total funding allocation of £30.47m for 2024/25, as shown in Table 1 below. This is a £50k increase from the £30.42m recently reported in the 2024/25 update due to reclaimed funds identified post year-end for 2023/24

As at the end of Month 1, there is a funding surplus of £3.38m identified, £3.2m of funding is awaiting confirmation of approved spend plans, whilst £91k has been reported as slippage.

£58k of the slippage is driven by an OT vacancy forecasted for Hospital Discharge Co-ordination in Monmouthshire, £19k from D2RA in Monmouthshire, £7k from Enhanced intermediate Care and £7k from the System Resilience Plan (SRP).

Please note that the Gwent Adult Strategic Partnership Board (GASP) will continue to review and monitor the SRP and potential spend plans to off-set the slippage identified.

Table 1. 2024/25 Gwent RPB Revenue Programme by Funding Stream

2024-25 GWENT REGIONAL PARTNERSHIP REVENUE PROGRAMME BY FUNDING STREAM		24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
RIF REVENUE	RIF Revenue Programme	20,709,110	20,025,064	(684,046)
	System Resilience Plan	2,293,948	2,287,134	(6,814)
	RIF Programme Support	280,782	280,782	0
	Regional Infrastructure Fund	750,000	675,998	(74,002)
	Reclaimed Funds from 2023/24	11,572	0	(11,572)
	TOTAL RIF MAIN REVENUE PROGRAMME	24,045,412	23,268,978	(776,434)
RING-FENCED FUNDS	Dementia	1,611,000	1,445,274	(165,726)
	Integrated Autism Service	571,286	571,286	0
	Memory Assessment Services	565,000	564,999	(0)
	Short Breaks for Unpaid Carers	247,269	0	(247,269)
	Unpaid Carers Hospital Discharge	191,000	0	(191,000)
	Unpaid Carers Hospital Discharge Reclaimed	37,265	0	(37,265)
	TOTAL RING-FENCED FUNDS	3,222,820	2,581,559	(641,260)
ADDITIONAL FUNDING	Neurodivergence Improvement Programme	912,418	0	(912,418)
	Further Faster	2,292,000	1,240,084	(1,051,916)
	TOTAL ADDITIONAL FUNDING	3,204,418	1,240,084	(1,964,334)
TOTAL RIF REVENUE POSITION		30,472,650	27,090,621	(3,382,028)

List below are the allocations that are currently awaiting approved spend plans for this financial year, as previously reported:

- **£674k RIF Revenue Programme** – RPB have agreed to focus this funding on support initiatives within the Children and Families programme and the Welsh Community Care Information System (WCCIS). The Children and Families Strategic Partnership Board Strategic Partnership Board is currently exploring potential opportunities and are next meeting on 15th July 2024, whilst further details relating to WCCIS is being collated and reviewed by the Health Board and Local Authorities, with a view to providing an update in Month 2.
- **£165k Dementia** – A potential spend plan has been submitted to the Dementia Board, who are due to review the business case on the 5th June 2024.

- **£247k Short Breaks for Unpaid Carers** – The Carers Strategic Partnership Board will be conducting a virtual review of the Bridging the Gap spend plan for 2024/25 in June 2024.
- **£191k Unpaid Carers Hospital Discharge Engagement** – The Carers Strategic Partnership Board will be conducting a virtual review the outcome of the pilot schemes in June 2024.
- **£1.05m Further Faster** - The Nursing Task and Finish Group are currently finalising spend plans for the nursing elements whilst the PMO team are facilitating plans for the Third Sector Fund. Further information will be available within the Month 2 update.

2.0 2024/25 Gwent System Resilience Plan (SRP)

To support the delivery of the system resilience plan (SRP), £2.294m of funding was delegated to the Gwent Adult Strategic Partnership Board (GASP), whilst a further £590k was approved to support the Hospital to a Healthier Home and GWICES equipment, pending funding availability.

At the end of Month 1, the SRP reported slippage to £7k due to slippage with the ED Resettlement Scheme delivered by the British Red Cross. Further details of the schemes are shown below in Table 2.

As mentioned above, the Gwent Adult Strategic Partnership Board (GASP) will continue to review and monitor the SRP and potential spend plans to off-set the slippage reported.

There are four potential spend plans currently identified, which are included at the bottom of Table 2. These schemes are currently awaiting a mid-point evaluation and funding availability. These schemes include:

- **£90k Hospital to a Healthier Home (Equipment)** – awaiting funding availability
- **£500k GWICES (Equipment)** – awaiting funding availability
- **£21k Cariatad Beds** – awaiting funding availability
- **£TBC MH Practitioner & WAST Response** – pilot awaiting evaluation

As part of the 18-month plan, GASP committed to undertaking a mid-point evaluation to consider the continuation of activity for 2024/25.

Table 2 – 24/25 System Resilience Plan Financial Summary

Gwent System Resilience Plan 2024/25 (Led by GASP)	Lead Provider	24/25 RPB Allocation £	24/25 Forecast M01 £	24/25 Slippage M01 £
SCTH Early facilitator discharge	ABUHB	443,592	443,592	0
Step Closer to Home	ABUHB	563,217	563,217	0
CRT Pharmacy	ABUHB	349,126	349,126	0
YYF Trusted Assessor - Stroke Pathway	LA	44,000	44,000	0
GWICES (Staff Support)	LA	40,000	40,000	0
BRC - ED Resettlement	Third Sector	286,468	279,654	(6,814)
Hospital to healthier home (Staff Support)	Third Sector	34,464	34,464	0
Falls Response	WAST	463,081	463,081	0
Rebalancing Rights & Responsibilities	Workforce	70,000	70,000	0
Total Gwent System Resilience Plan Total Funding		2,293,948	2,287,134	(6,814)
Potential Schemes (Pending Evaluation and Funding Availability)		£	£	£
GWICES (Equipment)	LA	500,000	0	(500,000)
Hospital to healthier home (Equipment)	LA	90,000	0	(90,000)
MH Practitioner & WAST Response	ABUHB	TBC	TBC	TBC

Cariad Bed	LA	21,000	0	(21,000)
Total of Potential Schemes Pending Evaluation/Funding Availability		611,000	0	(611,000)

3.0 2024/25 Ring-Fenced Funds

As mentioned above, the below ring-fenced funding streams are currently awaiting approved spend plans for this financial year:

- **£165k Dementia** – A potential spend plan has been submitted to the Dementia Board, who are due to review the business case on the 5th June 2024.
- **£247k Short Breaks for Unpaid Carers** – The Carers Strategic Partnership Board will be conducting a virtual review of the Bridging the Gap spend plan for 2024/25 in June 2024.
- **£191k Unpaid Carers Hospital Discharge Engagement** – The Carers Strategic Partnership Board will be conducting a virtual review the outcome of the pilot schemes in June 2024.

4.0 Additional Funding Streams

4.1 2024/25 Neurodivergence Improvement Programme (NDIP)

To support the continued developments of the Neurodivergence Improvement Programme, the Welsh Government (WG) awarded the region £912k for 2024/25, as shown in Table 3 below.

Plans have not yet been finalised as the proposals currently exceed the funding available. The Integrated Autism and ND Steering Group initially reviewed the proposals on the 20th May 2024, with a follow-up review due to take place on the 11th June 2024.

Table 3 – 2024/25 Neurodivergence Improvement Programme Funding Summary

Neurodivergence Improvement Programme (NDIP) Funding Allocation	22/23 £	23/24 £	24/25 £
Allocation A - To build greater sustainability and capacity to existing neurodivergence services for children and adults.	268,604	268,604	268,604
Allocation B - To bring additional capacity to existing services and for local scoping and piloting of innovative approaches to deliver wider neurodivergence services that are integrated and enable access to pre and post diagnostic support		451,915	643,814
Total NDIP Funding	268,604	720,519	912,418

4.2 2024/25 Further Faster Funding

Further Faster Funding of £2.29m has also been awarded for 24/25. Similarly to 23/24, WG has provided indicative allocations against the following priority areas:

- **£0.55m** for Weekend Community Nursing
- **£0.14m** for Weekend/Bank Holiday Specialist Palliative & End of Life Care Nursing

- **£0.45m** for Anticipatory Care Planning for 0.5% People Most at Risk of Urgent Care
- **£1.15m** for Community Capacity

£2.29m Further Faster Funding for 24/25

Following the recent RPB approval of the Further Faster Update for 24/25, Table 4 below summarises the funding allocations which highlight that £1.05m of funding is currently awaiting confirmation of spend plans.

The Nursing Task and Finish Group are currently finalising spend plans for the nursing elements whilst the PMO team are facilitating plans for the Social Value Sector Fund.

RLG will continue to monitor and manage this funding stream throughout the year.

Table 4. 24/25 Further Faster Financial Summary

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Weekend Community Nursing	ABUHB - Nursing	550,000	0	(550,000)
Weekend Palliative & End of Life Nursing	ABUHB - Nursing	140,000	0	(140,000)
Acute Frailty Response/ CRT	ABUHB - PCCS	873,528	873,528	0
CRT Monmouthshire	ABUHB - PCCS	366,556	366,556	0
Social Value Sector Fund	Central	359,916	0	(359,916)
TOTAL FURTHER FASTER		2,290,000	1,240,084	(1,049,916)

5.0 Social Value Sector

Table 5 below shows the position relating to the Social Value Sector allocation. It provides an update in relation to:

- 1) **RIF Revenue Funding Only** – This is monitored by Welsh Government with an expected minimum allocation of 20% to the social value sector partners, which excludes the RIF Infrastructure Fund and Ring-Fenced Funds.

As at month 1, 18% of RIF Revenue funds re allocated to social value sector partners.

- 2) **Total Revenue Funding** – This includes all funding streams and is included for information

Table 5. 24/25 Social Value Sector Investment Summary

24/25 Social Value Sector Investment	WG ALLOCATION £	WG MIN. 20% £	AS AT M01 £	ALLOCATION POSITION £	ALLOCATION %
1) RIF Revenue Funding Only (As monitored by WG)	23,283,840	4,656,768	4,169,900	(486,868)	18%
2) Total Revenue Funding (incl. ring- fenced and additional funds)	30,472,650	6,094,530	4,406,691	(1,687,839)	14%

6.0 Carers

Table 6 below shows the position relating to the allocation for Carers. It provides an update in relation to:

- 1) **RIF Revenue Funding Only** – This is monitored by Welsh Government with an expected minimum allocation of 5% to Carers, which excludes the RIF Infrastructure Fund and Ring-Fenced Funds.

As at month 1, 6% of RIF Revenue funds re allocated to Carers.

- 2) **Total Revenue Funding** – This includes all funding steams and is included for information

Table 6. 24/25 Carers Investment Summary

24/25 Carers Investment	WG ALLOCATION £	WG MIN. 20% £	AS AT M01 £	ALLOCATION POSITION £	ALLOCATION %
1) RIF Revenue Funding Only (<i>As monitored by WG</i>)	23,283,840	4,656,768	4,169,900	(486,868)	18%
2) Total Revenue Funding (<i>incl. ring-fenced and additional funds</i>)	30,472,650	6,094,530	4,406,691	(1,687,839)	14%

7.0 Welsh Government Resource Match Update

The introduction of match funding and tapering as part of the RIF funding model was in response to learning from previous programmes and was intended to support the longer-term sustainability of these models of care. However, since its inception, the financial landscape within which the RIF is situated has shifted significantly. In recognition of the difficult financial landscape and system pressures, Ministers have agreed to the remove tapering from the RIF.

However, the requirement to provide match resources still remains. To build on the momentum and good work done in the first two years of the RIF, the RPB is expected to continue identifying, aligning and reporting on the match resources secured. This is to ensure that the region continue to realign resource within the system in a way that enables effective community care, help people to live and stay well at home and prevent or reduce the need for hospital admission.

An exercise to review the resource match requirement will be carried out with delivery partners, in line with project evaluations.

8.0 Frailty

The initial 2024/25 Frailty update will be available after quarter 1, in July 2024.

9.0 Appendices

Appendix 1. 24/25 Slippage Tracker

Project Name	Provider	Slippage Reported M01
Enhanced Intermediate Care	Monmouthshire County Council	(£6,827)
SRP ED Resettlement Scheme	British Red Cross	(£6,814)
Hospital Discharge Co-ordination - Monmouthshire	Monmouthshire County Council	(£58,376)
D2RA - Monmouthshire	Monmouthshire County Council	(£18,638)
Other Slippages		(£117)
Total 24/25 In Year Revenue Slippage		(£90,772)

Appendix 2. 24/25 Forecast by Strategic Partnership & Programme

STRATEGIC PARTNERSHIP	PROGRAMME	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
All	SP09 Assistive Technology	313,895	313,893	(2)
Carers	SP01 Support for Unpaid Carers	1,849,384	1,373,850	(475,534)
Children & Families	SP02 Children's Early Intervention & Resilience	3,003,381	3,003,381	0
	SP04 Children's Emotional Health & Development	1,756,193	1,756,190	(3)
	SP05 Workforce Development	200,871	200,871	0
Dementia Board	SP06 Dementia: Assessment & Diagnosis	854,104	854,099	(4)
	SP07 Dementia: Living with Dementia	1,361,750	1,361,749	(1)
GASP	SP11 Improving System Flow	4,737,489	4,653,648	(83,841)
	SP10 Place Based Graduated Care	5,504,057	5,497,166	(6,891)
	SP08 Prevention & Wellbeing	3,879,163	3,879,137	(26)
	SP05 Workforce Development	370,000	370,000	0
MH&LD	SP08 Prevention & Wellbeing	195,250	195,250	0
	SP12 Neurodivergent & Learning Disabilities Improvement Programme	1,434,523	1,434,523	0
Regional Resource	Regional Resource	956,780	956,780	0
Further Faster	Further Faster	2,292,000	1,240,084	(1,051,916)
Unallocated	Unallocated	1,752,238	0	(1,752,238)
Reclaimed Funds	Reclaimed Funds	11,572	0	(11,572)
TOTAL REVENUE PORTFOLIO		30,472,650	27,090,622	(3,382,028)

Appendix 3. 24/25 Forecast by Partner Organisation

LEAD PROVIDER	PARTNER ORGANISATION	PARTNER ORGANISATION	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
HEALTH	ABUHB - CHC	ABUHB COMPLEX CARE	1,073,014	1,072,949	(65)
HEALTH	ABUHB - Corp Nursing	ABUHB CORPORATE NURSING	323,048	323,046	(2)
HEALTH	ABUHB - Corp Public Health	ABUHB PUBLIC HEALTH	993,476	993,476	0
HEALTH	ABUHB - Corp Workforce	ABUHB WORKFORCE	300,000	299,998	(2)
HEALTH	ABUHB - E&F	ABUHB ESTATES & FACILITIES	109,200	109,200	0
HEALTH	ABUHB - F&T	ABUHB FAMILY & THERAPIES	1,993,006	1,993,003	(3)
HEALTH	ABUHB - MH&LD	ABUHB MENTAL HEALTH & LEARNING DISABILITIES	1,775,775	1,775,775	0
HEALTH	ABUHB - PCCS	ABUHB PRIMARY CARE & COMMUNITY SERVICES	5,327,377	5,327,374	(3)
HEALTH	ABUHB - SCH	ABUHB SCHEDULED CARE	99,962	99,958	(4)
LOCAL AUTHORITY	Blaenau Gwent County Borough Council	BLAENAU GWENT LOCAL AUTHORITY	1,333,036	1,333,036	0
LOCAL AUTHORITY	Caerphilly County Borough Council	CAERPHILLY LOCAL AUTHORITY	2,377,400	2,377,400	0
LOCAL AUTHORITY	Monmouthshire County Council	MONMOUTHSHIRE LOCAL AUTHORITY	2,278,270	2,194,428	(83,842)
LOCAL AUTHORITY	Newport City Council	NEWPORT LOCAL AUTHORITY	3,849,073	3,849,069	(4)
LOCAL AUTHORITY	Torfaen County Borough Council	TORFAEN LOCAL AUTHORITY	1,829,996	1,829,992	(4)
WAST	WAST	WAST	463,081	463,079	(2)
THIRD SECTOR	THIRD SECTOR	THIRD SECTOR	3,235,943	3,229,106	(6,837)
PMO	PMO	PMO	442,816	442,816	0
CENTRAL	CENTRAL	CENTRAL	3,908,260	617,000	(3,291,260)
TOTAL REVENUE PORTFOLIO			31,712,734	28,330,705	(3,382,028)

Appendix 4. 24/25 Support for Unpaid Carers – SP01/UC

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Bridging the Gap Gwent	Central	247,269	0	(247,269)
Carers Support - Blaenau Gwent	Blaenau Gwent County Borough Council	102,272	102,272	0
Carers Support - Caerphilly	Caerphilly County Borough Council	127,015	127,015	0
Expanded Carers Small Grants Scheme	Adferiad	63,000	63,000	0
Expanded Carers Small Grants Scheme	Central	63,000	63,000	0
Hub & Spoke	Adferiad	123,000	123,000	0
Hub & Spoke	Central	253,000	253,000	0
Young Carers in School Accreditation - Monmouthshire	Central	40,000	40,000	0
Carers Café	Adferiad	104,386	104,386	0
Carers Support - Monmouthshire	Monmouthshire County Council	96,146	96,146	0
Carers Support - Newport	Newport City Council	109,608	109,608	0
Carers Support - Torfaen	Torfaen County Borough Council	101,423	101,423	0
UNPAID CARERS - PROJECT STAFF, Young Carers and Regional Engagement & Events	Central	191,000	191,000	0
Unallocated - Unpaid Carers	Central	191,000	0	(191,000)
TOTAL SUPPORT FOR UNPAID CARERS PROGRAMME		1,812,119	1,373,850	(438,269)

Appendix 5. 24/25 Children's Early Intervention & Resilience Programme SP02/CEPR

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Skills For Living	Action for children	200,000	200,000	0
Enhanced Edge of Care - Blaenau Gwent	Blaenau Gwent County Borough Council	124,847	124,847	0
Family Group Conferences - Blaenau Gwent	Blaenau Gwent County Borough Council	77,694	77,694	0
Mediation Support - Blaenau Gwent	Blaenau Gwent County Borough Council	34,847	34,847	0
SGO Support - Blaenau Gwent	Blaenau Gwent County Borough Council	135,521	135,521	0
Enhanced Edge of Care - Caerphilly	Caerphilly County Borough Council	324,551	324,551	0
Family Group Conferences - Caerphilly	Caerphilly County Borough Council	190,530	190,530	0
Mediation Support - Caerphilly	Caerphilly County Borough Council	100,000	100,000	0
SGO Support - Caerphilly	Caerphilly County Borough Council	258,532	258,532	0
Enhanced Edge of Care - Monmouthshire	Monmouthshire County Council	169,140	169,140	0
Family Group Conferences - Monmouthshire	Monmouthshire County Council	34,835	34,835	0
Mediation Support - Monmouthshire	Monmouthshire County Council	34,835	34,835	0
SGO Support - Monmouthshire	Monmouthshire County Council	120,957	120,957	0
Enhanced Edge of Care - Newport	Newport City Council	276,088	276,088	0
Family Group Conferences - Newport	Newport City Council	108,448	108,448	0
Mediation Support - Newport	Newport City Council	79,172	79,172	0
SGO Support - Newport	Newport City Council	272,568	272,568	0
Enhanced Edge of Care - Torfaen	Torfaen County Borough Council	161,148	161,148	0
Family Group Conferences - Torfaen	Torfaen County Borough Council	110,128	110,128	0
Mediation Support - Torfaen	Torfaen County Borough Council	61,432	61,432	0
SGO Support - Torfaen	Torfaen County Borough Council	128,108	128,108	0
TOTAL CHILDREN'S EARLY INTERVENTION & RESILIENCE PROGRAMME		3,003,381	3,003,381	0

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Integrated Assessment And Planning (ISCAN / IAP Pilot)	ABUHB - F&T	269,589	269,589	0
Children's Centre Psychology	ABUHB - F&T	174,414	174,414	0
Intensive Positive Behavioural Support	ABUHB - F&T	200,000	200,000	0
SPACE Wellbeing	ABUHB - F&T	111,423	111,423	0
Family Intervention Team (FIT)	Action for children	663,787	663,787	0
Family Intervention Team (FIT)	ABUHB - F&T	154,200	154,200	0
Platform 4YP	Platform	182,780	182,780	0
TOTAL CHILDREN'S EMOTIONAL HEALTH & DEVELOPMENT PROGRAMME		1,756,193	1,756,193	0

Appendix 7. 24/25 Workforce Development SP05/WD

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
SRP Rebalancing Rights & Responsibilities	Central	70,000	70,000	0
Wellbeing Workforce	ABUHB - Corp Workforce	300,000	300,000	0
Gwent Attachment Service (GAS)	ABUHB - F&T	200,871	200,871	0
TOTAL WORKFORCE DEVELOPMENT PROGRAMME		570,871	570,871	0

Appendix 8. 24/25 Dementia: Assessment & Diagnosis Programme SP06/DAP/AD

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Dementia Programme Manager	ABUHB - Corp Nursing	27,774	27,774	0
MAS: Advance Nurse Practitioners	ABUHB - MH&LD	315,325	315,325	0
MAS: Audiology MDT approach	ABUHB - SCH	99,962	99,962	(0)
MAS: Consultant Capacity	ABUHB - MH&LD	149,712	149,712	0
Memory Rehabilitation	ABUHB - MH&LD	261,330	261,330	0
TOTAL DEMENTIA: ASSESSMENT & DIAGNOSIS PROGRAMME		854,104	854,103	(0)

Appendix 9. 24/25 Dementia: Living Well With Dementia Programme SP07/DAP/LwD

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Mapping, Education and Carers Service (MECS) Behavioural Support Team (BST)	ABUHB - MH&LD	205,579	205,579	0
Mapping, Education and Carers Service (MECS) Behavioural Support Team (BST)	ABUHB - MH&LD	117,271	117,271	0
Dementia Connect	Alzheimers Society	219,957	219,957	0
Dementia Programme Manager	ABUHB - Corp Nursing	27,774	27,774	0
Early Intervention Dementia Reablement Services - Blaenau Gwent	BGCBC	136,317	136,317	0
Early Intervention Dementia Reablement Services - Caerphilly	CCBC	136,317	136,317	0
Early Intervention Dementia Reablement Services - Monmouthshire	MCC	136,317	136,317	0
Early Intervention Dementia Reablement Services - Newport	NCC	136,317	136,317	0
Early Intervention Dementia Reablement Services - Torfaen	TCBC	136,317	136,317	0
Shared Lives Dementia	CCBC	92,750	92,750	0
Support For Those With Early On-Set Dementia	Hospice of The Valley	16,834	16,834	0
TOTAL DEMENTIA:LIVING WELL WITH DEMENTIA PROGRAMME		1,361,750	1,361,750	0

Appendix 10. 24/25 Prevention & Wellbeing Programme SP08/P&W

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Gwent Advocacy to Access (GATA)	BGCBC	115,000	115,000	0
Community Car Scheme & Befriending Service	Bridges Centre	221,330	221,330	0
Community Connectors - Caerphilly	CCBC	353,146	353,146	0
Community Co-Ordinators - Newport	NCC	135,013	135,013	0
Community Co-Ordinators - Torfaen	TCBC	97,115	97,115	0
Community Support - Monmouthshire	MCC	343,944	343,944	0
Compassionate Communities Hub Capacity - Newport	ABUHB - PCCS	207,805	207,805	0
SRP Falls Response	WAST	463,081	463,081	0
Community Prevention Programme - Blaenau Gwent	BGCBC	142,471	142,471	0
Integrated Wellbeing Networks (IWN)	ABUHB - Corp Public Health	656,426	656,426	0
Preventing & Mitigating Sightloss	Sightloss Cymru	35,400	35,400	0
Small Grants Fund - Blaenau Gwent IPB	GAVO	100,000	100,000	0
Small Grants Fund - Caerphilly IPB	GAVO	100,000	100,000	0
Small Grants Fund - Monmouthshire IPB	GAVO	100,000	100,000	0
Small Grants Fund - Newport IPB	GAVO	100,000	100,000	0
Small Grants Fund - Torfaen IPB	TVA	100,000	100,000	0
Health Inclusion Service	ABUHB - PCCS	217,084	217,084	0
Falls Response Unit	ABUHB - PCCS	391,348	391,348	0
Additional support for primary care mental health team	ABUHB - PCCS	45,000	45,000	0
Gwent Emotional and Mental Wellbeing Programme	ABUHB - Corp Public Health	150,250	150,250	0
TOTAL PREVENTION & WELLBEING PROGRAMME		4,074,413	4,074,413	0

Appendix 11. 24/25 Assistive Technology Programme SP09/AT

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Community Technology Coach Pilot - Torfaen	Torfaen County Borough Council	43,740	43,740	0
SRP GWICES Support	Torfaen County Borough Council	40,000	40,000	0
Implementation of Better Care Project - Blaenau Gwent	Blaenau Gwent County Borough Council	46,031	46,031	0
Implementation of Better Care Project - Caerphilly	Caerphilly County Borough Council	46,031	46,031	0
Implementation of Better Care Project - Monmouthshire	Monmouthshire County Council	46,031	46,031	0
Implementation of Better Care Project - Newport	Newport City Council	46,031	46,031	0
Implementation of Better Care Project - Torfaen	Torfaen County Borough Council	46,031	46,031	0
TOTAL ASSISSTIVE TECHNOLOGY PROGRAMME		313,895	313,895	0

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Step Up-Down Beds/CARIAD - Blaenau Gwent	BGCBC	347,536	347,536	0
Community Night Support	MCC	287,154	287,154	0
SRP CRT Pharmacy	ABUHB - PCCS	349,126	349,126	0
CRT Pharmacy Project	ABUHB - PCCS	290,000	290,000	0
Early Discharge - Caerphilly	CCBC	185,430	185,430	0
Enhanced Intermediate Care	MCC	298,415	291,588	(6,827)
Fast Track / End of Life Dom Care	ABUHB - CHC	66,205	66,205	0
GP Alignment & HRAC delivery	ABUHB - PCCS	256,054	256,054	0
Hospital Admission Avoidance Project (HAAP)	ABUHB - PCCS	68,000	68,000	0
Infection Prevention & Control - Care Home In-reach	ABUHB - Corp Nursing	267,500	267,500	0
Neuro-Community Service	ABUHB - F&T	701,991	701,991	0
North Torfaen Integrated Hub Pilot	TCBC	378,323	378,323	0
Raglan Project	MCC	76,378	76,378	0
Shared Lives	CCBC	81,040	81,040	0
Speech & Language Therapy Community Capacity	ABUHB - F&T	180,518	180,518	0
SRP Step Closer to Home	ABUHB - CHC	563,217	563,156	(61)
Step Up-Down Beds - Newport	NCC	595,466	595,466	0
Step Up-Down Beds - Torfaen	TCBC	199,067	199,067	0
Step Up-Down Beds - Caerphilly	ABUHB - PCCS	117,629	117,629	0
Step Up-Down Beds - Caerphilly	CCBC	195,008	195,008	0
TOTAL PLACED BASED GRADUATED CARE PROGRAMME		5,504,057	5,497,169	(6,888)

Appendix 13. 24/25 Improving System Flow Programme SP11/FLOW

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Patient Flow - ABUHB	ABUHB - PCCS	258,004	258,004	0
D2RA - Blaenau Gwent	ABUHB - PCCS	123,877	123,877	0
SRP ED Resettlement Scheme	British Red Cross	286,468	279,654	(6,814)
D2RA - Caerphilly	CCBC	155,950	155,950	0
ED Wellbeing & Home Safe Service at GUH	British Red Cross	181,115	181,115	0
Grange University Hospital (GUH) Discharge Team	ABUHB - PCCS	303,282	303,282	0
Home First	NCC	1,799,418	1,799,418	0
Hospital to a Healthier Home	Care & Repair	173,361	173,361	0
Transport to Health Scheme	ABUHB - E&F	109,200	109,200	0
In-Reach Phase 3	NCC	50,000	50,000	0
Hospital Discharge Co-ordination - Monmouthshire	MCC	202,814	144,438	(58,376)
D2RA - Monmouthshire	MCC	219,344	200,706	(18,638)
D2RA - Newport	ABUHB - PCCS	95,200	95,200	0
Hospital Discharge Pathway from RGH - Newport	NCC	132,600	132,600	0
SRP SCTH Early Facilitator Discharge	ABUHB - CHC	443,592	443,592	0
D2RA - Torfaen	ABUHB - PCCS	124,800	124,800	0
SRP YYF Trusted Assessor - Stroke Pathway	CCBC	44,000	44,000	0
SRP Hospital to a Healthier Home	Care & Repair	34,464	34,464	0
TOTAL IMPROVING SYSTEM FLOW PROGRAMME		4,737,489	4,653,661	(83,828)

Appendix 14. 24/25 Neurodivergent & Learning Disabilities Improvement Programme SP12/NDLDIP

PROJECT	PROVIDER	24-25 RPB ALLOCATION £	24-25 FULL YEAR FORECAST £	FULL YEAR (SURPLUS)/ SHORTFALL £
Integrated Autism Service	ABUHB - MH&LD	571,286	571,286	0
My Day My Life	Monmouthshire County Council	51,000	51,000	0
My Mates	Monmouthshire County Council	160,960	160,960	0
No More Barriers	Growing Space	97,176	97,176	0
Reducing Health Inequalities	ABUHB - MH&LD	155,272	155,272	0
Safe Project - Male Pilot	Volunteering Matters	31,925	31,925	0
Transition - Blaenau Gwent	Blaenau Gwent County Borough Council	70,500	70,500	0
Transition - Caerphilly	Caerphilly County Borough Council	87,100	87,100	0
Transition - Newport	Newport City Council	108,344	108,344	0
Transition - Bridges	Bridges Centre	100,960	100,960	0
TOTAL NEURODIVERGENT & LEARNING DISABILITIES IMPROVEMENT PROGRAMME		1,434,523	1,434,523	0

Appendix 15: 24/25 Centrally Held Allocations

PROJECT	24-25 RPB ALLOCATION	24-25 FULL YEAR FORECAST	FULL YEAR (SURPLUS)/ SHORTFALL
	£	£	£
Bridging the Gap Gwent	247,269	0	(247,269)
Expanded Carers Small Grants Scheme	63,000	63,000	0
Hub & Spoke	253,000	253,000	0
Young Carers in School Accreditation - Monmouthshire	40,000	40,000	0
UNPAID CARERS - PROJECT STAFF, Young Carers and Regional Engagement & Events	191,000	191,000	0
SRP Rebalancing Rights & Responsibilities	70,000	70,000	0
Unallocated - Revenue	600,093	0	(600,093)
Unallocated - Revenue	74,002	0	(74,002)
Unallocated - Dementia	165,725	0	(165,725)
Unallocated - Unpaid Carers	191,000	0	(191,000)
Unallocated - Further Faster	1,051,916	0	(1,051,916)
Unallocated - ND Improvement Programme	912,418	0	(912,418)
Unpaid Carers Hospital Discharge Slippage from 2023/24	37,265	0	(37,265)
Reclaimed Funds	11,572	0	(11,572)
TOTAL ALLOCATION HELD CENTRALLY	3,908,260	617,000	(3,291,260)

Appendix 16: 24/25 Finance Monitoring Returns

Lead	Partner Organisation	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Health	ABUIHB - CHC												
Health	ABUIHB - Corporate												
Health	ABUIHB - F&T												
Health	ABUIHB - MH&LD												
Health	ABUIHB - PCCS												
Health	ABUIHB - Surgery												
Other	WAST												
Local Authority	Blaenau Gwent												
Local Authority	Caerphilly												
Local Authority	Monmouthshire												
Local Authority	Newport												
Local Authority	Torfaen												
Third Sector	Action for children												
Third Sector	Alzheimers Society												
Third Sector	Bridges Centre												
Third Sector	British Red Cross												
Third Sector	Care & Repair												
Third Sector	GAVO												
Third Sector	Growing Space												
Third Sector	Adferiad												
Third Sector	Hospice of The Valley												
Third Sector	Platform												
Third Sector	Sightloss Cymru												
Third Sector	TVA												
Third Sector	Volunteering Matters												
Third Sector	Age Cymru												

KEY

	Received On-Time
	Received Late
	Not Received

Joint Commissioning Committee

Joint Commissioning Committee Governance Framework

Dyddiad y Cyfarfod / Date of Meeting	25/09/2024
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Awdur yr Adroddiad / Report Author	Jacqui Maunder, Committee Secretary
Cyflwynydd yr Adroddiad / Report Presenter	Rani Dash, Director of Corporate Governance, on behalf of Jacqui Maunder, Committee Secretary
Noddwr yr Adroddiad / Report Sponsor	Ian Green, Chair of the JCC

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt /consideration at Committee/Group)		
Committee/Group/Individuals	Date	Outcome
Sub Committee Structure Chair of the JCC Chief Commissioner JCC SLT Working Group of NHS Wales DoCG / Board Secretaries SLT Development Day JCC Development Day NHS Wales Directors of Corporate Governance (DoCG) peer group NHS Wales Joint Commissioning Committee (JCC)	August 2024 17 September 2024	Noted Feedback has assisted in developing the drafts Endorsed
Hosting Agreement and Memorandum of Agreement Chief Commissioner DoCG / Board Secretary CTMUHB NHS Wales Directors of Corporate Governance (DoCG) peer group	06 September 2024	Noted Feedback has assisted in developing the drafts Endorsed

NHS Wales Joint Commissioning Committee (JCC)	17 September 2024	

Acronyms / Glossary of Terms	
JCC	NHS Wales Joint Commissioning Committee
LHB	Local Health Board
HBs	Heath Boards
SFI's	Standing Financial Instructions
SOs	Standing Orders
MoA	Memorandum of Agreement
DoCG	Directors of Corporate Governance
SoD	Scheme of Delegation
HA	Hosting Agreement
CTMUHB	Cwm Taf Morgannwg University Health Board
ToR	Terms of Reference
ARC	CTMUHB Audit and Risk Committee

1. SITUATION/BACKGROUND

The purpose of this report is to present an update on developing the final elements of the NHS Wales Joint Commissioning Committee’s (JCC) (*“Joint Committee”*) governance framework and to request that the 7 x Health Board (HB) Board meetings approve the documents at their September 2024 Board meetings.

In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework is reserved to HBs. On the 17 September 2024 the Joint Committee reviewed and endorsed the proposed sub-committee structure, the accompanying terms of reference, the hosting agreement (HA) and the memorandum of agreement (MoA) for submission to individual HB Board meetings in September 2024 for final approval.

This report and the accompanying documents were presented to the NHS Wales Directors of Corporate Governance (DoCG) peer group on 6 September 2024 and the documents were discussed and subsequently refined to reflect the advice and discussion, resulting in the final proposal presented to the Joint Committee for endorsement on 17 September 2024. The group supports the documents being presented to the HBs for final approval recognising that the documents will be kept under review with a formal review proposed in April 2025 following a full year of operation of the JCC to be conducted in partnership with HB DoCGs.

1.1 JCC Governance Framework

The Governance Framework for the JCC contains a number of key components which, combined, set out the legislative framework, constitution and ways of working for the JCC in its operations and handling of business. These documents

are an integral part of the wider governance framework of HBs and have been developed within that context.

The Governance Framework of the JCC contains the following and an update on each element is provided in **Figure 1** below.

Figure 1 – JCC Governance Framework



1.2 Standing Orders and Standing Financial Instructions

The 7 x HBs approved the JCC Standing Orders (SOs) and Standing Financial Instructions (SFIs) in March 2024, and the Joint Committee adopted the JCC Standing SO's and SFIs at its inaugural meeting on 8 April 2024, and they were included as a schedule to each of the Health Boards (HBs) own SOs and have effect as if incorporated within them.

The Joint Committee were advised that work was ongoing during the transition phase to finalise other elements of the governance framework including the Hosting Agreement (HA), the Memorandum of Agreement (MoA) and the Scheme of Delegation (SoD).

2. MEMORANDUM OF AGREEMENT (MoA)

To ensure the effective operation of the JCC as a Joint Committee, a MoA between all 7 x HBs has been established, which sets out the commitment and ways of working, including the agreed roles and responsibilities of the Chief Executive Officers of each constituent HB as individual officer members of the JCC. The MoA is presented at **Appendix 1** for approval by the 7 x HBs at the September HB Board meetings.

It is acknowledged that whilst the JCC continues to transition into the new organisation, work will continue to focus on ensuring clarity of role and relationship of the JCC with HBs as commissioners and providers, and with the newly formed NHS Executive.

The draft MoA is presented to the Board for approval noting a formal review will be undertaken in April 2025 in partnership with HB DoCGs.

3. HOSTING AGREEMENT (HA)

A HA between the Host Body Cwm Taf Morgannwg University Health Board (CTMUHB) and the six other HBs has been established to outline the accountability arrangements and resulting responsibilities of the Host Body and the JCC and its team. This is supported by an Interface Agreement between the Host Body Chief Executive Officer and the Chief Commissioner of the JCC Team, detailing the relationship and accountabilities of the two Officers given it is intended they both hold respective Accountable Officer responsibilities delegated by Welsh Government (WG).

During engagement on the development of the draft HA, it has been identified that further work is required to ensure clarity on roles and responsibilities of the JCC in relation to:

- The Handling of Concerns; and
- Consultation & Engagement relating to service change

Work has already commenced with the establishment of working groups with HB representation to develop protocols in relation to each of these areas. Engagement with DoCGs and other HB Executive leads will be essential in ensuring the processes are agreed and reflect the statutory responsibilities of the HBs and the role and delegations of the JCC.

Draft protocols will be developed and shared with DoCGs for review and comment prior to submission to the Joint Committee in November 2024. Subject to the detail and proposed approach, the protocols may then require an amendment to the Scheme of Delegation (SoD) which, if necessary, will be brought back to the Joint Committee for endorsement before final approval by HB Boards.

Noting the development of the supporting protocols described above, the HA is presented at **Appendix 2** for approval by the 7 x HBs at the September HB Board meetings.

4. PROPOSED JCC SUB-COMMITTEE STRUCTURE

Section 5.5 of the JCC SO's stipulate that the Joint Committee may and, where directed by the HB Boards jointly, or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the

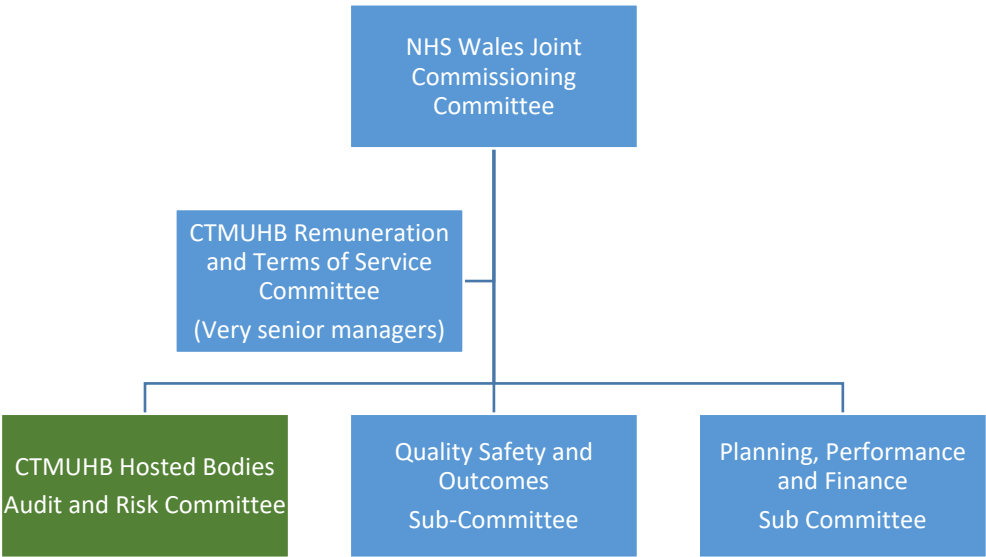
Joint Committee’s behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees). The Joint Committee shall determine, for agreement by the HBs, a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent HBs.

As a minimum, it shall ensure that there are joint sub-Committee arrangements which cover the following aspects of Joint Committee business:

- Audit and Risk
- Quality, Safety and Outcomes
- Planning and Performance.

To fulfil the provisions of the SOs the sub-committee structure outlined in **Figure 2** below was presented to the Joint Committee at their development session on 22 August 2024, and to the JCC meeting on 17 September 2024 and were supported and endorsed.

Figure 2 – Proposed JCC Sub-Committee Structure



The Terms of Reference (ToR) have been drafted for both the Quality, Safety and Outcomes sub-committee at Appendix 3, and for the Planning, Performance and Finance sub-committee at Appendix 4. The draft Terms of Reference for both sub-committees have been shared and discussed with HB DoCGs, with their comments and contributions reflected in the final proposed versions attached. The documents are presented for approval by the 7 x HBs at the September HB Board meetings.

The ToR for the CTMUHB Audit and Risk Committee (ARC) for hosted bodies are

contained within the CTMUHB ARC ToR which are under review and have been updated to reference the newly established JCC. The revised ToRs will be presented to the CTMUHB board meeting on 26 September 2024 for approval. An update will be taken to the JCC meeting scheduled for 12 November 2024 confirming the new ToR for the ARC for hosted bodies.

It is proposed that the new sub-committee structure comes into force on 1 December 2024, to coincide with the appointment of the new Joint Committee Lay Members. As the sub committees are meetings held in public, the papers will be published on the JCC website.

The revised statutory sub-committee structure no longer includes the legacy sub-committees of the Welsh Health Specialised Services Committee (WHSSC), specifically the All Wales Individual Patient Funding Request (IPFR) panel, the WHSSC Management Group (MG) and the Welsh Kidney Network (WKN). Consideration of the most appropriate reporting arrangements in the new governance model for the JCC will take account of the proposed establishment of a new JCC Collaborative Commissioning Leadership Group (CCLG) to be chaired by the Chief Commissioner. The Joint Committee is advised, until the proposals for the new CCLG are fully developed, the current transition reporting arrangements for the IPFR panel, Specialised Services Management Group and the WKN continue reporting directly to the Joint Committee. The JCC Director of Transition & Transformation is working with the Interim Chief Commissioner and representation from the Joint Committee to draft ToR for the proposed CCLG which will then be shared with HB CEOs prior to being brought back to the Joint Committee on 12 November 2024.

5. RECOMMENDATIONS

The Board is asked to **Approve:**

- the terms of reference (ToR) for the JCC Quality, Safety and Outcomes Sub-Committee
- the terms of reference (ToR) for the JCC Planning, Performance & Finance Sub-Committee
- the Memorandum of Agreement (MoA) and the Hosting Agreement (HA) for the JCC
- the continuation of the transitional reporting arrangements for the IPFR Panel, WKN and Specialised Services Management Group pending the establishment of a new Collaborative Commissioning Leadership Group (CCLG).

The Board is asked to **Note:**

- the terms of reference (ToR) for the CTMUHB Audit and Risk Committee (ARC) for hosted bodies are contained within the CTMUHB ARC ToR which are under review and will be presented to the CTMUHB board meeting on 26 September 2024 for approval.

6. NEXT STEPS

6.1 JCC Scheme of Delegation (SoD) and Reservation of Powers

A SoD from HBs to the Joint Committee and from the Joint Committee to Sub-Committees and the Chief Commissioner was agreed in March 2024 as part of the governance framework for the establishment of the JCC.

Work to develop the SoD to reflect the new Sub-Committees and delegations beyond the Chief Commissioner is ongoing and will be influenced by the development of the operating model for the new JCC.

Any proposed amendments following discussion with the Director of Corporate Governance of CTMUHB as Host Body, will be brought back to the HB DoCGs for engagement and consultation prior to Joint Committee consideration and final HB Board approval.

Work to develop the SoD is ongoing and will be finalised following the approval of the JCC hosting agreement and memorandum of agreement, and following discussion with the DoCG of CTMUHB as Host Body to confirm within its respective SoD and Reservation of Powers any functions delegated to the Chief Commissioner and Joint Commissioning Committee Team as the employer and provider of administrative (e.g. finance, workforce) services.

6.2 Review

A formal review of the governance framework for the JCC will be undertaken in April 2025 in collaboration with the HB DoCGs following a full year of operation as the new JCC.

Objectives / Strategy		
Dolen i Nod(au) Strategol BIP CTM /Link to JCC Strategic Goal(s)	Not Applicable	
	The JCC was established on 1 April 2024. Draft Strategic Objectives are being presented for approval at the September Joint Committee Meeting.	
Dolen i Feysydd Strategol BIP CTM /Link to JCC Strategic Areas	Not Applicable	
	The JCC was established on 1 April 2024. Draft Strategic Objectives are being presented for approval at the September Joint Committee Meeting.	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales	
	If more than one applies, please list below:	
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership	
	If more than one applies, please list below:	
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective	
	If more than one applies, please list below:	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies, please list below:	
Impact Assessment		
Ansawdd	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Outcome:	Consideration has been given to the Duty of Quality as set out in section 1A of the NHS (Wales) Act 2006 ("the 2006 Act") as it applies to the Welsh Ministers. The Duty of Quality places Ministers under an additional duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health services. The establishment of the new JCC arrangements will support the delivery of the Duty of Quality requirements.
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☐ Outcome:	No: ☒ A Regulatory Impact Assessment is contained with the Explanatory Memorandum to The National Health Service Joint Commissioning Committee (Wales) Regulations 2024.
Cyfreithiol / Legal	In accordance with the JCC scheme of delegation and reservation of powers, approval of the Joint Committees governance framework terms of reference is reserved to HBs. National Health Service Joint Commissioning Committee (Wales) Directions 2024 National Health Service Joint Commissioning Committee (Wales) Regulations 2024	

Enw da / Reputational	There is no direct impact on the reputation of the Local Health Boards or the Joint Committee as a result of the activity outlined in this report.
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.



MEMORANDUM OF AGREEMENT

RELATING TO THE

NHS WALES JOINT COMMISSIONING COMMITTEE

**Established under the National Health Service Joint
Commissioning Committee (Wales) Directions 2024**

THIS MEMORANDUM OF AGREEMENT is made on the **01 April 2024**
BETWEEN

1. ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having headquarters at St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ
2. BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW
3. CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 2nd Floor, Woodland House, Maes y Coed Road, Cardiff CF14 4HH
4. CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taf, CF45 4SN.
5. HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ystwyth Building, St David's Park, Carmarthen SA31 3BB.
6. POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at Mansion House, Bronllys, Brecon, Powys, LD3 0LS.
7. SWANSEA BAY UNIVERSITY HEALTH BOARD having headquarters at 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR

WHEREAS:

- A. In accordance with the [National Health Service Joint Commissioning Committee \(Wales\) Directions 2024](#) (the Directions) the Local Health Boards (LHBs) are required to establish a Joint Committee for the purpose of jointly exercising the relevant functions from 1 April 2024.
- B. The relevant functions of the Joint Committee are the planning, securing and commissioning of:
 - a. specialised services for:
 - (i) cancer and blood disorders
 - (ii) cardiac conditions
 - (iii) mental health and vulnerable groups
 - (iv) neurosciences and
 - (v) women and children.

- b. services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis
 - c. emergency medical services
 - d. non-emergency patient transport services
 - e. emergency medical retrieval and transfer services
 - f. NHS 111 services
 - g. sexual assault referral centres, and
 - h. other services as directed by the Welsh Ministers.
- C. The [National Health Service Joint Commissioning Committee \(Wales\) Directions 2024](#) provides that the host Local Health Board (the Host LHB) must provide administrative support for the operation of the Joint Committee and establish the NHS Wales Joint Commissioning Committee Team (JCCT); and that the Host Local Health Board will be Cwm Taf Morgannwg University Health Board (CTMUHB).
- D. The [National Health Service Joint Commissioning Committee \(Wales\) Regulations 2024](#) (the Regulations) make provision for the constitution and membership of the NHS Wales Joint Commissioning Committee including its procedures and administrative arrangements.
- E. Each of the seven LHBs functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and tertiary services for the citizens in their respective areas. The JCC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning, securing and commissioning of services delegated to it and will establish the Joint Committee for the purpose of jointly exercising those functions.
- F. The Directions and Regulations require that the Chief Executives of each of the 7 LHBs listed as Parties to this Agreement be members of the Joint Committee. This Agreement defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the Joint Committee. This is in accordance with their objective to make collective decisions as to the provision of national services as described above and in the interests of NHS Wales and the health needs of their individual populations. The NHS Wales JCC Standing Orders provides further detail on this.

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1. INTERPRETATION

'the Act'	the National Health Service (Wales) Act 2006 (C.42)
'Chair (JCC)'	the person appointed by Welsh Ministers to lead the NHS Wales Joint Commissioning Committee and to ensure it successfully discharges its overall responsibility on behalf of the LHBs.
'Chief Commissioner'	Chief Commissioner of the NHS Wales Joint Commissioning Committee and Associate Member of the JCC
'Chief Executives'	the Chief Executives of the constituent LHBs and members of the JCC
'Committee Secretary'	the person appointed by the JCC as its principal advisor on all aspects of governance.
'Dispute Process'	the arbitration process agreed with Welsh Government.
'Host LHB'	Cwm Taf Morgannwg University Local Health Board (CTMUHB)
'JCC'	The NHS Wales Joint Commissioning Committee
'JCCT'	The JCC Team employed by the host Health Board (CTMUHB), including the Chief Commissioner, to provide the relevant services.
'LHB'	Local Health Board established in accordance with section 11(2) of the Act
'Provider LHB'	a LHB which provides relevant services to the JCC as identified within the Directions:

2. CORPORATE IDENTITY

- 2.1 The corporate identity for the Joint Committee will be in accordance with the Corporate Identity Guidelines issued by Welsh Government to LHBs.
- 2.2 The NHS Wales Joint Commissioning Committee will be referred to as the 'NHS Wales Joint Commissioning Committee acting on behalf of Local Health Boards' on stationery and signage.

3. PRINCIPLES

- 3.1 The Joint Committee is a statutory committee established under sections 12 (1)(b) and (3), 13(2)(c), (3)(c) and (4)(c) and 203(9) and (10) of the Act.
- 3.2 The LHBs are required to establish a Joint Committee for the purpose of jointly exercising the relevant functions from 1 April 2024.
- 3.3 Each LHB is accountable, through its statutory responsibilities, to use its resources to plan, fund, design, develop and secure the delivery of services for their population.
- 3.4 In performing its role, the Joint Committee and each individual Chief Executive as a member, shall work in the wider interest of NHS Wales. In so doing, they shall work with all of the Joint Committee's appropriate partners and stakeholders in the best interests of NHS Wales. In so doing, the Joint Committee will take account of the following key principles:
 - 3.4.1 Collaboration should be designed to deliver changes in services and demonstrable population benefit
 - 3.4.2 Collaboration should ensure a more extensive and consistent use of evidence supported by a robust analysis of need
 - 3.4.3 Collaboration must not diminish clinical engagement
 - 3.4.4 Collaboration should support LHBs in working together more effectively, in an open and transparent way, for the benefit of the local population
 - 3.4.5 Collaboration must enhance resource utilisation in the planning process to reduce duplication and overlap

- 3.4.6 Collaboration should focus upon articulating need, reviewing evidence of good practice, designing models of care and producing clear service specification
 - 3.4.7 Collaboration should promote equity in service delivery.
- 3.5 Each LHB acknowledges the following principles:
 - 3.5.1 The accountability arrangements of the JCC, its members and the JCC Team, are as set out in the agreed Accountability Map attached at **Annex A**
 - 3.5.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services for residents within their area. Refer to Standing Order 2.19
 - 3.5.3 That any decision taken and approved by the Joint Committee in respect of the provision of the Relevant Services is binding on the constituent LHBs and may not be undermined by any subsequent decision or action taken by a constituent LHB. Refer to Standing Order 2.22
 - 3.5.4 That their respective Chief Executives have an individual responsibility to contribute to the performance of the role of the Joint Committee and to share in the decision making in the interests of the wider population of NHS Wales. At the same time, they acknowledge their own Chief Executive's individual accountability to their constituent LHB and their obligation to act transparently in the performance of their functions. Refer to Standing Orders 6 and the Accountability Map at **Annex A**
 - 3.5.5 That each Chief Executive, as a member of the Joint Committee, will require the JCC Team of the Joint Committee to ensure that in the timetabling of the annual work Price sufficient time will normally be allowed to enable each Chief Executives to consult with their own LHB and appropriate local partners and stakeholders

- 3.5.6 That when an individual Chief Executive is unable to attend a meeting of the Joint Committee, they may nominate a deputy to attend on their behalf. The nominated deputy must be an Executive Director (and hold office in accordance with regulation 3(2) of the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009) of the same organisation who can fully engage and take decisions in the absence of the CEO. Nominated deputies will formally contribute to the quorum and will have delegated voting rights. Refer to Standing Order 7.2
- 3.6 Each Chief Executive will agree to advise the Chair of any circumstances where there is an actual or perceived conflict of interest, including where it is considered that there may be a conflict of interest between the performance of the functions of the Joint Committee and the effect of any such decision on the scope of the services which the constituent LHB provides. Refer to Standing Order 8.5.
- 3.6.1 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may vary dependent on the type of interest declared and further detail on the options takes are set out within the JCC's Guidance on the Handling of Interests.
- 3.7 The JCC must discharge its collective duty for the population of Wales and any individual involved in making decisions that relate to JCC functions must be acting clearly in the interests of the JCC and of the population of Wales, rather than furthering direct or indirect financial, personal, professional or organisational interests. The Joint Committee's aim is to always achieve collective decision making in a collaborative manner through consensus. The Joint Committee will have a collective responsibility to try to resolve and minimise any local challenges or any disproportionate impact of national decisions on any one LHB or a specific geographical area. Refer to Standing Order 6.8
- 3.8 The Joint Committee will make decisions based on a majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

In order to ensure balanced and collective decision, Members are not permitted to abstain during voting, given that the JCC must discharge its collective duty for the population of Wales. Refer to Standing Order 7.20

4. ROLE OF THE NHS WALES JOINT COMMISSIONING COMMITTEE

As set out in Standing Order 2.20, the Joint Committee's role is to:

- Determine a long-term strategy for the commissioning of services delegated to the JCC
- Produce an Integrated Medium-Term Plan which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and complements the LHBs Integrated Medium-Term Plans (IMTPs)
- In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards and will, for the relevant functions:
 - Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered
 - Develop policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
 - Determine annually those services that should be commissioned on a regional or national basis
 - Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers
 - Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales.
- Ensure the JCC operates within an appropriate governance framework.

5. ANNUAL WORK PROGRAMME AND PLANNING

- 5.1 The Joint Committee will operate its annual work programme, reporting and planning requirements in-line with Standing Orders. Refer to Standing Order 7.8 and 9.2.

- 5.2 The Joint Committee Chair shall report formally, regularly and on a timely basis to the LHB Boards on the Committee's activities. This includes written submission of Chair summary or highlight reports throughout the year and an in-person attendance at every LHB, meeting annually with Board Members. Refer to Standing Order 9.1.
- 5.3 The Joint Committee will operate its business in-line with its delegated powers and Scheme of Delegation and Reservation of Powers and any Scheme of Delegation to Officers. Refer to Standing Order 4 and 5.

6. ROLE OF JOINT COMMITTEE CHAIR

- 6.1 The LHBs acknowledge that the Regulations require that the Chair be appointed by the Cabinet Secretary for Health and Social Care as an independent appointment and in accordance with the Nolan Principles. It is further acknowledged that the Chair is accountable to the Cabinet Secretary for Health and Social Care in respect of their performance as Chair of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners. The Cabinet Secretary for Health and Social Care undertakes a performance appraisal of the Joint Committee Chair and sets objectives accordingly. This is set out within the Accountability Map at **Annex A**.
- 6.2 As a Joint Committee of LHBs, the Joint Committee Chair will have a bi-lateral relationship with each of the Chairs of the 7 LHBs, in respect of the Joint Committee's role carried out on their behalf and to ensure that the Joint Committee's governance framework remains appropriate to the overarching governance framework of the 7 LHBs. This is set out within the Accountability Map at **Annex A**.

7. STATUS AND ROLE OF THE CHIEF COMMISSIONER AS AN ASSOCIATE MEMBER

- 7.1 The Joint Committee will delegate certain functions to the Chief Commissioner. For these aspects, the Chief Commissioner, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Commissioner will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers. Refer to Standing Order 6.15

- 7.2 The LHBs acknowledge that the Chief Commissioner will be an Associate Member of the Joint Committee and attend on an ex-officio basis. In accordance with the Directions, the Chief Commissioner will not have the right to vote in any meetings or proceedings of the Joint Committee. Refer to Standing Order 6.5.
- 7.3 The Associate Member will be entitled to engage and participate in the discussions. It will be the responsibility of the Joint Committee Chair to secure that they may seek to influence and/or challenge the decision making by their participation during the course of the debate.
- 7.4 The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services, by the Joint Committee, on behalf of the 7 LHBs. Refer to Standing Orders 6.15 and the Accountability Map at **Annex A**.
- 7.5 In respect of personal performance this will include an annual performance review undertaken by the Committee Chair. This will take into account those functions delegated from the host, as set out within the Hosting Agreement, and will therefore be informed by the Chief Executive of the Host Body. Feedback from other Joint Committee members will also be sought in informing the appraisal of the Chief Commissioner. Refer to Standing Orders 6.15 and the Accountability Map at **Annex A**.
- 7.6 As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host Body in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. As the employer, the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair. Refer to Standing Orders 6.15 and the Accountability Map at **Annex A**.
- 7.7 As a Joint Committee of LHBs, the Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs. Refer to Standing Orders 6.15 and the Accountability Map at **Annex A**.

- 7.8 The Chief Commissioner will hold Accountable Officer status for certain elements of their role, namely the propriety and regularity for public finances delegated to them by the LHBs and will be accountable to the Director General/NHS Wales Chief Executive in this regard. Further detail on this accountability relationship is set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body.

8 ROLE OF COMMITTEE SECRETARY

- 8.1 The LHBs acknowledge that the role of the Committee Secretary, is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee and is a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary will be required to act as the guardian of good governance within the Joint Committee. The role of the Committee Secretary is set out within Standing Order 6.16.
- 8.2 The Committee Secretary is accountable to the Joint Committee Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner for their performance as an employee of the Host Body and a member of the JCC Commissioning Team. Refer to Standing Orders 6.16 and the Accountability Map at **Annex A**.
- 8.3 As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs. Refer to Standing Orders 6.16 and the Accountability Map at **Annex A**.
- 8.4 As an employee of the Host Body (CTMUHB), the Committee Secretary will also have a relationship with the Host Body's Director of Corporate Governance with regard to the governance of those functions delegated to the JCC Team via the Hosting Agreement. Refer to Standing Orders 6.16 and the Accountability Map at **Annex A**.

9 RELATIONSHIP WITH HOST

- 9.1 Cwm Taf Morganwg University Health Board is appointed as the Host Body under Ministerial Direction and is accountable for the delivery of the functions of host body, as required by the NHS Wales Joint Commissioning Committee (Wales) Directions 2024 (the JCC Directions). As the host body they are required to provide administrative support for the operation of the JCC and establish the JCC Team. Refer to Standing Orders 1.7
- 9.2 The Board of the Host Body will not be responsible or accountable for the planning, funding and securing of those services delegated to the JCC by the 7 LHBs, or as directed by Welsh Ministers, save in respect of residents within the areas served. Refer to Standing Orders 1.7
- 9.3 A Hosting Agreement between the Host Body (CTMUHB) and the six other Local Health Boards outlines the accountability arrangements and resulting responsibilities of the Host Body and the JCC and its team. This is supported by an Interface Agreement between the Host Body Chief Executive Officer and the Chief Commissioner of the JCC Team, detailing the relationship and accountabilities of the two Officers given they both hold respective Accountable Officer responsibilities delegated by Welsh Government.

10 AUDIT, PROCUREMENT AND FINANCIAL MANAGEMENT

- 10.1 The Joint Committee's Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions for the regulation of the NHS Wales Joint Commissioning Committee's financial proceedings and business. Refer to Standing Orders 3.1
- 10.2 The JCC's Standing Financial Instructions (SFIs) form an annex to the JCC's Standing Orders, which form a schedule to each LHBs own Standing Orders and have effect as if incorporated within them. They are designed to translate statutory and Welsh Government financial requirements for the NHS in Wales into day-to-day operating practice. These SFIs align with the JCC's Scheme of Delegation and Reservation of Powers and are also be underpinned by an operational Scheme of Delegation which provides delegated authorisation levels and other delegated responsibilities in respect of financial management and control.

- 10.3 The Hosting Agreement between the Host Body (CTMUHB) and the six other Local Health Boards outlines the arrangements in place in respect of accounting, audit, procurement and contracting arrangements.

11 FINANCIAL PRINCIPLES

- 11.1 The following represent the key financial principles to be adhered to by the LHBs:

- To achieve financial neutrality and stability, where possible, for LHBs
- To adopt a fair and practical approach to the challenges of establishing the Joint Committee and to the functioning of the Joint Committee
- To ensure that a risk sharing methodology will be reviewed and agreed annually.

12 BUDGET AND FUNDING

- 12.1 In accordance with the Joint Committee's Standing Orders, the Joint Committee must agree the total budget to plan and secure the Relevant Services delegated to it. The Joint Committee must also agree the appropriate contribution of funding required from each LHB. Refer to Standing Order 2.20
- 12.2 Each year the Joint Committee will prepare an Integrated Medium-Term Plan which shall outline an appropriate level of funding for the provision of services and determine the contribution from each LHB to allow the JCC to plan and secure those services, including the running costs of the JCC Team. Refer to Standing Order 2.20 and Standing Financial Instructions 1.3
- 12.3 Each LHB shall be bound by the decisions of the JCC in the exercise of its delegated functions and will be required to make available to the Joint Committee the level of funds outlined within the agreed Integrated Medium-Term Plan, as per point 12.2 above.
- 12.4 The funds shall be drawn down in cash on a monthly basis from each of the LHB's as proposed by the Director of Finance for the Joint Committee.

- 12.5 On a monthly basis, the Director of Finance for the Joint Committee shall prepare a report to the Joint Committee which outlines the performance of the Joint Committee, highlighting any variances from the original annual plan, in total, and also broken down to each LHB level.
- 12.6 In cases where the performance report highlights an adverse variance to the Integrated Medium-Term Plan or where the report anticipates future unfunded cost pressures, the Joint Committee will be required to put in place contingency measures to ensure that a break-even position is maintained.
- 12.7 In cases where the performance report highlights a favourable variance to the annual plan, the Joint Committee shall be required to return the funding to each LHB in accordance with the risk sharing agreement.
- 12.8 The Joint Committee will comply with all Welsh Government financial monitoring arrangements. The Director of Finance of the Joint committee is responsible for ensuring that a financial monitoring return is submitted to Welsh Government in the prescribed format and to the required deadlines.
- 12.9 Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its delegated functions. Any disputes over the level of funding proposed by Joint Committee shall be handled in-line with the dispute process set out at Section 14.
- 12.10 The Hosting Agreement between the Host Body (CTMUHB) and the six other Local Health Boards outlines the arrangements in place in respect of accounting between the Joint Committee and the Host Body.

13 GIFTS AND HOSPITALITY

- 13.1 The Host Body's Standards of Behaviour Policy (Incorporating Declarations of Interest, Gifts, Hospitality, Sponsorship and Honoraria) applies to the Joint Committee's Chair, Lay Members and Chief Commissioner, and prohibits Joint Committee members from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way. Refer to Standing Order 8.9.

- 13.2 The recording of gifts, hospitality and sponsorship for the JCC's Officer Members will be undertaken in accordance with the respective LHB's Standards of Behaviour Policy and reporting arrangements. Refer to Standing Order 8.9.

14 DISPUTES AND ARBITRATION

- 14.1 In accordance with the principles set out in this Agreement, the Local Health Boards (LHBs) will seek to work cooperatively with each other as constituent members of the Joint Committee, with the Joint Committee as a whole, and with the JCC Team. Where there is an impasse which cannot be resolved by means of conciliation between appropriate individuals, then as a last resort the following process should be followed.
- 14.2 In the event of any dispute between LHB(s) and the JCC and/or JCC Team, all parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and trying to resolve the issues. All reasonable efforts must be made before escalating any disputed issues.
- 14.3 If a dispute cannot be resolved in accordance with the provisions of paragraph 14.2 it shall be referred to the Chief Commissioner and the Chief Executive of the respective LHB for further discussion.
- 14.4 If a dispute cannot be resolved in accordance with the provisions of paragraph 14.3, the respective LHB Chief Executive and the Chief Commissioner should have a further meeting with the other six LHB Chief Executives (as parties to this agreement and officer members of the Joint Committee) to determine if the matter can be resolved in-line with the principles of this Memorandum of Agreement.
- 14.5 If a dispute cannot be resolved in accordance with the provisions of paragraph 14.4 it shall be referred to the Chair of the JCC and the Chair of the respective LHB for further discussion. The LHB Chair may wish to engage its wider Board on this matter.
- 14.6 If a dispute still cannot be resolved in accordance with the provisions of paragraph 14.5, it shall be referred to the Welsh Government Director General for Health and Social Services and ultimately onwards to the Cabinet Secretary for Health and Social Care for resolution.

15 CONCERNS AND CLAIMS (PUTTING THINGS RIGHT)

- 15.1 Concerns notified about care and treatment will be dealt with by the organisation providing the treatment. Concerns will be considered under The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Provider organisations must, as part of the contractual agreement, advise the LHB in which the patient lives that a complaint has been made and the LHB will ensure that this is reviewed in conjunction with the Quality and Patient Safety Sub Committee.
- 15.2 Section 13 of the Hosting Agreement sets out the procedures to be followed for the management of concerns in respect of those services commissioned by the JCC and/or the functions delivered by the JCC Team.

16 COMMUNICATION

- 16.1 The Committee Secretary and the Directors of Corporate Governance of the respective LHBs will ensure robust communication methods are in place to support the effective operation of the Joint Committee.
- 16.2 Each LHB will ensure that they utilise appropriate mechanisms to facilitate active debate amongst stakeholders, professionals and communities served to ensure appropriate independent representation and participation.
- 16.3 Each LHB is responsible for responding to individual enquires concerning their individual geographical population. Where it is an issue relating to a decision made by the Joint Committee, then the Committee Secretary will be responsible for co-ordinating the response in consultation with the respective LHBs.
- 16.4 Where a request under the Freedom of Information Act or Data Protection Act is received by the JCC/JCCT Team, the request will be dealt with in accordance with the Host Body's procedures. Where the request is considered to be an issue relating to a public body covered by the FOI Act then the request will be forwarded to that particular body to deal with.

17 ROLE OF PUBLIC HEALTH

- 17.1 A Service Level Agreement will be entered into between the

Host LHB and Public Health Wales, should the Joint Committee consider it necessary and appropriate, describing the services which Public Health Wales will provide to the Joint Committee and the process of engagement which will take place.

18 EQUALITY AND DISCRIMINATION

18.1 The LHBs undertake, in relation to the provision of the Relevant Services by the Joint Committee to the public or any member of the public, to exercise the role of the Joint Committee so as to have regard to the need to eliminate discrimination, and other prohibited conduct, in accordance with human rights and equality legislation.

19 REVIEW

19.1 This Agreement will be reviewed on an annual basis or as Standing Orders and Standing Financial Instructions are amended.

SIGNED under hand and delivered the XX 2024:

SIGNED and DELIVERED by Aneurin Bevan University Local Health Board acting by Nicola Prygodzicz, Chief Executive
SIGNED and DELIVERED by Betsi Cadwaladr University Local Health Board acting by Carol Shillabeer, Chief Executive
SIGNED and DELIVERED by Cardiff and Vale University Local Health Board acting by Suzanne Rankin, Chief Executive

SIGNED and DELIVERED

By **Cwm Taf Morgannwg University Local Health Board**
acting by

Paul Mears Chief Executive

SIGNED and DELIVERED

by **Hywel Dda University Local Health Board**
acting by

Phil Kloer, Interim Chief Executive

SIGNED and DELIVERED

by **Powys Teaching Local Health Board**
acting by

Hayley Thomas, Chief Executive

SIGNED and DELIVERED

by **Swansea Bay University Local Health Board**
acting by

Richard Evans, Interim Chief Executive

ANNEX A

NHS Wales Joint Commissioning Committee - Accountability Map
APPROVED – March 2024

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Health Boards	Health Board Chief Executives are equal members of the Joint Committee, delegated to act on the behalf of respective Boards.	The JCC is a Joint Committee of the 7 LHBs. Ultimately all 7 LHBs are bound by the decisions taken by the JCC, in-line with the powers delegated to it from the 7 LHBs or as directed by the Minister for Health and Social Services. The JCC is accountable to Health Boards via respective CEOs as set out below.		As a Joint Committee of Health Boards, each of the 7 LHB's ultimately remain accountable to Welsh Government for planning, securing and delivering health services to their respective populations.

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Joint Committee		The Joint Committee will report to the individual LHBs on its activities. It is formally accountable to the individual LHBs, via the respective CEO as a JCC Member and a LHB Board Member, in respect of its role carried out on the LHB's behalf.		The Joint Committee may form part of the NHS performance management system, via the Chief Commissioner, as determined by Welsh Government. Ultimately, the 7 LHBs remain accountable for the performance of those activities delivered via the JCC on their behalf. The individual accountability of the Committee Chair is set out below.

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Committee Chair		As a Joint Committee of LHBs, the Committee Chair will have a bi-lateral relationship with each of the Chairs of the 7 LHBs, in respect of the JCC's role carried out on their behalf and to ensure that the JCC's governance framework remains appropriate to the overarching governance framework of the 7 LHBs.	The Committee Chair will have a relationship with the Host Body's CEO given their respective accountability arrangements with regard to the Chief Commissioner (Tier 1 Director) (as described further below under Chief Commissioner arrangements and set out within the Hosting Agreement). The arrangements to support the relationship between the Chair and the Host Body CEO are further detailed in the Hosting Agreement.	The Committee Chair is accountable to the Minister for Health and Social Services in respect of their performance as Chair of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners. The Minister for Health and Social Services undertakes a performance appraisal of the Committee Chair and sets objectives accordingly.

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Lay Members	On a day-to-day basis, Lay Members are responsible to the Committee Chair for discharging their roles as Lay Members of the JCC (and any subsequent sub-Committee). The Committee Chair will undertake performance appraisals of Lay Members on behalf of the Minister for Health and Social Services.			The Committee Lay Members are appointed by, and are accountable to, the Minister for Health and Social Services in respect of their performance as Lay Members of the JCC, upholding the values of the NHS and promoting the confidence of the public and partners.

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Chief Commissioner (Tier 1 Director)	The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the Joint Committee, on behalf of the 7 LHBs, to the Commissioning Team for the planning, securing and commissioning of the relevant services. In respect of personal performance this will include an annual performance review undertaken by the Committee Chair. This will take into account those functions delegated from the host, as set out within the Hosting Agreement, and will therefore be informed by the Chief Executive of the Host Body. Feedback from other Joint Committee members will also be sought in informing the appraisal of the Chief Commissioner.	As a Joint Committee of LHBs, the Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs.	As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host LHB (CTMUHB) in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. In this regard, the Host Body CEO will inform the annual performance review of the Chief Commissioner, undertaken by the Committee Chair. As the employer, the Host Body is responsible for the Terms of Conditions and employment matters associated with the Chief Commissioner, informed by the Committee Chair. The governance and issues relating to the hosting of the JCC will be incorporated into the standard business of the existing Host Body's Audit Committee. The assurance for the governance and issues relating to the hosting of the JCC will be to the Host Body's Board. Issues relating to the functions of the JCC delegated from the 7 LHBs will be fed into a separate Host Body Audit Committee for the JCC specifically, operating within its own work cycle as required. The assurance for this will be to the 7LHBs.	The Chief Commissioner will hold Accountable Officer status for certain elements of their role, namely the propriety and regularity for public finances delegated to them by the Health Boards, and will be accountable to the Director General/NHS Wales Chief Executive in this regard. Further detail on this accountability relationship will be set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body. The Chief Commissioner will have a relationship with Welsh Government officials, with regard to informing and discharging policies relating to the resources and functions delegated to the JCC. The Chief Commissioner and Officers of the JCC Team may seek advice where matters present a conflict with the Host Body as a provider of services commissioned by the JCC. Detail on the handling of conflicts between the Chief Commissioner and the JCC Team are further described within the Hosting Agreement.

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Tier 2	Tier 2 roles will have a relationship with the JCC Chair and the wider Committee, recognising the professional advice that these roles will provide. Tier 2 roles will be accountable to the Chief Commissioner (Tier 1 Director) for their performance as an employee of the Host Body and a member of the JCC Commissioning Team.	As a Joint Committee of LHBs, Tier 2 roles will have a relationship with the Executive Teams of the 7 LHBs, in respect of the role and functions delegated to the Commissioning Team by the Joint Committee, on behalf of the 7 LHBs.	Tier 2 roles will be accountable to the Chief Commissioner (Tier 1 Director) for their performance as an employee of the Host Body and a member of the JCC Commissioning Team. Where Tier 2 roles have regulated professional accountabilities, these roles will be professionally accountable to the appropriate member of the Executive Team of the Host Body (CTMUHB) and will be explicitly set out within the Hosting Agreement.	The Chief Commissioner and Officers of the JCC Team may seek advice from Welsh Government where matters present a conflict with the Host Body as a provider of services commissioned by the JCC. Detail on the handling of conflicts between the Chief Commissioner and the JCC Team are further described within the Hosting Agreement. Tier 2 Officers will have a relationship with Welsh Government officials with regard to informing and discharging policies relating to the resources and functions delegated to the JCC.

From \ To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Committee Secretary	The Committee Secretary is accountable to the JCC Chair for all matters in relation to the responsibilities delegated in respect of the JCC's Governance Framework, within the context of the overarching Governance Framework of the 7 LHBs. The Committee Secretary is accountable to the Chief Commissioner (Tier 1 Director) for	As a Joint Committee of LHBs, the Committee Secretary will have a relationship with the Directors of Corporate Governance of each of the 7 LHBs, in respect of the overarching governance framework of the 7 LHBs.	As an employee of the Host Body (CTMUHB), the Committee Secretary will have a relationship with the Director of Corporate Governance of the Host Body (CTMUHB) with regard to the governance of those functions delegated to the JCC Team via the Hosting Agreement.	The Committee Secretary will have a relationship with the Head of NHS Governance within Welsh Government, as a Senior Governance Professional within NHS Wales.

	their performance as an employee of the Host Body and a member of the JCC Commissioning Team.			

From To	JCC/Committee Chair	Health Boards	Host Body	Welsh Government
Host Body	The Chief Executive of the Host Body for those elements set out within the Hosting Agreement will ensure the Chief Commissioner is discharging their responsibilities as an employee of the host body. The Host Body CEO and Chair will have a relationship with the JCC Chair relating to the Hosting Agreement, particularly in relation to any disputes between the JCC Team and the Host Body. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.	The Host Body will enter into an agreement with 6 other LHBs for the delivery of the Hosting Agreement to support the effective functioning of the JCC on their behalf. The 6 LHBs will have a relationship with the Host Body CEO and Chair relating to the Hosting Agreement, particularly in relation to any disputes between the JCC Team and the Host Body. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.	The Host Body's CEO will be responsible to the Board of the Host Body for the effective delivery of the Hosting Agreement. The Chair of the Host Body will have a relationship with the JCC Chair and the 6 LHB CEOs, relating to the Hosting Agreement, particularly in relation to any disputes between the JCC Team and the Host Body. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.	CTMUHB is appointed as Host Body for the JCC under Ministerial Direction, ultimately CTMUHB is therefore accountable to the Minister for Health and Social Services for the effective delivery of the Hosting Agreement. The dispute process in respect of these arrangements is set out within the Hosting Agreement in further detail, with an expectation that disputes are resolved locally as far as possible prior to any escalation to the Minister for Health and Social Services for arbitration.

**HOSTING AGREEMENT
RELATING TO THE
NHS WALES JOINT COMMISSIONING COMMITTEE**

THIS MEMORANDUM OF AGREEMENT is

BETWEEN

(1) CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD
("Cwm Taf Morgannwg CTMUHB") having headquarters at Ynysmeurig
House, Navigation Park, Abercynon, Rhondda Cynon Taf, CF45 4SN.

And

ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having
Headquarters at St Cadoc's Hospital, Lodge Road, Caerleon,
Newport, NP18 3XQ

BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having
headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor,
Gwynedd, LL57 2PW

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having
headquarters at 2nd Floor, Woodland House, Maes y Coed Road,
Cardiff CF14 4HH

HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having
headquarters at Ystwyth Building, St David's Park, Carmarthen
SA31 3BB.

POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at
Mansion House, Bronllys, Brecon, Powys, LD3 0LS

SWANSEA BAY UNIVERSITY HEALTH BOARD having headquarters at
1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12
7BR

A. Cwm Taf Morgannwg University Health Board (CTMUHB) has been identified as Host LHB to provide administrative support for the running of the JCC and to establish the NHS Wales Joint Commissioning Committee Team (JCCT).

B. This Agreement should be read in conjunction with the Memorandum of Agreement made between the seven Local Health Boards themselves which defines the governance arrangements for the JCC and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the JCC.

C. The purpose of this Agreement is to outline what the accountability arrangements and resulting responsibilities mean for each party.

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1. INTERPRETATION

'the Act'	the National Health Service (Wales) Act 2006 (C.42)
'Chair (JCC)'	the person appointed by the Minister to lead the NHS Wales Joint Commissioning Committee and to ensure it successfully discharges its overall responsibility on behalf of the LHBs.
'Chief Commissioner'	Chief Commissioner of the NHS Wales Joint Commissioning Committee and Associate Member of the JCC
'Chief Executives'	the Chief Executives of the constituent LHBs and members of the JCC
'Committee Secretary'	the person appointed by the JCC as its principal advisor on all aspects of governance. Refer to Standing Orders: The Role of the Committee Secretary.
'Dispute Process'	the arbitration process agreed with Welsh Government.
'Host LHB'	Cwm Taf Morgannwg University Local Health Board (CTMUHB)
'JCC'	The NHS Wales Joint Commissioning Committee
'JCCT'	The JCC Team employed by the host Health Board including the Chief Commissioner to provide the relevant services.
'LHB'	Local Health Board established in accordance with s 11(2) of the Act
'NHS Wales'	the comprehensive health service for Wales established by the NHS (Wales) Act 2006 (C.42)
Provider LHB'	a LHB which provides relevant services to the JCC as identified within the Directions.

'Provider Trust' the Trust which provides emergency ambulance services to the JCC

'Relevant Services' As per the Directions:

- a) specialised services for
 - 1. cancer and blood disorders,
 - 2. cardiac conditions,
 - 3. mental health and vulnerable groups,
 - 4. neurosciences, and
 - 5. women and children,
- a) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,
- b) emergency medical services,
- c) non-emergency patient transport services,
- d) emergency medical retrieval and transfer services,
- e) NHS 111 services,
- f) sexual assault referral centres, and

other services as directed by the Welsh Ministers.

'Role of the Joint the role ascribed to the JCC
Committee' in section 4 of this Agreement.

2. ROLES AND RESPONSIBILITIES OF CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD

The responsibilities of CTMUHB are:

2.1 To appoint and employ such officers as may be required to support the commissioning of the Relevant Services and provide all necessary corporate services and management support, to include human resources, estates, procurement, banking and accountancy services, as may be required, including the processing of orders and the making of payments to providers of the Relevant Services, with such JCCT officers;

2.2 To provide advice to the Joint Commissioning Committee on compliance with CTMUHB policies, Standing Financial Instructions (JCC and Host Body versions as appropriate), Procurement Rules, Human Resource policies and other procedures;

2.3 To be the legal entity which enters into agreed procurement arrangements to include, but not restricted to, quotations, tenders, procurement contracts, service level agreements and terms of engagement commissioned by the JCCT, on behalf of the JCC, and to ensure that the individuals appointed and employed to support the functions of the JCC carry out those tasks which are stated as annexes to the Standing Orders to be the role of the JCC;

2.4 To have in place such appropriate governance arrangements and Schemes of Delegation as may be necessary and required on the part of CTMUHB to enable the JCCT's role to be carried out;

2.5 To hold the management budget for the JCC/Relevant Services and make payments and receive income as necessary.

2.6 To be authorised to appoint lawyers and other professional advisors in line with approved procurement procedures, and to agree the terms and conditions of their engagement and give them instructions from time to time on behalf of the JCC.

2.7 CTMUHB will not be responsible or accountable for the commissioning of the Relevant Services save in respect of the residents within the geographical area of responsibility of CTMUHB.

2.8 In fulfilling its obligations and responsibilities under this Agreement, CTMUHB shall not be required to do or not do and shall not do or omit to do anything which does not comply with CTMUHB statutory powers and duties, Standing Orders and Standing Financial Instructions (JCC and Host Body versions as appropriate) corporate governance requirements generally, procurement requirements or any legal obligations not covered by the foregoing.

2.9 In line with the Welsh Risk Pool Services All Wales Policy on Insurance, NHS Indemnity and related risk management for potential losses and special payments CTMUHB provide the indemnity for the Chair (and Lay Members) of JCC. Should any claim or legal matter arise this would be processed by Legal and Risk Team responsible for CTMUHB.

3. EMPLOYMENT OF STAFF

3.1 All officers, including the Chief Commissioner, who are part of the JCCT, are to be employed by CTMUHB. The legal status of the employees would be CTM employees and with respect to any employment litigation with respect to JCCT members, CTM would be held liable.

3.2 As employees of CTMUHB, all JCCT members will be required to abide by CTMUHB policies, procedures and guidance and will be entitled to be treated as any other employee of CTMUHB and have the benefit of all applicable policies and procedures.

3.3 The CTMUHB Remuneration and Terms of Service Committee will provide advice to the CTM Board on the remuneration and the terms of service of the Chief Commissioner and any other members of the JCCT who fall within the Framework set out by the Welsh Government and are paid at executive and senior pay terms and conditions of service.

3.4 As an employee of the Host Body, the Chief Commissioner will be accountable to the Chief Executive of the Host LHB (CTMUHB) in respect of the responsibilities delegated to the Chief Commissioner set out within the Hosting Agreement. In this regard, the Host Body CEO will inform the annual performance review of the Chief Commissioner, undertaken by the Committee Chair.

3.5 All other members of the JCCT will be accountable to the Chief Commissioner for their performance as an employee of CTMUHB and a member of the JCCT.

3.5 The human resource services which will be provided are identified at **Appendix B**.

4. PROCEDURES FOR TENDERS & PROCUREMENT Estates, Facilities and IT Support; Others (Communications; Corporate Support; Welsh Language; Equality and Diversity; Risk Management; Concerns and Information Governance)

4.1 CTMUHB will provide all the support services to the JCC as described at **Appendix C**.

4.2 Agreed procurement arrangements via quotations, tenders, procurement contracts, service level agreements and terms of engagement will be entered into and signed by CTMUHB on behalf of the JCC in accordance with the CTMUHB procurement policy and Standing Financial Instructions.

4.3 CTMUHB shall not execute or, through performance create, any third party contract in respect of the JCC unless authorised to do so by the Chief Commissioner or an officer of the JCCT to whom the Chief Commissioner has delegated authority in line with the approved Scheme of Delegation

4.4 The seven Health Boards will provide sufficient funds and other relevant resources to meet the requirements of all third party contracts entered into by Cwm Taf Morgannwg in pursuance of paragraph 4.3.

4.5 CTMUHB shall provide the Chief Commissioner (as appropriate) with drafts of all third party contracts and the JCC shall be entitled to require CTMUHB to use its reasonable endeavours to negotiate such amendments to the terms of such contract as the Chief Commissioner and/or the JCC reasonably see fit.

5. GOVERNANCE ARRANGEMENTS

5.1 The JCCT will utilise CTMUHB arrangements to assist it in discharging its governance responsibilities.

5.2 Where the JCC utilises CTMUHB sub-committee arrangements such as the Audit and Risk Committee, and the Remuneration and Terms of Service Committee, CTMUHB will ensure that the appropriate responsibilities are afforded to the JCC and the agenda is constructed to ensure relevant issues are to be properly managed to allow the JCC to satisfy itself from a risk management and controls assurance perspective.

5.3 The JCCT will adopt the risk assessing mechanisms of CTMUHB. Any adaptation to the agreed risk processes of the Host Body, which may be required owing the specific functions of the JCC/JCCT, should only be made after consulting with the Host Body Executive Director of Finance and the Director of Corporate Governance/Board Secretary.

5.4 As part of the agreed accountability arrangements, the Chief Commissioner will have accountability to the Chief Executive of CTMUHB in respect of ensuring adherence to all relevant legislation, policies and procedures. This accountability will be formalised in the form of quarterly meetings to take place between the Chief Commissioner and the Chief Executive of CTMUHB and will include a discussion on the Hosting arrangements as a standing agenda item.

5.5. Tier 2 roles, within the JCCT , which have regulated professional accountabilities e.g. the Medical Director will be professionally accountable to the relevant CTMUHB Executive Director e.g. the CTMUHB Executive Medical Director.. Arrangements will be established to put in

place quarterly meetings where any issues can be discussed and for re-validation.

5.6 CTMUHB will also work with members of the JCCT to establish regular meetings between relevant members of the CTMUHB Executive Team including the Executive Director of Finance, Executive Director of People and Director of Corporate Governance; and senior members of the JCCT including those responsible for finance and governance.

5.5 The Chief Commissioner will provide reports from the JCC to the Cwm Taf Morgannwg Board in line with the CTMUHB scheme of delegation to enable CTMUHB to assure itself that appropriate control measures are in place with respect to Hosting Arrangements.

5.6 The Chief Commissioner, with support from the Committee Secretary will produce an Annual Governance Statement for the JCC/JCCT.

6. BUDGET AND FUNDING

6.1 The JCC will transfer funds to CTMUHB on a quarterly basis in advance to allow CTMUHB to perform its functions on behalf of the JCC, provided that the JCC may attach conditions to the expenditure of such funds.

6.2 The seven Health Boards will meet the CTMUHB overhead costs reasonably incurred in the support of the JCC as may be agreed by the JCC acting reasonably at all times.

6.3 The Chief Commissioner or their Director of Finance will authorise the transfer of funds to CTMUHB in line with agreed funding levels, which funds shall be accounted for by CTMUHB as income to the JCC.

6.4 CTMUHB will set up and manage an Income and Expenditure Account for the JCC, namely a JCC Account. This includes all the income for the JCC received from the LHBs and all other JCC expenditure. This account shall be separate from all other CTMUHB funds. The Chief Commissioner or their Director of Finance will make decisions relating to expenditure from this account provided that CTMUHB shall not at any time be obligated to operate the JCC Account in deficit.

6.5 The Chief Commissioner and their Director of Finance shall be responsible for ensuring that all relevant reports, financial information and commentary are provided to CTMUHB so that the appropriate monitoring return can be prepared.

6.6 The Chief Commissioner and their Director of Finance will provide all the necessary information to the CTMUHB Executive Director of Finance to ensure that a consolidated set of financial statements can be prepared in

accordance with deadlines set out and agreed with Welsh Government and Audit Wales.

7. OWNERSHIP OF ASSETS

7.1 All assets (including intellectual property rights) acquired by CTMUHB in connection with the JCC and JCCT shall belong to CTMUHB but be held upon trust for the JCC and JCCT.

7.2 CTMUHB shall, to the extent it is legally entitled to do so, transfer ownership and any other rights in such assets to such party or body as the JCC shall require and within such timescales as are reasonably required.

7.3 In the event that any income is derived from such assets or from their disposal, such revenues shall be regarded as part of the JCC income and accounted for accordingly.

8. ACCOUNTABILITY ARRANGEMENTS

8.1 The accountability arrangements of the Joint Commissioning Committee Team (JCCT) and the Chief Commissioner and their relationship with CTMUHB are set out in Appendix D.

9. DUTY OF CARE

9.1 CTMUHB shall be responsible for ensuring that all reasonable skill, care and diligence are exercised in carrying out those services, which it is required to perform under this Agreement properly and efficiently in accordance with this Agreement and the Memorandum of Agreement and its overall responsibilities under the Act and all other appropriate legislation. CTMUHB shall keep the JCC informed of any foreseeable or actual changes in circumstances which are likely to affect its ability to comply with the terms of this Agreement as the Host LHB.

10. CWM TAF MORGANNWG ORGANISATION

10.1 CTMUHB shall provide and maintain an organisation having the necessary facilities, equipment and employees of appropriate experience, to undertake the specific functions and provide all the services identified in this Agreement.

10.2 All personnel deployed on work relating to the Agreement must have appropriate skills and competence.

11. LEGISLATION

11.1 CTMUHB shall ensure that it, and its employees and agents, shall in the course of this agreement comply with all relevant legislation, Welsh Government Directions and Guidance and procedures.

11.2 Where responsibilities for compliance with legislation is delegated to the JCCT it will be set out within the Scheme of Delegation e.g. Duty of Quality, Safeguarding, the Equality Act 2010 etc.

12. INTERNAL AND EXTERNAL AUDIT

12.1 CTMUHB, through the NHS Wales Shared Services Committee arrangements, will provide an effective independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Government.

12.2 CTMUHB will ensure that relevant external audit arrangements are established with the Auditor General for Wales, which give due regard to the functions of the JCC.

13. MANAGEMENT OF CONCERNS (INCLUDING INCIDENTS, COMPLAINTS & CLAIMS)

13.1 Section 15 of the Memorandum of Agreement sets out the procedures to be followed for the handling of disputes and arbitration relating to the business of the JCC/JCCT and the responsibilities of the provider organisations.

13.2 Where a matter is regarded as an individual concern in respect of those services commissioned by the JCC and/or the functions delivered by the JCC Team, CTMUHB will only be responsible for the management of those concerns where liability in Tort is established, which relate to its geographical area of responsibility. In such circumstances, the Chief Executive of CTMUHB will be responsible for investigating and responding to the concern in accordance with *The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*.

13.3 Individual concerns relating to patients resident outside CTMUHB's geographical area of responsibility will be referred to the Chief Executive of the LHB in the appropriate geographical area.

13.4 Where a matter is considered to be a review of funding decisions it will be dealt with in accordance with the Review Process set out in All Wales Policy for Making Decisions on Individual Patient Funding Requests (IPFR).

13.5 Individual concerns relating to emergency ambulance services will be referred to the Chief Executive of the provider organisation.

14. MANAGEMENT OF FOIA / DPA REQUESTS

14.1 For the purposes of Freedom of Information and Data Protection, CTMUHB is the organisation registered with the Information Commissioner's Office (ICO). In common with all other CTMUHB employees, members of the JCCT will be required to follow all the relevant CTMUHB information governance and data protection rules, policies and procedures, including the policy on Records Management and Schedule for the Retention and Destruction of Records. As the legal entity and organisation registered with the ICO, CTMUHB, would be held liable for any data breach or fine issued by the ICO which arose from activity within the JCCT.

14.2 Where a request under the Freedom of Information Act or Data Protection Act is received by the JCC/JCCT, the request will be dealt with in accordance with CTMUHB procedures. Where the request is considered to be an issue relating to a public body covered by the FOI Act then the request will be forwarded to that particular body to deal with.

15. NOTICES

15.1 Any notices served in respect of matters covered by this Agreement shall be sent to the Chief Executive on behalf of CTMUHB and the Chief Commissioner (as appropriate) on behalf of the JCC.

16. DISPUTE

16.1 In the event of any dispute between CTMUHB and those involved in the JCC/JCCT, all parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and trying to resolve the issues. All reasonable efforts must be made before escalating any disputed issues.

16.2 If a dispute cannot be resolved in accordance with the provisions of paragraph 16.1 it shall be referred to the Chief Commissioner and the Chief Executive of CTMUHB for further discussion.

16.3 If a dispute cannot be resolved in accordance with the provisions of paragraph 16.2 it shall be referred to the Chair of the JCC and the Chair of CTMUHB for further discussion.

16.4 If a dispute cannot be resolved in accordance with the provisions of paragraph 16.3, CTMUHB and/or the Chief Commissioner should have a further meeting with the other six LHBs to determine if the matter can be resolved.

16.5 If a dispute still cannot be resolved in accordance with the provisions of paragraph 16.4, it shall be referred to the Welsh Government Director General for Health and Social Services and ultimately onwards to Cabinet Secretary for Health and Social Care for resolution.

17. GENERAL

17.1 This agreement shall be capable of being varied only by a written instrument signed by a duly authorised officer or other representative of each of the parties.

17.2 No third party shall have any right under the Contracts (Rights of Third Parties) Act 1999 in connection with this Agreement.

17.3 This Agreement shall be governed and construed in accordance with the laws of England and Wales.

17.4 In the event of the Cwm Taf Morgannwg Board determining (acting reasonably) that the performance by CTMUHB of its obligations under this Agreement is having a detrimental or prejudicial effect on the CTMUHB ability to fulfil its core functions, the Cwm Taf Morgannwg Board may instruct the Chief Commissioner and CTMUHB Chief Executive to review the operation of this Agreement.

17.5 In carrying out a review of this Agreement further to clause 17.4, the Chief Commissioner and CTMUHB Chief Executive shall consider the source and manner of any detriment identified by the Cwm Taf Morgannwg Board further to clause 17.4 and shall put forward such amendments and variations to this Agreement and the associated governance arrangements between the JCC and CTMUHB as they may consider appropriate. At this point given CTMUHB is directed to host the

JCC by Welsh Ministers, the Welsh Government should also be advised of this.

17.6 The Cwm Taf Morgannwg Board shall consider the recommendations made further to clause 17.5 and may recommend to the JCC and the Chief Executive of CTMUHB that this Agreement and the associated governance arrangements are amended accordingly.

SIGNED under hand and delivered the XX 2024.

SIGNED and DELIVERED by Cwm Taf Morgannwg University Local Health Board acting by [Paul Mears] Chief Executive
SIGNED and DELIVERED by Aneurin Bevan University Local Health Board acting by [Nicola Prygodzicz] Chief Executive
SIGNED and DELIVERED by Betsi Cadwaladr University Local Health Board acting by [Carol Shillabeer] Chief Executive
SIGNED and DELIVERED by Cardiff and Vale University Local Health Board acting by [Suzanne Rankin] Chief Executive

SIGNED and DELIVERED by Hywel Dda University Local Health Board acting by [Phil Kloer] Interim Chief Executive
SIGNED and DELIVERED by Powys Teaching Local Health Board acting by [Hayley Thomas] Chief Executive
SIGNED and DELIVERED by Swansea Bay University Local Health Board acting by [Richard Evans] Interim Chief Executive

APPENDIX A

Role of the Joint Commissioning Committee (JCC) (refer to Standing Order 2.20):

The role of the JCC is to:

- Determine a long-term strategy for the commissioning of services delegated to the JCC
 - Produce an Integrated Medium-Term Plan which describes how these services will be delivered on behalf of LHBs through clear 'commissioning intentions' which informs and compliments the LHBs Integrated Medium-Term Plans (IMTPs)
 - In commissioning services, the JCC will act in accordance with the Directions and Scheme of Delegation of the health boards and will, for the relevant functions:
 - Identify and evaluate existing, new and emerging services and treatments and advise on the way in which these services should be delivered
 - Develop policies for the equitable access to safe and sustainable, high quality health care services across Wales for those services which fall within the scope of the JCC
 - Determine annually those services that should be commissioned on a regional or national basis
 - Determine the appropriate level of funding for the commissioning of directed and delegated services at a regional or national level and determine the contribution from each LHBs for those services (which will include the running costs of the JCC and the Joint Commissioning Team) in accordance with any specific directions set by the Welsh Ministers
 - Secure the provision of services delegated at a regional and national level including those to be delivered by providers outside of Wales
- Ensure the JCC operates within an appropriate governance framework

From the Standing Orders (2.20)

- .

APPENDIX B

EMPLOYMENT OF STAFF

Identified human resources services to be provided by Cwm Taf Morgannwg University Health Board

Service	Description
<i>Recruitment and Selection</i>	To provide a comprehensive recruitment and selection service which complies with employment legislation and standards of good practice as directed by the Welsh Government.
<i>Employee Relations</i>	To provide support to the Joint Commissioning Team (JCCT) in the management of sensitive issues relating to all employment policies including discipline, grievance, collective disputes, performance and capability, allegations of bullying and harassment whistle blowing and sickness absence etc.
<i>Policy Development</i>	- To develop, implement and advise on employment policies and procedures which comply with employment legislation and NHS guidance; and - To provide training to JCCT Managers in the interpretation and use of policies and procedures.
<i>Remuneration and Payroll</i>	- To provide advice on pay and associated terms and conditions of employment; - To provide a comprehensive payroll service; and - To undertake the matching and evaluation of all new and revised roles, including and re-banding which may be necessary. Ensure that Welsh Government is advised of any roles which require evaluation under Executive and Senior Pay arrangements and any approved roles at that level go through the Host Body Remuneration Committee processes.
<i>Training and Organisational Development</i>	To provide appropriate training and development to members of the JCC and JCCT

<i>HR administration</i>	To maintain securely employment records for Chair, Lay Members and JCCT and provide accurate workforce data and information as required.
<i>Well-Being and Occupational Health</i>	To provide a comprehensive well-being and Occupational Health service to members of the JCCT

APPENDIX C

3.1 Procedures for Tenders & Procurement

Service	Description
Procurement (Tendering and ordering goods and services)	- Tendering for goods & services in accordance with SOs and SFIs - Entering into procurement contracts and Agreements - Raise orders for properly approved requisitions
Creditor Payments (Payment of suppliers, contractors and service providers) JCC Finance Team	- Pay all duly authorised invoices - Deal with supplier queries etc. - Provide management information on payment performance in accordance with WG requirements
Systems maintenance and administration (ORACLE)	- Process feeders into JCC ledgers and maintain financial management system - Maintain passwords and hierarchies (cost centre and approval) - Oracle training as and when required including external training if required - Access to help desk facility - Undertake testing of upgrades - Liaise with Oracle Central Team and All Wales groups
Accounting Services (bank accounts, annual accounts consolidation, VAT) JCC Finance Team	- Provision of bank accounts and petty cash facilities - Consolidation of Annual Accounts and other returns as required by WG - Provide VAT advice and consolidate VAT returns, including access to contracted out VAT advisory services - Payment of Tax, National Insurance and Superannuation to appropriate authorities - Reconciliation of all accounts due against the payroll system
Financial Governance (internal and external)	Responsible for the securing of internal audit service via external contract

audit, counter fraud, audit committee) JCC Finance Team	• Access to Local Counter Fraud Specialist • Advice on financial procedures and other issues of governance • Ensure appropriate external audit provision in place.

3.2 Estates, Facilities and IT Support

Service	Description
Estates Maintenance	• To provide an efficient service in response to all aspects of estates maintenance in the running of the JCC offices.
Fire Safety	• To provide professional advice and support in relation to all aspects of Fire Safety ensuring compliance with legislation and guidance issued by the Welsh Government; and • To provide appropriate training to the Chair and Lay members of the JCC and officers who comprise the JCCT.
Health and Safety	• To provide a Health and Safety Policy statement as and when required. The Policy must comply with the requirements of the Health and Safety at Work Act. All other relevant rules and regulations must be observed at all times; • To be responsible for the testing, where appropriate, labelling and recording of all portable appliances in their ownership under the Electricity at Work Act 1989; • To provide advice and support on the operational delivery of health and safety arrangements in the JCC offices in accordance with CTMUHB policies and procedures; and • To provide appropriate training to the Chair and Lay members of the JCC and officers who comprise the JCCT.
IT Support	• To provide a comprehensive IT support service including : ○ User registration; ○ Resolution of faults reporting via the Helpdesk ○ Purchase and set up new IT equipment; ○ Supply of printing consumables • To provide support in relation to the management of files and databases; • To ensure the secure storage of data, back up, restore and recovery

3.3 Others

Service	Description
Communications (including internet and intranet)	To provide some communications support on a range of activities to the JCC in addition to the JCC's own communications service.
Corporate Support	- To provide access to the Director of Corporate Governance and Board Secretary for advice and support on Corporate Governance matters as required. - To co-ordinate the Audit and Risk Committee, and Remuneration and Terms of Service Committee agenda and papers, circulate and take minutes of the meetings. - To provide access to the range of groups and committees including Information Governance Group, Equality Forum etc.
Welsh Language	- Offer advice and information about the Welsh Language - Promote and encourage the use of Welsh within the workplace - Encourage the use of bilingual aids within the workplace such as signage, stationery etc. - Provide Welsh Language taster lessons for staff - Give bilingual front-line telephone training - Translate small in-house, day-to-day, translations - Help co-ordinate the translation of larger documents - Attend public meetings to provide a Welsh Language service for Welsh speakers.
Equality, Diversity and Inclusion	- To provide advice and information to the JCC and JCCT; - To develop a work plan and meet quarterly to review progress against the plan;

	• To ensure that relevant training is provided to the members of the JCC and JCCT in relation to awareness raising and impact assessment; • To provide an assurance mechanism on behalf of the LHBs that robust processes are in place to meet the Equality and Diversity agenda
Risk Management	• To work with the Committee Secretary to provide advice and information on all areas of Risk Management to the JCC/JCCT; • To support the development of a Risk Assurance Framework for the JCC • To provide support (structure and advice) for the use of DATIX to facilitate the management of risk within the JCCT • To develop a work plan and meet quarterly to review progress against the plan
Concerns	• To provide training and awareness for all staff in relation to the management of concerns; • To provide advice and support in relation to the concerns process; • To provide support (structure and advice) for the use of DATIX to facilitate the management of concerns within the JCCT. • To be responsible for all claims relating to staff and services commissioned which relate to CTMUHB Residents
Information Governance	• To provide timely advice to all information governance related enquires; • To process requests made under the Freedom of Information and Data Protection Acts; • To provide training and awareness for all staff in all areas of Information Governance

APPENDIX D

Accountability Arrangements

1. The NHS Wales Joint Commissioning Committee (Wales) Directions 2024 state that the LHBs will jointly exercise the Delegated Functions from 1 April 2024.
<https://www.legislation.gov.uk/wsi/2024/135/contents/made>
2. This means that the Delegated Functions are those of the individual constituent LHBs and not CTMUHB.
3. The Directions state that CTMUHB will exercise its functions so as to provide administrative support for the running of the JCC and establish the JCCT.
4. The membership of the JCC consists of the Chief Executives of the seven LHBs or their nominated representative, the Chair and not more than five non-officer (lay) members who are appointed by the Cabinet Secretary for Health and Social Care. In addition the Chief Commissioner will be an Associate Member of the JCC.
5. The Chair is directly accountable to the Cabinet Secretary for Health and Social Care at Welsh Government
6. As per point 4, the Chief Commissioner will attend meetings as an Associate Member of the JCC and will have such responsibilities as may be prescribed by the JCC.
7. The Chief Commissioner is accountable to the Committee Chair in relation to discharging the role and functions delegated by the JCC on behalf of the seven LHBs to the JCC for the planning, securing and commissioning of relevant services.
8. The Chief Commissioner will have a relationship with the Chief Executive Officers and Executive Teams of the seven LHBs in respect of the role and functions delegated to the JCCT by the JCC on behalf of the seven LHBs.
9. As an employee of CTMUHB the Chief Commissioner will be accountable to the Chief Executive of CTMUHB in respect of the responsibilities delegated to the Chief Commissioner set within the Hosting Agreement in this regard, CTMUHB CEO will inform the

annual performance review of the Chief Commissioner undertaken by the Committee Chair.

10. In respect of the effective management and controls of finances and resources, as delegated by the seven LHBs, the Chief Commissioner will be accountable to the Director General/NHS Wales Chief Executive for propriety and regularity. Further detail on this accountability relationship is set out in an Accountable Officer Memorandum and an Interface Agreement between the Chief Commissioner and the Chief Executive of the Host Body.
11. The Chief Executive of CTMUHB is only accountable to the Director General and Chief Executive of the NHS in Wales in so far as the functions relate to administrative support.
12. The Chief Executives of the Constituent LHBs are individually accountable to the Director General and Chief Executive of the NHS in Wales.
13. The Director of Finance for CTMUHB is only accountable to the Director of Finance for the NHS in Wales insofar as their functions relate to administrative support.
14. JCCT Tier 2 roles will be accountable to the Chief Commissioner (Tier 1 Director) for their performance as an employee of the Host Body and a member of the JCCT.
15. Tier 2 roles, which have regulated professional accountabilities, will be professionally accountable to the relevant CTMUHB Executive Director.
16. The governance and issues relating to the hosting of the JCC will be incorporated into the standard business of the existing Host Body's Audit Committee. The assurance for the governance and issues relating to the hosting of the JCC will be to the Host Body's Board.
17. Issues relating to the functions of the JCC delegated from the seven LHBs will be fed into a separate Host Body Audit Committee for the JCC specifically, operating within its own work cycle as required. The assurance for this will be to the seven LHBs.



QUALITY SAFETY AND OUTCOMES SUB- COMMITTEE (QSOSC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

Document Author:	Committee Secretary
Lead Director	Director of Nursing and Quality
Approved By	Joint Commissioning Committee
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NWJCC@Wales.nhs.uk

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Version Control

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Version 1				

Sub-Committee Arrangements:

This schedule forms part of and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

1. Introduction & Constitution

- 1.1 In accordance with NWJCC Standing Order 5.5, the NHS Wales Joint Commissioning Committee (NWJCC – the Joint Committee) may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee or on behalf of the Joint Committee to each LHB Board and/or its other committees). The Joint Committee shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.
- 1.2 In accordance with Standing Orders (SOs) (and the JCC Scheme of Delegation), the Joint Committee shall nominate annually a sub- committee to be known as the **Quality, Safety and Outcomes Sub-Committee**. The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this sub-committee are set out below.

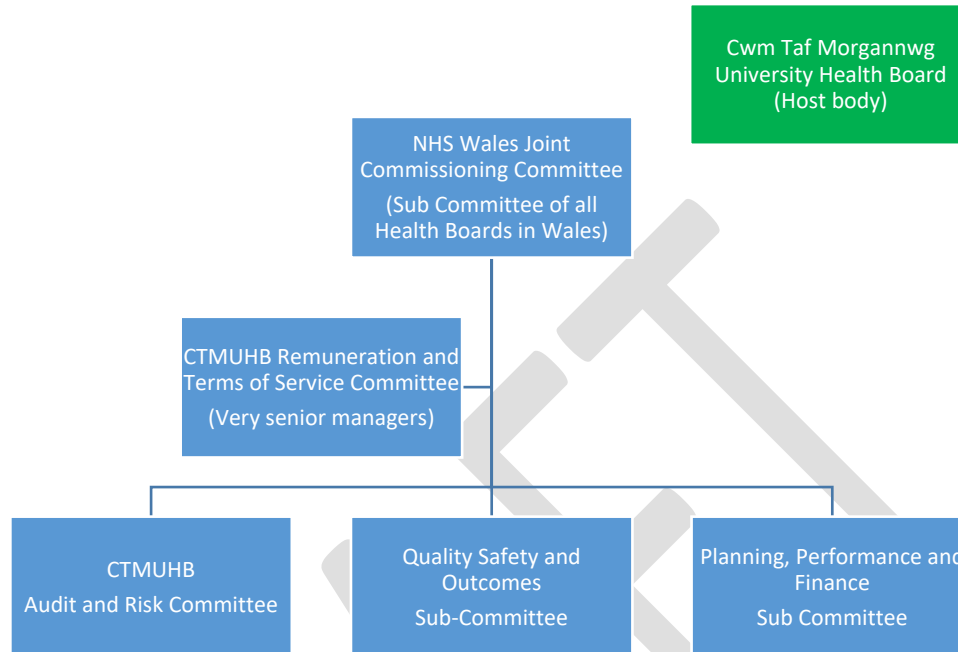
2. Purpose

- 2.1 The purpose of the Quality, Safety and Outcomes Sub-Committee "the Sub-Committee" is to be assured that the Joint Committee is commissioning appropriate, high quality and safe services from providers (Health boards, Trusts and private sector providers) on behalf of health boards in Wales.

This will be achieved by:

- Providing scrutiny and assurance to the Joint Committee for the Quality Safety and Outcomes of services commissioned from providers including health boards, NHS Trusts and private providers who are accountable for the provision of safe, quality services)
- Reporting to and providing advice to the Joint Committee, including escalation of issues that require urgent consideration and action by the NWJCC
- Addressing concerns delegated by the Joint Committee ensuring that individual LHB Quality and Patient Safety Committees are informed of any issues relating to their population recognising that concerns of the services commissioned may impact on primary and secondary and vice versa (whole pathway) and contribute to the achievement of the Duty of Candour; and
- Providing assurance to the Joint Committee in relation to improving the experience of patients, carers, citizens and those that come into contact with the services commissioned by the NWJCC.

Figure 1 – JCC Sub-Committee Structure



3. Scope and Duties

- 3.1 The Sub-Committee will provide scrutiny and assurance in and will, in respect of its provision of advice to the Joint Committee:
- Monitor and support the development and implementation of the Commissioning Assurance Framework ensuring that there is continuous improvement in the commissioning of safe, effective and sustainable services for the people of Wales
 - Consider the quality, patient safety and outcome implications arising from the development of commissioning strategies, including developments outlined in the agreed JCC Integrated Medium Term Plan (IMTP)
 - Ensure that all aspects of commissioning activity, through regular reporting to the sub-committee consider quality, safety and outcomes as part of the commissioning of services
 - Receive, when required, items for urgent consideration and escalation
 - Ensure a robust process is in place for the development and approval of evidence-based service specifications, focussed on quality and safety of service provision, for all services commissioned by the JCC
 - Have responsibility for the commissioning risks designated to the Sub-Committee for monitoring ensuring that quality, safety and outcomes of services commissioned are a priority for the organisation

- Monitor and scrutinise risk management and assurance arrangements for the risks designated to the Sub-Committee for monitoring from the perspective of clinical and patient safety risks
- receive assurance from provider organisations that concerns management arrangements are robust and reported through the appropriate governance routes; and
- Receive assurance that patient safety incidents, complaints and claims (relating to the services commissioned by the JCC) are routinely monitored and are considered a critical part of the evaluation of services in the JCC commissioning cycle.

Sub-Committee Programme of work

- 3.2 Each year the Joint Committee will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's Commissioning Assurance Framework and Corporate Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the Joint Committee throughout the year.

4. Membership

Members

- 4.1 The Membership of the QS&O Sub-Committee is as follows:

Chair	Lay (Independent) Member of the Joint Committee
Vice Chair	Lay (Independent) Member of the Joint Committee
Member	One further Lay (Independent) Member of the Joint Committee

- 4.2 The membership of the Sub-Committee shall be determined by the Joint Committee, based on the recommendation of the Chair of the Joint Committee and lay members, taking account of the balance of skills and expertise necessary to deliver the subcommittee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.
- 4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, receive from nominations from the CEOs of Local Health Boards
- 4.4 The Membership will be reviewed annually.

Support to Sub-Committee Members

- 4.5 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:
- Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
 - Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

4.6 In Attendance

One representative Chief Executive or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)
JCC Director of Nursing and Quality (Lead Director for the Committee)
JCC Medical Director
JCC Director of Commissioning for Specialised Services
JCC Director of Commissioning for Ambulance and 111
JCC Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups (MH, LD & VG)
Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Committee Chair
Llais Representative
Staff side representative.

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

- 4.7 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk or matters that are the responsibility of that Director / member of staff.
- 4.8 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Member Appointments

- 4.9 The membership of the Sub-Committee shall be determined by the Chair of the Joint Committee, taking account of the balance of skills and expertise necessary to deliver the committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5 Quorum & Attendance

- 5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.
- 5.2 For effective governance, at least two JCC Team directors, one of which must be a Clinical Director should be in attendance at the meeting.

6 Meeting Secretariat

- 6.1 The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

7 Frequency of Meetings

- 7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.
- 7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.
- 7.3 Additional meetings may be held with the chairs of the LHBs Quality and Safety Committees where there is requirement.
- 7.4 Members will be required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.
- 7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Committee Business.

8 Withdrawal of Individuals in Attendance

- 8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9 Circulation of Papers

- 9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.
- 9.2 The Committee Secretariat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.
- 9.3 The JCC Committee Secretariat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.
- 9.4 The Sub-Committee highlight report will also be shared with members and HB Directors of Corporate Governance / Board Secretaries.

10 Access

- 10.1 The Chair of the Quality, Safety and Outcomes Sub-Committee shall work closely with the Director of Nursing and Quality and have reasonable access to the JCC Directors and other relevant senior staff within the JCC Team.

11 Accountability, Responsibility & Authority

- 11.1 Although health boards have delegated authority to the Joint Committee and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each health board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for their citizens through the effective governance of their organisation.
- 11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the Joint Committee that Quality, Safety and Outcomes are being managed appropriately within the commissioning cycles.

Authority

- 11.3 The Sub-Committee is authorised by the Joint Committee to investigate, or have investigated, any activity within its terms of reference.
- 11.4 The Sub-Committee is authorised by the Joint Committee to obtain outside legal or other independent professional and clinical advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the JCCs procurement, budgetary and other requirements.
- 11.5 The Sub-Committee will ensure that it is aware of and receives relevant reports on the activities and reports of external independent regulators and agencies, such as Healthcare Inspectorate Wales, Care Quality Commission, National Audit Office and Audit Wales, that relate to the commissioning of services.

Sub Groups

- 11.6 The Sub-Committee may, subject to the approval of the Joint Committee establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

Strategy

- 11.7 Oversee and monitor the development and implementation of the JCCs Strategies for patient quality, safety and outcomes:

- **Patient Quality, Safety and Outcomes**

- Provide assurance to Joint Committee on implementation of the Quality aspects within the Integrated Medium Term Plan (IMTP) for the Joint Committee
- Provide assurance to the Joint Committee in relation to the Commissioning Assurance Framework.
- Contribute to and oversee the development of effectiveness of the Joint Committee's Annual Quality Statement and the Annual Governance Statement
- Monitor quality via the Quality Dashboard.
- Monitor and receive reports on the organisation's progress with embedding and implementing the Health & Care Quality Standards
- Ensure arrangements are in place to review and act on clinical audit activity which responds to national and local priorities applicable to the business and services commissioned by the JCC as part of the commissioning cycle.
- Receive recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response.

Organisational Risk

- 11.8 Regularly review and provide assurance to the Joint Committee on the risks included on the organisational Risk Register and assigned to the Sub-Committee by the Joint Committee.

Quality Improvement activities

- 11.9 The Commissioning Assurance Framework provides the framework for quality improvement projects supporting compliance with the Duty of Quality. The Quality, Safety and Outcomes Sub-Committee will:
- Provide scrutiny and assurance to the Joint Committee that priorities relating to quality, safety and outcomes are progressing.

11.10 Patient Experience

- Receive and review progress reports relating to Patient Experience and the requirements identified in the Commissioning Assurance Framework
- Ensure that the JCC engages with and co-operates with representatives of Llais as appropriate on ongoing patient engagement or major service change. (S.O. 7.7)

11.11 Concerns

- Receive as presented within the quarterly quality report, reports on Concerns relating to the services commissioned by the JCC (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with emphasis on ensuring that lessons are learnt and are built into the evaluation of services as part of the JCC commissioning cycle.
- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) relating to commissioned

services from across NHS Wales, in accordance with the legislation under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

- Receive assurance of effective and timely management of concerns (including incidents, complaints & claims) contributing to HB approaches providing information related to the services commissioned to support them in complying with their have legal and contractual requirements.

Delegated Powers

11.12 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

11.13 This Sub-Committee is responsible for providing scrutiny and assurance to the Joint Committee that Quality, Safety and Outcomes are being managed appropriately within the evaluation of services as part of the JCC commissioning cycle.

The Sub-Committee will:

- Seek assurance that the JCC's **Commissioning Assurance Framework** remains appropriate, is aligned to the Duty of Quality and is embedded in practice.
- Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:
 - Seek assurance on the delivery of the Patient Experience Plan within the Commissioning Assurance Framework; and
 - Contribute information from the commissioning perspective to HBs in their implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned through the commissioned service lens.
- Seek assurance that arrangements for the **provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
 - the Commissioning Assurance Framework arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of commissioned services
 - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities
 - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response
 - the development of the Joint Committee's Annual Quality Statement including annual quality priorities; and

- performance against key quality focussed performance indicators and metrics.
- Seek assurance on the arrangements in place to support **improvement and innovation**, including:
 - an overview of the research and development activity for commissioning within the organisation
 - alignment of the commissioning of services with the national objectives published by Health and Care Research Wales (HCRW);
 - an overview of the quality improvement activity for commissioned services within the organisation.
- Seek assurance that arrangements for commissioned services are **compliant with mental health legislation** are sufficient, effective and robust, including:
 - the Mental Health Act 1983
 - Mental Health Act Code of Practice for Wales and associated regulations (2016);
 - the Mental Capacity Act 2005 Code of Practice and associated regulations;
 - the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice and associated regulations; and
 - the Mental Health Measure (Wales) 2010.

11.14 The Sub-Committee will seek assurances on the management of strategic risks delegated to the Sub-Committee by the Joint Committee, from the JCC Risk Register.

Dealing with Members interests during meetings

11.15 Declarations of interest will be a standing agenda item for all meetings.

11.16 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.

11.17 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the JCC Standing Orders.

12 Reporting

12.1 The Sub-Committee Chair shall:

- Report formally, regularly and on a timely basis to the Joint Committee on the Committee's activities. This includes:
 - Assurance that Quality, Safety and Outcomes are being managed appropriately
 - oral updates on recent activity
 - submission of written Sub-Committee highlight reports throughout the year

- to receive annual reports, which will incorporate key information on quality, safety and outcomes.
 - Bring to the Joint Committee’s specific attention any significant matters under consideration by the Committee; and
 - Ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, Chief Commissioner, HB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the JCC and HBs.
- 12.2 The Sub-Committee shall provide a written, annual report to the Joint Committee on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.
- 12.3 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Quality, Safety and Outcomes are being managed appropriately, for inclusion on suitable HB Committee agendas.
- 12.4 The Joint Committee may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee’s assurance role relates to a joint or shared responsibility.
- 12.5 The JCC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee’s performance and operation.

Relationship with the Joint Committee and its Sub-Committees / Groups

- 12.6 Although the Joint Committee has delegated authority to the sub-committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and outcomes of healthcare for its commissioned services through the effective governance of its organisation.
- 12.7 The Sub-Committee is directly accountable to the Joint Committee for its performance in exercising the functions set out in these Terms of Reference.
- 12.8 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the Joint Committees other Sub- Committees to provide advice and assurance to the JCC through the:
- joint planning and co-ordination of Joint Committee business; and
 - sharing of information.
- 12.9 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the JCCs overall risk and assurance arrangements.

12.10 The Sub-Committee, through its Chair and members, shall work closely with LHB Quality and Safety Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the JCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the JCC's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

12.11 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

13 Applicability of Standing Orders to Sub-Committee Business

13.1 The requirements for the conduct of business as set out in the JCC Standing Orders are equally applicable to the operation of the Sub-Committee, except in the area relating to the quorum.

13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the JCC Team or Joint Committee, as appropriate.

14 Chairs Action on Urgent Matters

14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Committee Secretary as appropriate, may deal with the matter on behalf of the Sub Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.

14.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

15 In Committee (Private Meeting)

15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

16 Review

- 16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ratified by the Joint Committee.

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GIG
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Cyd-bwyllgor
Comisiynu
Joint Commissioning
Committee

PLANNING, PERFORMANCE AND FINANCE SUB- COMMITTEE (PPFSC)

Terms of Reference & Operating Arrangements
(Schedule 3.1 of the Standing Orders)

Document Author:	Committee Secretary
Lead Directors	Director of Finance and Information Director of Planning and Performance
Approved By	Joint Commissioning Committee
Issue Date	
Review Date	
Version	1

Last Approved: NWJCC Meeting ()
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Version Control

Version	Issued To	Date	Outcome	Next Review Date
Version 1				

Sub-Committee Arrangements:

This schedule forms part of, and shall have effect as if incorporated in the NHS Wales Joint Commissioning Committee Standing Orders.

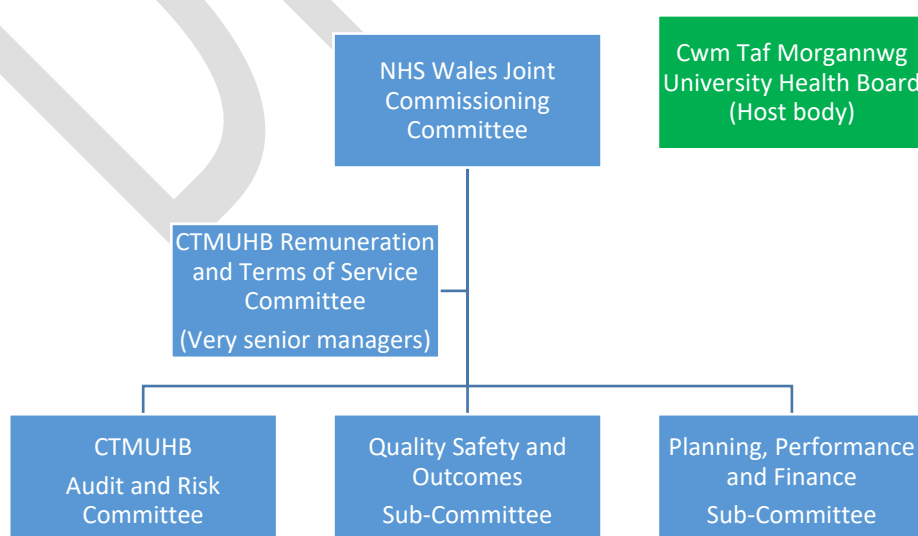
1. Introduction & Constitution

- 1.1 In accordance with JCC Standing Order 5.5 , the NHS Wales Joint Commissioning Committee (NWJCC – the Joint Committee) may and, where directed by the LHB Boards jointly, or the Welsh Ministers must, appoint joint sub-committees of the JCC either to undertake specific functions on the JCC's behalf or to provide advice and assurance to others (whether directly to the JCC or on behalf of the JCC to each LHB Board and/or its other sub-committees). The JCC shall determine, for agreement by the LHBs, a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs.
- 1.2 In accordance with Standing Orders (SOs) (and the JCC Scheme of Delegation), the Joint Committee shall nominate annually a sub- committee to be known as the **Planning, Performance and Finance Sub-Committee**. The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this sub-committee are set out below.

2. Purpose

- 2.1 The purpose of the Planning, Performance and Finance Sub-Committee is to be assured that the Joint Committee is effectively managing the strategic planning, performance and financial duties outlined in the Joint Committees SOs and Standing Financial Instructions (SFIs) relating to planning, securing and commissioning the services delegated to the JCC.

Figure 1 – JCC Sub Committee Structure



3. Scope and Duties

The Sub-Committee will provide scrutiny and assurance in relation to the duties below:

3.1 Planning

- Monitor the process for the development of the Integrated Medium Term Plan (IMTP) in line with the relevant SOs, SFIs and the NHS Wales Planning Framework
- Receive assurance on the delivery of the IMTP
- Scrutinise the alignment of service, workforce, digital and financial commissioning plans in the IMTP (as appropriate to the business of the NWJCC)
- Scrutinise the development and delivery of strategic or major service plans through the agreed Service Transformation Programme in the IMTP.

3.2 Performance

- Advise on and assure the development and implementation of the NWJCC's Performance Management Framework
- Monitor in-year performance against the financial plan and activity targets that support the relevant metrics agreed by the Joint Committee
- Monitor overall performance of commissioned services against the JCC's IMTP and the national targets for NHS Wales (Ministerial Priorities).

3.3 Organisational Risk Register

- Regularly review the planning, performance and finance risks included on the JCC Risk Register and assigned to the Sub-Committee by the JCC.

3.4 Finance

- Monitor delivery of financial plans and savings programmes
- Monitor risk to financial delivery including mitigating actions to appropriately manage the risks
- Robustly challenge and support progress against delivery of savings plans including consideration of impact on services
- Scrutinise investments in line with the Standing Financial Instructions (SFIs) and the Scheme of Delegation prior to submission to the Joint Committee for approval
- Monitor activity and productivity including operational efficiency and effectiveness
- Report on significant financial variances and issues, including potential mitigation decisions.

3.5 Sub-Committee Programme of work

Each year the Joint Committee will determine the Sub-Committee's priorities for its annual programme of work, based on the Joint Committee's IMTP and Corporate Risk Register. This approach will ensure that the Sub-Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that

these Terms of Reference are provided as a framework for the Sub-Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Sub-Committee's programme of work will be dynamic and flexible to meet the needs of the Joint Committee throughout the year.

- 3.6 The Sub-Committee, in monitoring and scrutinising the above areas, will discuss and recommend corrective action where necessary. This will include the transformation, recommissioning and value in health care approach.
- 3.7 The Sub-Committee will monitor the development of appropriate Key Performance Indicators (KPIs) across all parts of the organisation.
- 3.8 Where necessary, the Sub-Committee will undertake detailed "deep dives" of specific areas. These reviews will be supported by appropriate benchmarking information to ensure all of the JCCs commissioned services are striving to achieve "best in class" in relation to planning, performance and finance.

4. Membership

Members

- 4.1 The Membership of the PPFSC Sub-Committee is as follows:

Chair	Lay (Independent) Member of the NWJCC
Vice Chair	Lay (Independent) Member of the NWJCC
Member	One further Lay (Independent) Member of the NWJCC

- 4.2 The membership of the Sub-Committee shall be determined by the Joint Committee, based on the recommendation of the Chair of the Joint Committee and lay members, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by Ministers or the Welsh Government.
- 4.3 The Chair of the Joint Committee and the Chair of the Sub-Committee, will receive a nomination from the CEOs of Local Health Boards as outlined below.
- 4.4 The Membership will be reviewed annually.

Support to Sub-Committee Members

- 4.5 The Committee Secretary, on behalf of the Sub-Committee Chair, shall:
 - Arrange the provision of advice and support to Sub-Committee members on any aspect related to the conduct of their role, and
 - Co-ordinate the provision of a programme of organisational development for Sub-Committee members as part of the overall JCCs Organisational Development programme.

4.6 In Attendance

One representative Chief Executive or designated nominated deputy who must be an Executive Director from a health board (and would be fully briefed on the issues to be discussed)
JCC Director of Planning and Performance (co-lead JCC Director)
JCC Director of Finance & Information (co-lead JCC Director)
Committee Secretary or representative who will routinely attend meetings ensuring governance support and advice is available to the Sub-Committee Chair
Staff side representative.

Directors may on occasion nominate a suitably senior deputy to attend the Sub-Committee on their behalf but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

- 4.7 The Chief Commissioner, and other directors / senior managers may be invited to attend when the Sub-Committee is discussing areas of risk or matters that are the responsibility of that Director / member of staff.
- 4.8 The Sub-Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Member Appointments

- 4.9 The membership of the Sub-Committee shall be determined by the Chair of the Joint Committee, taking account of the balance of skills and expertise necessary to deliver the sub-committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5 Quorum & Attendance

- 5.1 A quorum shall be at least two members comprising of two Lay (Independent) Members.
- 5.2 For effective governance, the Director of Finance and Information and the Director of Planning and Performance are required to attend all meetings.

6 Meeting Secretariat

- 6.1 The JCC Committee Secretary will determine the secretarial and support arrangements for the Sub-Committee.

7 Frequency of Meetings

- 7.1 The Meetings shall meet no less than 6 times a year, and otherwise as deemed necessary by the Chair of the Joint Committee.

- 7.2 Additional meetings may be called as appropriate with agreement of the Sub-Committee Chair.
- 7.3 Additional meetings may be held with the chairs of the LHBs Planning, Performance and Finance Committees where there is requirement.
- 7.4 Members will be required to attend a minimum of 75% of all meetings. Attendance will be monitored and reported to the Joint Committee through the Sub-Committee's Annual Report.
- 7.5 The Sub-Committee will arrange meetings and align with key statutory requirements during the year consistent with the Joint Committee's annual plan of Business.

8 Withdrawal of Individuals in Attendance

- 8.1 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

9 Circulation of Papers

- 9.1 All papers will be distributed at least 7 calendar days in advance of the meeting.
- 9.2 The Committee Secretariat will ensure that the draft minutes will be provided to the Sub-Committee Chair within ten working days following the meeting.
- 9.3 The JCC Committee Secretariat will ensure that a Sub-Committee highlight report is provided for presentation by the Sub-Committee Chair to the next Joint Committee meeting.
- 9.4 The Sub-Committee highlight report will also be shared with members and HB Directors of Corporate Governance / Board Secretaries.

10 Access

- 10.1 The Chair of the Planning, Performance and Finance Sub-Committee shall work closely with the Director of Finance and Information and the Director of Planning and Performance and have reasonable access to the Directors and other relevant senior staff within the JCC Team.

11 Accountability, Responsibility & Authority

- 11.1 Although health boards have delegated authority to the Joint Committee and subsequently to this Sub-Committee for the exercise of certain functions as set out within these terms of reference, each health board retains overall responsibility and accountability for ensuring the quality and

safety of healthcare for their citizens through the effective governance of their organisation.

- 11.2 This Sub-Committee is responsible for providing scrutiny and assurance to the JCC that Planning, Performance and Finance are being managed appropriately within the commissioning cycles.

Authority

- 11.3 The Sub-Committee is authorised by the Joint Committee to investigate, or have investigated, any activity within its terms of reference. The Sub-Committee is authorised by the Joint Committee to obtain outside legal or other independent professional and clinical advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with procurement, budgetary and other policy requirements.

Sub Groups

- 11.4 The Sub-Committee may, subject to the approval of the JCC establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

Delegated Powers

- 11.5 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

Dealing with Members interests during meetings

- 11.6 Declarations of interest will be a standing agenda item for all meetings.
- 11.7 Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for a meeting.
- 11.8 Interests declared at the start of, or during a meeting will be managed in accordance with section 8.2 of the JCC Standing Orders.

12 Reporting

- 12.1 The Sub-Committee Chair shall:
- Report formally, regularly and on a timely basis to the Joint Committee on the Sub-Committee's activities. This includes:
 - Assurance that Planning, Performance and Finance are being managed appropriately
 - oral updates on recent activity
 - submission of written Sub-Committee highlight reports throughout the year
 - to receive annual reports, which will incorporate key information on planning, performance and finance

- Bring to the Joint Committee's specific attention any significant matters under consideration by the Sub-Committee; and
 - Ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, Chief Commissioner, HB Chief Executive or Chairs of other relevant Sub-Committees of any urgent/critical matters that may affect the operation and/or reputation of the JCC and HBs.
- 12.2 The Sub-Committee shall provide a written, annual report to the Joint Committee on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Sub-Committees self-assessment and evaluation.
- 12.3 The Sub-Committee shall provide a highlight report to each HB after each meeting providing assurance that Planning, Performance and Finance are being managed appropriately, for inclusion on suitable HB Sub-Committee agendas.
- 12.4 The Joint Committee may also require the Sub-Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Sub-Committee's assurance role relates to a joint or shared responsibility.
- 12.5 The JCC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation.

Relationship with the Joint Committee and its Sub-Committees / Groups

- 12.6 Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the effective planning, performance and financial management of healthcare for commissioned services through the effective governance of its organisation.
- 12.7 The Sub-Committee is directly accountable to the Joint Committee for its performance in exercising the functions set out in these Terms of Reference.
- 12.8 The Sub-Committee, through the Sub-Committee Chair and members, shall work closely with the Joint Committees other Sub-Committees to provide advice and assurance to the JCC through the:
- joint planning and co-ordination of JCC and Committee business; and
 - sharing of information.
- 12.9 In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the JCCs overall risk and assurance arrangements.

- 12.10 The Sub-Committee, through its Chair and members, shall work closely with LHB Planning, Performance and Finance Committees to ensure that LHB Boards are informed of any issues relating to their population, recognising that concerns of the services commissioned by the JCC may impact on primary and secondary services and vice versa (i.e. the whole pathway). The Sub-Committee shall embed the JCC's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.
- 12.11 The Sub-Committee shall embed the organisational values and strategic objectives through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

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- 13.2 This Sub-Committee is a scrutiny and assurance sub-committee and therefore where a decision is required the matter will be referred to the JCC Team or Joint Committee, as appropriate.

14 Chairs Action on Urgent Matters

- 14.1 There may, occasionally, be circumstances where decisions which normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Committee Secretary as appropriate, may deal with the matter on behalf of the Sub-Committee, after first consulting with one other Lay (Independent) Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 14.2 Chair's urgent action may not be taken where the sub-committee Chair has a personal or business interest in the urgent matter requiring decision.

15 In Committee (Private Meeting)

- 15.1 The Sub-Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

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- 16.1 These Terms of Reference shall be adopted by the Sub-Committee at its first meeting and subject to review at least on an annual basis thereafter, with endorsement ratified by the Joint Committee.

**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG**

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
27 March 2024	ABUHB 2703/17	Quarter 3 - Performance and Outcomes Report Update on the CAMHS/ND Action plan to be provided at a future Board meeting.	Chief Operating Officer	November 2024	Not yet Due An update on performance is included in the Board's routine performance report (July and September 2024). A focussed performance report on Children's services is scheduled for presentation to the Board in November 2024.
17 July 2024	ABUHB 1707/13.3	Activity and Performance The targeted intervention actions and timelines, relating to Urgent and Emergency Care, to be shared with the Board.	Chief Operating Officer	August 2024	Complete A detailed report on the Health Board's escalation status and corresponding improvement actions were reported to the Board's Finance and Performance Committee on 9 th September 2024 (see link provided). abuhb.nhs.wales/files/key-documents/finance-and-performance-committee/2024-09-03-17-32-30-final-boardbook-pdf/

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
17 July 2024	ABUHB 1707/14	Community Therapy MSK Transformation Update An update report to be scheduled for 9 – 12 months' time (May 2025)	Secretariat	May 2025	Not Yet Due

All actions in this log are currently active and are either part of the Board's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Board meeting will be ready.

Once the Board is assured that an action is complete, it will be removed. This will be agreed at each Board meeting.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Senior Information Risk Owner Annual Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Paul Solloway, Director of Digital
SWYDDOG ADRODD: REPORTING OFFICER:	Paul Solloway, Director of Digital

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This annual report provides the performance and assurance of how the organisation manages risks to protect against the loss, damage or destruction of information assets.

Management and mitigation of these risks ensures the Confidentiality / Integrity and Availability of information.

- Confidentiality - the Health Boards keeps data secure through ensuring access to information is controlled through role-based access and suitable password controls for example. This also includes the physical controls to protect paper records
- Integrity - information is accurate and not tampered with and is typically protected through technical controls and data quality metrics
- Availability - information is available when needed through reliable systems and networks

Cefndir / Background

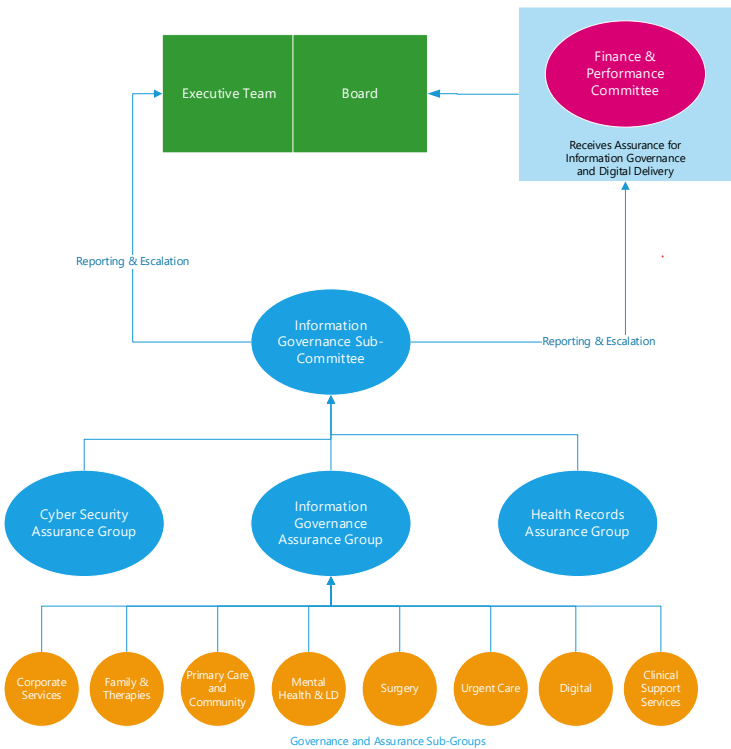
The Senior Information Risk Owner (SIRO) is responsible for owning the risks associated with Information Security and ensuring these risks are identified, assessed and supported by policies and procedures.

The SIRO also promotes a culture of security in the organisation through governance arrangements, awareness and training and supports the organisation in meeting the legislative requirements of the Network & Information Systems Directive (2018), Data Protection Act (2018) and the associated General Data Protection Regulations (2018).

The SIRO is supported by several roles and teams across the Health Board:

- Data Protection Officer (DPO) – ensures compliance with the Data Protection Act
- Caldicott Guardian – responsible for protecting the confidentiality of patient information through the eight Caldicot Principles
- Senior Information Asset Owners – responsible for managing assets within their area of responsibility and ensuring staff are suitably trained
- Cyber Security Team – responsible for technical controls protecting the Health Board from cyber security risks
- Information Governance Team – supports the DPO in compliance with data protection legislation

A formal governance structure is now in place for Information Governance as outlined below:



This annual report provides assurance of the information security arrangements across the Health Board for 2023/2024.

Asesiad / Assessment

The report details performance across a range of areas as highlighted below.

1. Information Governance Toolkit

The Information Governance Toolkit is completed by all NHS Wales organisations on an annual basis to measure their level of compliance against national standards and legislation associated with Information Governance.

The toolkit comprises a range of sections as part of self-assessment including policies and procedures, training and awareness, data protection impact assessments, risk management, information security and business continuity.

For 2023/2024 the Health Board’s compliance was 98%. Improvement was identified in relation to contractual arrangements with 3rd parties and is part of the Information Governance operational plan for 2024/2025.

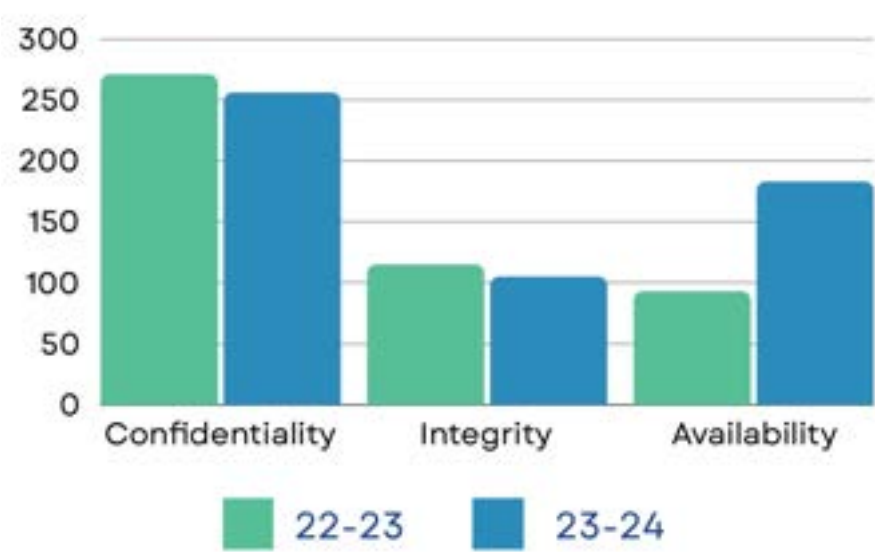
2. Governance Arrangements

A key part of the governance arrangements is the Governance & Assurance Groups (GAGs) which provide a forum for each division to discuss information security arrangements, and these groups ensure:

- Implementation of consistent Information Governance policies, standards and procedures
- Promote and disseminate good practice
- Ensure Data Protection Impact Assessments (DPIA) are undertaking for all new services
- Management of divisional Information Asset Register (IAR)
- Support training across the division
- Discuss Information Governance incidents and audits

3. Incidents and Complaints

During the year there were 462 incidents relating to either confidentiality, integrity or availability which were raised through the Datix Incident Management System. The majority of these were graded low with 3 medium incidents.



69 complaints were received and of these 11 were reported to the Information Commissioner’s Office (ICO), 9 of these are closed and 2 cases are still ongoing.

The Health Board use the National Intelligent Integrated Audit Solution (NIIAS) solution to monitor staff accessing patient records and identify where inappropriate access might have occurred. During the year there were 41 incidents, and these are managed in conjunction with the division and Workforce & Organisational Development team.

4. Access to Health Records

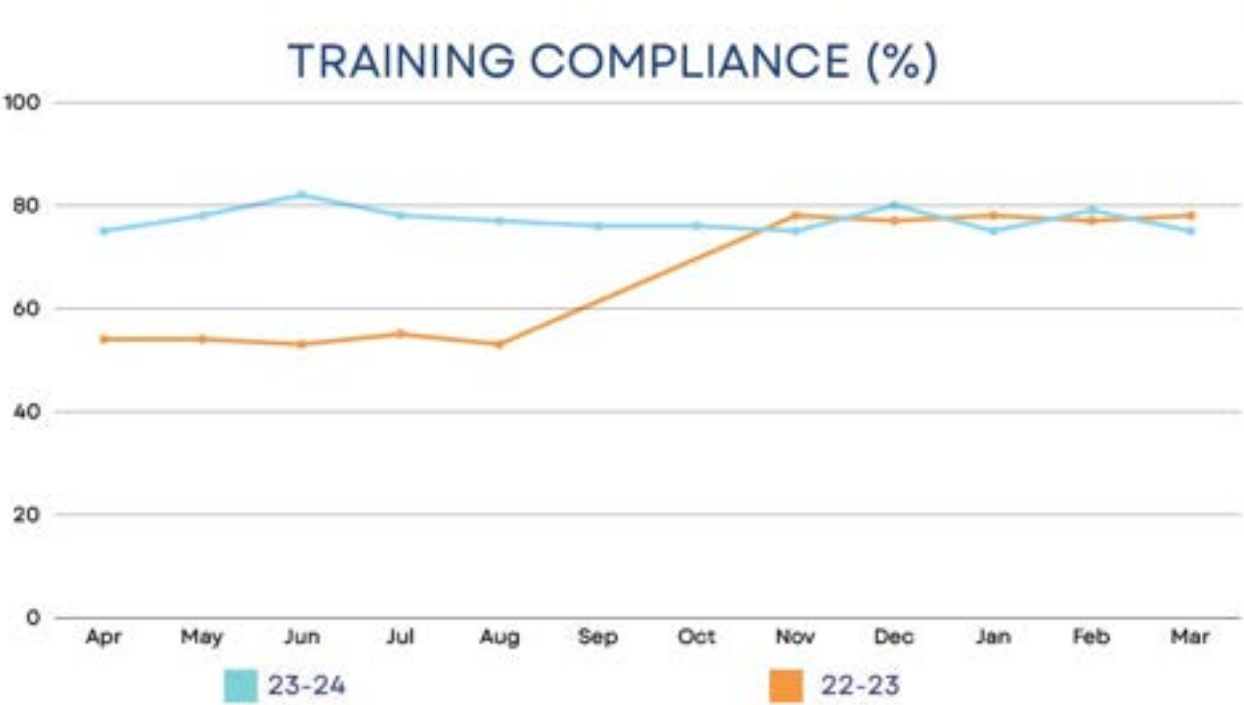
Through legislation individuals are allowed to request a copy of the information we hold about them and following any requests the Health Board must respond within 28 days.

During the last year the team received 6,652 requests and in year compliance rates have improved from 24% to 96%. This improvement was achieved through changes in recruitment and the implementation of a new digital solution to manage subject access requests.

5. Training Compliance

As part of the Electronic Staff Record there is a mandatory training module for Information Governance, Cyber Security and Health Records which all staff need to complete.

The training compliance for the Health Board is shown below:



Currently the training compliance is below the target of 85% and the Information Governance team are providing bespoke training to facilities staff as they typically have limited access to digital equipment to support improvement.

In addition, the current combined e-learning package can take over an hour to complete which is seen as a challenge for clinical staff. Nationally there are now proposals to split out the training into three shorter modules, one for Information Governance, one for Cyber Security and one for Health Records. Whilst no

timelines exist currently for this change, we envisage for this to be complete in 2024/2025.

6. Data Protection Impact Assessments

Any new system, service or project that is being implemented requires a Data Protection Impact Assessment (DPIA). These assessments identify any risks that need to be mitigated before a system or project goes live.

52 of these were completed in 2023/2024 and are regularly reviewed and updated to reflect working practices and system changes.

7. Cyber Security

There were no major cyber security incidents during 2023/2024 and an audit in April 2023 provided the Health Board with substantial assurance over the arrangements in place for our cyber security improvement plan, cyber security reporting and system backups.

Further progress has been made on compliance with the Network & Information Systems Directive with a recent audit for the Cyber Resilience Unit highlighting a compliance of 66% against the National Cyber Security Centre (NCSC) Cyber Assessment Framework (CAF).

Areas for improvement have fed into our Operational Plan for 2024/2025 with compliance improvements expected at our next audit.

Some of our Key Performance Indicators from the report are outlined below:

- Annual patching compliance of end user devices at 86.75% (95% target)
- Annual patching compliance of servers at 91.37% (95% target)
- 49 Code of Connection requests completed to enable 3rd party suppliers to securely access our systems for support and maintenance
- To campaigns in year undertaking by our phishing exercises resulted in increase in awareness of 7.98%

The cyber security team continues to undertake operational duties to manage the security threats against the Health Board:

- Daily morning checks
- Proactively manage vulnerabilities that exist on our network
- Undertaking simulated phishing campaigns to improve staff awareness of risks via electronic mail
- Cyber assurance of new projects and services

8. Health Records

At the end of the reporting period 577,541 patients now have a digitised health record an increase of 24,372 in year. By March 2024 97.06% of patients presenting to the Grange University Hospital had a digitised record.

The service also maintained its 48-hour turnaround target for paper records being scanned following discharge from a hospital admission.

During 2023/2024 20,323 records were reviewed for eligibility for destruction with 13,752 records destroyed.

Several modernisation initiatives have been completed in Health Records utilising Robotic Process Automation supporting improvements in referral processing and admission, discharges and transfers.

9. Clinical Coding

There are two Welsh Government targets in place for the delivery framework for Clinical Coding:

- % of episodes clinically coding within one reporting month post episode discharge date (95% target)
- % of coding errors corrected by the next monthly reporting submission following identification (90% target)

In year there was a reduction in coding completeness from 83.1% to 81.7% and following approval at Executive Committee a revised Clinical Coding structure and resource plan has now been put in place and completed over the summer. These new arrangements will support a trajectory of improvement during 2024/2025.

Coding accuracy saw significant improvements during the later half of the year and surpassed the target of 90% in February and March 2024.

The service has implemented Robotic Process Automation for coding the least complex activity such as day case episodes.

Argymhelliad / Recommendation

The Board is asked to RECEIVE the annual report from the Senior Information Risk Owner.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.4 Information Governance and Communications Technology 3.5 Record Keeping 4.2 Patient Information Choose an item.
Blaenoriaethau CTCI IMTP Priorities	Not Applicable Choose an item.
Link to IMTP	

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Digital, Data, Intelligence
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	SIRO – Senior Information Risk Owner DPO – Data Protection Officer GAGs – Governance and Assurance Groups DPIA – Data Privacy Impact Assessments IAR – Information Asset Register ICO – Information Commissioners Office NIIAS – National Integrated Intelligent Audit Service NCSC – National Cyber Security Centre CAF – Cyber Assurance Framework
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Information Governance Team Health Records Team Cyber Security Team Clinical Coding Team

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

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

2024

SIRO REPORT



EXECUTIVE SUMMARY

This report provides the performance and assurance of Information Governance and Information Security arrangements for the Health Board.

It provides assurance about the way the Health Board manages its information about patients and staff and highlights compliance with legislation and standards.



PAUL SOLLOWAY

**DIRECTOR OF
DIGITAL**

I'm delighted to share with you as Senior Information Risk Owner the Aneurin Bevan University Health Board's annual report on how we keep our information safe and secure, manage information risks, ensure policies and procedures are in place with effective staff training.

It has been a team effort across the organisation over the last 12 months as we have worked within our governance structures to embed a culture of information security, and I thank all those involved in the creation of this report.



PURPOSE OF THE REPORT

The report provides the mandatory and legislative reporting requirements and provides assurance about the way in which the Health Board manages its information about patients and staff and highlights compliance with Information Governance legislation and standards.



BACKGROUND & CONTEXT

The Finance & Performance Committee is provided with performance information regarding the Health Boards compliance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018). The Health Board must monitor its performance against the regulations and needs to be assured that its achieving an agreed and acceptable standard and have in place processes and procedures in order to achieve that standard.





ASSESSMENT & CONCLUSION

1. Senior Information Risk Officer, Caldicott Guardian & Data Protection Officer

1.1 Senior Information Risk Officer (SIRO)



Senior Information Risk Officers have responsibility for understanding how the strategic business goals of the organisation may be impacted by any information risks and for taking steps to mitigate them.

They must provide the Chief Executive with assurance that information risk is being managed appropriately and effectively across the organisation.

Aneurin Bevan University Health Board have set up a formal governance structure to provide Information Governance and Cyber Security assurance to the Board.

The Senior Information Risk Officer for Aneurin Bevan University Health Board is Paul Solloway - Director of Digital.

1.2 Caldicott Guardian (CG)



The Caldicott Guardian is responsible for protecting the confidentiality and reflecting patients' interest regarding the use of patient identifiable information. They are responsible for ensuring patient identifiable information is shared in an appropriate, ethical and secure manner.

The Caldicott Guardian for Aneurin Bevan University Health Board is James Calvert - Medical Director; Deputy Chief Executive Officer (CEO).

1.3 Data Protection Officer (DPO)



The Data Protection Officer facilitates the Health Board's compliance with its legal and ethical obligations in relation to the management of personal information by providing expert advice around its duties and responsibilities.

The Data Protection Officer is responsible for:

- To supervise all issues relating to the processing of personal data and monitor compliance with the principles of General Data Protection Regulation (GDPR) and other policies and regulations of data protection;
- To inform and provide advice to all staff members on how best to handle issues relating to privacy;
- To provide advice when Data Protection Impact Assessments (DPIA) need to be carried out;
- To co-operate with and act as a contact person for the Information Commissioner's Office;
- To raise awareness and train staff in Data Protection when dealing with individuals Personal Identifiable Information (PII), such as Name, Address, Date of Birth etc.

The Data Protection Officer for Aneurin Bevan University Health Board is Jonathan Meredith - Head of Information Governance.



NHS WALES

INFORMATION

GOVERNANCE TOOLKIT



The Welsh Information Governance Toolkit is completed by Health Boards across Wales on a yearly basis, with the submission date being the last day in March of each year. Each module within the toolkit is divided into 2 levels, these are:

- Minimum Expectations.
- Expectations Exceeded.

Compliance with the Welsh Information Governance Toolkit is now defined as an Achievement Status, which can either be:

- Minimum Expectations Met.
- Minimum Expectations Not Met.

Health Boards cannot achieve 'Expectations Exceeded' until all minimum expectations have been met.

Aneurin Bevan University Health Board current compliance for 2023/24 is **98%**.



The toolkit comprises of the following sections:

- Accountability:
 - Leadership and Oversight.
 - Policies and Procedures.
 - Training and Awareness.
 - Individual Rights.
 - Records of Processing and Lawful Basis.
 - Contracts and Information Sharing.
 - Risks and Data Protection Impact Assessments (DPIAs).
 - Breach Response and Monitoring.
- Freedom of Information (FOI) and Environment Information (EIR).
- Information security.
- Business Continuity.

An area that was identified for improvement was to ensure there are current contracts in place with 3rd Party Contractors for the following:

- Secure Destruction of Equipment.
- Secure Destruction of Paper Records.

The Information Governance Team is supporting the Facilities Department with this process.





GOVERNANCE & ASSURANCE GROUPS (GAGS)

The purpose of the Governance & Assurance Groups (GAGs) is to provide a forum for each Division to consider Information Governance requirements within the Division and to provide a consistent way in which it is managed.

In order to ensure that standards are achieved then the Group will:

- Ensure there is regular engagement across all services within the Health Board such as Urgent Care, Medicine, Surgery etc.
- Oversee the implementation of consistent Information Governance policy, standards and procedures within the Division.
- Input into Health Board Information Governance standards and consistent ways of working.
- Promote and disseminate good practice.
- Work collaboratively to influence and create good practice throughout the organisation.
- Undertake 'projects' and subject matter reviews.
- Facilitate the processes to ensure that the integrity of data and information is protected, ensuring that it is valid, accurate, complete and timely to support decision making within the Division and across the organisation.





Membership of the group consists of lead Divisional Staff reflecting the Division's structure and spans of responsibility. It also includes Information Governance Portfolio Managers providing relevant Information Governance support. The group is chaired by a Senior Manager from the Division, but secretariat services are provided by staff within Information Governance.

The Information Governance Team provide support and assistance by:

- Creation and management of a comprehensive Information Asset Register.
- Producing information dashboards to provide meaningful information to ensure compliance for Information Governance training, complaints, incident and breach management.
- Providing Information Governance training compliance statistics.
- Enabling Information Governance Audits.
- Assisting with Data mapping exercises.
- Undertaking Data Protection Impact Assessments.
- Providing advice and guidance on Information Governance standards and data protection legislation.





INFORMATION GOVERNANCE INCIDENTS

These incidents comprise of incidents relating to the 3 cornerstones of Information Governance; Confidentiality, Integrity, and Availability (CIA).

For this period, a total of **462** incidents relating to a compromise of either the Confidentiality, Integrity and Availability of patient data were raised via the Datix Incident Management System.

The majority of these incidents have been graded low, indicating that the incidents had lower impact on patient clinical care or affected a small number of patients, and that all incidents were well managed and in a timely manner by the services affected.

There were **3** incidents relating to Confidentiality that were graded as medium risk. Incidents that are graded medium or above, require consultation with the Data Protection Officer and consideration given to reporting to the Information Commissioner's Office.



 **Datix[®]**

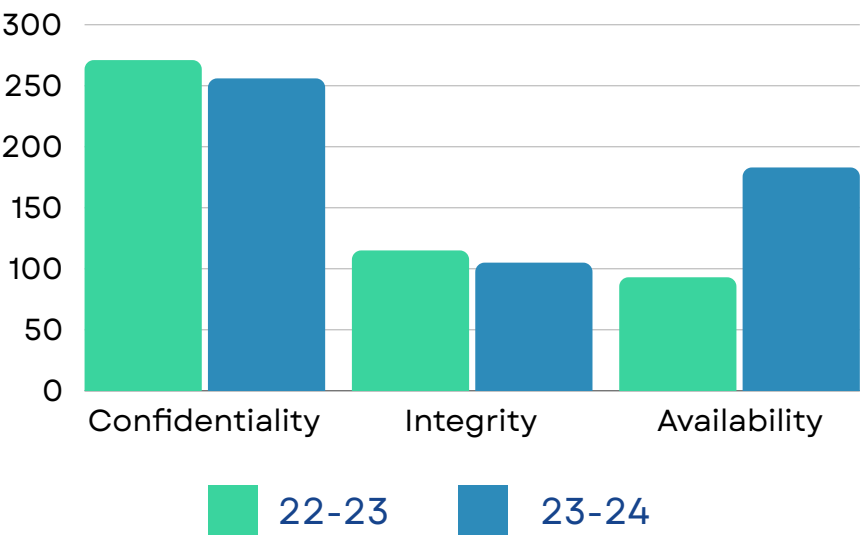


NUMBER OF INCIDENTS

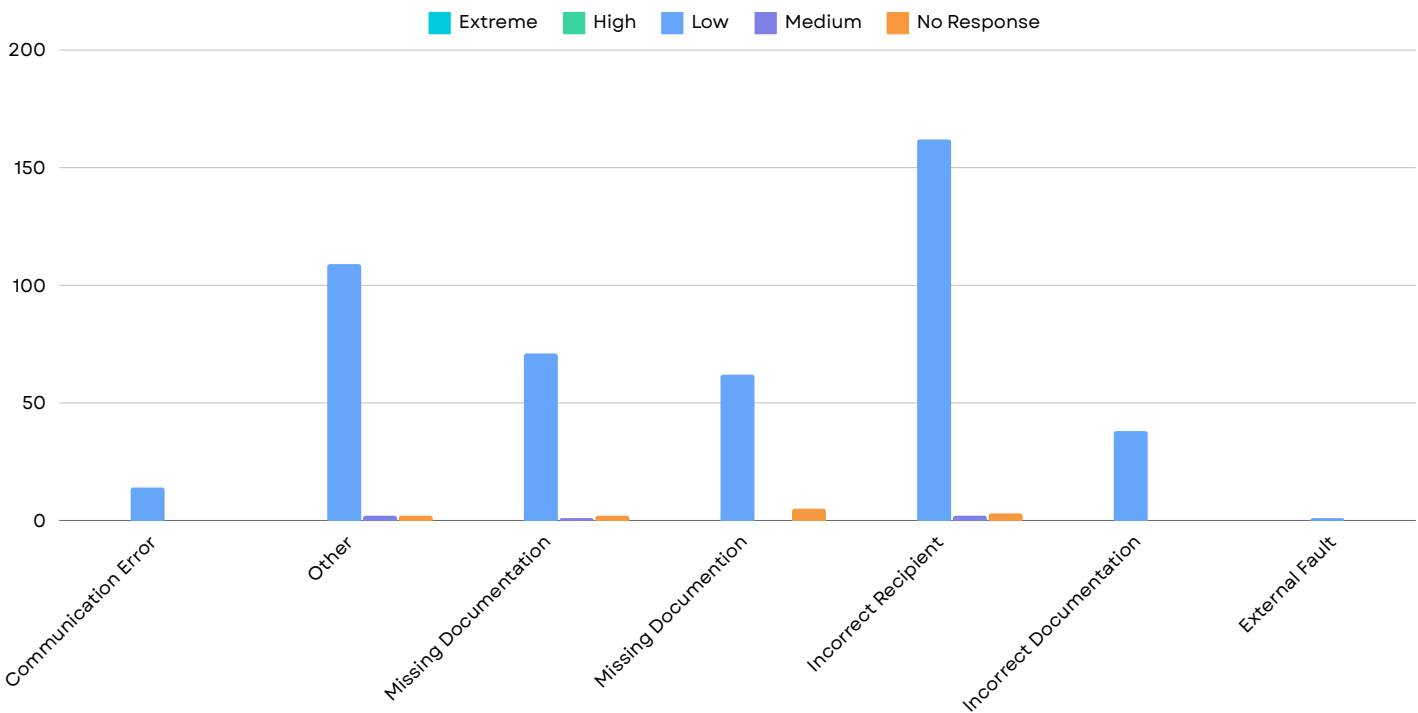
Confidentiality – i.e. it has been made available or disclosed to unauthorised entities.

Integrity – i.e. the accuracy and completeness of information has been compromised.

Availability – i.e. the data is not accessible when required by authorised personnel.



TYPE OF INCIDENTS & GRADES





COMPLAINTS AND INCIDENTS REPORTED TO THE ICO



Complaints received by the Information Governance Team for the period April 2023 – March 2024 = **69**

Upheld Complaints – Evidence was found to substantiate the complaint and the matter is being taken further.

Total number (for the period) = **46**

During this period incidents reported to the Information Commissioner's Office (ICO):

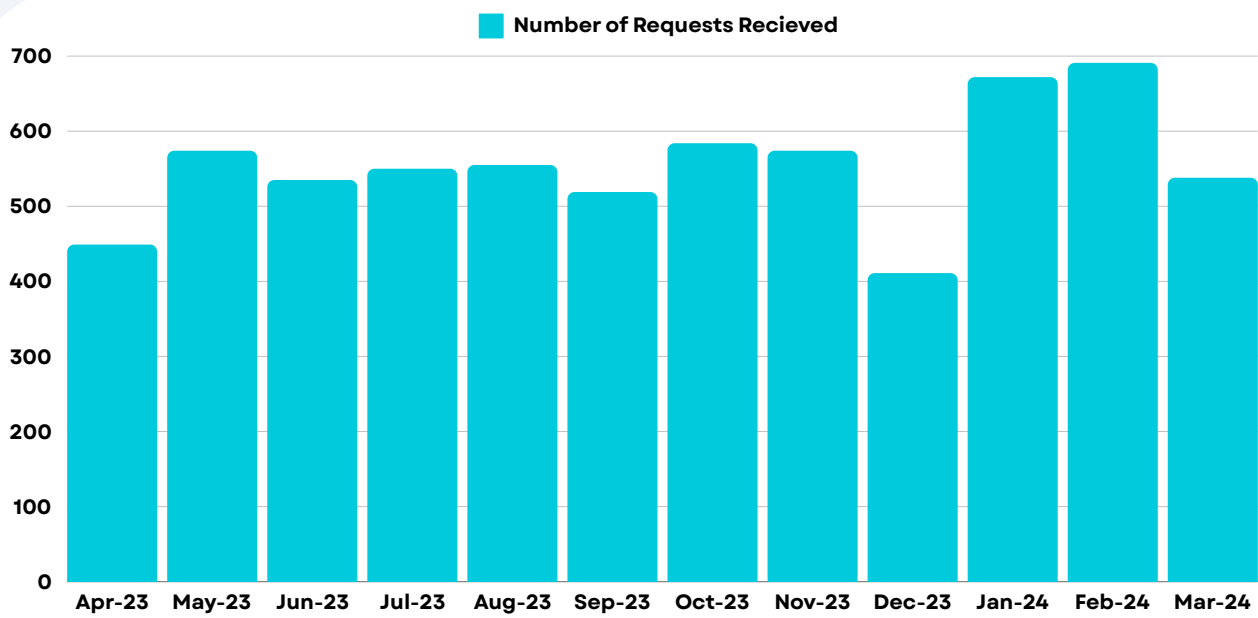
- By the Health Board – **0** reports; however, the Information Governance Team have contact with the ICO in certain circumstances to ascertain whether a breach needs to be reported or not.
- By Others – **11. 9** closed with no further action, **2** cases still ongoing.



ACCESS TO HEALTH RECORDS

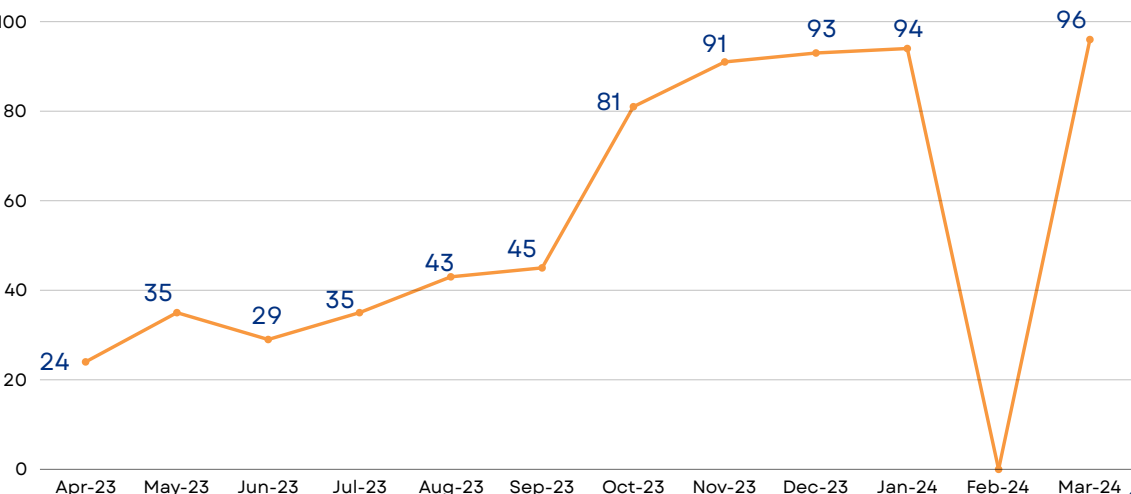
General Data Protection Regulation and the Data Protection Act 2018 allows individuals to request a copy of information we hold about them. To comply with legislation, the Health Board need to respond to these requests within 28 days.

Below shows the numbers of subject access requests received by the Access to Health Records department each month for the period 1st April 2023 – 31st March 2024. A total of **6652** requests have been received for this period.





ACCESS TO HEALTH RECORDS COMPLIANCE RATE %



Access to Health Records have seen a steady increase in requests for access to patient records. These requests come from various sources including but not limited to Police, Courts, Solicitors and from the patient themselves.

The department has now got a very good compliance rate; however, there were on some occasions where compliance with the volume of requests were not met. Improvements were made in recruitment, and the implementation of a new digital solution to manage subject access requests.

Please note that there is no compliance figure available for February due to the implementation of new digital solution to manage subject access requests.





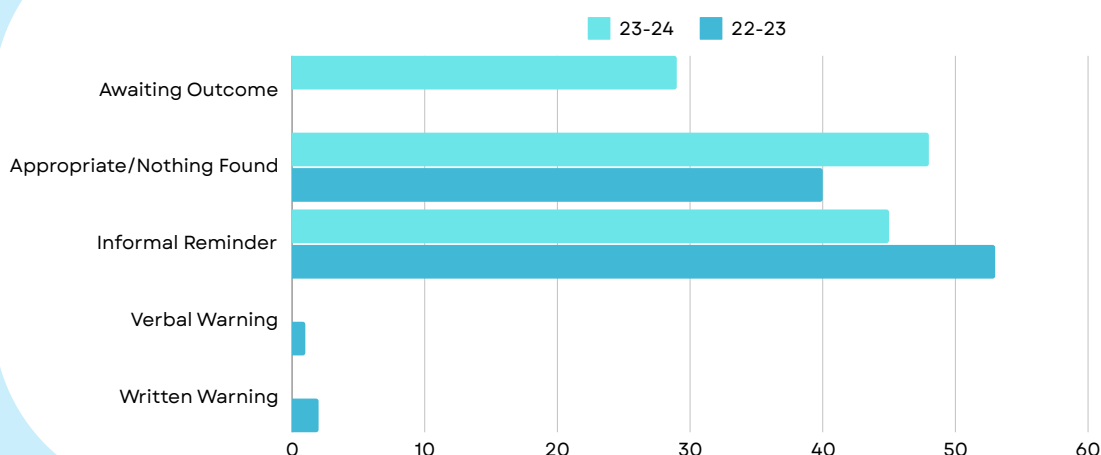
NATIONAL INTELLIGENT INTEGRATED AUDIT SOLUTION (NIIAS)



Inappropriate access to Aneurin Bevan University Health Board systems is monitored consistently by Information Governance via the National Intelligent Integrated Audit Solution (NIIAS), which monitors access to own records and those of family members.

When identified, the extent of access is graded, again in accordance with National Information Commissioner's Office (ICO) Risk Assessment Guidelines, to help to support both managers and HR with a measure of the severity of the breach. For this reporting period, a total of **41** incidents have been investigated by Information Governance, and all have been graded low, although a number are still awaiting further information from management. Any lack of response is picked up with Senior Management or via Divisional Governance Assurance Groups.

INAPPROPRIATE ACCESS

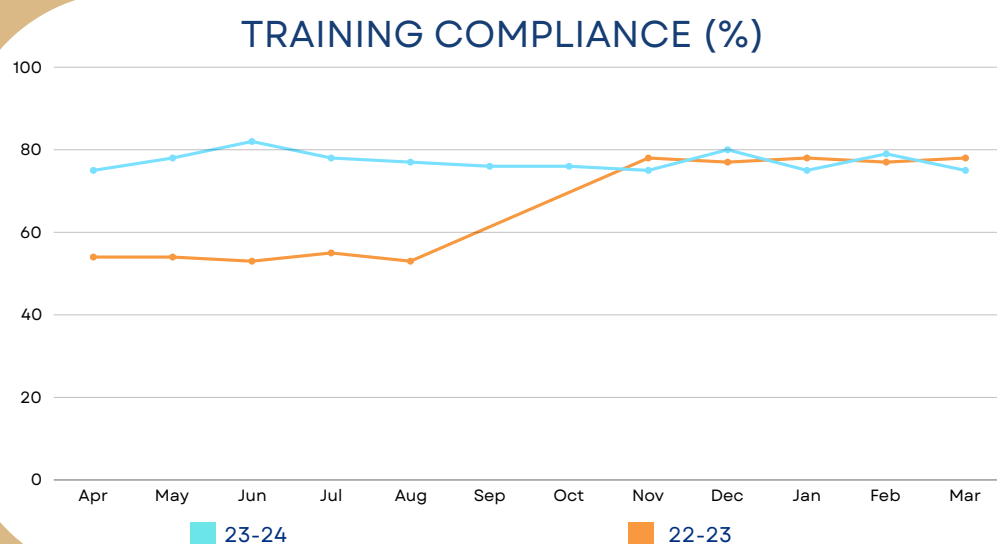




TRAINING COMPLIANCE



Below shows Information Governance, Cyber Security and Health Records training compliance percentage across the Health Board for the period 1st April 2023 to 31st March 2024.



The eLearning training package is a National product containing Information Governance, Cyber Security and Health Records which is time consuming for staff to complete and has affected the compliance rates of all Health Boards.

Discussions are ongoing on a National basis to separate the training into individual modules which should improve matters.

The Information Governance Team continue to work with divisions to ensure mandatory training is undertaken and support through specific induction and bespoke training.

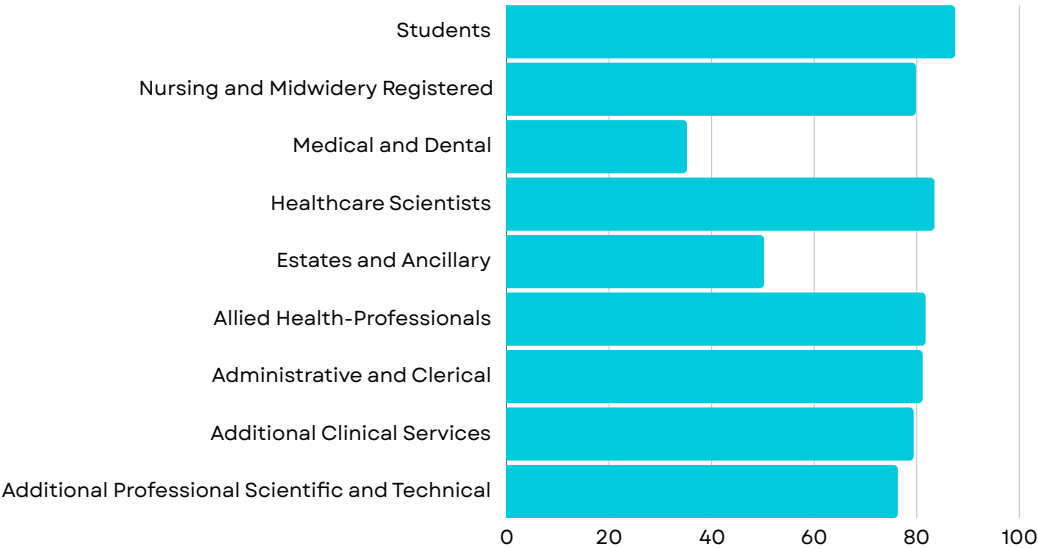
The current training compliance target is **85%**.



Below shows the percentage compliance rate broken down by staff groups. Work is ongoing through Governance & Assurance Groups to boost compliance rates with specific areas.



TRAINING COMPLIANCE BY STAFF GROUP (%)





DATA PROTECTION IMPACT ASSESSMENTS (DPIA)

In order to comply with Data Protection legislation, Data Protection Impact Assessments need to be undertaken in the event of any new system, service or project being implemented in the organisation. Data Protection Impact Assessments identify any Information Governance risks with the new system or project so these risks can be mitigated before a system or project goes live. The Information Governance Team works with services to complete Data Protection Impact Assessment screening questions and where necessary complete a full Data Protection Impact Assessment.

During the reporting period of 1st April 2023 – 31st March 2024, the Information Governance Team have been working with services and **52** Data Protection Impact Assessments have been undertaken. These Data Protection Impact Assessments help to support the Divisions in implementing the new service or system and are regularly reviewed and updated where necessary to reflect current working practices.



2024

CYBER SECURITY



EXECUTIVE SUMMARY

- No major cyber security incidents have impacted the Health Board during the period April 2023 to March 2024.
- In 21/22, Aneurin Bevan University Health Board completed a Self-Assessment against the Network & Information Systems Cyber Assessment Framework (NIS CAF) managed by the Cyber Resilience Unit (CRU). The Health Board were 66% compliant in terms of good practice within Network and Information Systems Directive (NISD). Following the initial Self-Assessment, the Cyber Resilience Unit (CRU) has undertaken two further on-site assessments, which have provided recommendations for improvement, which are currently being progressed.
- In April 2023, the NHS Wales Shared Services Partnership conducted their annual audit against the Network & Information Systems Cyber Assurance Framework (NIS CAF). The 3 areas audited were “Cyber security improvement plan”, “Cyber security reporting” and “Backup security”. The Health Board achieved Substantial assurance across all areas audited.
- The Cyber Security Team has maintained its monthly compliance reviews with the Health Boards technical teams to ensure compliance against agreed Service Level Agreements (SLA) as outlined in the relevant policies.
- The Cyber Security Team has also extended compliance reviews to cover the Windows Upgrade Project, which covers the eradication of unsupported devices across the Health Board.
- Security enhancements over the past 12 months include the reintroduction of monthly vulnerability scans, which provides assurance and identifies current security vulnerabilities across the entire server infrastructure of the Health Board.
- The security build for all new desktop PCs and laptops is scanned for vulnerabilities monthly to ensure the latest security updates are being applied to newly built devices.
- New Anti-Virus is now active across all our endpoints i.e., desktop PCs and laptops. All devices are enrolled, actively monitored through the platform, the security compliance of our endpoints is captured within the Monthly Cyber Report.



- Simulated Phishing Campaigns provided through software, support increased email security awareness amongst staff and allows targeted staff training if required. Malicious emails are one of the main routes that malware can enter an organisation so increasing security awareness of our staff provides an additional layer of defence.
- The Cyber Security Team has introduced the Report Phishing button via Outlook so staff can report suspicious emails directly to the Cyber Security Team. Further security is provided by the introduction of specialist software, which inspects the links within emails and blocks access if the link is deemed to be malicious.
- The Cyber Security Team has enrolled the Health Board in the National Cyber Security Centre (NCSC) Early Warning Service, which is a threat notification service that informs of potentially suspicious activity on networks from a variety of open source, commercial and private data sources.
- The Cyber Security Team has continued to develop its monthly Management Report which has been built out to also include Phishing Campaigns, Vulnerability Scanning, Anti-Virus reporting and Mobile Device reporting.
- Technical security enhancements that have begun in 2023 and are to complete in 2024 include the implementation on the new national Security Information and Event Management (SIEM) solution and the replacement of our firewalls with modern next generation firewalls capabilities in detection, monitoring, and alerting.





MONTHLY REPORT



Each month the Cyber Security Team produces a Monthly Report, which is provided to Senior Management and Executives.

This report highlights the current patch compliance and the Operating System (OS) of our Desktop, Server and Mobile Estate, vulnerabilities that exist on Desktops and Servers estate, results on Simulated Phishing Campaigns, Security Enhancements made throughout the month, operational challenges and more.



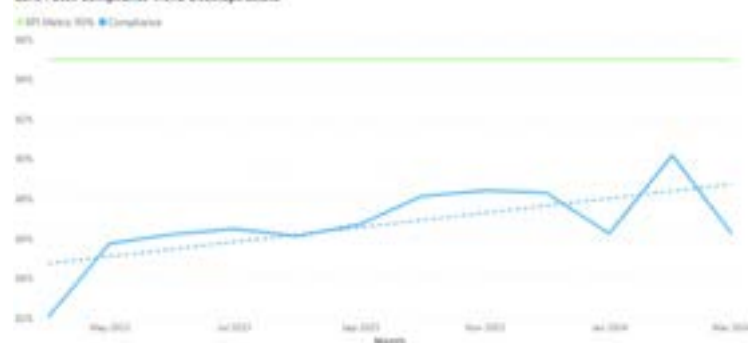
CYBER SERVICE PLAN





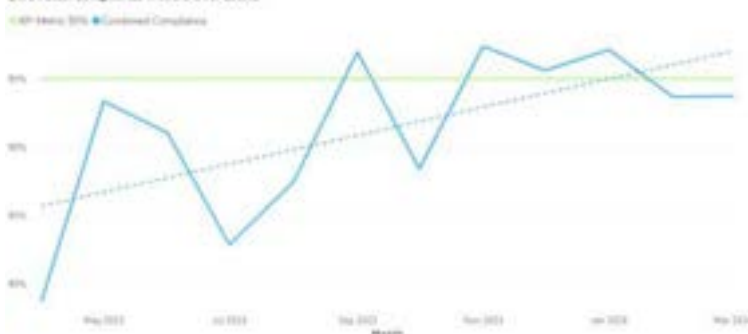
A SUMMARY OF OUR YEAR IN NUMBERS

Zero Patch Compliance Trend Desktops Estate



Compliance Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24
Desktop patches 81.01% 81.76% 82.22% 82.49% 83.12% 83.73% 84.12% 85.01% 85.31% 86.26% 90.18% 86.26%

Zero Patch Compliance Trend Server Estate



Compliance Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24
3rd Party Managed Servers 29.67% 81.67% 75.00% 16.27% 22.00% 85.11% 34.78% 85.24% 88.80% 91.20% 71.24% 71.47%
AB/MS Managed Servers 85.22% 84.84% 83.62% 91.23% 84.26% 86.43% 84.62% 87.81% 87.95% 90.62% 90.13% 86.14%
Overall Patching Status 79.70% 83.35% 81.38% 52.00% 87.46% 86.30% 85.40% 87.24% 93.61% 97.12% 82.48% 83.72%

Patching levels

Desktops

Workstations average annual patching compliance is **86.75%**.

Servers

Aneurin Bevan managed servers' annual patching compliance is **94.76%**.

Third Party managed servers' annual patching compliance is **63.12%**.

Overall server annual patching compliance is **91.37%**.

Ticket system

In July 2023, Aneurin Bevan decided to retire ServicePoint as our ticketing system and introduced Halo ITSM. Halo has allowed for more flexible and advanced reporting, data flows as part of a ticket template and is more visually pleasing.

Since 17th of July, our Annual SLA Incident Response Compliance is **86%** and our Annual SLA Request Response Compliance is **72%**.

In 2022/23, the Cyber Security Team resolved **294** tickets. In 2023/24, the Cyber Security Team has resolved a total of **583** tickets within ServicePoint and Halo ITSM. This is an increase of **98.30%**.





GOVERNANCE & COMPLIANCE

NHS WALES SHARED SERVICES PARTNERSHIP AUDIT

The scope of the audit is to provide assurance to Aneurin Bevan University Health Board that the mechanisms in place for ensuring cyber security are appropriately designed, and procedures and controls have been implemented within the previously agreed time frames, as outlined within the recent external review of cyber security.

The audit was substantial.

Purpose

To provide assurance that the organisation is working to improve its cyber security position, and that appropriate reporting is in place that shows the current status.

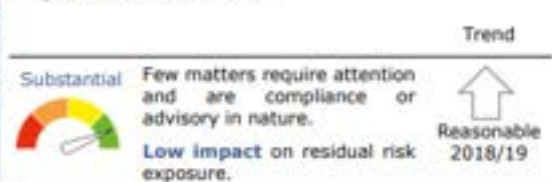
Overview

We have issued substantial assurance on this area.

A cyber security improvement plan is in place, which includes actions identified from the Cyber Assessment Framework (CAF). There is evidence that security has been improved, and continues to do so.

There are no matters requiring management attention.

Report Classification

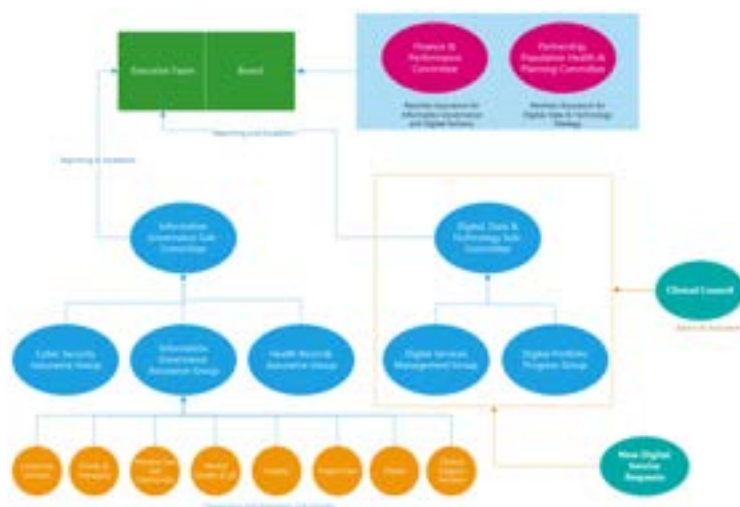


Assurance summary¹

Assurance objectives	Assurance
1 Cyber security improvement plan	Substantial
2 Cyber security reporting	Substantial
3 Backup security	Substantial

Cyber Security Assurance Group (CSAG)

In 2023/24, a new Information Security Governance Framework was introduced to provide assurance to the board through a Cyber Security Assurance Group, which reports into the Information and Governance Sub-Committee Group and allows for reporting and escalation to the Executive Team and The Board.





NETWORK & INFORMATION SYSTEMS CYBER ASSESSMENT FRAMEWORK (NIS CAF)

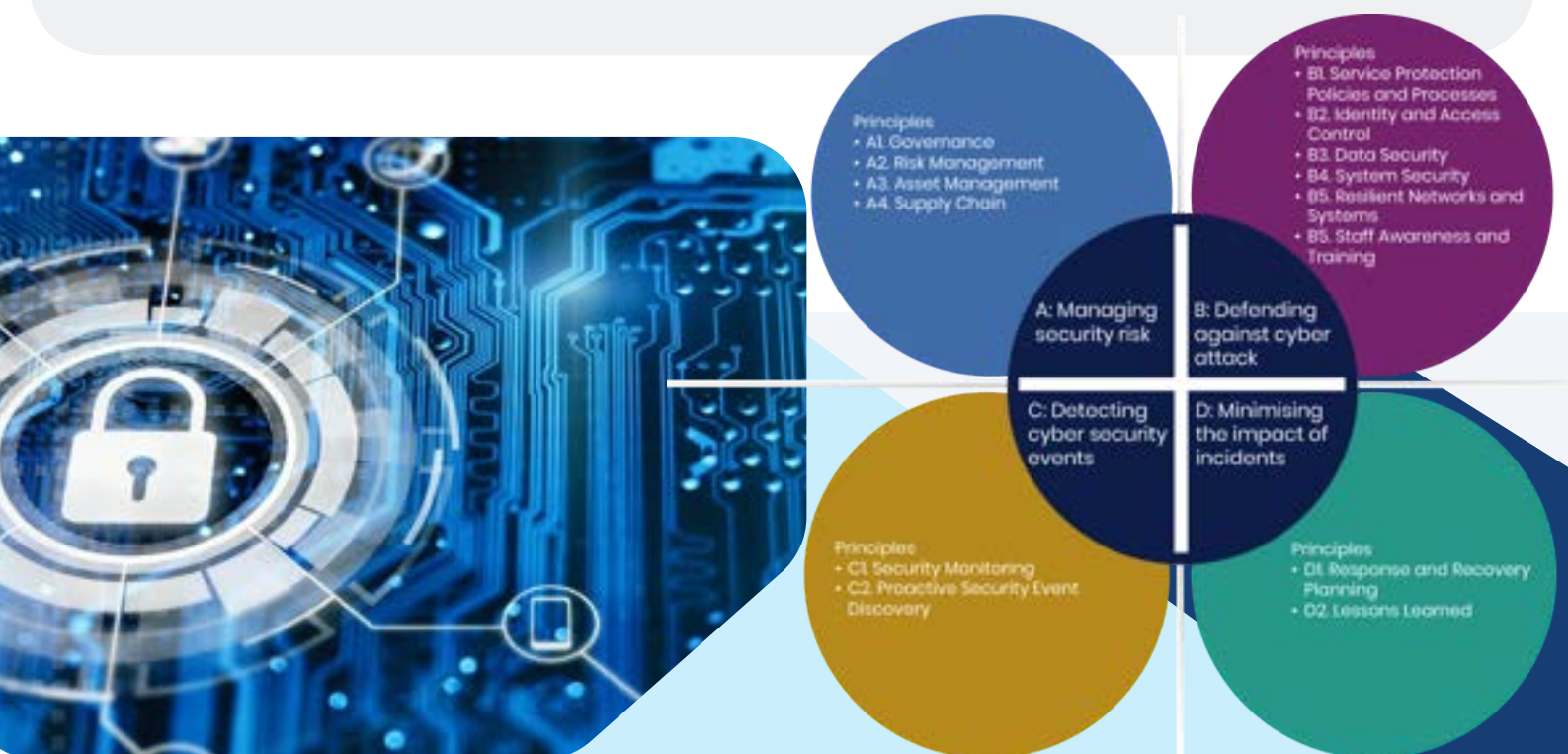
During Autumn 2023, the Cyber Security Team started preparing for the upcoming NIS CAF assessment by reviewing the self-assessment that took place in 2021/22.

During December 2023, the Cyber Security Team provided Cyber Resilience Unit with evidence against the scope that Aneurin Bevan would be audit against in January.

During January 2024, Cyber Resilience Unit attended site to conduct a review of our current stance against the 14 principles over a 4-day period.

Monthly beginning in March 2024, the Cyber Security Team provides Cyber Resilience Unit with a Findings Update against the outcome recommendations from the audit that took place.

The Cyber Resilience Unit will in the future undertake further audits, which will be used to provide assurance to the Board.





CYBER ACTIVITIES

Morning Checks

There are daily checks carried out within the team to check for any anomalies on our systems within our Network.

Management of Vulnerabilities

We have systems that detect vulnerabilities on our server and endpoints estate.

Security Information & Event Management (SIEM)

Digital Health and Care Wales (DHCW) are currently in the middle of onboarding a new national SIEM. This will replace the current system to allow effective reporting across our infrastructure.

Firewall

The Cyber Security Team have supported the procurement of our next generation firewalls with software to support management of Internet of Things devices (medical equipment, sensors and so forth), advanced web filtering and threat analysis.

Code of Connection (CoCo)

During 2023/24, the Cyber Security Team has completed 49 Code of Connections processes for our 3rd parties to provide remote support.

Projects

The Cyber Security Team work with Project Managers to provide cyber assurance on upcoming projects through our New Digital Service Request process.

Data Protection Impact Assessment (DPIA)

The Cyber Security Team has provided assurance on 52 DPIA alongside the Information Governance (IG) Team.

Security Training & Awareness

In April 2023, Welsh Government provided NHS Wales with mandatory Cyber Security training for all NHS Staff on ESR. The Cyber Security Team also provides Simulated Phishing Campaigns that target those within the Health Board.





INTERNAL COLLABORATION

Compliance meetings

Each month the Cyber Security Team hosts compliance meetings with technical teams to discuss the patching levels outcome, and any vulnerabilities that need to be addressed.

The Cyber Security Team also joins the Senior Project Manager once a month to receive an update on the Critical Server Refresh Programme so that we can track progress and report this in our Cyber Monthly Report.

Project meetings

The Cyber Security Team attends the ICT Programme board and the Capital Estate Project Summary Meeting to get the latest updates and provide Cyber Assurance on upcoming/ongoing projects.

Service Delivery Management Board (SDMB)

On a monthly basis, the Cyber Security Team presents our Monthly Report to SDMB members.

Governance and Assurance Groups (GAGs)

The Cyber Security Team attends GAG meetings on a regular basis alongside our Information Governance (IG) Team, covering divisions across the Health Board.

Contract Reviews

The Cyber Security Team assure that Cyber Security requirements are identified as part of the contract reviews and included in any new contracts.

Procurement Reviews

The Cyber Security Team has identified Security requirements to support the procurement processes and tender evaluations.



NHS

COLLABORATION

Operational Security Service Management Board (OSSMB)

The Cyber Security Team attend bi-weekly OSSMB meetings and a monthly OSSMB meetings, this is where all Cyber Security representatives from all Health Boards in NHS Wales meet and discuss upcoming activities around Information Security and good practices, and shared issues.

Microsoft 365 Service Management Board (M365 SMB)

There are monthly M365 SMB meetings that the Cyber Security Team attends, which highlights any changes that are happening within the tenant and any updates around EoL (End of Life) support around Microsoft applications and Operating Systems.

Task and Finish Groups

The Cyber Security Team, alongside ICT Support Teams provide updates on relevant activities.

Projects

In some cases, there will be national projects that the Cyber Security Team will get involved in and other Cyber representatives from other Health Boards will also be assuring the project.





CYBER SECURITY AWARENESS

KEEPING STAFF AWARE

In Phase 1, **23.45%** of staff did not recognise the simulated Phishing email as potentially malicious.

In Phase 2 **15.47%** of staff did not recognise the simulated Phishing email as potentially malicious.

Email Security Awareness training delivered in Phase 1 and provided to the Governance & Assurance Groups (GAG) by the Cyber Security Team has resulted in an increase of awareness of **7.98%** between the Phase 1 and Phase 2 of the campaign.



Staff awareness

The Cyber Security Team regularly attends Governance and Assurance Groups (GAG) alongside Information Governance with Divisions across the Board. In these groups, the Cyber Security Team provide Phishing Campaign Results, training videos, how to report to the Cyber Security Team, and discuss important Cyber Security activities that should be part of their working environment.

The Cyber Security Team also promotes its Intranet site.

The future of Simulated Phishing Campaigns

As part of our ongoing service improvement, the Cyber Security Team are looking to plan and rollout Phase 3 of our Simulated Phishing Campaigns.

Why conduct Phishing Campaigns

For the Cyber Security Team to gain an understanding of staff's knowledge on Phishing emails and to provide training where possible to educate members of staff on the importance of Email Security.

During 2024/25, Phase 3 will focus on identifying staff that input their credentials into a Simulated Phishing email links and will provide those staff with eLearning packages around email security awareness.



OUR PRIORITIES FOR 2024/25

Governance

- Policy Development to include an Information Security Policy and Policy subset to support the Information Security Policy.

Monitoring

- Develop security incident and event monitoring capabilities.
- Support implementation of next generation firewall solution to include Internet of Things devices, advanced URL filtering, and threat analysis.
- Anti-Virus - Determine capabilities of utilising additional security features to enhance arrangements.
- USB Device Blocking - Review the policy applied to USB port blocking with view to enhancing capabilities.

Assurance

- Pen Testing - Explore additional penetration testing of clinical systems.
- Build out enhanced phishing campaigns and training campaigns.
- Explore provision of retained Incident Response Unit paid annual retainer for service.

Reporting

- Build new Anti-Virus report for the Monthly Cyber Management Report.

Exercising

- Build out scheduled scenario-based Incident Management and BC/DR related exercising using Exercise in a Box tool or similar. Cover all areas to include Governance and Assurance Groups Incident Management.

Projects

- Account Management - to include privilege accounts, generic accounts, and use of Multi-Factor Authentication – nationally managed Task and Finish Group.
- Eradication of any unsupported Windows Operating Systems.
- Management of Shadow IT and control of non-domain joined devices.
- Process development for Remediation of vulnerabilities scans identified through monthly scanning.

Regulatory

- NIS CAF Assessments.
- Development of Asset Register to fully support NIS and capture clinical critical Systems.
- Business Impact Assessments (BIA) to be developed by Senior Information Asset Owners (SIAO's) to identify critical systems enhance development of ICT recovery planning in any BC/DR related incident.
- Review Remedial Actions and maintain NIS CAF Risk Register.

Risk Management

- Chair Cyber Security Assurance Group, to support identification and management of Cyber related risks, to support the governance framework to include the Information Governance Sub Committee Group.

2024

HEALTH RECORDS



DIGITISED HEALTH RECORDS PERFORMANCE INDICATORS

APR 2023 - MAR 2024



Digitised Health Records Performance

- 577,541 patients with a digitised record.
- 24,372 patients / 29,182 folders scanned from the library.
- Maintaining 48-hour turnaround target to ensure all paper records are kept up-to-date and are available on clinical systems should patients return following discharge for further care.

Additional Work: Medical Examiner, Physiotherapy, Bladder & Bowel Nursing Records & Lymphoedema

- Medical Examiner work absorbed in teams due to release of time from RPA.
- Physiotherapy (6 months post discharge and archive).
- Bladder & Bowel Nursing Records (Archive complete and maintenance scanning only required now).
- Lymphoedema – part of Phase 3 business case but storage pressures have expedited the scanning requirement.

Month	Medical Examiner Records	Physiotherapy	Bladder & Bowel	Lymphoedema
April 23 – Mar 2024	4,177	32,084	727	1,832



Action Plan

Maintaining the 48-hour turnaround target

When a patient is discharged following a hospital admission, records are collected from wards and returned to the Clinical Coding department to code various aspects of patient care. This can add delays in the Health Records service receiving the records.

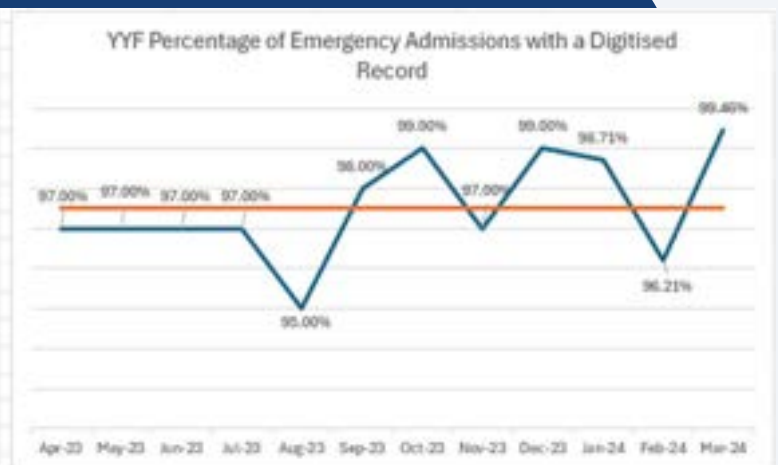
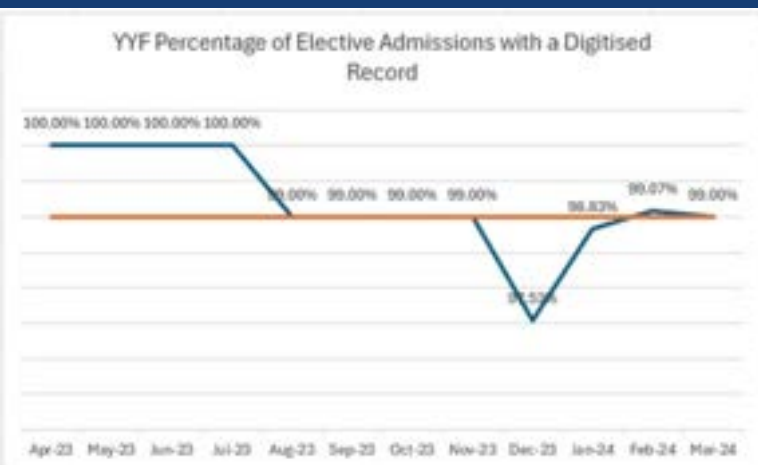
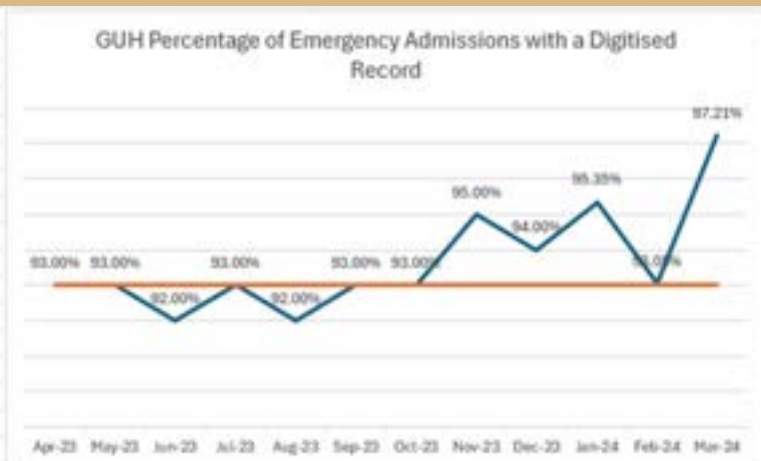
The Health Records Team have been reviewing this with the Clinical Coding service with an agreement that records are sent to the Health Records Service to reduce backlogs where possible.





ELECTIVE/EMERGENCY ADMISSION PERFORMANCE INDICATORS

APR 23 – MAR 24





DESTRUCTION PERFORMANCE INDICATORS

APR 2023– MAR 2024



Destruction

- 20,323 records reviewed for eligibility for destruction.
- 13,752 records destroyed.
- Destruction rate **67.67%**.

TRAINING & AWARENESS SESSIONS

APR 2023 – MAR 2024

AND QUALITY AUDITS

ACTION PLAN TRAINING & AWARENESS

- Increase Uptake of training.
- Commitment required from senior management to support the audit findings of poor records management and release of staff for training.
- Poor record keeping standards require to be addressed.
- Audits of Health Records being returned from services/wards/departments to commence April 2024 and links with the Quality & Patient Safety to be made to ensure that learning is shared.



MENTAL HEALTH ARCHIVE SERVICE



- Two Health Records staff (utilising vacancy hours due to urgency of requirement) redeployed to Mental Health at St Cadocs taking in the archive records from the sites as per the agreement with the Division, tracking and refiling.
- It has been identified that there are environmental challenges of where paper records are stored. There is work to be undertaken to improve the environmental conditions of storage.

Mental Health Archive Action Plan

Business case approval underway on the progression of the Phase 3 business case for Mental Health, Therapies and other services to:

- Alleviate risk to health and safety for staff, patients whose records could be compromised due to extremely poor environmental and storage conditions.
- Potential unauthorised access and delays in retrieval due to the way in which records are being stored and Access to Health having to formally extend timescales for release of information as a result.



ROBOTIC PROCESS AUTOMATION

Robotic Process Automation (RPA) is a software technology that uses software “robots” to automate repetitive, rule-based, digital tasks. Robotic Process Automation used software bots to mimic human actions and interactions with digital systems and software, increasing productivity and streamlining workflows, as well as freeing employees from mundane tasks for more valuable work.

Achievements made:

- Admission/Transfer/Discharge.
- Clinic Pulling Lists – 200+ clinics per day.
- Clinic Continuation sheets & Patient ID labels for patients attending clinics.
- Capsure Batch Deletions (deletion of temporary image files that have been exported).
- Capsure Batch Creations – (creation of batches for scanning inpatient and outpatient records).
- Referral processing – one speciality left (COTE) to go live – all others now live for urgent and routine patients – achieving target turnaround processing in 24 and 48 hours.

ROBOTIC PROCESS AUTOMATION ACTION PLAN

- Migration of Robotic Process Automation (RPA) platform during July 2024.
- Care of the Elderly referrals to go live in August 2024.
- USC referrals to go live August/September 2024.
- Further enhancements/refinements to referral processing during this period.

2024

CLINICAL CODING



CLINICAL CODING

Clinical Coding is the translation of medical terminology, as written by the clinician in the patient notes or record to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into alphanumeric codes which are nationally and internationally recognised.

Clinically coded information can be used to provide accurate and consistent data, which can be utilised across many areas of healthcare:

- Consultant appraisals.
- National and local audits.
- Research and development.
- Business Cases.
- Finance and costing.
- Planning.
- Freedom Of Information (FOI) requests.
- Performance and benchmarking.
- Disease surveillance.
- Commissioning.

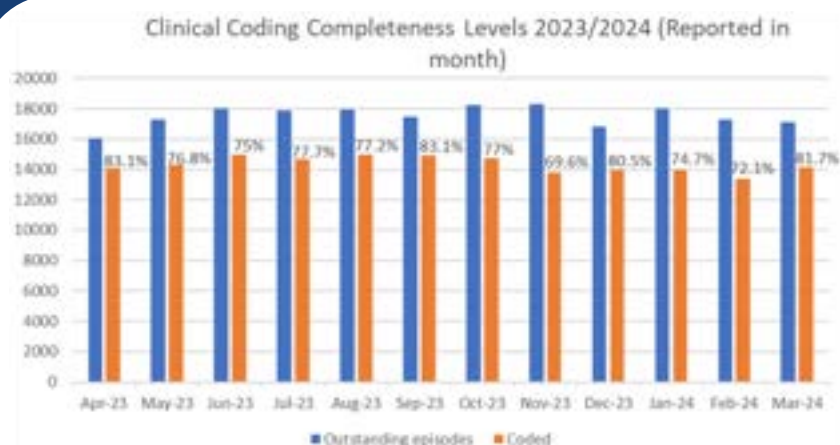




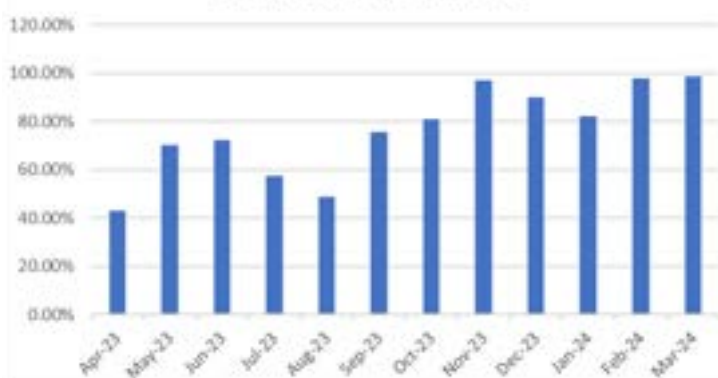
Clinical Coders are skilled health informatics professionals, whose job it to translate medical terminology into codes, using the international Classification of Disease (ICD-10) and the Classification of Interventions and Procedures version 4 (OPCS). Clinical Coding is a specialist field, those working within coding are either ACC (Accredited Clinical Coder) or working towards the National Clinical Coding Qualification (NCCQ).

There are two Welsh Government Targets in place which normally form part of the NHS Wales Delivery Framework:

1. Percentage of episodes clinically coded within one reporting month post episode discharge date. Target to maintain the 95% target or demonstrate an improvement trend over 12 months.
2. Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification. Target of 90%.



DHCW Accuracy Dashboard

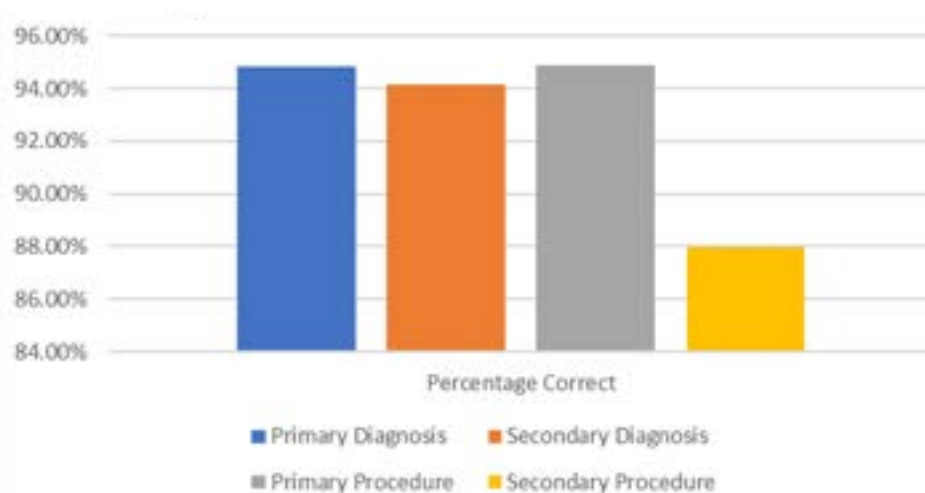


To measure our accuracy rate, Digital Health and Care Wales (DHCW) publish a weekly Dashboard (see table below) of our accuracy scores as well as undertake audits on an annual basis. ABUHB has consistently scored well above the accuracy measures (see table below for the results from the latest DHCW audit 2023/24. Aneurin Bevan University Health Board exceeded the recommended minimum percentage of errors, 90% for Primary Diagnosis and Primary Procedure and 80% for Secondary Diagnosis and Secondary Procedure



CLINICAL CODING AUDIT 23/24

Digital Health and Care Wales Audit Results



Primary Diagnosis code - the main condition treated.

Secondary Diagnosis codes - e.g., External Cause codes.

Primary Procedure codes - main procedure undertaken.

Secondary Procedure codes - e.g., site codes.

Digital Health and Care Wales (DHCW) undertake audits at each Welsh Local Health Boards and Velindre NHS Trust on an annual basis, episodes are randomly generated from the activity data held within the Patient Episode Database for Wales (PEDW).

Aneurin Bevan University Health Board has consistently score well above the accuracy measures and shown improvement compared to last years audit.

With regards to an improvement plan:

- Clinical Coders are reminded to abstract all the necessary information form the medical record and consistently apply the full four step coding process.
- Clinical Coders are supported with attendance on regular training courses in order to retain and refresh their skills. In addition, staff are given time to undertake specialist Clinical Coding E-learning modules.
- As part of the recent Clinical Coding restructure, new posts have been created within Training and Audit, which will assist in the expansion of the current audit programme and further develop our clinical coding validation programme.





ISSUES AFFECTING CLINICAL CODING TARGETS

Documentation

- No issues to report with availability of paper records or scanned.
- The continued use of handwritten procedure forms for some specialities, such as ophthalmology. All should be electronic.
- Pre-assessment forms are still handwritten, making it impossible to utilise for RPA coding automation.
- Poor documentation on E-discharge Summaries, such as, use of full stop instead of a formal diagnosis, unclear diagnosis documented, use of abbreviations.

Staffing levels

Recruitment and retention of staff is the biggest issue facing the service for various reasons, such as higher rates being paid across the border and in private hospitals. The ability to work from home has further exacerbated this, as people can now work for any Health Board or Trust across the UK.

A review of the Clinical Coding structure highlighted the need for additional posts and roles to improve the ability to attract additional staff and to provide a better career structure for clinical coders. The recruitment for this is underway although there has been some difficulty in attracting suitable candidates even for the enhanced roles at higher bands.

In order to improve compliance with the coding completeness target the recruitment to the additional posts identified is critical. Without additional staffing the ability to meet the Welsh Government targets will be compromised.

Staff in Post

Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
29.28	29.28	29.28	29.28	29.28	29.51	29.51	29.51	31.51	31.51



ROBOTIC PROCESS AUTOMATION

The Clinical Coding Service has been working towards more digital ways and is now using Fully Automated Coding Solution, responsible for coding our least complex activity such as Day case episodes.

Benefits of automating coding:

- Coding Automation works in parallel with the Clinical Coding Team allowing for a business user friendly solution, which is enabling us to improve our coding completeness levels and service overall.
- Newly created posts (Coding Analysts) as part of the re-structure conduct quality checks, which is reducing as accuracy is proven.
- Partially bridges the resource gap in the team.
- Remove all requirements for agency support.
- Less mundane coding for the team, allows for the Trained Clinical Coders to concentrate on more complex activities.

Improved information leading to better health and care for every patient is at the heart of Clinical Coding. The way information flows around the health service makes it possible to deliver faster and safer patient care.

The vision of the Clinical Coding Service is paramount in ensuring that the Quality and Completeness of coded data equals the high standard expected within the Health Board.



Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Er Sicrwydd/For Assurance

Sefyllfa / Situation

This paper sets out the Health Board's response to the Annual letter from the Public Services Ombudsman Wales to provide assurance to the Health Board that it is compliant with the PSOW recommendations as set out within the letter (Appendix 1).

Cefndir / Background

The action plan for 'Groundhog Day 2: an opportunity for cultural change?' was presented to PQSOC in December 2023, and all actions agreed have been completed by the Health Board.

The management of complaints handling continues to receive organisational and Executive focus with significant focus on both the timeliness and quality of complaint responses.



One public interest report has been published in the time period relating to the Health Board's offer of Fampridine, following its approval for NHS use in Wales in December 2019. The Health Board has subsequently been able to comply with all PSOW recommendations regarding the report.

In the last year the PSOW itself has seen an overall increase in the volume of approaches being made across Wales however for Health Boards this has remained broadly similar to the previous year. For Aneurin Bevan University Health Board (ABUHB) in 2023/24 the PSOW received 175 complaints related to the Health Board (which was in line with the Welsh average per 1,000 residents) and intervened on 37% of cases, which was the highest intervention rate of all Health Boards and above the average intervention rate across Wales of 31%.

Asesiad / Assessment

As a Health Board it is imperative to continue fostering good relations with PSOW colleagues. The Putting Things Right (PTR) team continue to meet quarterly with PSOW's Head of Complaints Standards and the Compliance and Improvement Officer. These collaborative meetings are both informative and supportive and have ensured relationships are further strengthened actively working to reduce the number of interventions and improve compliance performance with recommendations.

Some of the following actions have already been undertaken in recognition of the Health Board's statutory requirements to PSOW, utilising identified themes to drive organisational improvement:

- Bi-weekly meetings and bespoke training for concerns teams are in place to enhance communication and support.
- An Acknowledgement Team has been introduced to ensure a person-centred approach to concerns management.
- The Patient Advice Liaison Service (PALS) has been successfully implemented.
- Continuous improvement workstreams are in place, leading to significant reductions in incidents like cardiac arrests and Never Events.
- Future PSOW recommendations will be tracked using the Health Board's internal Audit Management and Tracking (AMaT) system.
- The Putting Things Right Concerns (Complaints) Policy has been reviewed and updated.

Recognising that the Health Board has received the highest number of interventions, the impact of the measures implemented towards the end of the last financial year and the current improvement plans in place to improve complaints processes will both increase the responsiveness to complainants and improve the quality of complaint responses. This will in turn reduce the number of complaints referred to the PSOW and reduce subsequent interventions.



The Quality Patient Safety (QPS) resources were centralised at the end of February 2024, in order to realise a number of benefits for the quality and patient safety processes including complaints specifically:

- retention of knowledge, skills and experience across the teams
- improving consistency within processes
- reducing duplication of effort
- more effective triangulation of concerns and incidents processes across the Health Board
- to ensure improved quality, timeliness and person-centred responses
- support a culture of shared learning.

Since February the new Quality Patient Safety teams have been collaborating closely with operational teams across the Health Board continue to improve processes and outcomes. This working relationship also ensures that realistic and achievable timescales are being agreed with Divisional teams who are ultimately responsible and accountable for the delivery of any learning and actions. Ongoing monitoring of these as well as any subsequent audits and assurance will be underpinned via AMaT.

Learning from the recommendations from PSOW investigations are incorporated into the new Listening and Learning Framework and will be discussed within the bi-monthly Health Board listening and learning forum.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this report and take assurance from the improvements in the PTR process and that the Health Board will continue to consider the data in the Annual letter, alongside the Health Board’s data, to understand more about organisational performance on complaints, including any patterns or trends and the organisation’s compliance with recommendations made by the PSOW office.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.2 Communicating Effectively 3.3 Quality Improvement, Research and Innovation 6.3 Listening and Learning from Feedback 4.2 Patient Information
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.



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

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

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





**Ombwdsmon
Ombudsman**
Cymru • Wales

Ask for:

Communications



01656 641150



Caseinfo@ombudsman.wales

Date: 9 September 2024

Ann Lloyd CBE
Aneurin Bevan University Health Board

By email only

ann.lloyd@wales.nhs.uk

Nicola.prygodzicz@wales.nhs.uk

Annual Letter 2023/24

Dear Ann

Role of PSOW

As you know, the role of the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. I also undertake investigations into public services on my own initiative.

Purpose of letter

This letter is intended to provide an update on the work of my office, to share key issues for health boards in Wales and to highlight any particular issues for your organisation, together with actions I would like your organisation to take.

Overview of 2023/24

This letter, as always, coincides with my Annual Report – “A New Chapter Unfolds” – and comes at a time when public services continue to be in the spotlight, and under considerable pressures. My office has seen another increase in the number of people asking for our help – a 17% increase in overall contacts compared to the previous year, with nearly 10,000 enquiries and complaints received. Our caseload has increased substantially - by 37% - since 2019.

Page 1 of 10

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac
ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond
to correspondence in Welsh.

During 2023/24 we considered and closed more enquiries and complaints than we ever have done before, and we reduced the average cost for each case and investigation. We started the year with a focus on reducing our aging cases, those over 12 months old, by 50% by the end of the year. These cases are often the most complex and distressing for the people making the complaint. I am extremely pleased to say we exceeded this target, reducing our aged investigations by over 70%. We are now well on track to meeting our objective to complete investigation of complaints within 12 months.

Public Service Complaints and compliance with recommendations

We received 939 complaints about health boards last year – roughly the same number as the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 31% of health board complaints - a similar proportion to previous years.

Last year, we received 175 complaints about Aneurin Bevan University Health Board, we closed 195 (some complaints were carried over from the previous year) and intervened in 37% of cases. This is the highest intervention rate of all health boards. Further information on the complaints we dealt with last year can be found in the appendices.

We published one public report in the public interest relating to the Health Board's failure to offer treatment to patients who have multiple sclerosis with the drug fampridine after its approval for NHS use in Wales in December 2019. I am pleased that the Health Board has complied with the recommendations in my report.

In total, we made 209 recommendations to your health board during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2023/24, 208 recommendations were due and 75% were complied with in the timescale agreed. The remainder were complied with, but outside the timescales agreed, or remained outstanding as at 9 April 2024.

Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Further to the report my office issued in June 2023, [Groundhog Day 2: An opportunity for cultural change in complaint handling?](#) I wish to thank the Health Board for its consideration of the report and recommendations. I trust that it has ensured that lessons learned from the PSOW's findings and recommendations on cases we considered last year are included in your Health Board's Annual Report on the Duty of Candour and Quality.

Supporting improvement of public services

We continued our work on supporting improvement in public services last year and worked on our second wider Own Initiative investigation. The investigation considers carers' needs assessments undertaken by local authorities in Wales. My report on this work will be finalised and published in the near future.

We have continued our work on complaints handling standards for public bodies in Wales and now have 56 public bodies following our model complaints handling policy. These public bodies account for around 85% of the complaints we receive.

We continued our work to publish complaints statistics into a third year with data, gathered from public bodies, now published twice a year. This data allows us to see information with greater context – for example, last year 6% of complaints made to Aneurin Bevan University Health Board's complaints went on to be referred to PSOW. I would encourage all health boards to use this data to better understand their performance on complaints and ensure that all complaints are appropriately logged.

Colleagues from my Improvement Team continue to meet regularly with Aneurin Bevan University Health Board to discuss compliance with our recommendations and our complaints standards work. We have seen real benefit come from these conversations, as well as improved working relationships, and we would like to pass on our thanks to Rhiannon Price and their team for their work with our officers.

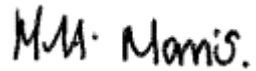
Action we would like your organisation to take

Further to this letter can I ask that Aneurin Bevan University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.
- Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality.
- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

Finally, I would like to thank you, and your teams, for your work with my officers in the last year. Their work is important in ensuring that patients and families receive timely and thorough responses to complaints, and in improving outcomes for all service users – not just those who complain.

Yours sincerely,

A handwritten signature in black ink that reads "M.M. Morris".

Michelle Morris
Public Services Ombudsman

Cc. Nicola Prygodzicz, Chief Executive, Aneurin Bevan University Health Board.



Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1,000 residents
Aneurin Bevan University Health Board	175	0.30
Betsi Cadwaladr University Health Board	214	0.31
Cardiff and Vale University Health Board	150	0.30
Cwm Taf Morgannwg University Health Board	109	0.25
Hywel Dda University Health Board	138	0.36
Powys Teaching Health Board	21	0.16
Swansea Bay University Health Board	132	0.35
Total	939	0.30



Appendix B - Received by Subject

Aneurin Bevan University Health Board	Complaints Received	% share
Admissions/discharge and transfer procedures	2	1%
Adult Mental Health	9	5%
Ambulance Services	0	0%
Appointment procedures (including outpatients)	2	1%
Child and Adolescent Mental Health	2	1%
Clinical treatment in hospital	82	47%
Clinical treatment outside hospital*	9	5%
Complaints Handling	41	23%
Covid-19	1	1%
Continuing care	4	2%
De-Registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	0	0%
Independent Health Care providers	0	0%
Medical records/standards of record-keeping	0	0%
Medication > Prescription dispensing	0	0%
Non-medical services	1	1%
Nosocomial*	0	0%
Other*	11	6%
Out of Hours GP care	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	2	1%
Poor/No communication or failure to provide information	1	1%
Prisoner Care	0	0%
Recruitment and appointment procedures	1	1%
Referral to Treatment Times	2	1%
Regulation and Inspection (including private sector provision)	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Services for people with a disability inc DFGs	0	0%
Service for vulnerable Adults (eg with learning difficulties or mental health issues)	0	0%
Total	175	



Appendix C - Complaint Outcomes
(* denotes intervention)

Aneurin Bevan University Health Board		% Share
Out of Jurisdiction	38	19%
Premature	12	6%
Other cases closed after initial consideration	59	30%
Early Resolution/ voluntary settlement*	48	25%
Discontinued	1	1%
Other Reports - Not Upheld	12	6%
Other Reports Upheld*	24	12%
Public Interest Reports*	1	1%
Special Interest Reports*	0	0%
Total	195	



Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% of Interventions
Aneurin Bevan University Health Board	73	195	37%
Betsi Cadwaladr University Health Board	81	256	32%
Cardiff and Vale University Health Board	34	158	22%
Cwm Taf Morgannwg University Health Board	39	129	30%
Hywel Dda University Health Board	55	154	36%
Powys Teaching Health Board	3	21	14%
Swansea Bay University Health Board	41	141	29%
Total	326	1054	31%



Appendix E – Compliance performance comparison

Health Board	Number of recommendations made in 2023-24	Number of Recommendations falling due in 2023-24	% of recommendations, complied with on time
Aneurin Bevan University Health Board	209	208	75%
Cardiff and Vale University Health Board	104	95	81%
Cwm Taf Morgannwg University Health Board	123	121	60%
Swansea Bay University Health Board	119	127	62%
Hywel Dda University Health Board	160	151	81%
Betsi Cadwaladr University Health Board	253	246	58%
Powys Teaching Health Board	10	12	67%

Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2023/24. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2023/24. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2023/24. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Appendix E shows compliance performance for all Health Boards.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Strategic Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> This report provides the Board with a comprehensive assessment of the strategic risks associated with the Board's strategic priorities and provides assurance that these risks are being effectively managed. It also aims to provide reassurance regarding the advancements being made in enhancing risk management within the Health Board.
<u>Cefndir / Background</u> At its most recent meeting in July 2024, the Board authorised the transfer of SRR 001H to the Corporate Risk Register, citing a lower risk score and exposure. The rationale for the decision was that the Executive Team would be better suited to manage the risk due to its operational nature. At the end of July 2024, the Strategic Risk Register included eight principal risks and 19 sub-risks , for which, the Board delegates responsibility to sub-committees for focused scrutiny of controls and assurances against specific strategic risks in accordance with the Committee's agenda.
<u>Asesiad / Assessment</u> <u>Strategic Risk Register</u>

In accordance with best practices, all strategic risks have undergone a thorough review to ensure that the control environment is robust and adequate for managing the identified risks. Where it has been determined that the existing controls are insufficient, the necessary additional controls have been documented, and actions are currently being taken to address these gaps. Similarly, assurances are evaluated across all three lines of defence to ascertain the effectiveness and reliability of the controls in place. If gaps in assurance are identified, the control environment is reassessed, and appropriate measures are implemented to close these gaps.

A high-level summary of the **eight** principle strategic risks is presented in Table 1 with further detail included in **Appendix A** (Strategic Risk Dashboard and individual risk assessments for the 19 sub-risks).

To note, **SRR 001E**, **SRR 007A** and **SRR 008A** have a risk score of 8 (moderate risk), therefore are not accounted for in the risk level columns in Table 1. Only the number of 'High' and 'Extreme' risks are provided.

Table 1

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

SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	A, B & C	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	*A & B	1	-	Transformation & Partnership Working	Partnerships, Public Health & Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	*A	-	-	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee
SRR 010 - The Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974	A	-	1	Compliance and Safety	Patient Quality, Safety & Outcomes Committee
TOTAL	19	9	7		

Since the last presentation of this report to the Board and the subsequent review of all strategic risks, the overall strategic risk environment has remained reasonably stable, with only one risk reducing its score and exposure, SRR 006A detailed below.

‘There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery, due to the full or partial failure of existing digital infrastructure and systems.’

The overall risk rating has been reduced from 15 (L4 x I5) to 12 (L4 x I3) due to significant improvements in risk mitigation and control effectiveness. This includes the establishment of improved governance mechanisms and enhanced reporting processes which has strengthened oversight and accountability. Further cyber security reviews and audits conducted with the Cyber Resilience Unit have also bolstered the Health Board’s ability to detect and address vulnerabilities, contributing to a more robust security position.

In addition, comprehensive testing of Disaster Recovery facilities between the Health Board’s two data centres has demonstrated a high level of resilience. Recent failover exercises during power loss incidents at Ysbyty Aneurin Bevan (YAB) and Mamhilad proved effective, as services were seamlessly transferred from the primary to the secondary data centre, minimising potential service disruptions and infrastructure risks.

These combined efforts have contributed to a reduction in both risk exposure and the overall risk score and as such requires approval from the Board to accept the change in risk score.

Whilst continued efforts to reduce the level of risk against the 19 sub-risks the Board should be aware of **six** sub-risks that remain outside the acceptable risk threshold for their respective domains. These are subject to ongoing discussions

with executive leads and responsible officers to determine what additional mitigation measures are required to reduce the likelihood or impact of these potential threats.

The status of these **six** sub-risks and the sources of assurance are detailed below, providing the Board with the reassurance that addressing risks outside the Health Board’s appetite remains a priority.

SRR 001G

Currently rated as "Extreme" with a score of 20 (Likelihood 5 x Impact 4), is the potential inability of the Health Board to sustain high-quality, safe, and sustainable services due to challenges in achieving a sustainable financial position and a long-term financial plan.

Despite the implementation of comprehensive mitigation measures, further controls are necessary to bring the risk within acceptable levels. The Executive Committee is placing a strong emphasis on adherence to these controls, which are fundamental to the successful delivery of the Board-approved Three-Year Route Map to Service and Financial Sustainability.

The recent internal audits on the 2023/24 Savings Programmes and Financial Controls have provided reasonable and substantial assurance, respectively. Looking ahead, the upcoming 2024/25 Financial Sustainability Internal Audit, scheduled for the third quarter, will offer additional evidence on the effectiveness of the current risk management strategies.

SRR 001I

Currently rated as "Extreme" with a score of 16 (Likelihood 4 x Impact 4), the risk relates to the potential failure of the Health Board to implement the necessary performance improvements in key areas of the organisation, as specified in the Health Board's Performance Management Framework. This includes critical domains such as Quality and Safety, Operational Delivery, and Finance. This risk is relatively new, having been approved by the Board in March 2024.

An improvement plan has been developed, with specific actions targeting areas that are under a level of escalation. The aim of this plan is to strengthen areas where weaknesses have been identified and to drive operational and cultural improvements, thereby enhancing overall performance.

The table below outlines the current status of escalation across all operational divisions, offering reassurance that the ongoing efforts to drive improvements across all three domains are yielding positive results.

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

Assurance that this risk is being managed effectively will be supported by the outcomes and findings of several internal audits scheduled for the coming quarters. These audits include reviews of Divisional Governance Arrangements and the Divisional Review of Mental Health and Learning Disabilities in Quarter 2 of 2024/25, as well as the Performance Framework audit planned for Quarter 3 of 2024/25.

SRR 002A

Currently rated as "Extreme" with a score of 15 (Likelihood 3 x Impact 5), the risk addresses the structural integrity and safety of buildings within the Health Board's estate, specifically concerning the presence of Reinforced Autoclaved Aerated Concrete (RAAC). RAAC is a material known for its susceptibility to degradation over time, leading to potential structural weaknesses.

The ongoing development of the Nevill Hall site is a critical component of the Health Board's response to this risk, addressing both the changing population needs and the remediation required to address RAAC-related risks.

Assurance that the risk related to RAAC is being managed effectively will be evidenced by the outcome of a focused internal audit review of RAAC, scheduled for Quarter 1 of 2024/25.

SRR 002B

Currently rated as "high" with a score of 12 (Likelihood 3 x Impact 4), this focuses on the significant levels of backlog maintenance and existing structural impairments within the Health Board's estate. These factors collectively create a serious risk of building failure, which could have severe consequences for the health and safety of patients, staff, and the ongoing operations of the Health Board.

The Board was informed at its July meeting that the Health Board would be receiving £4 million in funding from the Welsh Government to address the backlog of maintenance, and that the works would be undertaken on a priority basis.

The Internal Audit into Estates Assurance, more specifically energy management, scheduled for Quarter 4 of 2024/25 may provide a level of assurance that the backlog maintenance plan is helping to deliver efficiencies in terms of utility expenditure.

SRR 004

Currently rated as "Extreme" with a score of 15 (Likelihood 3 x Impact 5), pertains to the Health Board's potential inability to effectively manage and respond to major incidents, business continuity disruptions, or critical situations.

This vulnerability stems from inadequate and insufficient emergency planning at both the corporate (strategic) and operational (tactical) levels. The potential consequences of this risk are significant, as a lack of preparedness could lead to delayed, inefficient, or ineffective responses during crises, thereby compromising patient care, public safety, and the overall continuity of essential services.

The Board should note that the current risk is being split into two distinct categories to ensure more effective management and oversight. The first category will be classified as a strategic risk, specifically addressing Major Incidents, given the significant impact such events could have on the Health Board's long-term objectives and strategic

priorities. The second category will be categorised as a corporate risk, focusing on Critical Incidents and Business Continuity.

This separation allows for more focused governance, with the Executive Team overseeing operational risks related to business continuity, while the Board maintains oversight of high-level strategic risks associated with major incidents.

Preparedness for major incidents can be demonstrated through outcome reports from both local and national exercises. In contrast, assurance of the Health Board’s readiness for a critical incident will be provided by the results of an internal audit scheduled for Quarter 3 of 2024/25, which will assess the Board's technical resilience and awareness of fault domains. This audit will ensure that the Health Board is optimising its infrastructure resilience and will offer assurance of its capability to respond to and manage a digital critical incident effectively.

SRR 010

currently rated as "High" with a score of 12 (Likelihood 3 x Impact 4), addresses the Health Board's potential failure to adequately protect the health and safety of its staff, patients, and visitors. This is a fundamental duty under the Health and Safety at Work Act 1974.

The risk arises from the possibility that the Health Board's systems, processes, governance structures, and assurance mechanisms may be inadequate or ineffective in implementing, embedding, and monitoring compliance with the Act's requirements.

Assurance that this risk is being managed effectively will be provided by the outcome of the Health and Safety Internal Audit, scheduled for Quarter 4 of 2024/25. The Committee will also be able to take a level of assurance from the 2023/24 Health and Safety Annual Report, which will be received by the Board in the coming months.

Risk Exposure

In terms of the Health Board's current risk exposure to the **19** strategic sub-risks, the infographic below illustrates that most strategic risks are in the upper right quadrant of the risk matrix, indicating a high level of risk exposure. As previously stated in the report, six of these risks fall outside the Board's agreed-upon appetite level.

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

2. Unlikely (11-40%)				3 x (Moderate)	
1. Rare (1-10%)					

The Corporate Governance Directorate continues to work with risk owners to evaluate and improve controls and assurances, as well as to increase transparency about the work being undertaken to implement mitigation in the short, medium, and long term. This will be demonstrated by a revised risk assessment template that places a greater emphasis on the high-level actions being taken to implement additional controls to bring the risk within appetite or to a level at which the Board is willing to tolerate the risk. This will be reviewed by the Executive Team and the relevant Committee before submitting to a future Board meeting for formal approval.

The closing position as at the end of August 2024, is that the Strategic Risk Register includes **eight** high-level strategic risks and **19** sub-risks, **six** of which are managed outside of their predefined risk appetite level.

Corporate Risk Register

Due to recent operational challenges, the Executive Team was unable to review the draft corporate risk portfolio during its scheduled session in July 2024. These challenges included unanticipated resource constraints and shifting priorities that required immediate attention, delaying the risk review process. However, the Corporate Risk Register will be considered in an upcoming Executive Team weekly business meeting. This will ensure that all proposed corporate risks are thoroughly evaluated, and necessary adjustments are made to the risk portfolio before being reported through to the relevant Committees and to the Board.

A comprehensive report, incorporating the latest risk assessments and any newly identified risks, will be presented to the Board in November 2024. This report will provide an updated status of all strategic and corporate risks, ensuring that the Board has a clear understanding of the current risk landscape. Following this, all risks will be included in subsequent reports to the relevant Committees, ensuring continued oversight and alignment with the Board's risk management framework.

Risk Management Processes and Systems

In 2020, a national initiative was launched to develop a "Once for Wales Risk Management System." The objective was to create a standardised workflow and set of data fields for the Enterprise Risk Management function within Datix Cymru, to be used across NHS Wales Health Bodies.

The Risk Workstream, tasked with overseeing this project, has reached a critical stage in the system's development. The Once for Wales Central team has confirmed that the module meets the programme’s specifications and is asking organisations to agree to migrate to the new Datix Cymru system by November 2024, with opportunities for further refinement post-implementation. However, the Risk Group has raised significant concerns about the current capabilities of the system. Issues include a lack of essential core functions, limited reporting capabilities, and overall system readiness. At this stage, the system does not meet the standards expected for a reliable and

intuitive risk management tool. Significant further development is required before the system can be implemented with confidence.

Contractually, from 30 November 2024, organisations wishing to continue using the legacy DatixWeb system will face additional costs. Details on these costs and how they will apply to health bodies choosing to retain DatixWeb until 2027, or until a new system is procured, have been requested.

At the Directors of Corporate Governance’s meeting on 6 September 2024, the Leadership Group presented a position report, seeking confirmation on whether to proceed with the Once for Wales RL Datix Risk Module. Representatives from the Risk Workstream Group also attended. The Directors of Corporate Governance unanimously agreed not to support the module's implementation in its current form and advocated for finding a new provider capable of offering a system that could be locally tailored to meet the specific needs of each organisation.

In the meantime, efforts are ongoing to cleanse and optimise the current DatixWeb system, ensuring the Health Board maintains a functional and reliable risk management platform whilst health bodies collectively determine the best path forward for future systems and processes.

Argymhelliad / Recommendation

The Board is requested to:

- **REVIEW** the strategic risks identified, ensuring that these remain fully reflective of any direct threat to the Board’s strategic priorities;
- **CONSIDER** whether it has sufficient assurance that strategic risks are being assessed, managed, and reviewed appropriately and effectively;
- **APPROVE** the reduction in score and risk exposure for SRR 006A; and
- **NOTE** the risks outside of the agreed-upon appetite for the risk domain.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.

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

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

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

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

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

Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives
Choose an item.

Strategic Risk Dashboard

				Risk Score Matrix														
Risk Description				2	4	5	6	8	9	10	12	15	16	20	25	Current Score	Target Score	
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.				X←						→0				●	
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff						X←			●		0				×
			c) Due to insufficient and ineffective leadership levels throughout the organisation.				X←					●		0				←
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level					X←				●		0				←
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs				X←	●						0				×
			f) Due to unsustainable service models					X←				●		0				×
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan						X←				0				●	×
			Director of Strategy, Planning and Partnerships.	h) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.						0X←					●			×
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aerated Concrete (RAAC) within structures	X→					0				●				×	
			b) Due to significant levels of backlog maintenance				X→	0				●					×	
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level				X←	0					●				×	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow						X←			●		0			×	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems					X←					●		0		×	
			b) Due to an adverse impact on service delivery in the implementation of new digital systems				X←					●		0			×	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future					X→				●		0			×	
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.		X←				●					0			×	
			b) Due to the impact of fragile services across the regional and supra regional geography		X←					●		0					×	
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement		X←				●					0			×	
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				X←	0					●				×	

Key

Current Score

●

Target Score

×

Appetite Threshold

0

Current to target

←

Key	Current Score	●
	Target Score	x
	Appetite Threshold	○
	Current to target	←

RISK THEME	PEOPLE									
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.							Publication Status		Public
Strategic Threat	a) Due to an inability to recruit and retain staff across all disciplines and specialties.					Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.				
Impact	➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Non-compliance with safe staffing principles and standards ➤ Reliance on agency and bank staff ➤ Litigation & Financial Penalties					Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.				
						SUMMARY The current risk level is Outside of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.				
Lead Director	Director of Workforce & Organisational Development		Risk Exposure	Current Level	Target Level	SRR 001A Risk Score Month Current Risk Score Target Risk Score Appetite Threshold				
Monitoring Committee	People & Culture Committee		Likelihood	4 <i>(Likely)</i> x	3 <i>(Possible)</i> x					
Initial Date of Assessment	01 June 2023		Impact	4 <i>(Major)</i>	2 <i>(Minor)</i>					
Last Reviewed	01 September 2024		Risk rating	= 16 <i>(Extreme)</i>	= 6 <i>(Moderate)</i>					
Next Review Monthly based on current score	01 October 2024									

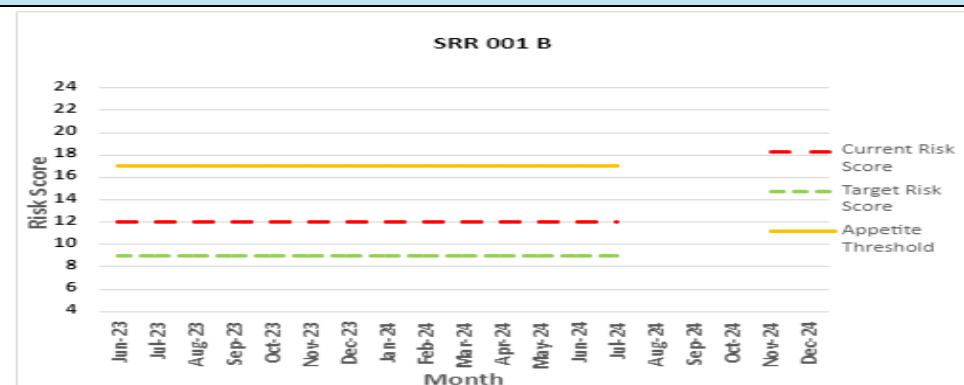
Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- Monitoring Framework to support roll-out of the People Plan. - Workforce Dashboard to track activity – recruitment, turnover, sickness absence. - Supply and demand tracker (Nursing and HCSW). - People Plan tracker to support delivery of actions within the People Plan 2022-25. - Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. - Management of attendance through All Wales Management Attendance at Work Policy. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. - Nurse Staffing Levels (Wales) Act 201625b/25c. - Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. - Workforce planning supported by Compendium of new roles to support innovative workforce models. - Recruitment KPI's. - IMTP (Integrated Medium-Term Plan) Educational Commissioning. - Workforce Establishment controls national working group has been instigated. - Value and Sustainability Board. - Collective Agreement (Non-Pay Deal) 2022/24	Retention - Development of career pathways (e.g., non-clinical to clinical). - NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 - Short project in progress with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis is underway with a 5 year past dataset shared. Variable Pay Reduction Development of action plan based on WHC to support the reduction in bank and agency usage. E- Systems - Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. - Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill. - Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. - Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i> - Workforce reports to the Nurse Strategic Workforce Group. - Monthly sickness monitoring reports. - Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. - Medical Staffing Co-ordinator review of medical rotas. - Cross site operational calls. - Occupational Health and Wellbeing dashboards report KPIs. - Recruitment KPIs - Medical & Dental and Student Streamlining fill rate reports	Gaps in Assurance	Positive Assurance
		Level 2 Organisational <i>(Executed by risk management and compliance functions)</i> - Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 - Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. - Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. - Measurements of Wellbeing through the ABUHB	Action to Address Gaps in Assurance	

Recruitment - Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician’s Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. - Annual programme of Apprentice recruitment - Overseas Nursing (All Wales Recruitment programme) - Nursing Workforce Strategy agreed - Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) - Partnerships with employability schemes and FE/HE to widen access. - Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. Retention: - Retention lead appointed with programme action plan in place for the next two years. - Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. - Week of events planned to support retention agenda in June 2024. This will include a mixed method of online webinars, videos and retention materials. - Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. - Changes in pension regulation and flexible retirement options from October 2023 and reduced break in service required following retire and return. - Development of HCSW skills matrix and career framework has commenced. - Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee. - Career conversations and succession planning resources designed; workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked - All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline. Variable pay reduction - Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. E- Systems - Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all ‘live’ and rolled out within the Health Board. E-Rostering is planned to go live shortly following ESR interface testing. Development of alternative and new roles	Development of alternative and new roles - Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. - Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. - Looking to increase Assistant band 4 in Community/Mental Health. - Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. - Increasing consultant therapy and nurse practitioners. - RCN introduction of Registered Nurse Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027. - Development of new roles and career pathways to support hard to fill roles in Health Visiting. - Re-design of the Health Board’s work experience programme with 246 applicants since March 2024 and 75 placements confirmed Training - HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy - Workforce planning training prospectus of local and online training launched September 2024 - Development opportunity being scoped for Business support staff. - Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. 236 attendees in July 2024. - Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire. - Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies. - A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention.	(Aneurin Bevan University Health Board) Staff Survey. - Routine Reporting against nurse staffing levels. - Variable Pay Programme Board reporting to Value and Sustainability Board Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i> - Internal Audit Reviews 2023 -24 - Long Term Sickness Absence Management (Q4) - Flexible Working (Q4) - External quarterly vacancy reporting to WG - External reporting on Nursing Staffing Levels - National Acuity Audits (Nursing) - National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

• A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent, and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care • The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management. Training • The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2024 and beyond which are required to support turnover and existing vacancies. • The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice. • HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience. • RCN Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (12 supported so far this year, with 3 more to interview) • Cadet Nursing programme in place (20 candidates last year) • K102 bridging model now being offered to support HCSW pathways into registered nursing. • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) is in its second year. Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024. Nursing and Midwifery Academy for senior level nurses and midwives, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff. Vacancy Numbers and establishment control • Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period August 2024 there were circa 636 WTE vacancies. No change from figures reported March 24. • Development of ESR establishments commenced on a national basis w/c 03 September 2023. Local delivery action plan has been developed and approved by Executive Committee in April 2024. Project workstream established and work commenced. National work programme proposal is also in development.				

Staff attendance - Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. “Hot spot” areas identified and plans in place to support.				

RISK THEME	PEOPLE			
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Strategic Threat	b) Due to a deterioration in, and a failure to improve, the well-being of staff.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact	➤ High absence levels, with some sustained long periods ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Non-compliance with safe staffing principles and standards ➤ Reputational damage to the health board as an employer ➤ Work-related industrial injury claims ➤ Moral injury			Risk Appetite Threshold – Open Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level
Monitoring Committee	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 July 2024	Risk rating	= 12 (High)	= 9 (High)
Next Review Due Quarterly based on current score	01 October 2024			



Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall)
- Monitoring Framework to support roll out of the People Plan. - Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. - Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. - Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority. - Strategic Equality plan - Rest and Facilities charter – monitoring and compliance. - Staff related policies. - National Staff Survey and Health Board Employee Experience Survey - External Employee Assistance Programme - Speaking up Safely action plan - Race/LGBT groups. - Wellbeing resources - Occupational Health Service - Staff diversity networks - Regular Schwartz rounds arranged across the Health Board - Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. - Close links with the Arts in Health programme - Chaplaincy service for staff	- Increase wellbeing initiatives. - Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders). - Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues. - Trained mediators so there is team and organisational resilience and network. - Scope, design and deliver a programme of research 'Healthy Working Day'. - Enhanced our financial well-being offer. - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales.	Level 1 Operational (Implemented by the department that performs daily operation activities)	Gaps in Assurance	Positive Assurance
		- Dashboard reporting - Reporting to monitor the rollout of the People Plan 22-25 - Reporting to monitor of demand on wellbeing services	Understand if support is reaching all staff	
		Level 2 Organisational (Executed by risk management and compliance functions.)	Action to Address Gaps in Assurance	
		- People and Culture Committee reports (People Plan 22-25) - Local wellbeing surveys - LNC – reporting of compliance of BMA Rest and Facilities	Meetings with Divisions ongoing to ensure all areas are aware of what's available.	
		Level 3 Independent (Implemented by both auditors internal and external independent bodies.)		
		- National workforce surveys - Monitoring and compliance of BMA Rest and Facilities via NHS Employers - Staff Welfare Charter - Sickness Absence Audit 2023/24		

- Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits. The programme has now won six awards including two from NHS Wales and generated five peer reviewed journal papers. Year one reductions are remaining consistent in year 2. This programme has now expanded across Wales and is being supported by income generated with a collaboration with HEIW. - The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB. This workstream began in October 2023 and will be developed over the next 12 months with a strong emphasis on evidence analysis and culture. The initial SUS Steering group was held on 14 March 2024, and an externally commissioned SUS hotline will be piloted in September 2024. - An external Employee Assistance Programme (Vivup) has been commissioned for 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative. Waiting times have now reduced on average by 30%. Occupational Health - Additional occupational health resources secured to reduce waiting times. - Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. - Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Support equality and diversity of workforce. - A part time Disability Inclusion Officer has been seconded to the EDI Team (December 2023 – December 2024). - Band 5 EDI Officer appointed and commence in post at the end of March 2024. - Inclusive Leadership sessions embedded in the Leading People Programme from January 2024 onwards. - Reverse Mentorship Programme launched February 2024. Other - Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC - Reducing fatigue poster developed.	Occupational Health. - Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. - Submission of response to All Wales KPI delivery and ongoing data analysis review in place. - Recently appointed 8a role to provide further clinical leadership and key priority for M1-3 is to undertake training needs analysis to develop OH team. Support equality and diversity of workforce. - Review of staff diversity networks. - Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. - Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. - Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing.			

RISK THEME	PEOPLE																																																																																					
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status	Public																																																																																
Strategic Threat	c) Due to insufficient and ineffective leadership levels throughout the organisation				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.																																																																																	
Impact	➤ Adverse impacts on delivery of care to patients across acute and non-acute settings; ➤ Failure to deliver health board priorities, required improvements and achieve sustainability; ➤ Poor levels of accountability and delivery; ➤ Reputational damage to the health board as an employer; ➤ Adverse impacts on staff recruitment and retention				Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.																																																																																	
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Talent and Succession Planning - Monitoring Framework to support roll out of the People Plan - focus on Talent and Succession Planning. - Monitoring frameworks with HEIW. - Lead appointed in July 2023 on a secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify, and develop talent for critical roles across ABUHB. - HEIW schemes 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Development leadership capabilities - Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Leadership development offer now available for entry level leaders and managers, Clinical Directors, Directorate Manager development programme (DMx) launched in Q1 2024/25, Senior Nurses and multi-disciplinary teams. - Learning Masterclasses have been designed and developed for the organisation addressing key themes such as giving feedback, developing teams, and having courageous conversations. - Leading People Programme started May 2024. 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council. The Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda. A further management graduate is due to start in September 2024, commencing rotation in Workforce and Organisational Development.	Talent and Succession Planning - Talent management and succession planning framework signed off by Executive Committee - SharePoint site development with a suite of resources to support colleagues and managers 1 day training on holding career conversations and succession planning with 100 spaces over the next 5 months. Development leadership capabilities - Currently exploring leadership funding options with USW in order to maximise Governmental Grants and utilisation of the apprentice levy. - Continued commitment to NHS graduate schemes. Values and Behaviour Framework - As part of the HB's 10-year strategy development we are involving colleagues in evolving our values and behaviours which will include all staff including those in leadership roles. We have four ways colleagues can get involved from spending 2mins scanning a QR code to attending a 90min in person session.	Level 1 Operational (Implemented by the department that performs daily operation activities) - WOD Divisional reporting - Evaluation of internal leadership programmes and regular review of our internal offer Level 2 Organisational (Executed by risk management and compliance functions.) - Reporting to People and Culture Committee - progress against People Plan 22-25 Level 3 Independent (Implemented by both auditors internal and external independent bodies.) - Internal Audit Review - Talent and Succession Board	Gaps in Assurance Action to Address Gaps in Assurance	Positive Assurance

RISK THEME	PEOPLE					
Strategic Risk - SRR 001	The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.				Publication Status	Public
Strategic Threat	d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Non-compliance with safe staffing principles and standards ➤ Litigation & Financial Penalties ➤ Reputational damage to the health board and loss of public confidence				Risk Appetite Threshold – Open Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.	
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Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level	SRR 001 D Risk Score Month Current Risk Score Target Risk Score Appetite Threshold	
Monitoring Committee	People & Culture Committee	Likelihood	3 <i>(Possible)</i> x	2 <i>(Unlikely)</i> x		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>		
Last Reviewed	01 July 2024	Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>		
Next Review Due Quarterly based on current score	01 October 2024					

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- All Wales Industrial Action Planning Group - Local Health Board planning arrangements - Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and - CODE OF PRACTICE Industrial Action Ballots and Notice to Employers - Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture - Effective derogation processes including Christmas Day cover definition. - Local Negotiating Committee (LNC) - Services Business continuity plans in place. - Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. - Command and control structure and leads established. - Derogation test completed. - Executive and Senior Manager leads established links with national planning cells. - All Wales training sessions provide by legal and risk to support industrial action. - Reducing impact on patients - Support for early supported discharge prior to industrial action. - Picketing guidance supported and agreed	- Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. - Issue of WHC AFC non pay elements of collective agreement 2022-24. Responded to WG on immediate assurance in May and an update provided in July 2024 on the progress within the Health Board on implementation. - Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). - Communication plans - public, stakeholders and partners. - Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. - Consideration of further additional national legal advice. - Awaiting confirmation of Agenda for Change Pay Award 2024/25 and at which point this risk will be reviewed.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance Further industrial action	Reasonable Assurance
		- Local Staff re-deployments assessment - Divisional engagement and service planning arrangements in place - Local Negotiating Committee (LNC) - Trade Union Partnership meetings		
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i> - Reporting to Executive team - Business Continuity groups - Command and control structure in place to be implemented as required.	Action to Address Gaps in Assurance	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i> - All Wales IA group and Welsh Government planning group. - Debriefing session planned to reflect and capture learning for any potential future action		

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.				Publication Status	Public
Strategic Threat	e) Due to inadequate strategic plans which respond to population health and socio-economic needs.				Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Increased demand ➤ Increased patient acuity levels ➤ Worsening of health inequalities ➤ Worsening of health outcomes ➤ Failure to train teams in multi-morbidity management ➤ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➤ Reputational damage and loss of public confidence				Risk Tolerance Level - OPEN SCORE 17 AND BELOW Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the set appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level	SRR 001 E 24 22 20 18 16 14 12 10 8 6 4 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Current Risk Score Target Risk Score Appetite Threshold	
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 <i>(Unlikely)</i>	2 <i>(Unlikely)</i> x		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	3 <i>(Moderate)</i>		
Last Reviewed	01 August 2024	Risk rating	= 8 <i>(Moderate)</i>	= 6 <i>(Moderate)</i>		
Next Review Due Bi-annually based on current score	01 November 2024					

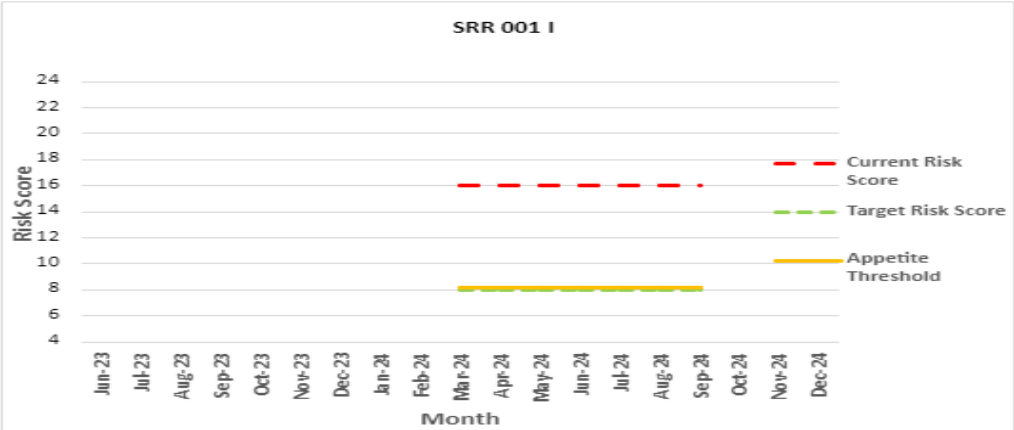
Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance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

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.				Publication Status	Public
Strategic Threat	f) Due to unsustainable service models				Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls; recognising that there could be a high-risk exposure.	
Impact	➤ Harm or injury to patients and/or staff ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Increased demand ➤ Increased patient acuity levels ➤ Worsening of health inequalities ➤ Worsening of health outcomes ➤ Failure to deliver health board priorities, required improvements and achieve sustainability ➤ Reputational damage and loss of public confidence				Risk Tolerance Level - OPEN SCORE 17 AND BELOW Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the set appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Strategy, Planning and Partnerships.	Risk Exposure	Current Level	Target Level	SRR 001 F Risk Score Month 24 22 20 18 16 14 12 10 8 6 4 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Current Risk Score Target Risk Score	
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	3 <i>(Possible)</i> x	2 <i>(Unlikely)</i> x		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>		
Last Reviewed	01 August 2024	Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>		
Next Review Due Quarterly based on current score	01 November 2024					

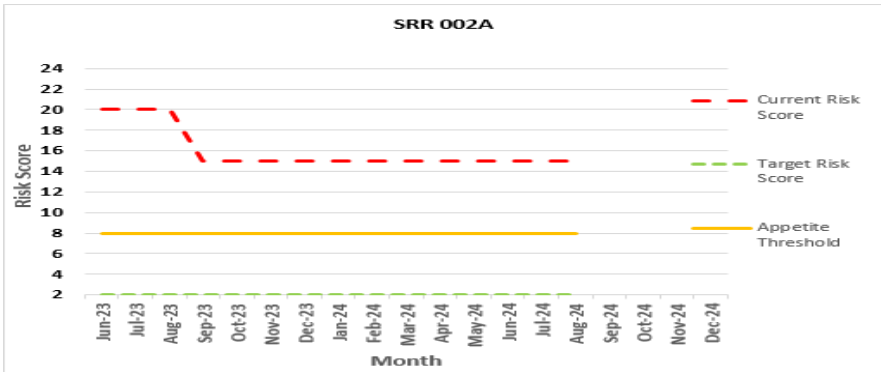
Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
- Development of new long-term strategy - The Health Board IMPT and associated KPIs - Clinical Futures Transformation programmes. - Public Health Wales surveillance data – Covid, flu and other communicable diseases. - QlikSense – performance information. - Population needs assessment and area plan development by the RPB. - Southeast Wales Plan for fragile services.	- Area plan is being refreshed through the RPB. - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Review of enhanced local general hospital service models to ensure sustainable quality services. - Development of SEW plan for fragile. - Review of organisational strategy – to launch Summer 2024.	Level 1 Operational (Implemented by the department that performs daily operation activities) - Public Health Wales surveillance data – JSNA - QlikSense – performance information.	Gaps in Assurance Evidence of individual arrangements in place to deliver service plans.	Reasonable Assurance
		Level 2 Organisational (Executed by risk management and compliance functions.) - IMTP delivery and outcomes reporting to Board. - RPB reporting to Board and Population Health, Planning and Partnerships Committee. - Regional Planning reporting to Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.	Action to Address Gaps in Assurance Recommendations from the Internal Audit of IMTP – Service Plans (Q2)	
		Level 3 Independent (Implemented by both auditors internal and external independent bodies.)		
		Internal Audit Reviews 2023-24 1. IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 2. IMTP – Service Plans (Q2)		

RISK THEME		FINANCIAL SUSTAINABILITY										
Strategic Risk: SRR 001		There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.								Publication Status		Public
Strategic Threat		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan.				Risk Appetite Level - Cautious. Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.						
Impact	➤ Breach of statutory duty to breakeven over 3 years. ➤ Instigation of NHS Wales Escalation & Intervention Arrangements. ➤ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➤ Prioritisation and possible disinvestment in service delivery. ➤ Reputational damage and loss of public confidence				Risk Appetite Threshold - Score 13 and below Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies.							
					SUMMARY The current risk level is OUTSIDE of the target and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.							
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target	SRR 001G 24 22 20 18 16 14 12 10 8 6 4 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Current Risk Score Target Risk Score Appetite Threshold							
Monitoring Committee	Finance & Performance Committee	Likelihood	5 <i>(Almost certain)</i> X	2 <i>(Unlikely)</i> X								
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Major)</i>	4 <i>(Major)</i>								
Last Reviewed	01 August 2024	Risk rating	= 20 <i>(Extreme)</i>	= 8 <i>(Moderate)</i>								
Next Review (Monthly based on current risk score)	01 October 2024											
Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>		Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>		Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>		Assurance Rating <i>(Overall Assessment)</i>				
- IMTP 2023/24-25/26 - IMTP Delivery Framework - Accountability Framework - Performance Framework - Scheme of Delegation - Standing Financial Instructions (SFIs) - Standing Orders (SOs) - Final budget delegation - Financial Control Procedure (FCP) Budgetary control - Financial Budget Intelligence (FBI) - Appropriately trained Finance Team (capacity & capability) - Budget holder training - Cost intervention procedures 23/24 savings plans & opportunities. - Health Board financial escalation processes. - Health Board Pre-Investment Panel (PIP) process. - Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. - Executive groups and structures established to deliver statutory duties. - Assessment of financial control environment within divisions and corporate teams. - Financial Escalation Meetings		- Revised V&SB approach for 2024/25 to help drive financial recovery, separating thematic and divisional scrutiny. - Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.		Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		Gaps in Assurance		Reasonable Assurance				
				- Adherence to SO/SFI/FCPs - Regular AFD meetings to discuss position and performance. - Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance.		- Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. - Development of detailed 3-year recovery plan.						
				Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>		Action to Address Gaps in Assurance						
				- Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. - Performance escalation meetings established. - Financial assessment and review report to the Board and Finance & Performance Committee - Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. - Board Briefing sessions on the financial position.		2024/25 IMTP plans focussed on ‘living within’ budget levels. 2024/25 savings plans to be delivered. - Detailed delivery plans will be a constant development over next 2 years.						
				Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>								
				Internal Audit Reviews 2023 – 24								

- Regular organisational Recovery plan meetings and briefings - Value & Sustainability Board established. - Revised accountability arrangements part of Executive governance. 3-year route map to sustainable recovery developed and approved by Board July 24.		- Savings Programmes – Reported to ARAC - Reasonable Assurance - Financial Controls – Reported to ARAC July 2024 – Substantial Assurance - Asset Management Q3 – Reported to ARAC April 2024 - Reasonable Assurance External Audit Reports 2023 -24 - Efficiency Review 23/24 Q3/Q4 – Not yet reported. - Structured Assessment - Received at ARAC November 2023. - Audit of Financial Statements Q4 2023/24 – True & Fair view given, minor recommendations, qualified on deficit and 3-year IMTP not agreed. - Financial assessment and review reports to Welsh Government – monthly - Enhanced monitoring T.I. meetings with Welsh Government – monthly		

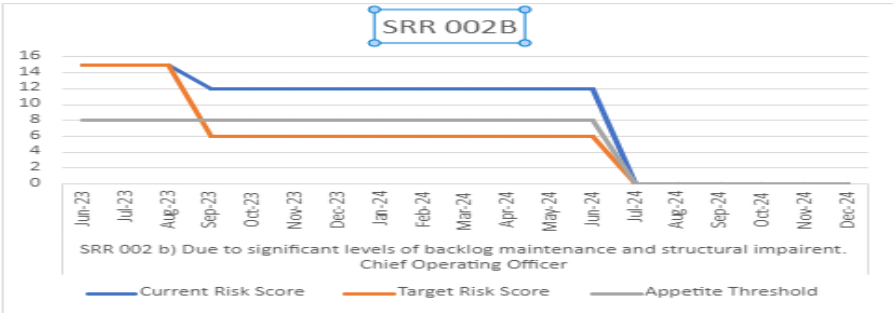
RISK THEME	COMPLIANCE AND SAFETY				
Strategic Risk: SRR 001	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services which meet the changing needs of the population			Publication Status	Public
Strategic Threat	i) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.			Risk Appetite Level - MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.	
Impact	➤ Unintended patient harm ➤ Negative patient/public experience ➤ Loss of patient/public trust and confidence ➤ Reduced staff morale leading to potential absence from work ➤ Scrutiny from external organisations (AW/HIW/WG) ➤ Punitive Action ➤ Adverse publicity ➤ Financial implications			Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.	
				SUMMARY The current risk level is OUTSIDE of target and the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					
Lead Director	Director of Strategy, Planning & Partnerships	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Finance and Performance Committee	Likelihood	4(Likely) X	2 (Unlikely) X	
Initial Date of Assessment	19 April 2024	Impact	4 (Major)	4 (Major)	
Last Reviewed	01 August 2024	Risk rating	= 16 (Extreme)	= 8 (Moderate)	
Next Review (Monthly based on current risk score)	01 October 2024				

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
Performance Management and Assurance Framework	6-month review of Performance Management and Assurance	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable Assurance
Executive Accountability letters	Alignment of internal mechanisms to national escalation	- DMTs in place for all Divisions - Divisional oversight arrangements – monthly/fortnightly meetings - Divisional plans in place and focussed agendas - Cross Divisional meeting monthly – progress the wider system way of working. - System Leadership Team for awareness and updates	- Capacity to run the performance framework and reporting requirements. - Review Business Partnering Support and Analytical Support during the 12-month Performance Management Framework review in Autumn.	
Divisional Directors Accountability letters	Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach.	Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place	Standardised Divisional Assurance Templates (pre-populated)	- Established reporting to the Executive Committee - Established reporting to the Finance and Performance and Patient, Quality and Safety Committee - Established reporting to the Board - Routine reporting through the IQPD process	Internal Audit 2024/25 Plan	
Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off	Commission external reviews to support improvements where required.	Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>	Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)	
Reporting through to Finance and Performance Committee via Executives	Appropriate Business Partnering Support and analytical support	- Internal Audit 2024/25 Plan - Directorate Review - Mental Health and Learning Disabilities (Q2) - Divisional Governance Arrangements (Q2) - HIW Inspections - Llais for feedback	Findings and recommendations from the Divisional Governance Arrangements (Q2)	
Specific areas of focus are discussed at Value and Sustainability Board	Realign capacity and/or redefine roles to provide explicit support			
System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc.				
External scrutiny via Welsh Government and NHS Executive				

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

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
• Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (most recent June 2023) • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance • Remediation work to areas of high-risk areas undertaken • Controlled access to roof areas • Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. • Ongoing engagement with expert surveyor • Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management • Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. <i>Note: H&S assessments are around the location of props not of RAAC itself and they flagged no issues or alterations</i> • Links with NHS England and other Health Boards in Wales for shared learning. • Fortnightly dialogue with Welsh Government and Shared Services Estates.	• Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues • Review of existing arrangements to monitor, manage and mitigate issues associated with RAAC is underway with external support and advice from the surveying contractor based on their experiences in NHS England and education bodies. This will inform any additional steps to monitor manage and mitigate led by the RAAC Working Group (chaired by the Director of Estates and Facilities Division)	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable Assurance
		• Fortnightly checks in place for the props in place • Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) • Review of existing arrangements in place supported by external body	• Ongoing management of the issues.	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		• Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. • Outcome of H&S risk assessment • Formal reporting to the Board • Formal update to the PPHPC in July with full SOC end of Q3.	• Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Internal Audit 2024/25 Plan • Nevill Hall RAAC (Q1) – In progress		
		Internal Audit 2024/25 Plan • Nevill Hall RAAC (Q1) • Review of existing governance arrangements (reporting early Q2) – report being finalised by external advisors and will be received in August for review within ABUHB		

RISK THEME		COMPLIANCE AND SAFETY		
Strategic Risk: SRR 002	There is a risk that there will be a significant failure of the Health Board Estates.			Publication Status Public
Strategic Threat	b) Due to significant levels of backlog maintenance and structural impairment.			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	➤ Harm or injury to patients and/or staff. ➤ Adverse impacts on the delivery of care to patients across acute and non-acute settings. ➤ Non-compliance with health and safety legislation. ➤ Litigation and financial penalties. ➤ Loss of estate			Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
				SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Health Protection & Planning Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 August 2024	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review Due Quarterly based on current score	01 November 2024			

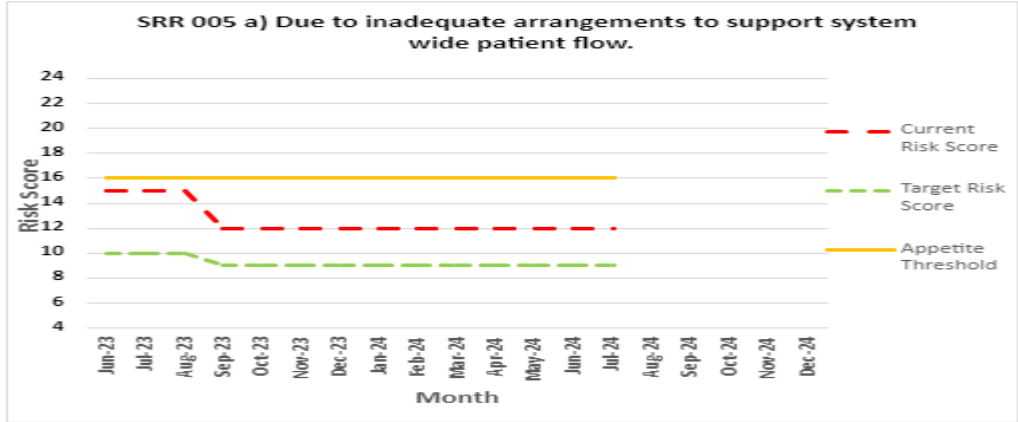


Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance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

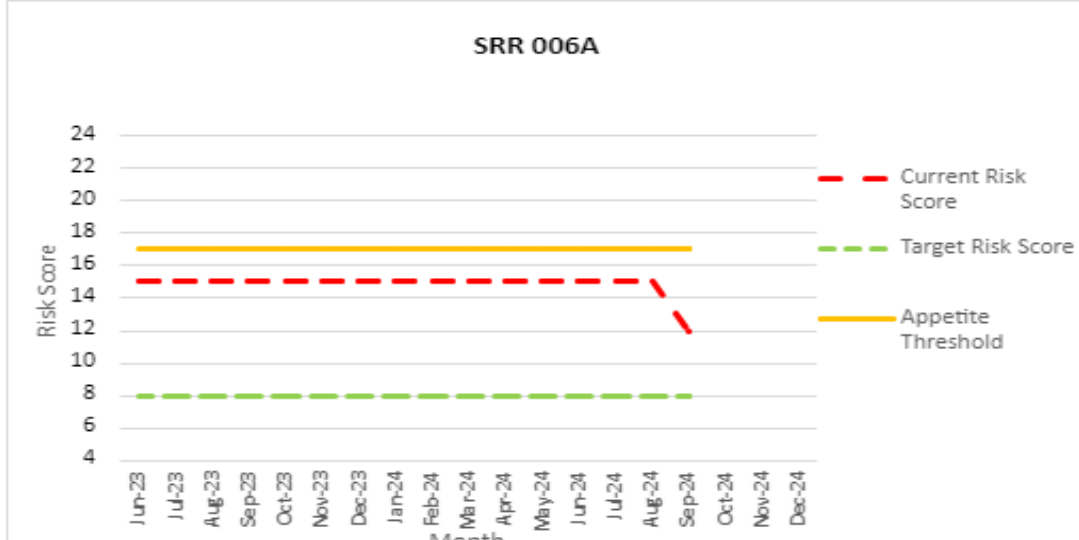
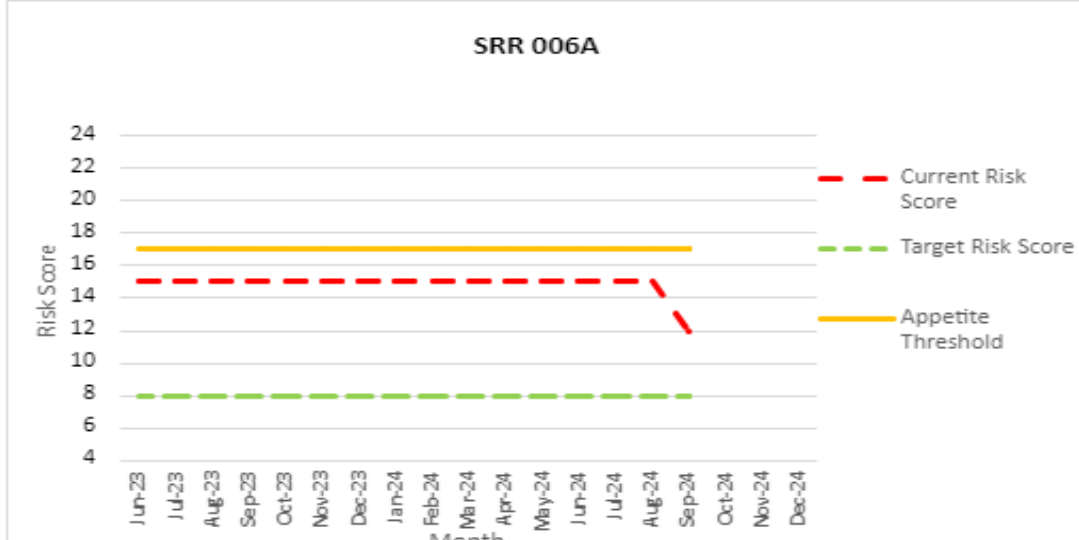
RISK THEME	COMPLIANCE AND SAFETY				
Strategic Risk: SRR 004	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.			Publication Status	Public
Strategic Threat	a) Due to ineffective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

Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
Major Incident - Major Incident Plan - Local/Divisional action cards are in place. - Training undertaken service-specific relating to local response. Business Continuity (BC) /Critical Incident - BC Policy - BC Response Guidance - BC Template - BC Exercise - BC debrief learning. - HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents. - EPRR Group Established. - Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. - Awareness raising of the requirement for BC across the Health Board through various training programmes Infectious Diseases - Joint plan with PH in response to infectious diseases and public health incidence response. Overall - Internal strategic on call training	- Major Incident Exercise ‘Euclid’ planned for 20th June 2024 – Faculty in place to plan scope and detail of exercise. - Testing programme of business continuity plans. - Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. - Develop further training programmes to support staff preparedness to response to an incident. - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. - Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. - Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power	Level 1 Operational (Implemented by the department that performs daily operation activities)	Gaps in Assurance Robustness of service business continuity plans within Divisions	Reasonable Assurance
		Departmental debrief following an incident to inform learning and enhance controls.		
		Level 2 Organisational (Executed by risk management and compliance functions.)	Action to Address Gaps in Assurance Recommendations for strengthening resilience following testing of service business continuity plans	
		- Debrief with key stakeholders following an incident to inform learning and enhance controls. - Report to the EPRR Group from debrief of incidents - Reports to the PPHP Committee on Emergency Planning Preparedness		
		Level 3 Independent (Implemented by both auditors internal and external independent bodies.)		
		Internal Audit Review(s) - Business Continuity Planning 2023-24 (Q2) outcome report published – Reasonable Assurance - Outcome and feedback from national exercises		

• Executive Team attending 2-day strategic training. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) • Joint Planning and Training with LRF and across Wales. • Ongoing Participation in exercises UK, Wales, LRF and HB. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP).	outages. (as this is not fully implemented, it is still being worked through thus would make it additional control until in place)			

RISK THEME	SERVICE DELIVERY					
Strategic Risk: SRR 005	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.				Publication Status	Public
Strategic Threat	Due to inadequate arrangements to support system-wide patient flow				Risk Appetite Level - Open Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact	➤ Avoidable deaths or significant harm ➤ Delays in releasing ambulances from hospital sites back into the community ➤ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➤ Litigation & Financial Penalties ➤ Reputational damage and loss of public confidence				Risk Appetite Threshold – Open SCORE 17 AND BELOW Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level	SRR 005 a) Due to inadequate arrangements to support system wide patient flow. 	
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	Likelihood	3 <i>(Possible)</i> X	3 <i>(Possible)</i> X		
Initial Date of Assessment	01 June 2023	Impact	4 <i>(Catastrophic)</i>	3 <i>(Minor)</i>		
Last Reviewed	01 July 2024	Risk rating	= 12 <i>(High)</i>	= 9 <i>(High)</i>		
Next Review Due (Quarterly based on current risk score)	01 October 2024					

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- Escalation Policy. - Performance and Accountability Framework - Major incident Procedures - Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. - Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. - fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. - Enhanced monitoring in place for U&EC - Range of performance measures/metrics in place - Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. - Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. - Planned care recovery meetings with the NHS execs. - Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. - WG – IQPD meetings to review areas of focus.	Operational framework – Being revamped through operational framework ahead of next winter. Improve regional acceptance of flow processes with neighbouring Health Boards. Repatriation meetings established and new Wales-wide protocols due to come in regarding repatriation.	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i> The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. Performance report against measures/metrics	Gaps in Assurance Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. The impact of the Performance and Accountability framework in improving patient flow	Reasonable Assurance
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i> Divisional Assurance reviews. Performance against measures/metrics reported to the Executive Committee	Action to Address Gaps in Assurance Close monitoring and reporting of the frameworks in practice to support learning and improvements.	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i> Internal Audit Reviews 1. Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9 th July 2024.		
		External inspections/visits.		

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

Key Controls (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control (Are further controls possible to reduce risk exposure within tolerable range?)	Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance/ Actions to Address Gaps (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Assurance Rating (Overall Assessment)
Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. Governance group terms of reference agreed. Meetings started in November 2023. Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase	Implement the recommendations from Templar report: Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. A recent cyber incident at several London Hospitals presented an opportunity for ABUHB to battle test its cyber response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan.	Level 1 Operational (Implemented by the department that performs daily operation activities)	Gaps in Assurance	Reasonable assurance
		Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.	Oversight from NHS Wales Cyber Resilience Unit.	
		Level 2 Organisational (Executed by risk management and compliance functions.)	Action to Address Gaps in Assurance	
		Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan.	An assessment against CAF was undertaken by CRU in January '24 and the report along with its recommendations has been circulated to key stakeholders.	
		Level 3 Independent (Implemented by both auditors internal and external independent bodies.)		

cyber security awareness and build cyberculture amongst non-ICT staff Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. Implement the recommendations from Templar report: Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. · Introduced scenario-based incident response exercising using National Cyber Security Centre developed ‘Exercise in a box’ the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.		Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2024/25 Technical Continuity – planned for Q3		

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

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

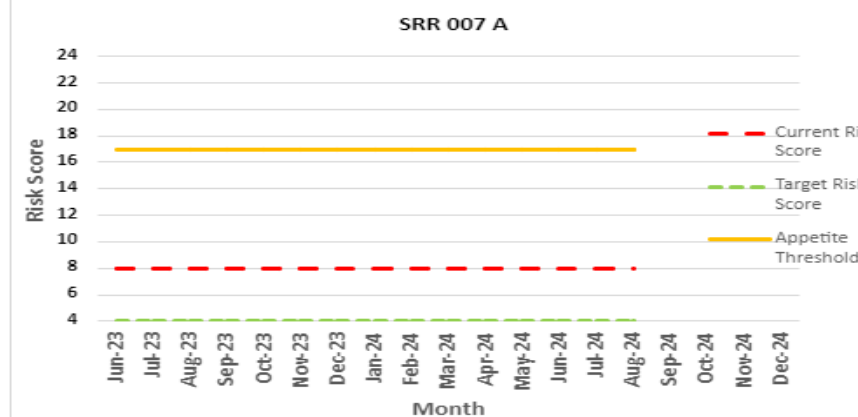
• Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. • Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. • Aggregated view of digital Lessons Learned available and lessons are reviewed during project initiation for best chance of success. • Information Governance Sub Committee and Cyber Security Subgroup established		• Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance Internal Audit 2024/25 • Implementation of the Welsh Intensive Care System – planned for Q1		

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

Key Controls <i>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>	Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance/ Actions to Address Gaps <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Assurance Rating <i>(Overall Assessment)</i>
- Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for MH & LD, Division of Medicine, Urgent Care & Families & Therapies - New governance structures to be put in place further to directorate restructuring - New Digital Service Request process in place which provides governance in several key areas: - Automation of request process via ‘Seren’ the ICT Portal - Information Governance – ensuring new services have appropriate controls to keep patient information safe. - Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. - Patient Safety – ensuring services do not introduce any patient safety risks. - Records – ensuring new systems comply with the requirements of records management. - Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are	- Portfolio optimisation to ensure the resources of the service are aligned to key priorities - New Digital Request quarterly reporting to DDAT sub-committee - Development of product management approach to delivery of core software applications and extending use of agile processes to ICT	Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>	Gaps in Assurance	Reasonable assurance
		Quarterly reporting to DDAT sub-committee	- If the NDSR process delivers anticipated improvements - The outcome of the the EDRMS audit	
		Level 2 Organisational <i>(Executed by risk management and compliance functions.)</i>	Action to Address Gaps in Assurance	
		Regular Reporting to the Finance & Performance Committee	- Monitor the performance of the NDSR process - Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.	
		Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies.)</i>		
		Cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.		
		Internal Audit 2023/24 - LINC Programme– Outcome Reasonable assurance - Network Infrastructure (VPN) - Outcome Reasonable assurance		

fit for purpose and delivery what stakeholders require. ○ Business change function which ensures implemented systems are effective and deliver the benefits required. ○ Formal framework in place for the adoption of new digital services and best practice guidance followed. ○ Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process ○ New Digital Request processes include fortnightly senior leadership scrutiny of requests, • New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards • Annual operational plan completed and aligned with IMTP • Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for CSS Divisions of Surgery & PCCS in place • Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints		Internal Audit 2024/25 • Electronic document and records management solution - planned for Q4		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk: SRR 007	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.			Publication Status Public
Strategic Threat	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.			Risk Appetite Level - OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact	➤ Unmet patient need resulting in harm ➤ Ineffective use of combined resources ➤ Delayed decision making ➤ Adverse impacts on delivery of care to patients across acute and non-acute settings ➤ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➤ Reputational damage and loss of public confidence			Risk Appetite Threshold - SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Strategy, Planning, and Partnerships.	Risk Exposure	Current Level	Target Level
Monitoring Committee	Partnerships, Public Health & Planning Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 August 2024	Risk rating	= 8 (Moderate)	= 4 (Low)
Next Review Due Bi-annually based on current score	01 November 2024			



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

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING						
Strategic Risk: SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.			Publication Status	Public		
Strategic Threat	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.		Risk Appetite Level – Open Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure Risk Appetite Threshold – Open SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold. Strategic Risk SRR 008 				
Impact	➤ Adverse impact on patient experience ➤ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➤ Reputational damage and loss of public confidence ➤ Failure to deliver Duty of Quality						
Lead Director	Director of Nursing	Risk Exposure				Current Level	Target Level
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	Likelihood				2 (Unlikely) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)			
Last Reviewed	01 July 2024	Risk rating	= 8 (Moderate)	= 4 (Low)			
Next Review Due (Bi-annually based on current risk score)	01 October 2024						

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

RISK THEME		COMPLIANCE & SAFETY																																																																																
Risk No: SRR 010		There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974				Publication Status	Public																																																																											
Strategic Threat		Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.			Risk Appetite Level - MINIMAL. Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below .																																																																													
					Risk Appetite Threshold - Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.																																																																													
Impact		➤ Unintended physical harm; ➤ Punitive actions from the Health and Safety Executive (HSE); ➤ Increased levels of staff sickness; ➤ Loss of estate due to unsafe environments; ➤ Financial implications; ➤ Adverse publicity; and, ➤ Reputational damage			SUMMARY The current risk level is OUTSIDE of target level and OUTSIDE appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.																																																																													
					Strategic Risk SRR 010 <table><caption>Risk Score Data</caption><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr><tr><td>Jun-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Jul-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Aug-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Sep-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Oct-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Nov-23</td><td></td><td>6</td><td>8</td></tr><tr><td>Dec-23</td><td>16</td><td>6</td><td>8</td></tr><tr><td>Jan-24</td><td>16</td><td>6</td><td>8</td></tr><tr><td>Feb-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Mar-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Apr-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>May-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jun-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jul-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Aug-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Sep-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Oct-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Nov-24</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Dec-24</td><td>12</td><td>6</td><td>8</td></tr></table>			Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-23		6	8	Jul-23		6	8	Aug-23		6	8	Sep-23		6	8	Oct-23		6	8	Nov-23		6	8	Dec-23	16	6	8	Jan-24	16	6	8	Feb-24	12	6	8	Mar-24	12	6	8	Apr-24	12	6	8	May-24	12	6	8	Jun-24	12	6	8	Jul-24	12	6	8	Aug-24	12	6	8	Sep-24	12	6	8	Oct-24	12	6	8	Nov-24	12	6
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Lead Director	Director of Therapies & Health Science	Risk Exposure	Current Level	Target Level																																																																														
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) X	2 (Unlikely) X																																																																														
Initial Date of Assessment	01 December 2023	Impact	4 (Major)	3 (Moderate)																																																																														
Date Reviewed	01 August 2024	Overall Risk Rating	= 12 (High)	= 6 (Moderate)																																																																														
Date of Next Review (Quarterly based on current risk score)	01 November 2024																																																																																	

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

• Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)		• Performance reviews at All Wales Health and Safety Management Steering Group • Internal Audit – H&S processes Review to be included in 2024/25 Plan. • South Wales Fire & Rescue Service fire safety audit programme. • Health and Safety Executive reviews/inspections.	demonstrate progress against the Improvement Plan	

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Regional Partnership Board Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Hannah Evans, Executive Director for Strategy, Planning and Partnerships
SWYDDOG ADRODD: REPORTING OFFICER:	Chris Dawson Morris, Deputy Director Strategy, Planning and Partnerships

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

Er Gwybodaeth/For Information

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

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

This report provides an update on the activities of the RPB.

Cefndir / Background

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

Assessment



System Resilience

Traditionally the RPB has utilised funding with the aim of alleviating system pressure in the winter period. Feedback from previous winter plans was that projects were not given enough time to maximise impact and it was accepted that system resilience is required around the year rather than just during winter. As a result, it was decided in October 2023 that some system resilience projects would be funded on an 18 month basis until March 2025. 13 projects were supported at a GASP meeting in October 2023 – 4 projects were supported until March 2024 and 9 were supported until March 2025.

Gwent Adult Strategic Partnership (GASP) evaluated previously funded winter activity and developed priorities to support the System Resilience plan. These include:

Priority	Intent
1. Education and engagement	Robust comms and engagement to manage expectations, educate on appropriate attendance/discharge across the following groups: • Current professionals working within the system (relates to several areas below) • Individuals and the public • Graduate programmes across disciplines (e.g. medical, AHP, nursing, etc.)
2. Clear roles and responsibilities for dedicated discharge resource	To mitigate confusion and duplicated effort, ensure clarity on the roles holding responsibility to manage oversight of clear discharge processes and D2RA pathways. Where necessary strengthen capacity to ensure assessments and care plans can be produced to facilitate discharge, embedding the functionality of the trusted assessor approach.
3. Implementing Trusted Assessor functionality across the system	Scaling the positive benefits of the Balancing Rights and Responsibilities training and mentorship programme, education and training to targeted staff groups in the first instance will ensure the right strengths-based conversations are held with individuals/patients, to support maintaining independence wherever possible, managing expectations and mitigating avoidable deconditioning
4. Preventative Community Capacity	Strengthen the community preventative offer, reflective of the pareto principle whereby 80% of the community activity should be a generic prevention model, providing 20% more specialist services, such as Frailty Rapid Medical, etc. This will include scoping of a TEC responder service, and a regional model of assistive technology availability. In addition, scaling of current strategic programme activity within the Place Based Graduated Care Programme will be considered.
5. Alternative capacity to support discharge	Develop a range of solutions that can support individuals to leave hospital when a waiting a package of care for a short term period, taking the learning from the Step Closer to Home model and work undertaken to date with the care home sector.



6. Workforce development	Maximising the reach of the Workforce development programme within the RIF Strategic Plan, offering an integrated approach to recruitment where needed to resource the system resilience plan, as well as the development of a Volunteering Strategy to mitigate the noted reduction in the volunteer workforce

At the end of quarter one 24/25 a mid point review has been undertaken of the projects and the findings presented to the RPB. Following the review GASP is taking action to realign projects or end projects which are not delivering the anticipated system impact. A full report can be made available to Board members on request, however some highlights include

- Piloting of a mental health response vehicle, the pilot demonstrated a reduction in conveyances to emergency departments, with many cases being treated and resolved at the scene. The team treated 74% of patients at the scene without further conveyance. Further piloting of the vehicle is needed, whilst there was a positive impact for those the vehicle reached this was only a small number across the pilot.
- Step Closer to Home, is a project that involves spot purchasing case home places on a short term basis for patient who are waiting for large packages of home care to be put in place. The number of people supported through this project has dropped significantly due to the improved domiciliary care position across our region; therefore there is an opportunity to repurpose this resource
- Hospital to Home is a scheme which uses Healthcare support workers outside of the hospital environment preferably in their own homes with personal care, mobility, meal preparation and medication prompting until longer-term support can be arranged. The scheme has enabled faster discharge. 11% of patients discharged no longer require long-term care. 26% have received support from H2H that has potentially avoided their re-admission.
- Additional Pharmacy support in Community Resource Teams, further equipment provision and additional transport have proven benefit.

Governance Review

Progress is being made against the actions set out in the Governance review. The role of the Leadership Group has been strengthened to provide greater ownership, clarity and scrutiny of items going to the RPB. Actions relating to the simplification of processes and papers have been completed. An overarching Governance Framework has been developed and will go to the September meeting of the RPB.

On 27 August 2024, the Cabinet Secretary for Health and Social Care made:

- [National Framework for the Commissioning of Care and Support in Wales Code of Practice and the Revised Code of Practice \(General Functions\) \(Appointed Day\) \(Wales\) Order 2024](#) ("the order"), which will bring the national framework and the part 2 code of practice (general functions) into force on 1 September 2024
- [The Directions to Local Health Boards and NHS Trusts in Wales on the National Framework for Commissioning Care and Support 2024](#) ("the direction"), which provides that local health boards and NHS trusts must carry



out their functions in accordance with the relevant provisions of the national framework

These pieces of legislation place additional requirements on RPBs in relation to self-assessment, reporting and membership. The Welsh Government are finalising the Regulations and the accompanying Statutory Guidance, which will be laid before the Senedd in the autumn. It is intended that the Regulations and Statutory Guidance will come into force by the end of the financial year.

Review of RPB Schemes

Following initial impact assessment categorisation by Strategic Partnership and programmes, reviews are currently taking place of schemes identified as not performing (Red/Amber). This work will conclude in quarter 3 and inform funding for 25/26.

Eliminate Agenda

In order for the local authorities in Gwent to be compliant with the Elimination of profit legislation by March 31st 2027, they require an additional 52 placements for children who are currently residing in for-profit placements. This does not address children currently in independent fostering placements, a percentage of whom may require residential provision if IFA's do not convert to not-for-profit models and the local authorities are unable to develop their fostering provision to meet the shortfall.

Welsh Government has written to RPBs to recommend the prioritisation of capital in order to support the eliminate agenda. This presents risk due to the current full commitment of capital and the current approval timescales enabling delivery of projects by 2027. The Leadership Group of the RPB will review the capital programme with consideration of the eliminate agenda alongside the regional capital strategy.

Argymhelliad / Recommendation

The Board is asked to NOTE the update provided.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:
Datix Risk Register Reference and Score:

SRR009 – Transformation and Partnership Working

Safon(au) Gofal ac Iechyd:
Health and Care Standard(s):

All Health & Care Standards Apply
Choose an item.
Choose an item.
Choose an item.



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

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

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



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

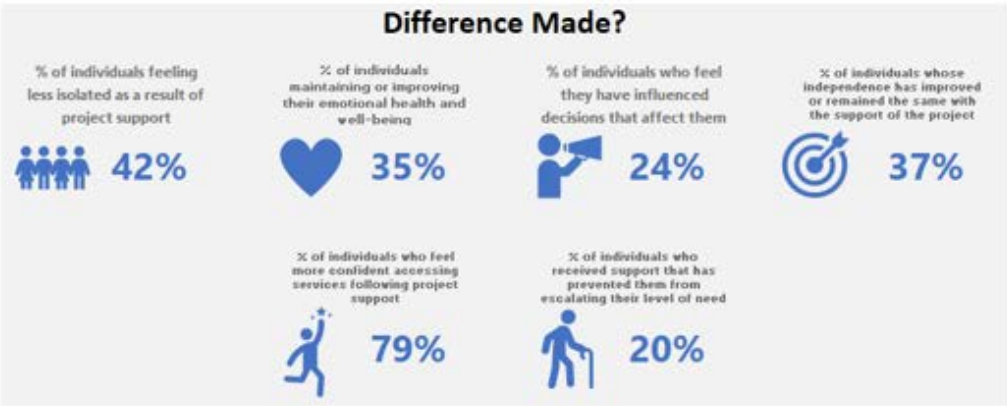
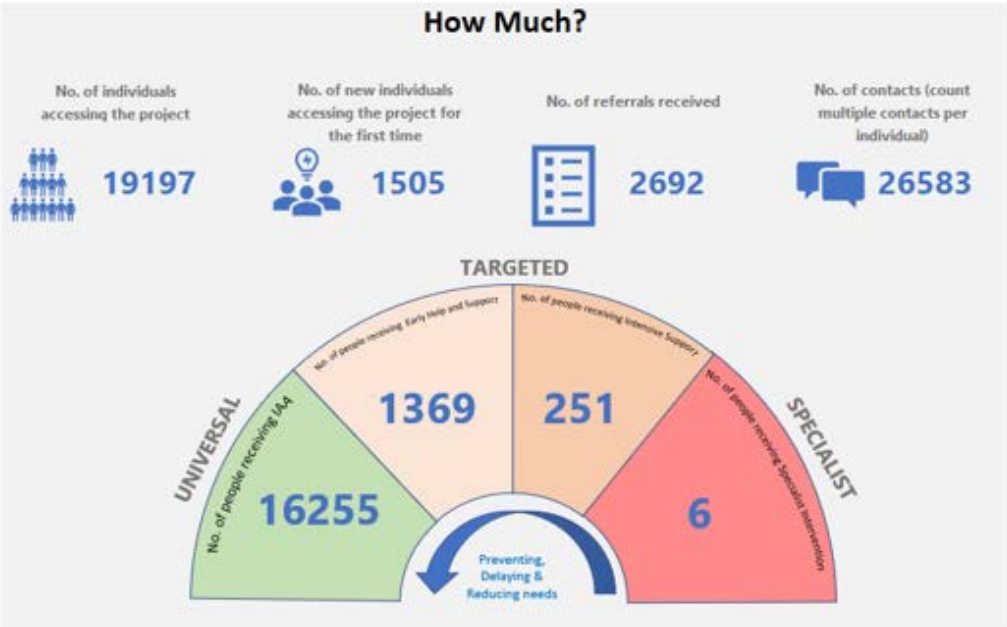
<https://futuregenerations.wales/about-us/future-generations-act/>

Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies
Choose an item.

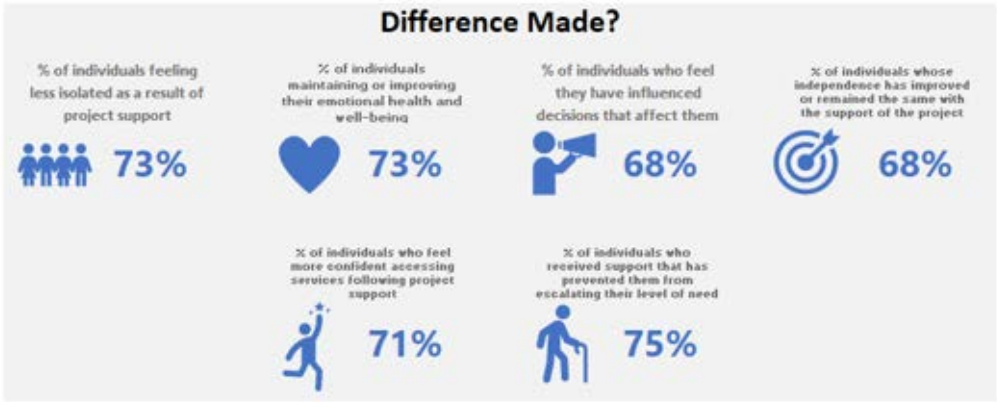
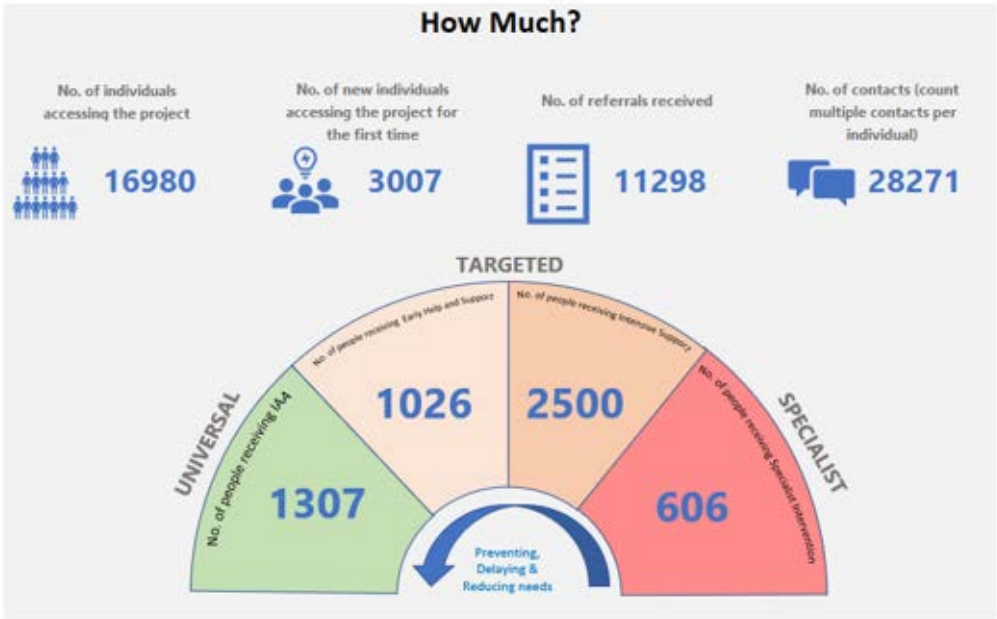


Appendix A: Strategic Partnership Portfolio Visuals

Carers Strategic Partnership

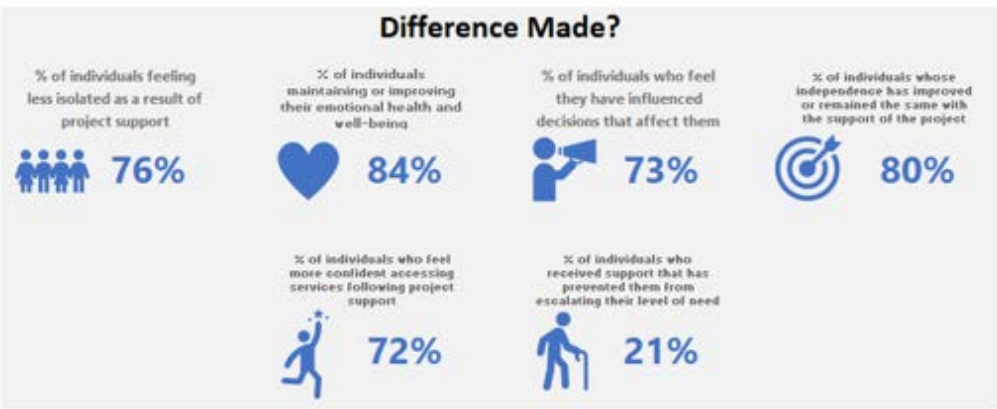
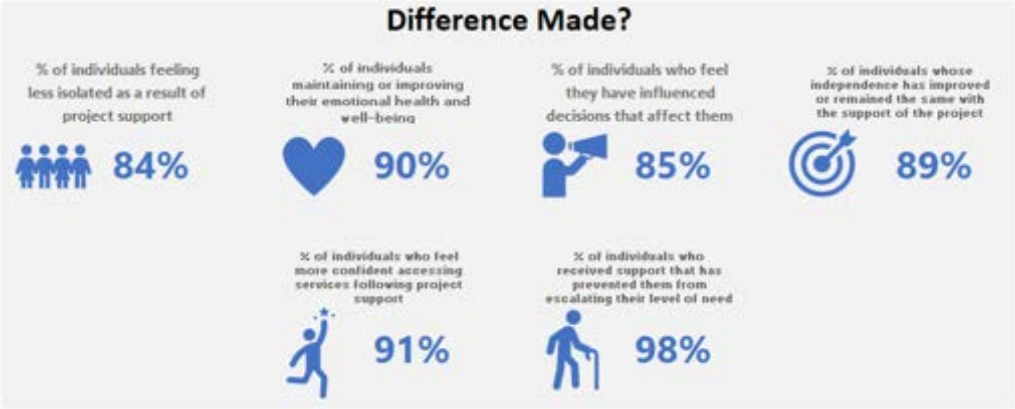
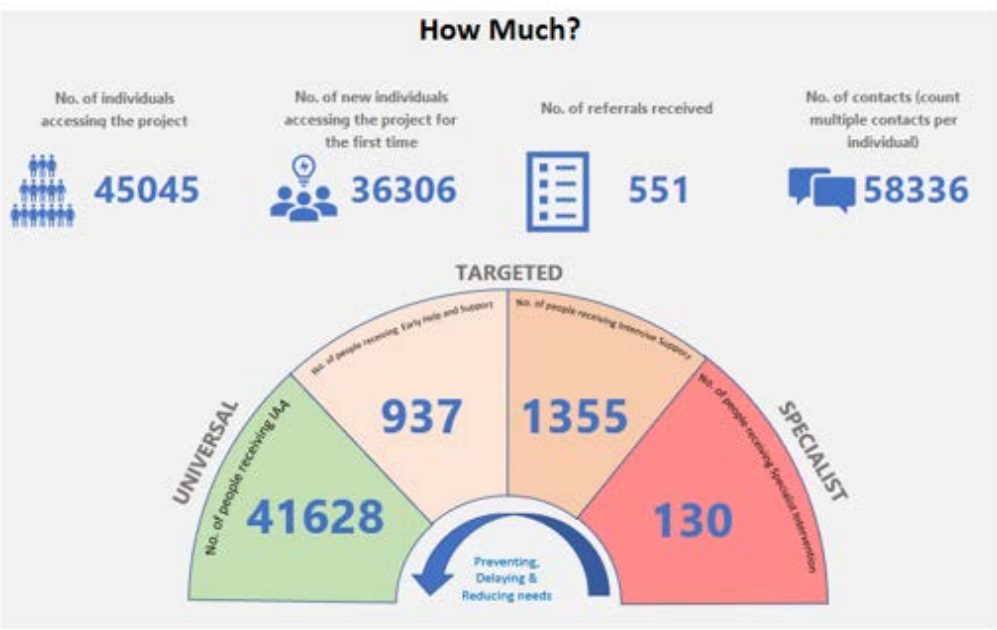
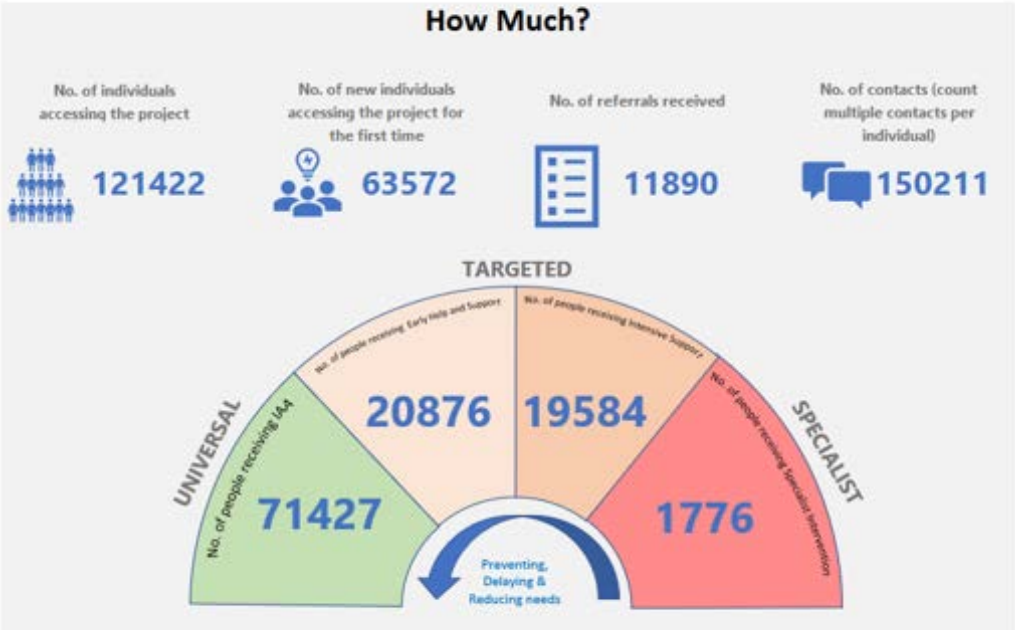


Children & Families Strategic Partnership

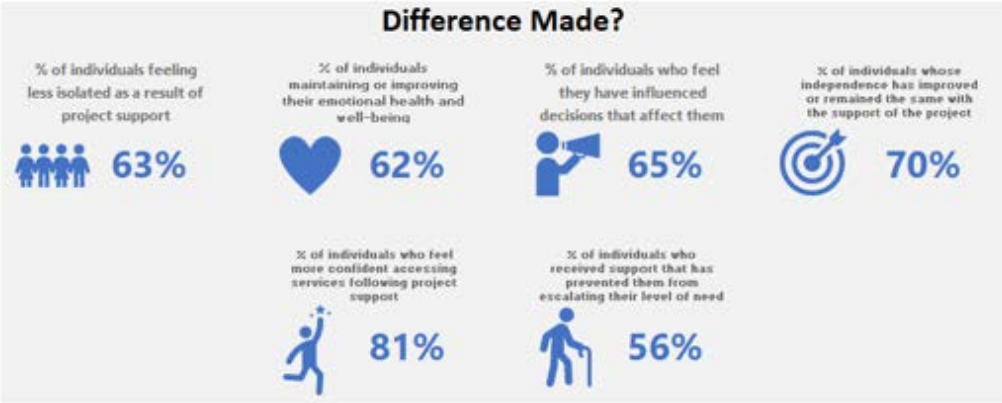
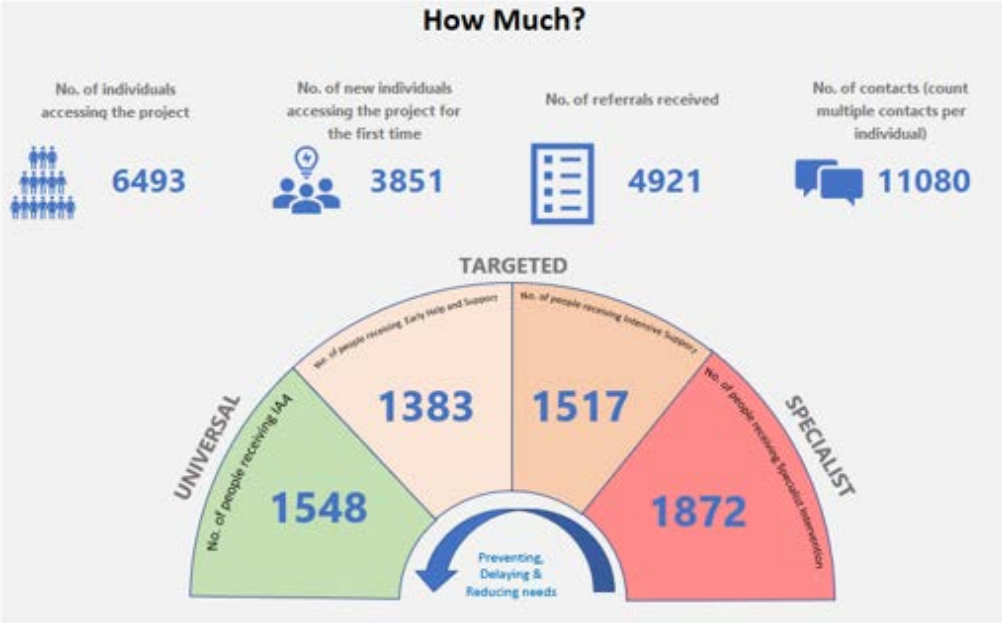


Gwent Adults Strategic Partnership

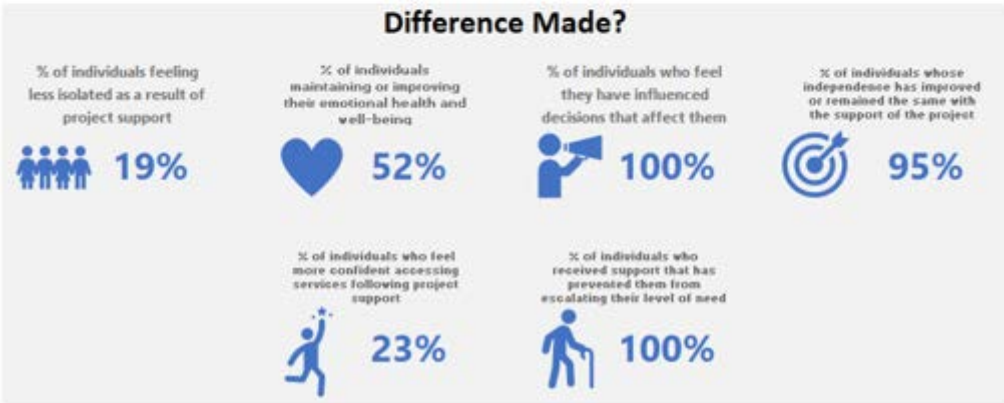
MH & LD Strategic Partnership



Regional Dementia Board



Housing Strategic Partnership (AT Programme)



DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Executive Committee Activity: 1 st July 2024 – 6 th September 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report provides the Board with an overview of a range of issues discussed by the Executive Committee during the period.

Due to the nature of the Executive Committee's business, not all issues will be suitable for disclosure into the public domain.

Cefndir / Background

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

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

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

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

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

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

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

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

During the period 1st July 2024 – 6th September 2024 the following matters reflect some of the issues considered by the Executive Committee:

Quality, Safety & Culture

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

Other matters discussed include:

Quality Annual Report 2023/24: The Executive Committee received the Quality Annual Report ahead of presentation to the Board and noted the progress of work over the past 12 months which included the implementation of two strategies aimed at improving services, clinical effectiveness, safety and staff wellbeing.

Update on Discharge Improvement Programme and Pathways of Care Delays (POCD): The Executive Committee was updated on the work of the Discharge Improvement Programme and Pathway of Care Delays. The Committee was informed of the current two main reasons for discharge delays which were when patients were awaiting completion of assessment by social care and for those patients awaiting joint assessment. The Committee was assured that an action plan was in place and the Health Board was progressing this to address the reasons for delays and that proposed joint escalation and governance arrangements had been developed with the five local authorities. The Executive Committee was updated on the roll out and technical difficulties experienced during the new CWS2 application. The Committee noted that this application was dependent upon WPAS which was experiencing server upgrade delays which resulted in data not being available. The Executive Committee noted that as a result the Health Board was now unable to meet the NHS Wales Executive D2RA reporting requirements by September 2024. The Committee was assured that extensive analysis had been undertaken to identify the root causes to these technical issues which had now been identified and implementation was therefore planned for December 2024.

Patient Quality and Safety Learning and Improvement Forum Draft Terms of Reference: The Committee received an outline of the new Patient Quality and Safety Learning and Improvement Forum and approved the Terms of Reference for this group.

Health & Safety & Fire Improvement Plan: The Executive Committee was updated on the progress made in delivering the Health, Safety & Fire Improvement Plan. The Committee noted that significant progress had been achieved across the seven high risk areas.

Putting Things Right (PTR) Annual Report 2023/24: The Executive Committee received the PTR Annual Report and noted the key priorities for the PTR Annual Work Programme 2024/25, which are focussed on:
Priority 1: PTR Regulations and Health Board Concerns Management
Priority 2: Improving Quality Patient Safety Experience, Learning and Improving
Priority 3: Partnership Engagement & Collaborative working.

Dementia Care Annual Report 2023/24: The Executive Committee received the Dementia Care Annual Report and noted progress report against the All-Wales Dementia Care Pathway which included: community engagement listening events had been held, the implementation of a memory assessment service pathway and carers education and support.

Safeguarding Annual Report: The Executive Committee received the safeguarding annual report which detailed the successes and challenges related to safeguarding during the reporting period. Eight priorities were highlighted to the Committee that framed the Safeguarding Annual Work Programme for 2024/25.

Commissioning Assurance Framework: The Executive Committee was provided with an overview of the Commissioning Assurance Framework ahead of presentation to Board. The Committee was informed that the strategic aim was to ensure that there was equitable access to safe, effective, and sustainable services, as close to the patients home as possible. It was proposed to the Committee that this could be

achieved through either directly providing, or commissioning, healthcare from other service providers. The Executive Committee agreed that due to the service spanning multiple specialisms and divisions, the monitoring process should be included within an Internal Integrated Framework.

High Consequence Infectious Disease: The Executive Committee was updated on an amendment made to High Consequence Infectious Disease Personal Protective Equipment as set out in the National Infection Prevention and Control Manual. The Executive Committee noted the aim of the revised guidance was to describe the personal protective equipment required for clinical staff caring for individuals with contact or airborne high consequence infectious diseases both suspected and confirmed. The Executive Committee discussed the proportion of staff who were FIT tested within the Health Board and considered the upcoming publication of papers detailing methods of mass FIT testing, to ensure satisfactory compliance.

Respiratory Assessment Zone (RAZ): The Executive Committee was updated on the current utilisation and protocols of the Respiratory Assessment Zone (RAZ) at the Grange University Hospital. The Executive Committee noted that RAZ was an approach which involved the use of cubicles to triage patients with respiratory conditions away from other patients. The report proposed to step down the RAZ in GUH as an area for respiratory purposes only due to the demand levels versus capacity available, with the understanding that should the need arise due to an increase in demand, such as spikes in seasonal disease, the RAZ would be reinstated. The Executive Committee supported the proposal.

Covid-19 Nosocomial Investigation, End of Programme Report: The Executive Committee received the end of programme report for the Covid-19 Nosocomial Investigation. The Executive Committee noted that the report was completed in line with the requirements of the National Programme commissioned by Welsh Government. The Executive Committee was assured learning from the investigation had been taken to the Health Board's Learning Group for implementation in other large-scale investigations. The Executive Committee noted that well-being support was in place to divisions to provide direct ongoing support.

Hospital Transfusion Committee Annual Report 2023-24: The Executive Committee was provided with an overview of the Hospital Transfusion Committee's activities for the year 2023-24 and was assured of the Health Board's management of blood against the Health and Care Quality Standards. The Executive Committee was assured that the Health Board was compliant with legislation and national guidance on the supply and appropriate use of blood, blood components and products.

Cancer Board Assurance Report: The Executive Committee was provided with assurance with regards to the implementation of Welsh Health Circular (WHC) 2024/007 on the management of cancer pathways. The Executive Committee was informed that there was a requirement for the provision of a gap analysis of the Health Board's compliance with the WHC, with particular attention to the Health Board's plan to become compliant. The Committee requested that a report be brought back for consideration setting out progress of the Health Board's performance against Cancer pathways.

Mortuary Serious Incidents Action Plan: The Executive Committee was updated in relation to progress against the action plans submitted as part of the Patient

Safety Incident (PSI) investigations. The Committee was assured that nineteen recommendations were made following the PSI investigations and that three outstanding actions remained.

Clinical Advisory Group and Priorities: The Executive Committee was informed that a Clinical Advisory and Priorities Group had been set up and its Terms of Reference was approved. The Executive Committee noted that the Group would be a multi-professional advisory group who would offer advice or recommendations to the Executive Committee on matters which included new treatments, strategy and policy, and quality impact assessments.

Quality Impact Assessment of Savings Plans: The Executive Committee discussed and agreed an approach for the Quality Impact Assessment of the 2024/25 Pipeline Savings Opportunities.

Review of Neurodevelopmental Service for Under 18s: The Executive Committee was provided with an overview of the Neurodevelopmental Service for Under 18s Divisional response to the NHSE Publication of the All-Wales Review of the Neurodevelopmental Service for Under 18s. The Executive Committee noted the approach to address the Neurodevelopmental Service's triage backlog, the recovery plan, and the transition processes for the service.

Overview of the Infection Prevention, Decontamination and Antimicrobial Stewardship Annual Report 2023/24: The Executive Committee received the annual report which included an overview of the key achievements and concerns. The Committee was updated on Welsh Government Reduction Expectation targets and noted that the Health Board had experienced an increase in C-Difficile when compared to the equivalent period 2022/2023. The Committee noted that improvements were required in IP&C standards compliance and antimicrobial prescribing. The Committee was assured on the progress against the priorities of the Infection & Prevention control Team for 2023/24 and outlined the priorities for 2024/25.

Antimicrobial Resistance & Healthcare Associated Infections Improvement Goals for 2024/25: The Executive Committee was updated on the Health Board's position in relation to the Antimicrobial Resistance & Healthcare Associated Infections Improvement Goals for 2024/2025. The Executive Committee noted that an overarching Healthcare Associated Infections action plan had been developed to support divisions. The Executive Committee supported the establishment of an enhanced monitoring arrangement through a Strategic Improvement Group for delivery of the action plan, and the Antimicrobial Stewardship action plan.

An Overview of Gram-Negative Bacteraemia April 2023 to March 2024: The Executive Committee was updated on gram-negative bacteraemia cases from April 2023 to March 2024 and noted that the Health Board had experienced an upward trend in the number of Gram-negative bacteraemia cases during the financial year 2023/2024 which were reported in three different categories: E coli, Klebsiella and Pseudomonas. The Executive Committee noted that given the increasing number of infections, it was recognised that the reduction of gram-negative blood stream infections was a high priority, and targeted interventions were required for urinary tract infection.

Bay and Ward Closures for the Management of Respiratory Illness: The Executive Committee was provided with an update on the necessary restrictions, in terms of bay and ward closures, required to minimise the transmission of respiratory infections namely Covid, Influenza and Respiratory Syncytial Virus. The Executive Committee noted that the current approach was above national guidance. The Executive Committee agreed to therefore follow national guidance but with very close monitoring to ensure no negative impact with escalation to the Executive Committee.

Review Options to Improve Mechanical Ventilation in our Hospital Settings: The Executive Committee was presented with a draft option appraisal to enhance the ventilation within the Health Board's hospital settings. Five options were outlined to improve mechanical ventilation in all sites, apart from GUH, that were non-compliant with ventilation standards, along with advantages and disadvantages and financial implications of each. The Executive Committee noted that that a combination of options would be most beneficial and agreed for initial work to begin and noted the risks.

Evaluation of the Configuration of Midwife Led Birthing Units: The Executive Committee was provided with an overview of the evaluation of the reconfigured Midwife led birthing units within the Health Board. The Executive Committee was assured that birth rates were in line with national benchmarking and that no informal or formal concerns had been raised regarding the inability to birth in RGH/NHH, and the changes to YYF. The Executive Committee noted that there had been no increase in unexpected/unplanned births before arrival.

Pharmacy and Medicines Management Annual Report 2022/23: The Executive Committee received the Medicines Management Annual Report 2022/23 which updated on pharmacy services, medicines management, primary care prescribing and homecare medicines services in ABUHB.

Delivery, Performance & Efficiencies

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

Other matters discussed include:

International Recruitment update and WG funding, May 2024: The Executive Committee noted the Welsh Government non-recurrent funding of £894,473 for international recruitment and approved the recruitment of fourteen overseas Mental Health Nurses. It was agreed that should the initial pilot be successful; approval would be sought to recruit more Mental Health Nurses as required to fill vacancies. The Executive Committee approved the recruitment of senior doctors from Kerala into the Health Board according to divisional requirements and within the limits of the funding set out and agreed that the Health Board enters into tenancy agreements to house international arrivals.

Charitable Funds - Available Funding & Consideration of Bids/Small Grants

Scheme: The Executive Committee agreed that future bids to be submitted to the Charitable Funds Committee would be considered by the Executive Committee prior to submission to the Committee.

Divisional Performance and Escalation Levels: The Executive Committee received a report which confirmed the escalation levels of Divisions following a 12-month review process, as part of the Performance and Accountability Framework. The Executive Committee noted the minutes and notes of the 12 monthly reviews that had taken place to date; agreed the escalation levels and discussed and agreed the response to escalation levels.

Non-Pay Elements and Pay Risks: The Executive Committee received the report which detailed pay-related issues and potential challenges arising from national agreements, programs, or changes in employment legislation that could pose risks to the Health Board's financial plan. The Executive Committee noted that no decisions could be made until the results for HCSW and GP Out of Hours were received.

Specialist Consultant Locum Rate and Planned Additional Activity Rate (PAAR): The Executive Committee was updated following the February 2024 report on Specialist Consultant Locum Rates and the Planned Activity and Additional Rate system. The Executive Committee was informed on key areas impacted which included mass vaccination and midwifery. The Executive Committee supported the inclusion of a Specialist Locum RTT and PAAR Rate for agreed areas, subject to agreement of the Remuneration and Terms of Service Committee.

Core Learning Committee (CLC) Submission – NHS Wales Blood Transfusion Training: The Executive Committee was updated on the work being undertaken by the Core Learning Committee. The Executive Committee noted Health Board's overall statutory and mandatory requirements compliance was 80.18% and noted the following competencies had been referred to CLC for mandate: Counter Fraud; Deprivation of Liberties (DoLS) and Consent training.

Deep Dives: The Executive Committee undertook performance deep dives into the following three specialities with a review of performance trajectories and sustainable solutions in the context of ministerial priorities: ENT, Ophthalmology and Orthopaedics.

Strategic Planning and Development:

Annual Plan Governance and Performance 2024/25: The Executive Committee was updated that there had been a significant learning process since the submission of the 2024/25 Annual Plan and following discussion at the Planning and Strategy Network a proposed new governance and oversight arrangements and outlined the timetable for the next planning cycle had been developed. The Executive Committee approved the establishment of governance arrangements and an overarching timetable for the next planning cycle and agreed for wider input into performance reports and agreed that the necessary commitment from respective teams would be provided to complete an integrated performance report on a quarterly basis.

Strategic Engagement Mid-Point Review: The Executive Committee received an update on the Midpoint Review of the Long-Term Strategy Engagement Programme, conducted in July 2024. As of 11th July 2024, the Health Board had engaged with 2,701 people across 152 events, with 517 individuals responding to the survey. The Executive Committee learnt feedback indicated that the people of Gwent possess diverse factors that they consider important for maintaining their health. The Executive Committee sought assurance as to the methods used with regards to key groups that included children in care and the need to engage more with the male population. The Executive Committee was assured that peer mentors had been trained to engage with individuals from various backgrounds.

Other Formal Business

As standing agenda items, the Executive Committee receives:

- Internal Audit reports issued, including 2023/24 Audit of Savings Programmes;
- Routine reporting against Audit Recommendations Tracking; and
- Published Welsh Health Circulars and Ministerial Guidance.
- Internal and External Audit Recommendations Tracker

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

- Quality and Safety Performance Report
- Workforce Performance Dashboard
- Strategic Risk Report
- Financial Performance Report
- Activity & Performance Report

System Leadership Group

The Executive Team holds monthly System Leadership Group meetings with leaders from across the Health Board. At the meeting held in July 2024 the Group considered "Take a Beat" which was an analytical approach to the prevention of cardiovascular disease and the use of whole person data to reveal Gwent's picture of health.

The meeting held on 16th September 2024 included a focus on the development of the long term (10 year) strategy and an overview of digital priorities and programmes.

Executive Team Development

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

[Argymhelliad / Recommendation](#)

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

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

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

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Key Matters from Committees of the Board
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Michelle Jones, Head of Board Business

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In line with the Health Board's Standing Orders, a number of Board Committees and Advisory Groups have been established. This report provides, for assurance, an overview of the business undertaken by these committees during the reporting period, and highlights key matters for Board consideration, where required.

Cefndir / Background

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

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

Assurance Reporting

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

- Partnerships, Population Health and Planning Committee 1st July 2024
- Charitable Funds Committee 3rd July 2024
- Audit, Risk and Assurance Committee – 9th July 2024
- Patient Quality Safety and Outcomes Committee- 30th July 2024

Asesiad / Assessment

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

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable

Gwybodaeth Ychwanegol: Further Information:

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

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

Name of Committee:	Partnerships, Population Health and Planning Committee
Chair of Committee:	Ann Lloyd
Reporting Period:	1st July 2024
Key Decisions and Matters Considered by the Committee:	
Committee Forward Work Programme of Business 2024/25	
The Committee approved its work plan for 2024/25. The Committee noted that it would be brought forward to each future Committee meeting for oversight.	
Committee Risk Report	
The Committee received an overview of the risk reporting for assurance, that included a summary of the current risks that had been delegated to the People and Culture Committee for monitoring. The Committee endorsed the de-escalation of risk SRR 001H (relating to funding within the Public Health Directorate) as it would be more appropriately monitored by the Executive Committee through the Corporate Risk Register.	
Audit Recommendations Tracker	
The Committee received an overview of the Audit Recommendations Tracker and noted that at the end of Quarter 4 2023/24 there were 38 active recommendations from six audit reports aligned with the PPHPC agenda.	
Regional Planning Update	
The Committee received an update on progress of the regional service planning programmes. The Committee was advised that a workshop had been held to canvas the appetite to developing a regional clinical plan. The Committee received updates in respect of Ophthalmology, Digital Cell Path Solutions, Endoscopy and the Hepatobiliary and Pancreatic Programme. The Committee noted that work continued in developing a business case for endoscopy, and a revised proposal and timescale for the Hepatobiliary and Pancreatic Programme had been issued for testing amongst partners to address the capacity challenges.	
Regional Partnership Board (RPB) Update	
The Committee received an overview of the Regional Integration Fund (RIF) for 2023/24 and noted that 36% of the Gwent population had been reached in utilising this fund. The Committee noted that there was a consensus that cost effectiveness evaluations needed to be undertaken against each scheme to determine value for money. The Committee acknowledged the ongoing work and highlighted the need for better communication amongst partners with an	

increased importance of increasing connectivity to shift from project initiatives to a systematic change for better population care and outcomes.

Public Service Board (PSB) Update

The Committee received an update on the work of the PSB and was advised that as a result of the July meeting being cancelled the community safety agenda would not be approved until September 2024. The Committee noted that the repeated cancellations of meetings was significantly impacting momentum and setting the strategic direction.

The Committee noted that Public Health Wales had shared the Shaping Places for Wellbeing in Wales programme, which aimed to establish three national learning groups, each working on a different theme for a period of two years.

The Committee noted that the Joint Strategic Needs Assessment (JSNA) to assess health and wellbeing outcomes in Gwent, and noted the absence of plans to deliver improvements and change.

The Committee discussed the need for the development of improved communication pathways between the PSB and RPB, with the aim of breaking down the PSB agenda into shorter timescales in order to see real term influence.

Emergency Planning and Assurance Report

The Committee noted the work taking place to enable the Health Board to meet the requirements of the Civil Contingencies Act 2004 (CCA). The Committee was assured that the Health Board had mechanisms in place to meet these requirements and noted that the 2023 Business Continuity Audit, Internal Audit had provided reasonable assurance.

Long Term Strategy Engagement Update

The Committee received an update in the development of the long-term strategy since being discussed at a Board Briefing and Strategy Steering Group meeting. The Committee noted that the strategy would cover the period from 2025 to 2035 and was informed by the ten design principles previously agreed by Board, and that eight weeks of engagement which had taken place.

The Committee noted that the strategy was being developed in response to the evolving health and care landscape, the variation across the region, and the technological and genetic advances in healthcare.

Nevill Hall Hospital Update, Including an Update on RAAC

The Committee received an update on the ongoing investigations into the presence of RAAC at Nevill Hall Hospital (NHH) and the planned development of the site and associated service reconfiguration.

In particular the Committee noted:

- The NHH Planning Working Group was progressing the development of the NHH clinical service model.
- The longer-term response to the challenges of RAAC at NHH were being managed through a clinical review of services to establish future clinical and service models as an Enhanced Local General Hospital (eLGH), and,
- Biannual surveys were conducted to monitor any changes in the status of RAAC, with the third round completed in June 2024.

Population Health Management Update and Joint Strategic Assessment Report

The Committee noted the development of a Population Health Management Strategy to support the Population Health Management Pioneer work which was taking place in 2024/25. The Committee was informed that this had been informed by the JSA overview of health and wellbeing indicators.

The Committee noted that the strategy would be presented to Board for approval in Autumn/Winter 2024.

Health Protection & Vaccination Programme Update Report

The Committee received an update on the proposed new ways of working and plans for vaccination delivery which had been informed by the opportunity to review structures and services through the provision of a recurrent discretionary allocation.

The Committee noted that it would take 3 years to fully catch-up on vaccination coverage and that the integration of vaccines into Primary Care was a key consideration in ensuring an increase in uptake.

Matters Requiring Board Level Consideration or Approval:

- Emergency Planning Report Outcomes
- Update on the Long- Term Strategy

Key Risks and Issues/Matters of Concern:

None noted

Planned Committee Business for the Next Reporting Period:

- Review of Committee Programme of Business
- Committee Risk Report
- Overview of Audit Recommendation Tracking
- Long Term Strategy Development
- IMTP/Annual Plan Development
- Development of any plans and strategies aligned to the IMTP and Annual Plan
- Estates Strategy Review
- Planning Maturity Matrix
- Monnow Vale Update
- Regional Partnership Board
- Public Services Board
- Regional Planning
- Armed Forces Covenant

- | |
|---|
| <ul style="list-style-type: none">• Population Health Management Update Report• Health Protection & Vaccination Programme Update |
| Date of Next Meeting: 30 th September 2024 |

Name of Committee:	Charitable Funds Committee
Chair of Committee:	Paul Deneen
Reporting Period:	3rd July 2024
Key Decisions and Matters Considered by the Committee:	
Committee Annual Programme of Business 2024/25 The Committee approved its Annual Programme of Business for 2024/25. Finance & Performance Report The Committee received the Finance & Performance Report and noted that expenditure as a percentage of the balance of funds had increased from 6% in 2021/22 to 19%. The Committee was advised that income was lower when compared to 2022/2023 and as a result there was an overall decrease in the value of funds. The Committee was provided with an update of the financial position as at March 2024, and the following was highlighted: • Income at Month 12 was £806k, which represented a reduction of £338k, when compared with 2022/23. This was as a result of a reduction in donations and legacies. • Expenditure at year end was reported as £1,257K, which was £209k higher than 2022/23. The increase in expenditure was as a result of increased expenditure for equipment for the Ophthalmology and Urology Divisions and for defibrillators within the community. • As at March 2024, this resulted in a decrease in funds of £49K. • The Cash balance at year end was £641K and there were no overdrawn accounts, 4 funds had been closed and 855 donations had been received to a value of £228K. The Committee approved the establishment of six new funds. The Committee was informed that the NHS Charities Together was launching a £16M Workforce Wellbeing Programme grant and that the Health Board would be eligible to apply for funding. Available Funding & Consideration of Bids/Small Grants The Committee approved the following: • £4,600K to develop a retreat for the workforce to assist with the retention of staff and support with materials for the programme. • £5K to support with the costs of running the Women’s Health Conference on International Women’s Day. • £25K to support the suicide postvention service across Gwent for a 6-month period to enable permanent funding to be secured. Spending Plans Over £25K The Committee received an overview of spending plans over £25k. The Committee was advised that a total fund value of £5.721M was held as at March 2024, which consisted of 401 individual funds, of which 44 funds had balances over £25k. The Committee was advised that the Charitable Funds team would monitor expenditure against planned spend, and would report expenditure updates to the	

Committee to enable the Committee to seek assurance from fund holders on spends levels.

Level of Reserves

The Committee noted that a reserve of £624k had been created for 2023/24, and was assured that the level of reserve was on track for the current year.

Attendance of fund holders for slow moving funds

The Committee received an update on the spending plans for the following slow-moving funds:

F140 ABUHB Media Funds

The Committee was provided with assurance that the Media Fund had been used to support training, the reconfiguration of an agile working space in Estates and Facilities, purchase of an IT plotter printer, headset sets and signage for the space, and a water cooler for the workforce based in the St Cadoc’s Hospital. £3k remained within the budget.

F696 STW Springfield Community Ward Project

The Committee was provided with assurance that there were plans in place over the next 6 to 12 month. The Committee noted that the funds would be spent on the reconfiguration of space at St Woolos Hospital to create a learning lab to support training and a clinical supervision programme away from the ward.

Matters Requiring Board Level Consideration or Approval:

There were no matters identified for escalation to the Board.

Key Risks and Issues/Matters of Concern:

There were no risks or issues identified for escalation to the Board.

Planned Committee Business for the Next Reporting Period:

- Review of Committee Programme of Business
- Annual Review of Committee Effectiveness
- Finance & Performance Report
- Funds available to the Committee
- Consideration of Bids/Small Grants
- Update on Property Matters
- Approval of admin charge/unrealised
- Draft Accounts and Annual report
- Attendance of fund holders for slow moving funds
- Update in the Bid Incontinence Project
- NHS Charites Grant update
-

Date of Next Meeting: 7th November 2024

Name of Committee:	Audit Risk and Assurance Committee
Chair of Committee:	Iwan Jones
Reporting Period:	09 July 2024
Key Decisions and Matters Considered by the Committee:	
Job Planning Assurance Note The Committee received an update on the implementation of Consultant Job Planning processes and systems. Concerns were raised regarding the current level of compliance and the compliance target of 85% and emphasised that the target should be 100%, with exceptions. It was agreed that the Committee would receive regular updates on Consultant Job Plan compliance.	
Closing Position for Q1 2024/25 Audit Recommendations The Committee reviewed the closing position for Q1 2024/25 audit recommendations, with 109 recommendations considered. Of those, 42 requested revised deadlines, 9 were completed, and 8 remained overdue. Concerns were raised regarding the repeated delays in completing some recommendations, leading to an agreement that any recommendation requiring more than two deadline extensions would now be accompanied by a detailed assurance report. The closing position was approved except for high-priority items from the 2017 Medical Devices report, which required further assurance due to repeated delays.	
Audit Recommendation Tracking Procedure The Committee deliberated on the revised Audit Recommendation Tracking Procedure, which was implemented to improve the management of audit responses. Clarification was requested regarding the manner in which audit points that were beyond the Health Board's scope would be addressed. This will be followed up with Internal and External Audit to establish an agreed-upon approach. The procedure was approved in principle, pending further amendments, which would come back to the Committee meeting on 12 September 2024 for formal approval.	
Capital Assets and Charges FCP The Committee was informed of the changes to the Capital Assets and Charges Financial Control Procedure (FCP) following internal audit recommendations aimed at improving asset management processes. The Committee approved the changes to Capital Assets and Charges Financial Control Procedure (FCP).	
Counter Fraud Functional Standard Return Declaration The Committee reviewed the Counter Fraud Functional Standard Return Declaration, noting the positive performance and improvements in risk assessment processes.	
Post Payment Verification Annual Report 2023/24 The Post Payment Verification Annual Report 2023/24 was presented, the Committee noted the report.	

Review of the Health Boards Annual Report, Overview & Performance section (Part 1) and Accountability Report, Including Annual Governance Statement (Part 2)

The Committee received the Health Boards Annual Report, Overview & Performance section (Part 1) and Accountability Report, including the Annual Governance Statement (Part 2) and acknowledged the significant effort in creating a well-written and balanced document.

The Committee endorsed Part 1 and 2 for submission to the Board.

Review Final Accounts and Financial Statements (Part 3) – To include losses and special payments.

The Health Board's Final Accounts and Financial Statements (Part 3) were received by the Committee, concluding a deficit of £49.766 million. The Finance Team and Audit Wales were recognised by the Committee for their substantial contributions to the development and finalisation of the accounts. However, the Committee expressed concerns about the impairment charges, particularly in relation to the Bevan Health and Wellbeing Centre project. The Committee proposed that a deep dive be conducted to gain a more comprehensive understanding of the Bevan Health and Wellbeing Centre project.

The Committee endorsed the Health Board's Final Accounts and Financial Statements (Part 3) for submission to the Board.

Audit of Accounts (ISA 260) including Letter of Representation

Audit Wales presented their Audit of Accounts (ISA 260), indicating an unqualified opinion on the financial statements but a qualified regularity opinion due to the Health Board's failure to meet its three-year break-even target.

The Committee accepted the audit opinion for submission to the Board.

To Agree a Recommendation to the Board in respect of the audited annual report and accounts

The Committee recommended that the Board approve the 2023/24 Annual Report and Accounts, along with the associated documents, including the Letter of Representation.

External Audit Progress Report 2024/25

The External Audit Progress Report 2024/25 was noted, with the Charitable Funds Audit scheduled for November 2024.

Audit Wales Community Pharmacy Data Matching Report

The Committee received the Audit Wales pilot study on community pharmacy risks, which focussed on expensive items, higher-cost formulations and specials. No recommendations were identified in the report; however, it posed three questions to assess Health Board practices and encourage improvements in expenditure and cost reduction. The Health Board response would be presented to the Committee at a future meeting.

Internal Audit Progress Report including 2024/25 Internal Audit Work Plan

The Committee acknowledged the reasonable assurance opinion for 2023/24, which encompassed 27 completed audits and noted that the 2024/25 plan was already in progress.

To Receive Internal Audit Reports

The Committee received the following internal audit reports for assurance.

Bevan Health and Wellbeing Centre

The Bevan Health and Wellbeing Centre received Limited Assurance, with concerns about recurring project issues. The Committee was reassured that new measures, including standardizing project management and introducing sanctions for underperforming contractors, would help prevent future problems. The Committee also requested the introduction of local KPIs alongside national ones.

Regional Partnership Board

The Regional Partnership Board (RPB) Financial Controls report received Limited Assurance, with challenges highlighted regarding non-standard transactions and unclear procedures, which caused issues despite proper transaction handling. Steps such as ending advance payments, creating a Memorandum of Understanding, and conducting a governance review are expected to improve financial processes.

Decarbonisation

For the Decarbonisation report, which also received Limited Assurance, the Committee noted improvements but acknowledged the difficulty of meeting decarbonisation goals without adequate funding. There was concern over the Health Board's initial response to a recommendation, which was later changed to "agreed in principle" after further consideration.

LINC Programme

The LINC Programme received Reasonable Assurance, but the Committee expressed concerns about the Health Board's capacity to manage multiple projects and its lack of involvement in the planning phase. A detailed report was requested for a future meeting.

Intra-Site Patient

Reasonable Assurance, no concerns raised.

Theatres (Stock)

Theatres received Reasonable Assurance however the Committee raised concerns about the reporting scope, particularly in relation to spending. It was suggested that broader scrutiny at the Directorate Management Team level with a suggestion for a follow-up review.

Financial Controls

Substantial Assurance, no concerns raised.

Flexible Working

Advisory, no concerns raised

The Committee Noted all internal audit reports for assurance.

Committee Risk & Assurance Report

The Committee received an overview of the Risk and Assurance Report, where the effectiveness of actions in reducing strategic risks was questioned. It was acknowledged that while the actions are effectively addressing the risks, the nature of these risks means that scores and risk levels may not decrease quickly. However, the Committee was assured that the actions are mitigating the likelihood and consequences of these risks

The Committee Noted the reports for assurance. Committee Programme of Business An overview of the Forward Work Programme was provided, confirming that the Committee was on track in receiving updates on its delegated responsibilities. The Committee Noted the report for assurance.
Matters Requiring Board Level Consideration or Approval: The Committee raised concerns about the Health Board's ability to manage multiple IT projects and its lack of participation in the planning phase following the publication of LINC Programme internal audit report for Board consideration.
Key Risks and Issues/Matters of Concern: As above.
Planned Committee Business for the Next Reporting Period: The following list of reports, which are scheduled for the Committee meeting on 12 September 2024, does not include standing items. - Changes to the Audit Recommendation Tracking Procedure - Mid-year Report on the delivery of the Clinical Audit Plan - Receive a Quarterly Report on Counter Fraud Activity - Review of Committee Programme of Business - Receive assurance on implementation of the Governance Priorities set out within the IMTP 2022-25 - Compliance with Ministerial Directions and Welsh Health Circulars (WHCs)
Date of Next Meeting: 12 September 2024

Name of Committee:	Patient Quality, Safety and Outcomes Committee
Chair of Committee:	Pippa Britton
Reporting Period:	30th of July 2024
Key Decisions and Matters Considered by the Committee:	
Committee Risk Report The Committee Risk Register contained three high-level risks with three sub-risks, and one corporate risk. Risks remained unchanged that were reported to the Board recently. The Corporate risk regarding the Pharmacy Robot, the recent purchase of the new pharmacy robot was due for implementation between August and October 2024.	
Quality Performance Report The Committee received a routine quality performance report presented by the Clinical Executives with key updates set out below: Patient Experience within the Emergency Department, highlights included; • Monthly meetings were being held with CIVICA to look at ways to improve patient feedback capture. • The establishment of a people participation panel had been initiated to enhance patient care. • Collaboration with Cardiff & Vale University Health Board had been initiated to ensure best practices for caring for dementia patients in ED and • Red Cross continued to support patients and staff. Health Board’s use of AMaT, the audit, management and tracking system was being used to address the 27 recommendations made by HIW. Improvement Plans for urgent and emergency care, highlights included; a reduction in the time to triage, down to 17 minutes, and a monthly reduction of patients with chest pains waiting longer than 60 minutes. Further discussion was held around the protocol for patients triggered for Sepsis, with the presentation of the comprehensive sepsis management review to come forward to a future meeting. Patient Safety Incident reporting to Welsh Government, saw a rise in reporting incidents due to the change in Welsh Government Policy to report still birth, birth loss and uterine death, infection prevention and control issues. The Health Board received feedback from the WG emphasising the need to improve the timely closure of patient safety incident reports. It was noted that tracked progress over the last three years showed significant improvement, with 8% of reports closed within the target timeframe in 2022, 13% in 2023, and 38% in 2024. A detailed report on the timeliness of closures would be presented to a future meeting for assurance. It was reported a decrease in the total number of falls and severity, with ongoing efforts to minimise harm. Part of the efforts would include collaboration with divisions to identify any anomalies or areas needing targeted intervention.	
Mortuary Incident Action Plan The Committee was updated on the investigation and subsequent improvement actions. The investigations had now been completed and the final report and	

corresponding action plan had been shared with the families. Peter Carr, Director of Therapies and Health Science, had met with those affected and an open offer had been extended if the families had any further questions and a media response had been implemented to ensure public confidence.

It was outlined that root causes which were noted as the failure of staff to follow policies and procedures of the Health Board.

There was a recent unannounced visit by the Human Tissue Authority to the Mortuary at GUH which yielded positive feedback on workplace culture and compliance.

Commissioning Assurance Framework

The Committee was informed that efforts were underway to create a standardised process for collecting quality information from commissioned services. This approach aimed to ensure consistent and rigorous data collection across the Health Board.

Maternity Services: Organisational Improvement and Action Plan

The Committee was updated on Maternity Improvement Plan which would improve outcomes for women and babies and support staff and innovations and improvement in practice for the future. The improvement plan focused on health promotion and improvements for women and babies and key strategic reports and focused on aspects of choice and early intervention.

There were four themes of the improvement plan and workstreams and actions under each theme and measurements within a set time to record improvements.

It was noted that there were 95 actions in total as part of the improvement plan over a three-year period and outlined Quarter 1 and Quarter 2 actions and upcoming actions for Quarter 3.

Review of Committee Programme of Business 2024/25

The Committee noted amendments and updates to the Committee’s Forward Work Programme.

The Committee received the following Annual Reports for assurance:

- Pharmacy & Medicines Management Annual Report 2022/23
- Hospital Transfusion Committee Annual Report
- Infection Prevention and Control and Cleaning Standards Annual Report 2023/24
- Safeguarding Annual Report

Matters Requiring Board Level Consideration or Approval:

None noted

Key Risks and Issues/Matters of Concern:

None noted

Planned Committee Business for the Next Reporting Period:

As per the Forward work plan for 2024/25

Date of Next Meeting: 2nd of September 2024.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Joint Commissioning Committee (JCC) Update Report – September 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Rani Dash, Director of Corporate Governance

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Joint Commissioning Committee (JCC) as a Joint Committee of the Board.

Cefndir / Background

On 1 April 2024, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) ceased to exist. They were replaced by the NHS Wales Joint Commissioning Committee. The new Joint Commissioning Committee (JCC) holds the functions of the former EASC and WHSSC together with commissioning of 111 and Sexual Assault and Referral Centres.

The JCC is a Joint Committee of all Health Boards in NHS Wales. Membership of the JCC consists of the Chief Executive Officer of each Local Health Board; an Independent Chair (the Chair); and not more than five Non-Officer Members (NOMs). The Chair and NOMs (to be known as Lay Members) are appointed by the Welsh Ministers. The JCC's membership also includes an Associate Member, who shall have no voting rights, who will be the Chief Commissioner of the Joint Commissioning Committee Team (JCCT). The Chief Commissioner is employed by CTMUHB as the Host Body and this individual holds the Accountable Officer status, as delegated by Welsh Government, for accountability for certain elements of their

role, namely the propriety and regularity for public finances as delegated to them through the JCC from Local Health Boards.

Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of services as identified below for residents within their area.

- specialised services for: · cancer and blood disorders
- cardiac conditions
- mental health and vulnerable groups · neurosciences, and · women and children.
- services where there is agreement between the Local Health Boards that they should be arranged on a regional or national basis
- emergency medical services
- non-emergency patient transport services
- emergency medical retrieval and transfer services
- NHS 111 services
- sexual assault referral centres, and
- other services as directed by the Welsh Ministers.

Asesiad / Assessment

The Joint Committee last met on 16th July 2024. The papers for these meetings are available at [Meeting Dates and Papers - NHS Wales Joint Commissioning Committee](#) .

A summary of the business discussed at this meeting included:

- Interim Chief Commissioners Report
- Emergency Medical Retrieval and Transfer Service Review update on recommendation 4 to develop a bespoke road based enhanced critical care response for rural and remote areas
- NHS Wales 111 Wales Commissioning Arrangements
- Development of Joint Commissioning Committee Integrated Medium Term Plan (IMTP) 2025-2028
- Plastic Surgery South Wales – Revised Ministerial Key Performance Indicators (KPIs)
- Gender Identity Services for Children and Young People – Final Report of the Cass Review
- NWJCC Performance Report – April 2024
- Financial Performance Report Month 2
- All Wales Molecular Radiotherapy (MRT) Programme
- Corporate Governance Report
- Ambulance Services Performance – Update

The full assurance report for this meeting is included at Appendix 1. A glossary of terms is also appended to this report.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this report by way of an update on NHS Wales Joint Commissioning Committee (JCC) Committee activity.

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

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb	No does not meet requirements

Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Choose an item.

Glossary of Terms

- EASC – Emergency Ambulance Service Committee
- WAST – Welsh Ambulance Service Trust+
- SDEC- Same Day Emergency Care
- ICAP – Integrated Commissioning Action Plan
- ROSC – Return of spontaneous circulation
- CHARU- Cymru High Acuity Response Units
- NEPTS- Non-Emergency Patient Transport Service
- EMRTS Cymru – Emergency Medical Retrieval and Transfer Service
- CASC – Chief Ambulance Services Commissioner
- BCUHB – Betsi Cadwalader University Health Board
- CTMUHB – Cwm Taf Morgannwg University Health Board
- C&VUHB – Cardiff and Vale University Health Board

- HDUHB – Hywel Dda University Health Board
- SBUHB – Swansea Bay University Health Board
- DHCW – Digital Health and Care Wales
- SEDC – Same Day Emergency Care
- SPC – Statistical Process Control

JOINT COMMISSIONING COMMITTEE (JCC) MEETING BRIEFING – 16 JULY 2024

The Joint Commissioning Committee (JCC) held its latest public meeting on 16 July 2024. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the JCC.

The papers for the meeting can be accessed using the link below:
[Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.](#)

1. Minutes of Previous Meetings

The minutes of the JCC meeting held on the 21 May 2024 were **approved** as a true and accurate record of the meeting.

2. Action log and matters arising

Members **noted** the progress on the actions outlined on the action log.

3. Patient Story

Members received the first patient story from Alan Owen who suffered a sudden cardiac arrest in 2022 and was transported to Cardiff via the Emergency Medical Retrieval Service (EMRTS) where he underwent emergency cardiac surgery and was fitted with two stents and an Implantable Cardioverter Defibrillator (ICD). CB explained that Alan has become a patient experience advocate and had written a book about his road to recovery to help others.

Alan provided members with a powerful story on experiencing a cardiac arrest whilst participating in a walking-football tournament at Caldicott leisure centre during 2022. He expressed his gratitude to all the NHS services and the public who saved his life and helped him overcome this traumatic event.

Members discussed the need to ensure that more people survive a sudden cardiac arrest and the importance of the community response, the timely arrival of specialist care on the scene via EMRTs and transfer to the specialist cardiac centre.

Members **noted** the patient story and thanked Alan for sharing his story.

4. Chairs Report

Members received the Chair's Report and **noted** updates on key meetings attended by the Chair as well as the following:

- **JCC Development Programme** – the Chair and lay members have continued to participate in induction sessions and two sessions took place on the 4th June 2024.
- **Annual Attendance at Health Board Meetings** – The Chair is keen to ensure open and transparent communication as the JCC exercises key commissioning responsibilities on behalf of the seven Health Boards (HBs). The JCC will report annually to each HB, whenever possible, in person and a letter has been issued to HB Chairs to request that this opportunity is built into HB forward plans.
- **Lay Member Recruitment** – WG is currently in the process of recruiting the final two Independent Lay Members, which will take the JCC to a full complement of six including the Chair. Interviews are scheduled for early September with a view that appointments will be made from 1 October 2024.

Members **noted** the report.

5. Interim Chief Commissioner's Report

Members received the Interim Chief Commissioner's Report and **noted** updates in relation to the following:

- Overarching assessment of delivery of Quarter 1 Transition Plan
- Establishing the JCC Sub-Committee Structure and work programme
- Public Health Input
- Infected Blood Inquiry
- Sexual Assault Referral Service (SARC) Update
- - Business Continuity for the upgrade works within Princess of Wales Hospital Maternal and Neonatal Unit
- North Wales Mother and Baby Unit (MBU)
- Extra Corporeal Membrane Oxygenation (ECMO).

Members **noted** the report.

6. Joint Commissioning Committee Risk Register

Members received a report presenting a transitional amalgamated risk register for the Joint Commissioning Committee (JCC) which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former Emergency Ambulance Services (EASC), National Collaborative Commissioning Unit (NCCU) and the Welsh Health Specialised Services Committee (WHSSC).

Members noted that the amalgamated risk register was categorised as a transitional risk register whilst further work is undertaken to fully develop and implement the CTMUHB Risk Management Strategy for the JCC (in line with the hosting agreement) and until the JCC has an opportunity to consider its risk appetite as part of the JCC development programme.

Members noted that a significant amount of work had gone into developing the new risk register, and it was important to emphasise that it was a work in progress and there was still much more work to be undertaken to strengthen and develop it in conjunction with risk owners, commissioners and providers.

Members (1) **Noted** the report, (2) **Noted** the work undertaken to date to produce a transitional amalgamated risk register, (3) **Noted** the review work undertaken by the commissioning teams to produce a refreshed, updated version of the transitional amalgamated risk register to be presented to the JCC meeting on 16 July 2024, (4) **Approved** the JCC risk register as at 30 June 2024, (5) **Noted** the further work planned to fully develop the CTM Risk Management Strategy for the JCC, and the steps required to implement it; and (6) **Noted** that the CTMUHB Audit & Risk Committee (ARC) meeting for hosted bodies on 15 August 2024 will receive an update on the progress of the JCC risk register.

7. NHS 111 Wales Commissioning Arrangements

Members received a report providing an update on NHS 111 Wales Commissioning Arrangements.

Members noted that responsibility for the commissioning of NHS 111 Wales transferred to the NHS Wales Joint Commissioning Committee (NWJCC) on the 1 April 2024 and that Quarter 1 had seen transitional arrangements in place, with the previous programme team continuing to hold meetings of the Commissioning Board and Delivery Assurance Group (DAG).

Members noted that the transitional arrangement had ended, and the NWJCC Team would now assume full responsibility for the commissioning of the service. The JCC Team had submitted a request to WG for resources to support this function and it was noted that WG had confirmed that some funding would be available which would enable the commissioning function to be established.

Members (1) **Noted** the report, (2) **Approved** the adoption of the commissioning arrangements for NHS 111 Wales into the existing committee arrangements until such time as the formal sub-committee structure of the NWJCC is fully established, (3) **Approved** the proposed actions outlined for each of the risks of the previous programme and the development of specific risks required for the NWJCC to monitor in relation to their responsibilities in commissioning the service; and (4) **Noted** the NWJCC team capacity to undertake the commissioning of the NHS 111 Wales service is limited without additional resource.

8. Emergency Medical Retrieval and Transfer Service (EMRTS) Review Update

Members received a report providing an update on the Emergency Medical Retrieval and Transfer Service (EMRTS) recommendation to develop a

bespoke road based enhanced critical care response for rural and remote areas and recommendation 4.

Members noted that:

- as part of the EMRTS Review a recommendation was agreed to develop a bespoke road-based enhanced/critical care response for rural and remote areas,
- Recommendation 4 was made in order to respond to the concerns raised by residents during the public engagement processes around the provision of emergency healthcare in rural and remote areas that would not fall into the remit of the EMRTS, this included 999 incidents for example such as falls, strokes and chest pain
- the Recommendation 4 Task and Finish Group had been established in line with the timescale agreed at the last NWJCC meeting. The group met on 28 June 2024 and as agreed, was chaired by the Interim Director of Commissioning – Ambulance and 111.
- the Task and Finish Group's project plan included a communications plan linked in with the national Communications and Engagement leads across NHS Wales, and that a Stakeholder Update had already been issued to the stakeholder distribution list summarising the current implementation position and that more detailed content was in development,
- the NWJCC continued to work closely with Wales Air Ambulance Charity Trust (WAACT) as its strategic partner in the delivery of pre-hospital critical care as we jointly implement the Review recommendations and future improvements to service delivery, and that the charity continued to actively engage with their stakeholders and the EMRTS on the implementation of the recommendations; and
- the EMRTS leadership team had welcomed the certainty the decision provided for them and the operational teams, that the leadership team continued to focus on the development of the operational implementation plan and that the team had met with staff at their bases and will continue to engage with colleagues across Wales through the changes required as part of this important service development.

Members (1) **Noted** the first meeting of the Recommendation 4 Task and Finish Group meeting held on 28 June 2024, (2) **Approved** the revised Terms of Reference for the Task and Finish Group, (3) **Discussed** and **Approved** the approach to communication and engagement relating to the additional bespoke road-based service (Recommendation 4), (4) **Noted** the Wales Air Ambulance Charity Trust position in relation to the decision of the NWJCC, the engagement with their stakeholders, the work being undertaken to secure an appropriately located operational base and the work with EMRTS on the joint transition plan, (5) **Noted** the EMRTS Leadership team position in relation to the decision of the NWJCC, and that the team will continue to engage with colleagues across Wales,

(6) **Noted** the petition that will be considered by the Petitions Committee for debate, (7) **Noted** the commissioning approach, (8) **Noted** the work to update the previous legal advice following the decision made at the NWJCC in April 2024; and (9) **Noted** the receipt of the Letter Before Action in relation to a potential judicial review.

9. Implementation of Legacy Plans – Quarter 1

Members received a report providing an update for assurance against the Quarter 1 deliverables of the extant predecessor organisation legacy Plans.

Members noted that prior to the formation of the JCC, WHSSC and EASC produced plans in line with the Welsh Government NHS planning requirements, which were approved by the respective Joint Committees in March 2024. These plans remained extant in 2024/2025 as part of the legacy arrangements and the NWJCC has responsibility for assurance of their delivery.

Members **Noted** the assurance on delivery of the legacy Plans at the end of Quarter 1.

10. Development of Joint Commissioning Committee Integrated Medium Term Plan (IMTP) 2025-2028

Members received a report outlining the proposed process for the development of the inaugural JCC Integrated Medium Term Plan (IMTP) 2025-2028.

Members (1) **Noted** the feedback on legacy planning arrangements and plans that had been received from DOPs, DOFs and CEOs/Chairs, (2) **Noted** that the JCC Standing Orders stated that the JCC will develop an Integrated Medium Term Plan (IMTP) for 2025-2028, (3) **Agreed** the approach laid out in section 3.4; and (4) **Agreed** the process and timeline for developing the 2025-2028 JCC IMTP.

11. Plastic Surgery South Wales – Revised Ministerial Key Performance Indicators (KPIs)

Members received a report outlining the options in relation to achieving the Welsh Government key performance indicators (KPIs) in 2024/2025 for the plastic surgery service for South Wales provided by SBUHB.

Members noted:

- that the waiting list and waiting times for plastic surgery had increased and that some patients were waiting in excess of the 104 weeks WG waiting time target,
- that the WHSSC Integrated Commissioning Plan (ICP) for 2024/25 did not include allocated funding above the SLA baselines to address long waits in plastics and achieve the 104 weeks target because choices were made on the balance of performance and finance in line with the difficult choices facing all HBs - the WHSSC Joint

Committee agreed not to accelerate improvement beyond a continued steady improvement towards the targets. However, following the approval of the ICP, WG published targets to achieve the 104 week waiting time target by March 2025. Members noted that this target was further revised through the NHS Wales CEO letter in May 2024 with revised Ministerial KPIs of no patients waiting over 104 weeks by the end of December 2024,

- that the NWJCC and SBUHB had worked collaboratively to consider the options for additional activity and cost to commissioners of achieving the WG KPIs for elective waiting times and members discussed these.

Following the detailed discussion around the affordability of the additional activity required and the other priorities HBs were needing to balance, members approved Option 2 subject to further urgent due diligence by the JCC Management Group.

Members (1) **Noted** the information presented within the report (2) **Advised** on the approach to the options in table; and (3) **Approved** Option 2 subject to additional due diligence by the Specialised Services Management Group.

12. Gender Identity Services for Children and Young People – Final Report of the Cass Review

Members received a report providing further information following the request made by the JCC on 21 May 2024 on the Cass Review recommendations. Members welcomed the additional work that had been undertaken and information that had been provided. It was agreed that the commissioning pathway for the service would continue, but recognised that it would be appropriate to review this in the future if further evidence became available.

Members (1) **Noted** the recommendations of the Cass Review and **supported** the continued alignment of the NHS Wales Joint JCC with the NHS England Implementation Plan; and (2) **Endorsed** the establishment of an 'Expert Clinical Advisory Group' to inform the review of the policy and specification for the adult gender identity service and associated terms of reference.

13. NWJCC Performance Report – April 2024

Members received a report providing an integrated overview of the performance of services commissioned by NWJCC up to the end of April 2024 for scrutiny and assurance.

Members (1) **Noted** the Performance Report for services commissioned by the NWJCC.

14. Financial Performance Report Month 2

Members received the month 2 and 3 financial positions.

Members noted that:

- the NWJCC financial position for 2024-2025 reported at Month 2 was a £1.6m overspend against the ICP financial plan to date, with a forecast year-end overspend of £655k at this point,
- the NWJCC financial position for 2024-2025 reported at Month 3 was a £2.8m overspend against the ICP financial plan to date, with a forecast year-end overspend of £2.5m,
- there had been a £1 million deterioration in position between the month 2 position and month 3 position with a £2 million deterioration in the year end forecast; and
- in relation to the savings target WG had requested a 2% savings target which amounted to a £10 million savings target. To date, only £802,000 savings were reported. Members noted that if this continued the NWJCC would be looking at a significant overspend at year end.

Members **noted** the month end financial position for Months 2 and 3 which was concerning and agreed the need for a recovery plan to ensure that the current rate of overspend was brought back in to balance. This would be brought to the JCC for consideration in September, having been worked up by the Director of Finance with commissioning teams and Health Board Directors of Finance

15. All Wales Molecular Radiotherapy (MRT) Programme

Members received a report setting out the context, challenges and opportunities for an All Wales Molecular Radiotherapy (MRT) service.

Members (1) **Noted** the report, (2) **Noted** the All-Wales MRT programme strategic report at for publication; and (3) **Supported** continuation of the programme as outlined in the All-Wales MRT programme strategic report subject to Welsh Government (WG) confirmation of continued funding to support a dedicated resources for the programme.

16. Corporate Governance Report

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members noted the Annual Reports for the former EASC sub-committee and sub-groups as part of the legacy work of the JCC, and noted the results of the former WHSSC committee effectiveness survey for 2023-2024 and that the results will be used to inform the work of the JCC development programme.

Members (1) **Noted** the report, (2) **Approved** the Annual Reports for the former EASC sub-committee and sub-groups as part of the legacy work, (3) **Noted** the results of the former WHSSC committee effectiveness survey for 2023-2024; and (4) **Received assurance** that the Annual Committee effectiveness self-assessment for 2023-2024 was completed for the previous WHSSC Joint Committee.

17. Ambulance Services Performance – Update

Members received a presentation on emergency ambulance services performance.

Members noted:

- All Wales Daily EMS Performance Tracker,
- Verified Incidents, Conveyances, Emergency Department (ED) attendances and lost hours,
- Lost Hours and Total Arrivals per HB,
- The top 10 conveyed by nature of condition,
- Lost Hours by Age Profiles 2023,
- Monthly Indicators Dashboard,
- Performance Plan – Actions.

Members discussed the data, patient pathways and demand and capacity. Members welcomed the deep dive into the data and requested additional granular detail and agreed that further discussion was required to tackle the challenges would be included the JCC Development Session in August 2024.

Members **noted** the presentation.

18. Other Reports

Members also **noted** update reports from the following joint Sub-Committees/groups:

- Audit and Risk Committee (ARC) Assurance Report
- Management Group Briefings
- Individual Patient Funding Request (IPFR) Panel
- Welsh Kidney Network (WKN)
- Quality Patient Safety Committee (QPSC)
- South Wales Trauma Network Delivery Assurance Group (DAG)
- Neonatal Transport DAG
- Non-Emergency Patient Transport Service (NEPTS) DAG Minutes
- Emergency Medical Retrieval Transport Service (EMRTS) DAG Minutes

DYDDIAD Y CYFARFOD: DATE OF MEETING:	25 September 2024
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership Committee (NWSSP) Update Report – September 2024
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Michelle Jones, Head of Board Business

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the NHS Wales Shared Services Partnership Committee as a Joint Committee of the Board.

Cefndir / Background

NHS Wales Shared Services Partnership Committee (NWSSP) was established in November 2010 and became operational in April 2011 and through its work delivers economies of scale; efficiencies and consistency of quality and process for the business and professional services that are directly managed and delivered by local NHS bodies.

The membership is comprised of representatives from each NHS organisation that use the services and from Welsh Government in an observer capacity. The NWSSP operates under the legal framework and Establishment Order of Velindre University NHS Trust. The Managing Director is the designated Accountable Officer for Shared Services in line with The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and is accountable to the Director General / CEO NHS Wales and Health Boards, Special Health Authorities and Trusts through the Shared Services Partnership Committee (the Partnership Committee). The Partnership Committee meets bi-monthly and is chaired by an Independent Member, Professor Tracy Myhill OBE.

Asesiad / Assessment

The Joint Committee last met on 18th July 2024 and the papers for meetings are available at [Committee Schedule and Papers - NHS Wales Shared Services Partnership](#) . A summary of key matters discussed included:

- **Business Justification Case South-East Wales RadioPharmacy**
The Committee approved the Transforming Access to Medicines South East Wales Radiopharmacy Business Justification Case, which was considered through respective Health Boards.
- **2023/24 Annual Review of NWSSP**
The Committee received the outcome of its Annual Review which is viewed as an opportunity to demonstrate best practice in governance, accountability and transparency and provides a platform to showcase NWSSP’s performance and promote the difference made to the NHS in Wales. The Annual Review also highlighted those areas within NWSSP’s Integrated Medium-Term Plan where there was an intention to do more work to improve efficiency and effectiveness for the benefit of staff and customers.
- **All Wales Overpayment Procedure**
The Committee approved the All-Wales Recovery of Overpayments procedure.
- **Procure to Pay (P2P) Governance Update**
The Committee received an update on the P2P Governance arrangements and approved a refreshed No PO No Pay policy.

The assurance report from this meeting is attached at **Appendix A**.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this update report on NHS Wales Shared Services Partnership Committee activity.

Amcanion: (rhaid cwblhau)	
Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. N/A
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Service Partnership Committee (SSPC)
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details	James Quance, Assistant Director of Corporate Services
Date of meeting	18 July 2024

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Chair's Report

The Chair updated the Committee on her activities since the last meeting and forthcoming events. This included:

- The Welsh Risk Pool Committee (WRPC) had met twice since the May 2024 SSPC meeting and a report on Scheme of Delegation and functioning of the Committee was presented, in addition to a report on the WRPC as a Sub-Committee of the SSPC being received;
- There had been two Chairs' Peer Group meetings in May and June 2024, attended by Chair and Judith Paget;
- A collaboration meeting took place on 30 May 2024 with Police Commissioners, the Crown Prosecution Services, Welsh Government members and NHS organisations' representatives to refresh the Obligatory Responses to Violence in Healthcare. This was attended by Chair and Managing Director highlights would be taken to the NHS Leadership Board in July 2024;
- The Chair met with the new Chair of the Joint Commissioning Committee;
- The SSPC autumn development workshop would be held on 11 October 2024. The Chair reminded Committee Members to diarise in advance to ensure good attendance and participation; and
- The Chair requested suggestions for areas the Committee would benefit from exploring as deep dive sessions in future meetings.

The Committee **NOTED** the update.

Ratification of Chair's Action

Chair requested the Committee ratify the Chair's Action taken between the May and July meetings, regarding the purchase of three isolators for RadioPharmacy to deliver the safe preparation of radioactive medicines in sterile conditions as set

out in the ratification paper.

The Committee **RATIFIED** the Chair's Action.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The financial position at the end of quarter 1 was a surplus of just over £1 million. There were challenges in the Covid allocation, which were currently being discussed with Welsh Government;
- There were no issues raised by Audit Wales in the audit of the NWSSP element of the Velindre University NHS Trust annual accounts;
- Around 80% of IMTP objectives were being met at present;
- The Radiopharmacy Business Justification Case was on the agenda for approval and the purchase of isolators was in progress, noting that it was likely that the selected supplier would be unable to deliver as anticipated and therefore discussions were ongoing regarding an alternative solution;
- Laundry Services continued to develop well and NWSSP continued to work with Health Boards on the transition of service;
- Regulations for the Death Certification Reforms were laid in parliament, including the introduction of a statutory Medical Examiner system on the 15 April 2024. The legislation would come into force on 9 September 2024, meaning independent scrutiny by a Medical Examiner would become a statutory requirement prior to the registration of all non-coronial deaths in England and Wales from this date;
- The new ESR system was being worked on with NHS England in a joint endeavour;
- Primary Care Services continued to work closely with Digital Health and Care Wales regarding the implementation of the new prescribing service;
- The National Health Application and Infrastructure Services (NHAIS) system decommissioning would take place and was being worked with Digital Health and Care Wales and colleagues in NHS England;
- Contingency plans for the Primary Care Workforce Intelligence Tool have been implemented to ensure resilience;
- Quantities of Personal Protective Equipment to be kept in storage and amounts to be purchased are being discussed with Welsh Government;
- Welsh Government outlined a new approach for the Flu Vaccination Program for the whole of Wales. NWSSP would acquire and store the vaccines to roll-out throughout Wales;
- An agreement regarding the new Medicine Buffer Stock had been finalised; and
- Reimbursement of medical negligence claims, circa of £6 million had been approved at the last Welsh Risk Pool meeting. Services had seen an increase in claims, such as maternity, radiology and cancer units.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Transforming Access to Medicines South-East Wales RadioPharmacy Business Justification Case

NF presented the Business Justification case for the RadioPharmacy Service covering the South East of Wales. This service is part of the overall TrAMS programme and its urgency to be started is due to the forced closure of the C&VUHB RadioPharmacy unit. As a result the NWSSP RadioPharmacy unit will be established to provide a safe regulatory compliant facility to meet the future expected clinical demand of the South East. The preferred location is IP5 in Newport.

The case recommends a capital investment of £9.2 million with no additional capital contribution required from health boards. £2.3 million funding from Welsh Government as base investment has already been approved by the Cabinet Secretary and has been received, which leaves a further £6.9 million of additional capital which will need to be agreed through Welsh Government. A new revenue model has been set out in the business case following in depth discussions with finance colleagues. The potential additional costs that would impact on the commissioner discussions with regard to Velindre's share of any revenue implications were noted in the business case. NWSSP has submitted a Planning Permission application to Newport Council covering the proposed area in IP5 where the new TRAMs unit is to be situated. Given the lead in times the purchase of radio pharmacy Isolators had been subject to the previously ratified Chair's Action and is in progress.

The Committee **APPROVED** the Business Justification Case.

Annual Review 2023/24

The Annual Review was received as a positive reflection of staff going the extra mile during the previous financial year to fulfil the objectives set out in the Integrated Medium-Term Plan, showcasing best practice and achievements. Chair echoed the feedback of Committee Members, highlighting the importance of providing a balanced view of the positive impact of NWSSP across NHS Wales. It was recommended that the areas for improvement and lessons learned be included in the report, going forward.

The Committee **ENDORSED** and **NOTED** the Report.

All Wales Overpayments Procedure

The Procedure was revisited based on feedback received and places more emphasis on repayments, affordability and avoiding unnecessary hardship to staff, as well as providing for local flexibility for colleagues to address a dispute locally. Consultation had been sought through the Directors of Finance Peer group, including Trade Union and it was endorsed by all parties. It had also been to the Local Partnership Forum and through the NWSSP Equality Integrated

Impact Assessment process.

Following approval, it would become operational from 1 October 2024, to allow time to translate all correspondence and to communicate the changes to all stakeholders. Members praised the focus on indicating accurately when the overpayment occurs, the reason for its occurrence, and the root cause, as to prevent reoccurrence.

The Committee **APPROVED** the Procedure.

Procure to Pay Governance Update

The All Wales Governance Group met on two occasions and seven priorities had been identified, to include the Procure to Pay (P2P) Policy, which required refreshing and updating. The Policy emphasised how payments should only be made against an approved purchase order that already exists in the system, subject to certain agreed exceptions.

The revised Policy had been approved by the Deputy Directors of Finance in each organisation. Under the current governance arrangements, the Committee was asked to approve the revised Policy, for relaunch. The Group would share the Policy with suppliers and the Directors of Finance in each organisation to sign and distribute to staff internally.

The Committee **APPROVED** the Policy.

Welsh Energy Group and Welsh Energy Operational Group Terms of Reference

The Welsh Energy Group and the Welsh Energy Operational Group had a requirement to review their Terms of Reference annually and therefore met to carry out a review. Minor amendments were suggested and the Committee was content to approve the sub-groups' proposed revised Terms of Reference.

The Committee **APPROVED** the updated Terms of Reference.

Items for Noting

2023/24 Annual Governance Statement

The Statement provides assurance that NWSSP has a sound system of internal controls that supports the achievement of its policies, aims and objectives. Whilst strictly not a legal requirement for a non-statutory hosted organisation, it remains best practice to produce one. A particular highlight to note is the achievement of NWSSP's organisational Customer Service Excellence. Attention was drawn to the Limited Assurance review of Decarbonisation, but there were no further control issues reflected in the report.

Members praised the assurances and transparency of the document and noted

that attendance at SSPC meetings could be improved, with some organisations not regularly being represented by a voting member. It was important that each organisation remains properly represented in the discussion and agreement of important issues, which support the work of NWSSP to benefit organisations.

The Committee **NOTED** the Report.

2023/24 Head of Internal Audit Opinion

The report was a vital source of assurance and the Opinion for the year was given as Reasonable Assurance overall. The report was presented to the Audit Committee, by the Head of Internal Audit on 25 July 2024. All reports from the 2023-24 Internal Audit Plan were almost complete with the exception of two, which were expected to be concluded shortly.

The Committee **NOTED** the Report.

Finance, Performance, People, Programme and Governance Updates

Finance – NWSSP reported a surplus of £1.153m at the end of month 3, made up of a reported surplus of £0.846m against core operational budgets and £0.307m against the Covid allocation, which was currently under review. Work was ongoing on the arrangements for the vaccination campaign as well as the PPE stockholding, logistics, distribution and storage. The Welsh Risk Pool (WRP) was on forecast at month 3 and WRP cost drivers for 2024 and 2025 were being reviewed and updated ready for reporting in September 2024. There had been a saving of £5.5 million on energy that had been communicated to NHS organisations for cascading.

People & OD Update – PADR compliance remained marginally below target at 83.6%. Reported sickness absence was consistent and within target and expectations. Turnover was being investigated in terms of accurately capturing the reasons people leave, with exception of Single Lead Employer, benchmarking turnover with the rest of Wales to understand performance. In terms of agency and bank staff, the numbers were expected to reduce in the next cycle. May 2024 figures show NWSSP has been non-compliant in several areas, while overall Time to Hire remained under target at 55 days (target 71 days). However, positive progress to improve these statistics had been made, internally and across the board.

Performance – Due to timing of the reporting cycle, there were no significant performance concerns to bring to the Committee's attention. The Procurement Team was working with Finance colleagues to identify savings within the organisation. Performance review meetings were completed with colleagues across NHS Wales to discuss further collaboration and areas of improvement. The Outcome Measures Report focussed on outcomes as per the IMTP. A workshop session was held with the SLG on 13 June 2024 and it was agreed that more work was needed on customer experience and benchmarking.

IMTP Quarter 1 Update Report – IMTP performance as at quarter 1 was on track and performance against divisional plans would be scrutinised in upcoming quarterly performance reviews.

Project Management Office Update – Current progress against projects was highlighted and confirmation received that controls were in place to ensure monitoring. Updates regarding higher risk projects would continue to be reported as a matter of course to the Committee. The Audit Committee also received further information on the TrAMS programme at its July 2024 meeting.

Corporate Risk Register – The refreshed and reframed version of the Register was presented following SLG consultation and would develop further through review and scrutiny. The decarbonisation risk had been split to show where NWSSP has a role both in delivering the organisation’s targets and where it provides support across NHS Wales.

The Committee **NOTED** the above reports.

Papers for Information

The following items were provided for information only:

- NWSSP Annual Report on Conflict of Interests Declarations and Gifts, Hospitality & Sponsorship 2023-24;
- Annual Performance Review on Welsh Language 2023-24;
- Health and Safety Annual Report 2023-24;
- Counter Fraud Annual Report 2023-24;
- Annual Report on Information Governance 2023;
- Finance Monitoring Returns Month 3;
- PPE Dashboard Report; and
- SSPC Forward Plan 2024-25.

Members noted the importance of the assurance that each of the Annual Reports gives to the Committee and to Velindre University NHS Trust as NWSSP’s hosting body. The hard work of the Teams involved in producing was recognised and appreciated.

The Committee **NOTED** the Information Reports.

Part B (Private Session)

Motion to exclude the public from the meeting in accordance with the provisions of section 1 (2) and (3) of the Public Bodies (Admissions to Meetings) Act 1960

Chair sought clarification that the Legal and Risk Case Management System procurement, as raised in the May 2024 meeting, had been approved by the Velindre University NHS Trust Board.

The Committee **NOTED** the following items discussed in Part B:

- 2.1 Wales Energy Operational Group Decision Outcome;
- 2.2 All Wales Costing System Commitment of Expenditure;

2.3 All Wales Junior Doctors E-Rota Monitoring Solutions; and	
2.4 Welsh Risk Pool and Legal & Risk Services Annual Review 2023 – 2024.	
Any Other Business (AOB)	
No further items were raised for discussion.	
Matters requiring Board/Committee level consideration and/or approval	
The Board is asked to NOTE the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
No further matters were referred to other Committees.	
Date of next meeting	19 September 2024