Aneurin Bevan University Health Board

Wed 27 July 2022, 09:30 - 13:00

Agenda

1. Opening Business/Governance Matters

1.1. Chair's Introductory Remarks

Verbal *Chair*

1.2. Apologies for Absence for Noting

Verbal *Chair*

1.3. Declarations of Interest for Noting

Verbal *Chair*

1.4. Draft Minutes of the Health Board Meetings held on 25th May and 14th June 2022

Attachment *Chair*

1.4 a Draft Board Minutes 25 May 2022 AL.pdf (15 pages)
1.4 b Draft Board Minutes 14 June 22.pdf (8 pages)

1.5. Board Action Log for Review

Attachment *Chair*

1.5 Action Log 25.05.22 .pdf (2 pages)

1.6. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

1.6 Report on Sealed Documents and Chair's Actions July 2022.pdf (7 pages)

1.7. Chair's Report

Verbal *Chair*

2. Patient Experience and Public Engagement

2.1. Report from Aneurin Bevan Community Health Council

Attachment *Chief Officer of CHC*

2.1 Community Health Council Report for Aneurin Bevan University Health Board meeting July 2022.pdf (18 pages)

2.2. Attention Deficit Hyperactivity Disorder Service for Adults in ABUHB

Attachment *Interim Director of Primary, Community Care and Mental Health Services*

2.2 a Proposal to develop an ADHD service for adults.pdf (6 pages)
2.2 b 1 Flowchart for ADHD Referrals.pdf (1 pages)

3. Items for Decision

3.1. Six Goals for Urgent and Emergency Care Programme Plan

Attachment *Director of Operations*

- 3.1 a Six Goals Urgent and Emergency Care Programme Plan - Board Paper July 2022.pdf (5 pages)
- 3.1 b six-goals-for-urgent-and-emergency-care.pdf (46 pages)
- 3.1 c ABUHB Urgent and Emergency Care Six Goals Programme Plan June 2022.pdf (15 pages)

3.2. Quarter One Outcomes Report and updated trajectories for 2022/23

To Follow *Director of Planning, Performance, Digital and IT*

Attachments 3.2b and c have been included in the Supporting Appendices, and Attachment 3.2d (Minimum Dataset) was shared separately alongside the version 2 of the Board books.

- 3.2 IMTP Q1 Report Cover Paper.pdf (3 pages)
- 3.2a IMTP 2022 to 23 Quater One Progress Report.pdf (37 pages)

3.3. Planned Care Position Report

To Follow *Director of Planning Performance, Digital and IT*

- 3.3 Planned Care Update Board 27 July.pdf (11 pages)

3.4. Delegation of Revenue Budgets - Quarter 2 Update

Attachment *Interim Director of Finance, Procurement and VBHC*

- 3.4 Q2_budget setting update 22.23 July board 14.07.22.pdf (17 pages)

3.5. ABUHB Arts Strategy

Attachment *Director of Therapies and Health Science*

- 3.5 a Draft Arts in Health Strategy 2022 - 2027.pdf (4 pages)
- 3.5 b Arts Strategy Report final.pdf (32 pages)

3.6. Community Therapy MSK Pathway

Attachment *Director of Therapies and Health Science*

- 3.6 MSK Paper CF Programme Board v5.pdf (12 pages)

3.7. Primary Care Sustainability

Attachments *Interim Director of Primary, Community Care and Mental Health Services*

3.7.1. a) Trosnant Branch Surgery Closure Application

- 3.7 a 1 Trosnant Lodge Medical Practice - Board Report.pdf (9 pages)

3.7.2. b) Glyn Ebwy Vacant Practice Process

- 3.7 b Glyn Ebwy Surgery - Board Report July 2022.pdf (6 pages)

3.7.3. c) St Brides Medical Practice Vacant Practice Process

- 3.7 c St Brides Medical Practice - Board Report July 2022.pdf (6 pages)

3.8. Domiciliary and Care Home Complex Care Fees – 2022/23

Attachment *Interim Director of Primary, Community Care and Mental Health Services*

3.8 a Domiciliary & Care Home Complex Care - Fees - V10.pdf (6 pages)
3.8 b Domiciliary & Care Home Complex Care - App 1.docx.pdf (7 pages)

4. Items for Discussion/Assurance

4.1. Winter Plan 2021/22 Evaluation

Attachment *Interim Director of Primary, Community Care and Mental Health Services*

4.1 a Winter plan report cover paper.pdf (3 pages)
4.1b Winter Plan Report final 21 22.pdf (15 pages)

4.2. Digital Strategy Update

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

4.2 Digital Strategy Update v2.00 (003).pdf (17 pages)

4.3. Financial Performance: Month 3 2022/23

Attachment *Interim Director of Finance, Procurement and VBHC*

4.3 a Board Finance Report _m3_July 2022_final.pdf (28 pages)
4.3 b ABUHB Finance board report appendices M3 (July22).pdf (18 pages)

4.4. Strategic Risk Report July 2022

Attachment *Interim Chief Executive*

4.4 a Strategic Risk Report board Jul2022docx.pdf (7 pages)
4.4 b Fully Assessed New Risks July 2022.pdf (14 pages)
4.4 c Corporate Risk Regsiter OverviewJune2022.pdf (8 pages)

4.5. Executive Team Report

Attachment *Interim Chief Executive*

4.5 a Executive Team Report July 2022_.pdf (6 pages)
4.5 b Attachment One ABUHB response to HSC Committee Inquiry on Hospital discharge.pdf (7 pages)

4.6. An Overview of Joint Committee Activity

Attachment *Interim Chief Executive*

4.6.1. a) WHSSC Update Report

4.6 a WHSSC Update Report_July22.pdf (5 pages)
4.6 a 1 Chairs Summary 10 May 22.pdf (5 pages)
4.6 a 2 WHSCC Joint Committee Briefing (Public) 12 July 2022.pdf (6 pages)
4.6 a 3 Chairs Summary QPS 12 July.pdf (26 pages)

4.6.2. b) EASC Update Report

4.6 b EASC Update Report_July2022.pdf (5 pages)
4.6 b 1 Chairs Summary 10 May.pdf (6 pages)
4.6 b 2 Chair's EASC Summary from 12 July 2022 Final.pdf (8 pages)
4.6 b 3 minutes 15 March.pdf (20 pages)
4.6 b 4 Confirmedminutes_EASC_10May2022_approved_EASC12July2022.pdf (14 pages)

4.7. Key Matters from Committees of the Board

Attachment *Committee Chairs*

4.7 a Committee and Advisory Assurance Reports.pdf (20 pages)

4.7 b SSPC Assurance Report 19 May 2022.pdf (6 pages)

5. Closing Matters

Wednesday 28th September 2022 at 9:30am

6.

Aneurin Bevan University Health Board is committed to openness and transparency, and conducts as much of its business as possible in a session that members of the public would normally be welcome to attend and observe. However, in light of the current advice and guidance in relation to COVID-19, the Board has adapted it's ways of working. Whilst we are now in a position to enable Board members to meet in person, we do not have the capacity to enable physical attendance of observers.

This unfortunately means that members of the public are unable to attend meetings in person, at this time. The Board has taken this decision in the best interests of protecting the public, our staff and Board members.

We are progressing plans to enable members of the public to observe our Board meetings and the Annual General Meeting. In the meantime, a recording of the Board's meeting will be published to the Health Board's website following the conclusion of business.

Aneurin Bevan University Health Board
Minutes of the Public Board Meeting held on
Wednesday 25th May 2022,
via MS Teams

Present:

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

In Attendance:

Rani Mallison	-	Director of Corporate Governance
Leanne Watkins	-	Director of Operations
Dan Davies	-	Chief of Staff
Nathan Couch	-	Audit Wales
George Puckett	-	Chair, Trade Union Partnership Forum
Jenny Winslade	-	Director of Nursing (replacing Rhiannon Jones)
Linda Alexander	-	Deputy Director of Nursing
Danielle O'Leary	-	Head of Corporate Services Risk & Assurance
Catherine Currier	-	Minute Taker

Apologies:

Jemma Morgan	-	Community Health Council
Louise Wright	-	Independent Member (Trade Union)

ABUHB 2505/01 Welcome and Introductions

The Chair welcomed members to the meeting. The Chair expressed her pleasure in holding the meeting in person for the first time for many months. However due to space restrictions, observers were only able to join via Microsoft Teams. Work was ongoing to see if this challenge could be resolved for the next

Public Board Meeting. The meeting would be recorded and published the Health Board's website following the meeting.

ABUHB 2505/02 Declarations of Interest

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

ABUHB 2505/03 Minutes of the previous meeting

The minutes of the meetings held on 23rd March 2022 were agreed as a true and accurate record.

ABUHB 2505/04 Action Log and Matters Arising

It was noted that all actions within the log were complete or in progress, as outlined within the paper.

ABUHB 2505/05 Report on Sealed Documents and Chair's Actions

Rani Mallison, Director of Corporate Governance, provided an overview of the use of the Health Board's Seal and Chair's Actions that had been undertaken during the period 9th March 2022 to 9th May 2022.

The Board **NOTED** and **RATIFIED** the use of the common seal and Chair's Actions in line with Standing Orders.

ABUHB 2505/06 Chair's Report

The Chair presented the Chair's Report and provided an overview of the activities she had undertaken, outside of her routine meeting.

- A series of All-Wales Meetings with Health Board Chairs and the Minister which focused on:
  - issues in relation to Urgent and Emergency Care;
  - The NHS Executive and its proposed establishment. The first meeting of the NHS Executive Steering Group was held on 24th May 2022.
  - Collaboration with the Regional Partnership Board and regional working.
- The Chair provided an update on the work of the NHS Wales Chairs, which included:
  - Writing to the Minister, outlying the Dental Care Services that were being promoted within Health Board areas.
  - Discussions with HEIW on the delivery of additional Dentists.
  - Reviewing with HEIW training and development opportunities for clinical staff.
  - Revising the Public Appointment Processes and the governance of Health Bodies, which Welsh Government are now progressing on the Chairs' behalf.
  - Discussing the COVID Public Inquiry and the arrangements being made by each Health Body.

- Following the reduction of social distancing guidance, the Chair had recommenced visits within the Health Board and had to date visited:
  - the Emergency Services areas in Nevill Hall Hospital;
  - the Medi Park site accompanied by Cllr Richard Clark and the Minister prior to the development of an outline Business Case for the development;
  - Presentation to the Test, Trace and Protect Team with their Staff Recognition Chair's Award for 2021.

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

ABUHB 2505/07 (2.1) An Update in Respect of Maternity Services Provision

Rhiannon Jones, Director of Nursing, explained the report presented aimed to provide a formal update to the Board of the urgent decision taken by the Executive Team on 5th May 2022 regarding Maternity Services and Midwifery. Specifically, the instigation of a temporary service change, which supported the Division's preferred option, of temporarily closing Midwifery-Led Units in the Royal Gwent and Nevill Hall Hospitals and at Ysbyty Ystrad Fawr and to adjust the service provision to a 9 am – 5 pm service, from a 24/7 service. The aim was to centralise some Midwifery Services at the Grange University Hospital, thereby releasing some Midwives from Midwife Led Care, to support the deficits across midwifery staffing.

It was highlighted that the Families and Therapies Division had been raising some concerns regarding midwifery and fragility of midwifery staffing during the COVID waves. There had been significant pressures in Maternity Services, due to an increase in demand, the number of births at the Grange University Hospital and the complexity of births. The decision taken by the Executive Team reflected previous decisions taken during the pandemic, where the Local Options Framework was used to adjust service provision.

Rhiannon Jones noted that the significant staffing issues were due to vacancies, parental leave and sickness levels. It was acknowledged the Band 7 Midwifery Team Leaders at the Grange University Hospital had raised formally their concerns about staffing deficits and the pressures they were facing, in a letter to the Division's Senior Leadership Team.

It was noted the publication of the Ockenden Independent Review Report of Maternity Services at Shrewsbury and Telford Hospital NHS Trust had increased the scrutiny of Maternity Services, and therefore raised awareness. It was noted the Ockenden report and the Health Board's response would be presented to Patient Quality Safety Outcomes Committee at the beginning of June 2022.

Rhiannon Jones confirmed that the decision made by the Executive Team to implement a temporary service change was an anticipatory approach to minimise risk from a quality, safety and experience perspective. To date, there had been no reportable serious patient safety issues or incidents resulting

from the staffing deficit. This was credited to the hard work of the teams across the service.

It was explained that a range of actions were being undertaken to address the staffing deficit. An update was provided on the Birth Rate Approach Assessment, which was currently being reviewed on an All-Wales basis. The report included information on activity levels across the service and the mis-match with the predicated activity levels for the Grange University Hospital, the impact on lengths of stay and service provision. Rhiannon Jones noted that the Executive Team had requested that the decision be carefully evaluated and a report be presented to the Executive Team in 6 weeks' time, along with ongoing reviews.

The Board welcomed the report, the pragmatic approach taken and the hard work of the teams.

Katija Dew, Independent Member, raised the issue of increased caesarean rates and requested assurance the rates were as a consequence of complexity and clinical need. Rhiannon Jones provided information on caesarean section rates, which were reflective across Wales. Some were based on women's choice. As Executive Lead for Maternity Services, Rhiannon Jones confirmed that she was assured on processes, oversight and governance.

Pippa Britton, Independent Member, asked how the Health Board could guarantee earlier intervention and whether or not there was any data to support the causes of complexity and whether or not extra services could be provided to support mothers and mothers-to-be. Rhiannon Jones responded there was a combination of factors and provided information on the public health work of Lead Midwives. Sarah Aitken, Director of Public Health and Strategic Partnerships also provided information on work being led by Public Health Wales in this area.

Paul Deneen, Independent Member, asked if there was anything the Board could do to help and support the current situation. Rhiannon Jones reiterated the request for Board Members to engage in the planned Midwifery Service visits as part of the overall visibility of Board Members.

Prof Helen Sweetland, Independent Member, reflected on the monthly activity levels and asked whether or not consideration was being given to the future models. Rhiannon Jones confirmed the data had raised questions on the ongoing and future provision of the Midwifery Led Units. Consideration of future models would be required from the Board on the situation as required.

Shelley Bosson, Independent Member, asked if more could be done to advise mothers on the benefits of Midwifery Led Units in providing the same standard of care as the Grange University Hospital in order to promote the Units as an attractive alternative. Rhiannon Jones confirmed teams were highlighting this at first assessment. The popularity of the Grange University

Hospital was a side-effect of the positive impact of the new hospital. Rhiannon Jones noted that a review of the model was key to understanding the number of units required and appropriate to staff.

The Chair requested a thorough review of the Health Board's longer-term service model for maternity services and its sustainability. The Chair asked Rhiannon Jones to provide an indication of the timescale for completion of the review outside of the meeting in order that this could be noted for a future agenda. **Action: Director of Nursing/Director of Corporate Governance**

The Chair reiterated the gratitude of the Board to the teams for the actions taken to protect patients and their children and for the support of the public. The importance of having a clear understanding on the standard for Nursing-Led Units and Consultant-Led Units to allow the Health Board to make the best decision it can to ensure safety in services was emphasised.

The Board **NOTED** the fragile staffing position across Midwifery Services and endorsed the decision made by the Executive Team.

ABUHB 2505/08 (2.2) Long COVID – Adferiad

Peter Carr, Director of Therapies & Health Science, provided an overview of the report and presented a video of a staff member who shared their experience of using the service and the impact of long-COVID on their health & wellbeing. It was explained that the service had developed in response to the experience of patients with prolonged and unpredictable symptoms following COVID-19 infection. Peter Carr provided information on the range of symptoms, experiences of patients and the development of the service using Welsh Government non-recurrent funding. The report provided information on the potential to develop a needs-based Rehabilitation Service model that could benefit other non-COVID related conditions, such as ME or Chronic Fatigue.

Katija Dew, Independent Member, declared an interest, as a Trustee for Newport Live, where some services have been provided.

Katija Dew, Independent Member, welcomed the holistic approach presented and asked if the Health Board was supporting employers in any way, including ACAS processes and whether or not there had been any involvement with the third sector. Peter Carr confirmed that the service had not been involved in any ACAS process. It was noted there had been no request from Service Users to engage with their employers. It was noted there was an opportunity to link with the third sector and wider health communities.

The Chair noted that the video had referenced a lack of support from managers and asked what had been done to ensure managers were educated in respect of Long-COVID. Peter Carr

observed that at the start of the pandemic, there was little understanding of long-COVID and the fluctuating nature of the associated symptoms. However, learning from the condition had allowed the service to educate managers and employers. Sarah Simmonds, Director of Workforce & OD, provided information on the work that had been undertaken to support managers to make informed decisions and to support employees in returning to work.

Paul Deneen, Independent Member, requested further information on activity levels, whether or not a pattern was distinguishable regarding the types of individuals affected by long-covid and for further information on the plans to fund the service after the allocated funding finished. Peter Carr provided an update on the sustainability work the Service was undertaking. It was noted that the report contained information on demographics and an update on activity information.

Cllr Richard Clark, Independent Member, asked if 'fit notes' still existed, and if so, how these were used by the Health Board as a tool to support the individual. Sarah Simmonds explained 'fit notes' were suspended during the early stages of pandemic to manage the pressure on Primary Care. However, 'fit notes' were now being issued and it was confirmed they should be used as a tool to facilitate support for returning to the workplace in a capacity that is suitable for the individual.

Pippa Britton, Independent Member, asked if the lack of confirmed funding impacted on the staffing levels. Peter Carr confirmed there was a staffing challenge due to fixed term contracts.

The Board **NOTED** the Long COVID Service Report and the positive impact demonstrated through the story presented.

ABUHB 2505/09 (3.1) Satellite Radiotherapy Unit Full Business Case

Nicola Prygodzicz, Director of Planning, Performance Digital & IT provided an overview of the project, which was being developed in collaboration with Velindre University NHS Trust. Information was provided on the proposed working arrangement, costs and the revenue model. It was noted provisional support had been received from the other Health Boards involved. An explanation was provided on the key benefits of the Radiotherapy Satellite Unit including increased activity, service resilience and reduced travel times for patients. An update on a Gateway Review of the business case was provided and it was noted that all key issues had been addressed. The next steps would include clarifying the governance, the service provision to be provided by Velindre NHS Trust, and working through the workforce requirements and developing a recruitment plan. The Board was asked to support the submission of the Business Case to Welsh Government.

The Board noted the improvement in providing care closer to home and the opportunity to invest in the Nevill Hall Hospital site.

Nicola Prygodzicz provided an update on the local Cancer Unit that was being planned and links to Velindre University NHS Trust. It was hoped that the local Cancer Unit Business Justification Case would be submitted to the Board for consideration in the Autumn.

The Board **APPROVED** the submission of the Radiotherapy Satellite Unit Business Case to Welsh Government.

ABUHB 2505/10 (4.1) Learning and Reflections from Business Continuity (Black Escalation Status)

Rhiannon Jones, Director of Nursing provided the background to the declaration of Black Escalation Status (Business Continuity) on Tuesday 29th March 2022 and explained how the decision had been made and the de-escalation processes used. It was confirmed that the declaration of Black Escalation Status had been discussed at the Community Health Council meeting and at a previous Board Briefing Session.

The review of lessons learnt had highlighted several actions for improvement and an update on the actions taken and to be taken was provided. It was confirmed that the Executive Team would oversee implementation of the action plan. The Board was informed that the lessons learnt from the declaration of Black Escalation Status were being used, as part of planning for high activity periods, such as bank holidays, and the Health Board was open to sharing lessons learnt with other NHS bodies.

Phil Robson, Special Advisor, requested an update on the Regional Partnership Board's plan to develop a whole system Escalation Plan, and for information on the whole system approach prior to the Black Escalation declaration. Rhiannon Jones provided an update on the revised Escalation Framework being led by Welsh Government. The Health Board acknowledged there was further work to be done with Partners to strength the local approach and information was provided on the liaison approach with Partners, as the situation escalated.

The Board **NOTED** and **DISCUSSED** the Learning and Reflections from Business Continuity (Black Escalation Status) report. The Board thanked the Welsh Ambulance Service Trust and Cwm Taf Morgannwg University Health Board for their help and support at the time, which had been invaluable.

ABUHB 2505/11 (4.2) Board Governance: Annual Review of Effectiveness 2021/22

Rani Mallison, Director of Corporate Governance, presented the Board's Annual Review of Effectiveness, which included improvements to be delivered in 2022-23. A Board Development Session had been held on 8th March 2022 which had reviewed the effectiveness of the Board's leadership and governance arrangements for 2021-22. The Board determined an amber-green rating for all aspects and recognised a green rating could not yet be achieved for 2021-22. The Board

identified several improvement actions for the coming year and the development of a delivery mechanism to oversee the actions. The report included an update on these actions.

The Chair noted this was a helpful exercise particularly following the pandemic, which has required the Health Board's governance arrangements to be adjusted to respond to the changing environment. It was confirmed that the Improvement Actions would form part of the Board Development Plan.

The Board **NOTED** the Board Governance: Annual Review of Effectiveness 2021/22 report.

ABUHB 2505/12 (4.3) ABUHB's People Plan

Sarah Simmonds, Director of Workforce & OD, introduced the Health Board's People Plan and explained how the plan had been developed. The plan would form the basis of the Workforce & OD Strategy, aligned with the IMTP and Clinical Futures Strategy. The People Plan was supported by a Delivery Framework. Sarah Simmonds thanked all staff, who had engaged in the development of the plan. The Board was asked to endorse and adopt the People Plan and the Delivery Framework.

The Board highlighted the need to strengthen the sections on employing people with disabilities and the development of the Volunteering Programme.

The Chair stated there was a need to review the different components of the culture of the organisation including monitoring of the Gender Pay gap and asked how the organisation would describe "a healthy working day" following the pandemic. It was confirmed that this idea was being developed with Cardiff University and via engagement with staff on what the concept meant for them and what support/mechanisms they would require to enact a health working day.

The Board APPROVED the People Plan and associated documentation.

ABUHB 2505/13 (4.4) Nurse Staffing Levels (Wales) Act Annual Assurance Report

Rhiannon Jones, Director of Nursing, introduced the Annual Assurance Report in relation to the Health Board's compliance with the Nurse Staffing Levels (Wales) Act. It was noted that the information and style of the report was mandated by Welsh Government. The report covered Medical, Surgical and Paediatric Wards and sections 25a, 25c and 25e of the Act. Information was provided on nurse staffing levels and the recruitment of nurses.

The report contained a number of metrics and Rhiannon Jones highlighted the increasing number of complaints received across the Health Board, which had been noted at the Patient Quality

Safety and Outcomes Committee. This was particularly associated with relatives, who were unable to contact family members and staff on wards during the periods of restrictions around visiting etc. The report demonstrated that the Health Board had complied with all the requirements of the Act. It was important to note that the roll out of 'Safe Care,' a data capture system across Wales, was key to ensuring appropriate reporting in a consistent manner across Wales and which would allow comparisons in the future. An update was provided on the roll out of 'Safe Care' programme.

The Board **APPROVED** the submission of the Nurse Staffing Levels (Wales) Act Annual Assurance Report to Welsh Government.

ABUHB 2505/14 (4.5) Trades Union Partnership Forum Annual Report

The Chair welcomed George Puckett, Chair of the Trades Union Partnership Forum. George Puckett noted that partnership working had been difficult over the last year due to disengagement and late engagement with the unions. An example was given of the SDEC and the unions' concerns on the impact of the change on working conditions. It was highlighted that with the support of the Executive Team, the situation had improved. However, there remained some managers who engaged late in the discussions relating to change and continued support from the Executive Team to remind managers of the need for early engagement was requested.

The Chair apologised, on behalf of the Board, for the lack of engagement and the approach of some managers and supported the need for early engagement and partnership work. She was pleased to note that improvements had taken place.

Glyn Jones, Interim Chief Executive Officer, as Joint Chair of the Partnership Forum, highlighted the importance of George Puckett being open with the Board about the challenges faced by the unions in working as partners. Glyn Jones apologised for the experience of the unions and noted the Health Board was committed to working with trade unions, particularly as work develops on recovering services post pandemic. George Puckett stressed the principle of engagement to support staff and the ability to have discussions in an open and free environment. The need to ensure managers are trained in people management with the support of Workforce & Organisational Development colleagues was highlighted.

Rhiannon Jones, Director of Nursing, supported the need for the organisation to be made aware of those managers who did not engage in a timely and appropriate manner, in order that the Health Board could take appropriate action. Rhiannon Jones agreed with the need for training for all levels including new Board and Executive Team members.

Sarah Simmonds, Director of Workforce & OD, agreed there was a need to consider how we move forward and support increased awareness and knowledge. It was noted that discussions had

taken place previously with the Board, Executive and Trade Union Partnership Development sessions training. This would be widened as much as possible to ensure managers had the confidence to engage effectively. This should also be built into the organisation's work on values and behaviours and become a fundamental part of the implementation of the People Plan.

The Board noted that it was a testimony to the established relationships across the Health Board and the Trade Unions that there could be open and frank discussions to a positive way to move forward.

Pippa Britton, Independent Member, suggested the development of a system, which would allow Trade Unions to report regularly themes to the People & Culture committee. This would provide a link from staff to the Committee.

Action: R.Mallison to review the frequency of reports from the Trade Union Partnership to the Board.

The Chair thanked George Puckett for attending the Board Meeting and providing such helpful and constructive feedback.

The Board **NOTED** the Trade Union Partnership Forum Annual Report as presented.

ABUHB 2505/15 (4.6) Strategic Partnerships Update Report

Sarah Aitken, Director of Public Health & Strategic Partnership, introduced the report, which provided an overview of the current activity of the statutory Partnership Boards. Sarah Aitken provided an update on the Public Service Board activities and highlighted:

- the Draft Wellbeing Assessment, which had been presented to the January 2022 Board meeting and been approved by the Public Service Board in March 2022;
- the Wellbeing Future Generations Act;
- work on Health Inequalities;
- the Public Sector's response to the humanitarian crisis in the Ukraine and in particularly a coordination of support to Ukrainian refugees;
- the Public Service Board agreed to explore future options for the Gwent COVID-19 Test, Trace and Protect Service with Local Authorities.

Chris O'Connor, Interim Director of Primary Care, Community & Mental Health, provided an overview of the work of the Regional Partnership Board which included:

- the introduction of a new funding scheme approach to Integrated Care Funding and transformation monies;
- the six National Models of Care and the local work reviewing current strategic priorities;
- an update on new capital funding arrangements for the Regional Partnership Board and the approval of the Newport East Health & Wellbeing Centre;

- an update on the work undertaken by the Regional Partnership Board and the Health Board in the development and review of an Integrated Winter Plan.

Shelley Bosson, Independent Member, asked if increased salaries of Community Workers had helped with recruitment, as it was noted that not all care packages had been filled. If not, the Board may need to consider options for the forthcoming year. Chris O'Connor responded that the increased salaries had stabilised the market and an improvement had been seen. However, workforce challenges remained and an update on discussions with Health and Social Care colleagues on alternative service models and the development of effective career structures would be provided.

Paul Deneen, Independent Member, requested an update on the letter from Cllr Cockeram on the national challenges being faced by Health & Social Services. It was confirmed no response had been received yet from Welsh Government. Paul Deneen asked for clarification on the insurance issues for Care Homes that had been raised. Sarah Aitken, Director of Public Health and Strategic Partnerships, agreed to check, although she believed that this was related to COVID during the pandemic.

Katija Dew, Independent Member, noted the cost of living crisis challenge should be included in this year's Winter Plan, as this would fundamentally impact on how healthy people will be.

Philip Robinson, Specialist Advisor, noted that the principles were more specific than previously which required the Health Board to be clear on its perspective of these issues and their alignment to Graduated Care. Philip Robinson asked what opportunities there were for the Health Board to develop new systems. The Chair stated it was important for the Health Board to have a clear idea of the advantages and disadvantages of proposed systems before anything was recommended or formally discussed at the Regional Partnership Board.

Action: Interim Chief Executive Officer to ascertain the timescale from the Regional Partnership Board on the project to propose a new systems approach.

Rhiannon Jones, Director of Nursing, provided an update on the work being undertaken within the Health Board to reduce the demand for Domiciliary Care.

Sarah Aitken, Director of Public Health and Strategic Partnerships, provided an update on the Public Health Wales work on 'Keeping Well During the Winter' framework.

The Board **NOTED** the Strategic Partnerships Update Report.

ABUHB 2505/16 (4.7) An Overview of Joint Committee Activity:

a) WHSSC Update Report Including Integrated Commissioning Plan 2022-25

Glyn Jones, Interim Chief Executive Officer, introduced the report and explained the new format being used. The reports highlighted the governance of the Board's Joint Committees, as set out within Standing Orders. The report provided a summary of activity and highlighted discussions at the WHSCC Committee about Planned Care Recovery for Specialist Services and the lack of assurance on the recovery of activity in elective services. It was agreed there should be a substantive discussion on Recovery Plans at the next meeting.
Action: Interim Chief Executive Officer

b) EASC Update Report including IMTP 2022-25

Glyn Jones, Chief Executive Officer provided a summary of the activity discussed at the most recent meeting of EASC. It was noted the focus was on the current Emergency Ambulance performance, handover delays, issues of transporting patients to hospitals and activity levels in Emergency Departments. It was noted that work was being undertaken between Welsh Government and Health Boards on an individual basis on improving urgent, emergency care pathways locally and nationally.

Rhiannon Jones, Director of Nursing, highlighted the need to be realistic about what can be achieved, the impact for staff and staff wellbeing when considering recovery plans. The Chair agreed and stated that the Minister was expecting an honest response on what was achievable and parameters services within which the organisation was working. Sarah Simmonds, Director of Workforce & OD, confirmed discussions were taking place with Welsh Government and Workforce & Organisational Development Directors on how the workforce might be better supported both locally and nationally during planned recovery activity.

Paul Deneen, Independent Member, requested information on the impact and approach taken on the withdrawal of Military support during the pandemic. Glyn Jones, Chief Executive Officer provided information on approach to the planned withdrawal of military at the end of March 2022 and the investment provided to the Ambulance Service to compensate for the loss. It was noted there were significant pressures on health and social care settings. A whole system approach was being taken to consider innovative ways to resolve issues and barriers across all levels of Health, Social and Emergency Services.

The Chair requested the following:
- Sight of the draft WAST Mental Health Service Specification;
- the Outcome of the first year of the operation of the Major Trauma Centre for assurance on value for money and access for the population;

- Confirm the accountability arrangements for the National Collaborative Commissioning Unit (NCCU)
- to have a Board Development Session on WAST Escalation Issues.

Action: **Interim Chief Executive Officer**

The Board **NOTED** the reports on the Overview of Joint Committees Activities.

ABUHB 2505/17 (4.8) Financial Performance Month 1, 2022/23

Robert Holcombe, Interim Director of Finance, Procurement and Value, presented the Financial Performance Report for April 2022, month 1 of the new financial year and highlighted the following key messages, as set out within the paper:

- Month 1 presented a revenue overspend, as expected in the context of the IMPT Financial Plan;
- Capital spend was in line with the plan.
- Payment Performance was on target.

Paul Deneen, Independent Member, asked what the Board could do to help with financial performance. Robert Holcombe responded that the approach being taken was to drive efficiency and cost avoidance through transformation and house-keeping steps. However, a request was made of the Board for their patience whilst plans were introduced and embedded. It was noted there would be the need for continuous discussions in Committees and Board meetings, to ensure maximum support was provided to patients and communities to get access to the best service possible. This would mean some difficult decisions would have to be made by the Board and Committees.

The Board **NOTED** the Financial Report for April 2022.

ABUHB 2505/18 (4.9) Performance Report, May 2022

Nicola Prygodzicz, Director of Planning, Performance Digital & IT, presented the Performance Report and noted this would be the last time the report was presented in this format. The new Performance and Outcome framework would be introduced at the July Board Meeting. Nicola Prygodzicz provided further information, as set out within the paper, on:

- Elective care;
- Diagnostics;
- Urgent Care;
- Ambulance Handovers;
- Length Of Stay,
- Cancer Services Targets,
- Stroke Services,
- and Mental Health Services.

Peter Carr, Director of Therapies & Health Science, provided an update on the work being undertaken to improve the access to Stroke Services and the development of a Recovery Plan.

Paul Deneen, Independent Member, requested further information on the EPEX system and its impact. Nicola

Prygodzicz explained the EPEX was a Mental Health clinical system and provided information on the limitations of the system and the work being undertaken to introduce an up-to-date WCCIS system. It was confirmed that the lack of data storage had not impacted on patient records nor had promoted the loss of data.

Sarah Aitken, Director of Public Health & Strategic Partnerships, provided an update on the funding for the Welsh Health Network of Healthy Schools, which should be used to support a whole school approach to mental wellbeing.

The Chair noted the huge amount of working being undertaken and thanked those involved in the production of the report. The Chair acknowledged the delays that patients were experiencing in accessing treatment as services recover from the impact of the pandemic and requested that everyone on the waiting lists be advised of the potential length of wait.

Pippa Britton, Independent Member left the Board Meeting at 13.19.

The Board **NOTED** the Performance Report for May 2022.

ABUHB 2505/19 (4.10) Strategic Risk Report, May 2022

Glyn Jones, Interim Chief Executive Officer, presented the report and provided an update on high level risks and actions being taken to mitigate risks. It was noted that the June Board Development Session would focus on risks, risk appetite, statements and definitions and would be an opportunity for a refresh.

Shelley Bosson, Independent Member, noted that the risk associated with the Ukraine Crisis had been discussed at the Audit, Risk and Assurance Committee. A full risk assessment would be undertaken including the cost of living. Glyn Jones, Interim Chief Executive Officer, informed the Board that Welsh Government was undertaking a full assessment on the broader impacts of the cost of living crisis.

The Board **NOTED** the Strategic Risk Report.

ABUHB 2505/20 (4.11) Executive Team Report

Glyn Jones, Interim Chief Executive Officer, highlighted the work underway to review the Executive Team's accountability arrangements, which would be reflected in the report presented to the Board. An update on the work of the Executive Team included:

- Work on Welsh Governments' 6 Goals for Urgent and Emergency Care and alignment to the delivery of the IMTP;
- The National Planned Care Recovery Plan and noted the Local Recovery Plan would be presented to a future Board meeting;
- Support to the Ukraine Refugee Resettlement Programme;
- The Well-Being Centre of Excellence.

The Board **NOTED** the Executive Team Report.

ABUHB 2505/21 (4.12) Key Matters from Committees of the Board

The Board **RECEVIED** Assurance Reports from the following Committees:

- Patient Quality, Safety and Outcomes Committee.
- Audit Risk & Assurance Committee
- People and Culture Committee
- Partnerships, Population Health and Planning Committee

The Board also noted an update from:

- NHS Wales Shared Services Partnership Committee

ABUHB 2505/22 (5.1) Date of Next Meeting

An extra Board meeting had been scheduled for 14th June 2022 meeting, which would have a limited agenda to receive the Annual Accounts, a Report on the 6 Goals for Urgent and Emergency Care Action Plan, Handover Improvement Plans, the Planned Care Action Plan, the Outcome of the Winter Plan and the Outcome of the Annual Plan 2021/22.

The next scheduled meeting of the Board, to be held in public, is to be held on Wednesday 27th July 2022 at 09:30 and followed by the Health Board's Annual General Meeting.

Aneurin Bevan University Health Board
Minutes of the Public Board Meeting held on Wednesday 14th June 2022, via MS Teams

Present:

Ann Lloyd	-	Chair
Glyn Jones	-	Interim Chief Executive
Sarah Simmonds	-	Director of Workforce and OD
Peter Carr	-	Director of Therapies and Health Science
Shelley Bosson	-	Independent Member (Community)
Katija Dew	-	Independent Member (Third Sector)
Nicola Prygodzicz	-	Director of Planning, Performance Digital and IT
Rob Holcombe	-	Interim Director of Finance, Procurement and VBHC
Paul Deneen	-	Independent Member (Community)
Iwan Jones	-	Independent Member (Finance)
Dr Chris O'Connor	-	Interim Director of Primary, Community and Mental Health Services

In Attendance:

Rani Mallison	-	Director of Corporate Governance
Leanne Watkins	-	Director of Operations
Bryony Codd	-	Head of Corporate Governance
Richard Harries	-	Audit Wales
Gwen Kohler	-	Assistant Finance Director
Gareth Lewis	-	Assistant Head of Financial Services
Susan Gauntlett	-	Assistant Head of Financial Accounting

Apologies:

Cllr Richard Clark	-	Independent Member (Local Government)
Keith Sutcliffe	-	Associate Independent Member (Chair of the Stakeholder Reference Group)
Louise Wright	-	Independent Member (Trade Union)
Pippa Britton	-	Interim Vice Chair
Philip Robson	-	Special Adviser to the Board
Prof Helen Sweetland	-	Independent Member (University)
Dafydd Vaughan	-	Independent Member (Digital)
Dr James Calvert	-	Medical Director
Rhiannon Jones	-	Director of Nursing
Dr Sarah Aitken	-	Director of Public Health & Strategic Partnerships
Jemma McHale	-	Aneurin Bevan Community Health Council

ABUHB 1406/01 Welcome and Introductions

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

ABUHB 1406/02 Declarations of Interest

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

ABUHB Annual Report and Accounts 2021/22

ABUHB 1406/03 Audit Wales' Audit of Accounts Report 2021/22

Richard Harries, Audit Wales, presented the Final Audit of Accounts 2021/22, confirming that an unqualified opinion would be issued.

It was noted that the regularity opinion would be qualified due to the financial statements including a provision (and corresponding expenditure) of £756,155 for the Health Board's estimated liability because of a Ministerial Direction in 2019. This had been discussed by the Audit, Risk and Assurance Committee and was consistent across all Welsh Health Boards.

It was noted that one misstatement in the financial statements remained uncorrected, relating to the full revaluation of NHS land and buildings. Again, this was noted as an all-Wales issue.

Richard Harries thanked Rob Holcombe, Interim Director of Finance, Procurement and Value, and the finance team for the way in which they had worked together through the audit process.

The Board RECEIVED the Annual Audit of Accounts Report 2021/22.

ABUHB 1406/04 Recommendation from the Audit, Risk and Assurance Committee in respect of the ABUHB Annual Report and Accounts 2021/22

Shelley Bosson, Chair, Audit, Risk and Assurance Committee, confirmed that the Committee had met on the 13th June to consider the Annual Report and Accounts, the Audit Wales' Audit of Accounts Report and the Letter of Representation.

The Committee was pleased to note that the Auditor General for Wales intended to issue an unqualified audit opinion on the Health Board's annual accounts 2021/22, except for the regularity opinion which the Auditor General intended to qualify. The Committee was also pleased to note the reasonable assurance rating within the Head of Internal Audit Opinion for 2021/22.

The Audit, Risk and Assurance Committee RECOMMENDED to the Board that it:

- RECEIVED the Audit of Accounts Report (2021/22) of External Audit (Audit Wales)
- APPROVED the Annual Report and Accounts 2021/22, which included:
  1. The Performance Report;
  2. The Annual Accountability Report; and
  3. The Financial Statements
- APPROVED the Letter of Representation; and
- AUTHORISED the Chair, Chief Executive Officer and Director of Finance, Procurement and Value, to sign these documents where required.

On behalf of the Audit, Risk and Assurance Committee, Shelley Bosson thanked Internal Audit, Audit Wales and the Finance and Corporate Governance Teams for their hard work in finalising the 2021/22 end of year reporting and associated audits.

The Chair thanked Shelley Bosson as Chair of the Audit, Risk and Assurance Committee for creating an environment for constructive discussion within meetings, which enabled the Board to be assured on those matters delegated to the Committee.

The Board NOTED the recommendation of the Audit, Risk and Assurance Committee.

To consider for APPROVAL and SIGNING ABUHB's Annual Reports and Accounts 2021/22

ABUHB 1406/05 Part One: Performance Report

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, presented for approval the Performance Report of 2021/22.

It was highlighted that 2021/22 had been another challenging year in a number of ways and the report presented outlined the progress and challenges of the Health Board.

Nicola Prygodzicz highlighted a number of key areas contained within the document, including:

- Progress against the priorities within the Annual Plan;
- The Mass Vaccination Programme, in particular the booster campaign over the Christmas period;
- Challenges faced by infection prevention and control and the need to continuously adapt;
- The Testing programme and the significant work undertaken to support our population, staff and patients;
- Flexible working by therapy services;
- Shared Lives programme;
- Patient experience and in particular the work undertaken in relation to dementia care.

The Chair thanked all staff for their hard work during another challenging year and recognised the significant achievements outlined.

The Board APPROVED the Annual Performance Report 2021/22.

ABUHB 1406/06 Part Two: Annual Accountability Report

Rani Mallison, Director of Corporate Governance, presented for approval the Annual Accountability Report, which was designed to demonstrate the way in which the organisation was meeting the accountability requirements to the Welsh Government.

Rani Mallison noted that this had been reviewed by Audit Wales, Welsh Government and the Audit, Risk and Assurance Committee, and includes the Head of Internal Audit Opinion.

Rani Mallison focussed the Board's attention to the conclusion of the Accountable Officer's Statement which confirmed that the Health Board remained in 'routine' monitoring as part of NHS Wales Escalation and Intervention arrangements and that, whilst there are areas for strengthening, no significant internal control or governance issues had been identified in 2021/22.

Rani Mallison highlighted one amendment to the report in relation to the NIS Internal Audit. The report had now been considered by the Audit, Risk and Assurance Committee and had received a reasonable assurance rating, not limited as stated in the report.

The Board thanked the Director of Corporate Governance and those involved in the development of the report for the significant work undertaken in a short period of time.

The Board APPROVED the Annual Accountability Report 2021/22.

ABUHB 1406/07 Part Three: Annual Financial Statements

Rob Holcombe, Interim Director of Finance, Procurement and Value, presented for approval the Annual Financial Statements 2021/22, which had been audited by Audit Wales.

It was noted that the Health Board had achieved its financial duties in relation to revenue and capital resource limits and percentage of invoices paid within 30 days.

The Board APPROVED the Annual Financial Statements 2021/22.

ABUHB 1406/08 Letter of Representation

The Board APPROVED for signing the Letter of Representation as included in Audit Wales' ISA260 2021/22.

ABUHB 1406/09 Six Goals for Urgent and Emergency Care Programme

Leanne Watkins, Director of Operations, outlined the Health Board's approach to delivering the Welsh Government "Six Goals for Urgent and Emergency Care Programme" launched in April 2022.

Leanne Watkins provided an overview of the governance structure which had been established, noting that the Health Board's previous 'Urgent Care Transformation' had been restructured in line with the national Six Goals for Urgent and Emergency Care Programme.

Improvement 'Triumvirate' Teams to support implementation of incremental change across the system were being established and in recognition of the leadership requirements, Welsh Government funding had been received for clinical, managerial and analytical leaders.

Leanne Watkins outlined some of the improvements expected as a result of the programme, including the establishment of SDEC opening in August 2022, which was expected to generate improvement across the system due to the capacity created.

Following a national risk summit in February 2022, a whole system reset was undertaken in March 2022. This showed modest improvements and enabled the organisation to understand the impact of some of the changes planned.

Leanne Watkins welcomed the framework and highlighted the continued use of patient stories and experience to drive this programme of work. More detailed plans would be prepared by the end of June, with associated improvement profiles.

The Chair commented that this was a critical area for patients and communities and a key priority for the Health Board and Welsh Government.

Shelley Bosson, Independent Member, asked when phase 4 of the programme would commence. Leanne Watkins confirmed that this would be in the new financial year, dependent on a robust evaluation to ensure the models have the biggest impact and target resource where it is most needed.

Paul Deneen, Independent Member, asked if there had been any feedback/learning from the Winter Plan. Chris O'Connor, Interim

Director of Primary, Community and Mental Health Services, confirmed a workshop to review learning had been held and a report would be presented to the next meeting. **Action: Director of Planning, Performance, Digital and IT / Interim Director of Primary, Community and Mental Health Services.**

Members requested assurance that the patient voice was being considered in developing the urgent and emergency care system. It was confirmed that patient stories and experience would continue to be used to drive improvements, however it was acknowledged that further work was required to simplify the system to ensure patients accessed the right place, first time. It was further noted that staff were provided with ongoing opportunities to share views and feedback. The importance of providing leadership and support, was acknowledged.

The Chair expressed the need for robust systems by which patients could express their concerns. It was noted that work was underway to establish a national platform to capture patient experience which would provide systematic feedback. The Board welcomed this development.

Sarah Simmonds, Director of Workforce and OD, explained that there was a national workforce enabling group looking at the longer-term plan for recruitment and retention, training and development. This would support local models and areas that staff had identified they would like to benefit from.

Shelley Bosson queried whether the plan would link to the overall outcome measures framework for the Health Board. It was confirmed that a comprehensive set of metrics would be developed to provide assurance.

The Chair noted the requirement for the Six Goals Programme Plan to be submitted to Welsh Government by end of June 2022 and requested that this be presented to the Board for ratification in July 2022.

Action: Director of Operations

The Board NOTED the report.

ABUHB 1406/10 Planned Care Programme of Recovery

Leanne Watkins, Director of Operations, presented for discussion by the Board, the Health Board's approach to resetting and relaunching the Planned Care Programme, following the launch of the Welsh Government's 'Our Programme for transforming and modernising planned care and reducing waiting lists in Wales' on 26th April 2022.

It was acknowledged that there were clear concerns about the volume of patients waiting for elective treatment across Wales and noted that this was a very ambitious plan.

Leanne Watkins highlighted significant risks in achieving some of the ambitions set out in the programme, particularly in relation to the waiting times targets of no patients waiting over 52 weeks for a first outpatient appointment by December 2022 and no patients waiting over 104 weeks for treatment by the end of March 2023. The IMTP trajectories, agreed by the Board in March 2022, were 9300 and 6500 patients respectively. It was noted that detailed demand and capacity work had been undertaken in preparing these trajectories for the IMTP.

Work was currently being undertaken to assess the impact of changes to social distancing and testing and updating the position regarding demand and capacity by the end of June. The Health Board would be resubmitting a minimum data set at the end of quarter one to Welsh Government. The Chair requested that this be shared with the Board at the next meeting.
Action: Director of Operations

Leanne Watkins highlighted that the targets would not be achieved without significant change/transformation and outlined a number of current examples; including all patients, following major joint surgery, moving to patient-initiated follow up appointments which could release up to 40% of follow up capacity.

The importance of bringing teams together across the system was highlighted and it was noted that the Planned Care Programme would be launched on 17th June, with five key priority areas of focus. This would inform more detailed plans and then improvement trajectories. Leanne Watkins highlighted that this would require significant additional work that the Health Board did not have the financial means to achieve.

Rob Holcombe, Interim Director of Finance, Procurement and Value, explained that there had been additional recurrent funding from Welsh Government as part of the annual allocation. However, to generate additional service capacity to deliver the targets would create a financial pressure.

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, highlighted a key challenge in balancing risk prioritisation with long waits. It was noted that all-Wales Directors of Planning were discussing this, and specific issues and opportunities to work together in collaboration.

The Chair noted that, based on the information presented, the Health Board was fully committed to improvement, but could not, at this stage, commit to achievement of the targets.

The Board NOTED the report.

ABUHB 1406/11 Date of Next Meeting

The next scheduled meeting of the Board, to be held in public, is to be held on Wednesday 27th July 2022 at 09:30.

Aneurin Bevan University Health Board Meetings –
Wednesday 25th May and 14th June 2022

ACTION SHEET

Minute Reference	Agreed Action	Lead	Progress/ Outcome
ABUHB 2505/07	**An Update in Respect of Maternity Services Provision:** To provide an indication of the timescale for when the review could be completed.	Director of Nursing	30th June - SBAR presented to Execs providing an update following temporary service change (closure of Midwifery Led Unit) at RGH/NHH plus reduction in opening hours at GUH). No adverse effects identified as a consequence – plan to continue this model with a further review in 6 weeks. Independent review of ABUHB MLU has been requested. National review of MLU being considered.
ABUHB 2505/14	**Trade Union Partnership Forum Annual Report:** To review the frequency of reporting	Director of Corporate Governance	Chair and Director of Corporate Governance to meet with TUPF Chairs to discuss alignment of TUPF and Board.
ABUHB 2505/15	**Strategic Partnerships Update Report:** Ascertain the timescale that the Regional Partnership Board will approve new Regional Integrated Fund and approach.	Interim Chief Executive	RIF plan and approach to be discussed and agreed at next RPB meeting (July 2022).
ABUHB 2505/16	**An Overview of Joint Committee Activity:** EASC / WHSSC Update Reports: • Circulate draft WHSSC Mental Health Strategy, • Outcome of the first year of the operation of the Major Trauma Centre for assurance on value for money and access,	Interim Chief Executive	Draft Strategy circulated Evaluation of the functional Network began in March 2022 and is expected to be completed in Summer 2022. The evaluation is reliant on the availability of national data and obtaining a year of relevant data. The one-year evaluation will not be available for Health

Minute Reference	Agreed Action	Lead	Progress/ Outcome
			Board distribution until December 2022 as the evaluation will need to be approved through the Network Governance Group, Clinical & Operational Board and Delivery Assurance Group (commissioning meeting).
	• Confirm the accountability arrangements for the National Collaborative Commissioning Unit (NCCU), and		The NHS Wales Collaborative currently has a primary governance accountability to the Collaborative Executive Group (Chief Executives) and, ultimately, to the Collaborative Leadership Forum (Chairs and Chief Executives), although for some specific pieces of work there is already a direct accountability to Welsh Government.
	• Board Development Session on WAST Escalation Issues.		This will be included as part of a wider board development session on urgent and emergency care on 10th August.
ABUHB 1406/09	**Six Goals for Urgent and Emergency Care Programme:** Winter Plan Evaluation to be provided to the next meeting.	Interim Director of Primary, Community and Mental Health Services	Included on the Agenda
	Six Goals Programme Plan to be submitted to Welsh Government by end of June 2022 and requested that this be presented to the Board for ratification in July 2022.	Director of Operations	Included on the Agenda

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th July 2022 Agenda Item:1.6

Aneurin Bevan University Health Board

Governance Matters:

Report of Sealed Documents and Chair's Actions

Purpose of the Report

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

The Board is asked to: (please tick as appropriate)			
Approve/Ratify the Report			✓
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Rani Mallison, Board Secretary			
Report Author: Bryony Codd, Head of Corporate Governance			
Report Received consideration and supported by :			
Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**N/A**
Date of the Report: 11th July 2022			
Supplementary Papers Attached: None			

Executive Summary

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between the 10th May and 11th July 2022.

The Board is asked to note that there have been seven (7) documents that required the use of the Health Board seal during the above period.

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

During the period between the 10th May and 11th July 2022, two (2) Chair's Actions have been agreed. This paper provides a summary of the Chair's Actions taken during this period, which are appended to this report.

Background and Context

1. Sealed Documents

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

2. Chair's Action

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

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

3. Key Issues

3.1 Sealed Documents

Under the provisions of Standing Orders the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. Seven documents were sealed between the between the 10th May and 11th July 2022, as outlined below.

Date	Title
13/5/2022	Transfer Deed for strip of land. No. 6 Manor Wood, Chepstow
17/5/2022	Unified Breast Care Unit, YYF – Confirmation Notice
19/5/2022	Transfer Deed for land adjoining Ringland Health Centre Newport
28/6/2022	Confirmation Notice 2 for Regional Supply Chain Partner Newport East Health and Wellbeing Centre
29/6/2022	JCT Standard Building Contract 2016 for the endoscopy ward refurbishment RGH
4/7/2022	Licence to occupy on a short term basis relating to Caerleon House, Cleppa Park
4/7/2022	Licence for Alterations –Coffee shop premises GUH

3.2 Chair's Action

All Chair's Actions undertaken between 10th May and 11th July 2022 are listed below. All of which were approved by the Chair.

Date	Title
09/06/2022	Provision of Childcare Vouchers
29/06/2022	Microsoft Server Licensing Renewal

Assessment and Conclusion	
In endorsing this report the Health Board will comply with its own Standing Orders.	
Recommendation	
The Board is asked to note the documents that have been sealed and to ratify the action taken by the Chair on behalf of the Board.	
Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Failure to report the sealing of documents to the Health Board would be in contravention of the Local Health Board's Standing Orders and Standing Financial Instructions.
Financial Assessment, including Value for Money	There are no financial implications for this report.
Quality, Safety and Patient Experience Assessment	There is no direct association to quality, safety and patient experience with this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no equality or child impact issues associated with this report as this is a required process for the purposes of legal authentication.
Health and Care Standards	This report would contribute to the good governance elements of the Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to Plan associated with this report.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Not applicable to this report
	Integration –Not applicable to this report
	Involvement –Not applicable to this report
	Collaboration – Not applicable to this report
	Prevention – Not applicable to this report
Glossary of New Terms	None
Public Interest	Report to be published in public domain

Description of Request:

To consider as Chairs Action the approval of a Request for Approval (RFA) to renew the current provision and provide a continuation of service for Childcare Vouchers under the Staff Benefits Scheme.

Financial Value	Contract for 2 years 13th April 2022 to 13th April 2024 with the option to extend by a further 2 year period on an annual basis – 2+1+1 Annual value of the current contract £249,144.08 Annual value of the new contract £232,006.80 – this is an estimate based on December 2021 utilisation of the childcare voucher scheme Total value of new contract £928,027.20

Situation

Request to approve the Request for Approval (RFA) for a two-year contract, with an option to extend, the provision of Childcare Vouchers.

Background

Childcare Vouchers allow employees to fund registered childcare for their children. The vouchers can be used to pay for all types of registered childcare across the UK, including but not exclusive to childminders, holiday schemes, nannies, nurseries, after school clubs, play groups and crèches. This scheme enables employees to save up to £933 per annum (depending upon amount of earnings) on tax and NI deductions and childcare. The employees under the current scheme receive their vouchers from Edenred via the Eastern Shire Purchasing Organisation's (ESPO's) Staff Benefits framework which has now expired.

The voucher scheme with service providers is currently closed to new applicants due to the government introducing a new tax-free childcare voucher scheme which was gradually rolled out over 2017. The child must be 11 or under to qualify and stop being eligible on 1st September after their 11th birthday.

Request:

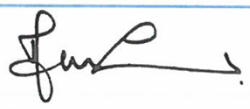
Following a review process it was recommended that the contract for Childcare Voucher Salary Sacrifice Scheme is extended and awarded to Edenred via the NPS Framework.

Accompanying documents:

RFA860.pdf

Approval:

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

Signatures: Chair / Vice Chair	Date:
	8/6/22
Signature: Chief Executive	**Date:**
	13/5/2022
Signature: Director of Corporate Governance	**Date:**
	13th May 2022
Signature: Director of Workforce & OD	**Date:**
	14/6/2022.
Signature: Independent member	**Date:**
SA Bosson	9/6/22
Signature: Independent member	**Date:**
Paul Deneen – by separate email	9/6/22

---- End ----

Description of Request:

To consider as Chairs Action a request for the renewal of Microsoft Server Licencing.

Financial Value	£800,000.00 (Inclusive of VAT)

Situation

Approval request for the Microsoft Server Licencing Renewal.

Background

The Health Boards subscription licensing for our servers has come to an end.

To remain legally compliant the Health Board must enter into a new 3-year agreement for the server licence platform.

Not renewing the licence would lead to all digital systems in the Health Board operating illegally and the Health Board could be subject to legal action and / or fines.

Request:

This request is for Approval of renewal of the Microsoft Server Licencing.

Funding will be via the Discretionary Capital Programme. The funding was approved at the Capital Group meeting of 21st June 2022.

Accompanying documents:

PPD 1204 Supporting Informa

PPD%201204.do

Approval:

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

Signatures: Chair / Vice Chair

Date:

29/6/22

Signature: Chief Executive 	**Date:** 28/6/2022
Signature: Director of Corporate Governance 	**Date:** 28th June 2022
Signature: Independent member  Pippa Britton	**Date:** 29/6/22
Signature: Independent member Paul Deneen- Please see separate email	**Date:** 29/6/22

---- End ----

Aneurin Bevan Community Health Council (CHC)

CHC Report

For Aneurin Bevan University Health Board Meeting

July 2022

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Accessible formats

This report is also available in Welsh.

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Contents

About the CHCs	3
Introduction	4
CHC update	4
Thanks	15
Feedback	15
Contact details	16

About the Community Health Councils (CHCs)

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

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

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

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

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

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

Introduction

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

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

CHC update

1. Whole system pressures

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

1.1 Access to Primary Care – We are hearing more now about people's experiences in approaching Pharmacy services:

- Waits for prescriptions (on the day)
- Delayed repeat prescriptions

We continue to hear a mix of positive and negative experiences when people are accessing GP services, but hearing furthermore that people who are waiting for planned care procedures are re-attending GP services for ongoing support whilst waiting for secondary care services. Some

examples include; increased pain management and increased mental health needs or worsening of conditions that may require Primary Care services to write to Secondary Care services to escalate original referrals.

In addition, the CHC is notified of Primary Care contract applications for service alteration or resignations, and is concerned about the risk to Primary Care contracts across GP, Pharmacy and Dental services, due to continuing pressures, increased demand and recruitment and retention difficulties.

1.2 Ambulance waits in the community and outside of hospital for handover to the Emergency Department.

1.3 Waits for discharge for the medically fit and the volume of people medically fit in hospital.

1.4 Waits for planned care or operations. People have reflected their experiences and shared the negative impact on their quality of life when waiting for planned operations.

We have heard from some people who have received their waiting list check letter (validation letter). It's encouraging to hear that this validation process is actively underway.

1.5 We continue to hear about people's positive experiences and thanks to the Teams within the Minor Injuries Units.

The CHC is keen to be regularly updated on the Health Board's recovery plans, in line with Welsh Government's aims within:

- Six goals for urgent and emergency care
- Transforming and modernising planned care and reducing waiting lists

The CHC is also interested in the Health Board's (and wider health and care partners') plans or work undertaken to date to

address the health related recommendations of the Health and Social Care Committee's report:

- Hospital discharge and its impact on patient flow through hospitals

2. Dementia Care in the Community

2.1 At the beginning of April 2022, our Dementia Care in the Community Survey went live until the end of June. We wanted to know what NHS Services were available in the community, to someone who is living with dementia.

To date we have received 24 responses. Some of the key feedback includes:

- Most respondents have told us that they access GP Services and Dementia or Memory Clinics, in relation to their dementia care needs.

- Most respondents felt that they would rate the care they received as poor.

- People have also told that they would benefit from having access to more community support services to improve their sense of purpose and give carers respite.

Report to be drafted July 2022.

3. Cancelled Procedures/Operations

3.1 On the 3rd May 2022, the CHC launched a survey to target people who have had to cancel, postpone or not attend a procedure/operation that had been offered to them in planned care services.

The survey was posted on social media platforms and was sent (by the UHB) on our behalf to the patients who have

cancelled, postponed or not attended an arranged procedure in the last 6 months. The survey was sent directly to just over 2000 people.

To date we have received 206 responses.

Some of the key feedback received:

- When asked what hospital their procedure or operation was due to take place in, the Royal Gwent Hospital has received the most responses.

- So far, there are mixed responses about the accuracy of the booking record, to say that the individual cancelled, postponed, did not attend their procedure or operation. Many people have told us they did not cancel the date.

- Below, are the themes we have identified for why people did cancel:
    - Some had Covid so couldn't attend
    - Date offered was too short notice and people either had work, childcare commitments or could not book transport in time. (one week or less notice in some cases)
    - Some said transport was booked but either it was cancelled on the day (by the service) or did not arrive
    - Some needed to give longer periods of notice to work and couldn't get paid time off agreed
    - Some were carers or parents and couldn't cover these commitments
    - Transport needs in general

- When we asked if people knew if they were still on the waiting list or had been discharged following the cancellation, a good proportion of people said they did not know if they were still on the list following the cancellation as no further contact had been made or information given.

Report currently being drafted.

4. Winter Patient Experience Project

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

We heard from 64 individuals who shared their experience at the Emergency Department/local Minor Injuries Unit.

Some of the key feedback included:

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

- It has been identified that members of the public seem to travel to all sites by car. This could be because it is quicker to get to hospital by car, rather than facing potential waits for an ambulance.

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

Response due from UHB July 2022.

5. Dental Mystery Shopper Exercise

5.1 In May 2022, our CHC members contacted 74 dental practices in the Aneurin Bevan area to ascertain if they offered NHS Services, and if so, were any appointments available as a new patient.

We are aware that some practices have signed up for "Contract Reform" with others still using the contract "Units of Dental Activity (UDA).

Some key feedback:

- We received a mix of positive and negative experiences from members of the public who accessed, or attempted to access, dental services over the last 18 months. Some positive comments were noted about access to urgent dental care via people's own dental surgeries and others (mostly children) who found access difficult.
- Varying waiting times for an appointment were found, one Practice could offer an appointment the following week but one practice had a four and half year waiting list in place.
- A general lack of understanding for what people should expect from Dental services in regards to UDA contracts versus General Dental Services Reform.

Report currently being drafted.

6. GP Exit Survey

6.1 In June, our CHC members attended five GP Practices in the Aneurin Bevan area, to engage with members of the public. This activity was undertaken outside of the GP Practice as an "exit poll".

The GP Practices visited:

- Isca Medical Centre
- Nant Dowlais Health Centre
- Usk Surgery
- Llandbradach Health Centre (Village Surgery)
- Brynmawr Health Centre

6.2 Practice Managers of each surgery were contacted 2 weeks prior to the visits to inform them that our members would be onsite to carry out surveys with patients leaving the surgery

on a particular day. A copy of the survey was also attached to the visit notification. A batch of bilingual surveys were also sent to the practices along with a poster, in order for patients to complete feedback surveys prior to our visit.

In total, we heard from 191 patients across the five GP practices in the Aneurin Bevan area.

Some of the key feedback received:

- Majority of patients told us that they usually make their routine appointment via the telephone, with only nine people using My Health Online.

- When asked if patients used My Health Online, most patients told us that they had "heard of it" but they do not use it.

- A large number of patients told us when they booked a routine appointment, they had to wait between 1-2 weeks.

Report to be drafted July 2022.

7. Palliative Care

7.1 In May 2022, with the support of the palliative care team in the UHB, our members visited the following hospitals to speak with patients who were in receipt of palliative care support:

- Royal Gwent Hospital
- Nevill Hall Hospital
- Ysbyty Ystrad Fawr
- The Grange University Hospital

7.2 Staff from the palliative care team supported CHC members on the day of their visits. Staff informed members which patients they were able to speak with and guided them to the wards. This approach was considered essential in recognition

of the sensitivities of working with patients who are receiving palliative care.

Paper survey packs were also sent to the palliative care hubs within the four hospitals, which enabled staff from the team to take surveys to patients on the wards if appropriate.

Our members spoke with nine palliative care patients.

Some of the key feedback we received:

- Most patients felt very satisfied with the care they received from the palliative care team.

- Two of the nine patients told us that they didn't always feel that the team treated them with dignity and respect. One of the patients told us that the team didn't seem to have enough time for them and "as they are not family, they don't understand."

- Privacy and dignity issues were highlighted during a visit to Nevill Hall Hospital, ward 4/4. Patients in a six-bedded bay were seen in a state of underdress and some of these individual's did not have a bed sheet to cover themselves. The ward was also noted as cold. This issue was raised with the Health Board immediately, and we were assured that, following our feedback, a Senior Nurse had regularly visited the ward during the week the members had visited. We were informed that the Senior Nurse visiting would increase, to ensure the whole team maintains patient dignity and no further instances were found. We were also informed that the Senior Nurse would undertake a Dignity and Essential Care inspection (D&ECi).

  Response due from UHB July 2022.

8. In-patient Stroke Services Survey

8.1 In November 2021, the CHC launched a survey to gain feedback regarding people's in-patient experiences when receiving care and treatment for a stroke. The survey was posted on our social media pages, website and circulated to our stakeholders.

The UHB supported the CHC with the distribution of surveys to identified people who were stroke survivors. We are grateful to the Health Board for supporting and facilitating this project.

Initially, the survey was going to be live from November 2021 to January 2022. However, due to the low number of respondents, we extended the project until the end of May 2022.

Unfortunately, despite our best efforts, we only received feedback from five members of the public. To try to gain more feedback, we organised two CHC Stroke Focus Groups. The purpose of the Stroke Focus Groups was to give the public an alternative way to engage with us in an informal way (via Microsoft Teams) to share their experiences.

Eight people expressed their interest in attending the focus groups, but unfortunately, no one attended the sessions.

A briefing paper has been submitted to UHB for their information and the CHC will consider a face-to-face visiting option in the future.

9. Primary Care Mental Health Survey

9.1 In March 2022, we launched a survey to ask members of the public about their experiences of accessing advice/support for their mental health or well-being. The survey was posted on our social media pages, website and circulated to our stakeholders. This survey closed at the end of May.

In total, we heard from 17 people.

Some of the key feedback included:

- Most respondents told us that they experienced waits over 2 months for an appointment. One person told us that their appointment "never happened".

- A common theme was identified when reviewing the feedback, whereby people felt waiting times to see someone, regarding his or her mental health or well-being was too long.

- More positively, many respondents told us that they felt they were treated with dignity and respect when seen or spoken to.

- It was clear that a high number of respondents felt that the Covid-19 pandemic had affected the way they could access support for their mental health and well-being. One person told us that they felt the pandemic had delayed their access to mental health services, but they felt that these services are not easily accessible at any time.

- From the responses we received, it seemed that people were still waiting to receive appointments and some feedback suggests that "no further action" letters were sent to individuals following referral triage.

Response from the UHB due July 2022.

10. Monthly public feedback survey

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

10.1 To date we have heard from 1382 people. In May and June 2022, we heard from 24 people.

10.2 We continue to receive a mixture of positive and negative feedback regarding people's experiences at the Grange University Hospital. In May, a patient told us *"I was very impressed. I would not change anything of my care and treatment at the Grange University Hospital."*

10.3 During this period, we also received a number of positive comments regarding those who have attended a vaccination centre to receive their Covid-19 booster injection.

11. Upcoming and ongoing CHC activities

11.1 In July 2022, we will be launching a **Post-Covid Syndrome (Long-Covid) Survey**. The survey will be live until March 2023.

The purpose of the survey is to ask those who suffer from post-Covid syndrome, or know someone who does, their experience of accessing NHS services to support their needs.

A formal report will not be written for this survey, instead bi-monthly reports will be produced and sent to the UHB for their information as the service continues to develop and embed.

11.2 We are planning to **engage with individuals in prison** within our area to ask about their experiences in accessing NHS services.

We are currently in contact with HMP Service Leads to ensure all NHS care services are covered in the most appropriate way.

Thanks

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

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

Feedback

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

Contact details

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CIC Aneurin Bevan CHC

Community Health Council

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th July 2022 Agenda Item: 2.2

Aneurin Bevan University Health Board

Development of a Service for Adults with Attention Deficit Hyperactivity Disorder (ADHD) in Aneurin Bevan University Health Board

Executive Summary

Currently in ABUHB there is no service available for adults who are referred for assessment and diagnosis regarding ADHD. This has been identified as a service gap and a priority to address within the Mental Health and Learning Disability Divisional IMTP. Within the Health Board this service deficit has led to a number of complaints and correspondence from patients, advocates and local politicians over several years.

There is no standard approach to the way in which assessment and diagnosis of ADHD is offered across Wales or the UK for adults. However, Aneurin Bevan University Health Board is an outlier in having no local provision for adults to access any type of service. There is work being undertaken nationally in Wales to consider future service models for delivering neuro-developmental services.

At present there is no designated funding available to establish a service for the assessment, diagnosis and treatment of adults with ADHD in the Health Board. Until the national work regarding potential neurodevelopmental services models is completed an interim service model is proposed which focusses on the provision of assessment and pharmacological intervention, within existing resource.

The Board is asked to note the contents of this report and support the recommendation to establish the proposed service.

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

Executive Sponsor:
Dr Chris O'Connor, Interim Executive Director of Primary, Community and Mental Health.

Report Authors:

Ian Thomas, General Manager, Mental Health and Learning Disabilities Division and Virginia Morgan, Strategic and Clinical Lead for Primary Care Mental Health Support Services, Mental Health and Learning Disabilities Division.			
Report Received consideration and supported by:			
Executive Team	**X**	**Committee of the Board [Committee Name]**	
Date of the Report: 10th July 2022			
Supplementary Papers Attached: Pathway for Managing ADHD Referrals			

Purpose of the Report

The purpose of this paper is to seek approval from the Board to establish the proposed service for adults with ADHD within the ABUHB area.

Background and Context

ABUHB is the only Health Board in Wales where adults are unable to be referred for assessment for ADHD locally. Currently, individual referrals into Mental Health Services in ABUHB are returned to the referrer advising that there is no local service available. Individuals and GPs are therefore left to try to make alternative provision through applying through the Individual Patient Treatment process or going directly to a private provider. While neighbouring Health Boards/Trusts in Cardiff and Bristol both have specialist Neurodevelopmental services that can provide this facility for their own populations, they are unable to take external referrals from outside their area due to demand.

However, there are regular requests from Primary Care to refer into Adult Mental Health Services for an assessment and other services such as Primary Care Mental Health Support Services. The Integrated Autism Service also identify significant numbers of adults who feel they could benefit from a diagnostic assessment for ADHD.

Following diagnostic assessment and prescription and titration of medication for dose stabilisation, the ongoing prescribing and monitoring of ADHD medication should be carried out under Shared Care Protocol arrangements with primary care. (NICE, 2018) This requires an agreement between the General Practitioner and the initiating prescriber. A healthcare professional with training and expertise in managing ADHD should review ADHD medication at least once a year (NICE, 2018).

Assessment and Conclusion

Assessment

Following the development of an options appraisal of potential service models for adults with ADHD the preferred model is the development of an interim service using Community Mental Health Teams (CMHT).

This model offers continuity of care with GPs already having known links into CMHTs and services being provided in each locality. Shared care protocols should be more easily arranged and local monitoring and review arrangements more easily developed.

A task and finish group was established with NCN and LMC representation along with clinicians from the Adult Mental Health Directorate to develop the proposed pathway.

A pilot was initiated and evaluated over a six month period with a Consultant Psychiatrist providing an additional session to see a small number of individuals already known to services. The evaluation was positive as regards the service model and outcomes for individuals but highlighted the high demand for adult ADHD services.

It was anticipated that the full service would be launched in Autumn 2021. As the necessary training courses for those involved were not available until January/February 2022 and resource was diverted elsewhere during the Pandemic, the launch date has been delayed until the summer of 2022.

A total of 15 professionals have now been trained in the management of ADHD, with further training planned. This includes diagnosis and assessment and pharmacological treatment of adults with ADHD. A bid for four Band 6 practitioners has also been included in the WG Mental Health Service Improvement fund bid submitted at the end of May. These posts will support assessments of both ADHD and ASD in adult services.

A service specification and pathway have been jointly developed and agreed with key stakeholders (see attachment).

The limitations of the model should be recognised. NICE guidelines detail the need for multi-modal treatment including non-pharmacological interventions. Given the limited resource available, initially the focus of the intervention will be on medication (where appropriate). It is envisaged that as the service evolves so will the range of interventions/support provided including the development of psycho-educational groups.

Demand and Capacity

It should be noted that the demand for the service is likely to be considerable and that waiting lists will develop rapidly (very much the experience of neighbouring health boards). Prevalence rates of ADHD in the adult population are estimated to be between 2.5% and 4.7%. This equates to between approximately 11,608 and 21,823 individuals in the ABUHB area.

Demand forecasts have been undertaken using data from other Trusts/Health Boards. Based on this it is forecast that an average of 55 referrals per month could be received once the service is operational. It is likely that initially this peak might be higher due to the inherent 'backlog' associated with having no service in ABUHB currently.

An initial assessment of capacity has been undertaken and, based on expected sessional commitments and availability of current trained medical staff, it is anticipated that capacity will be around 10 assessments per month, increasing to around 80 per month following the appointment and training of nursing staff to undertake assessments and with doctors becoming more familiar with the assessment process. This is likely to occur in the autumn. The bottleneck at this point is likely to be medical time to review and prescribe.

A list of contact details for over 300 individuals is already being held within the MH&LD Division, the initial agreement being they would be notified when a service becomes available.

There are risks in developing the service, notably the current fragility of the adult mental health medical staffing situation in Caerphilly and Torfaen Boroughs which could potentially make the delivery of an equitable service provision across the Health Board challenging.

Resource Implications

There is no additional resource for medical input into the service and no additional funding for NICE approved medication that may be prescribed under a care protocol. There will be drug costs associated with any patient prescribed ADHD medication. It is suggested that the impact of this is monitored through the Medicines Management Programme Board as the majority of medication costs will fall to Primary Care. However, the annual cost of ADHD medication for most patients is likely to range between £350-£700 per patient depending on dose/brand prescribed.

In addition, demand is inevitably going to be extremely high for the service but there will be little room to flex up capacity in the short term. This is likely to see long waiting times developing for the service within a short space of time. On the balance of risk, it is felt important to start providing an adult ADHD service offer in ABUHB, particularly as the Health Board is an outlier in Wales in this respect.

It is anticipated that national guidance will be issued on the future direction of Neurodevelopmental services in the near future that will help to shape the future service model and development.

Engagement with the LMC and CHC

The current proposal to establish an ADHD service was considered by the LMC on the 8th July and whilst the limitations of the proposed service were acknowledged the proposal was supported.

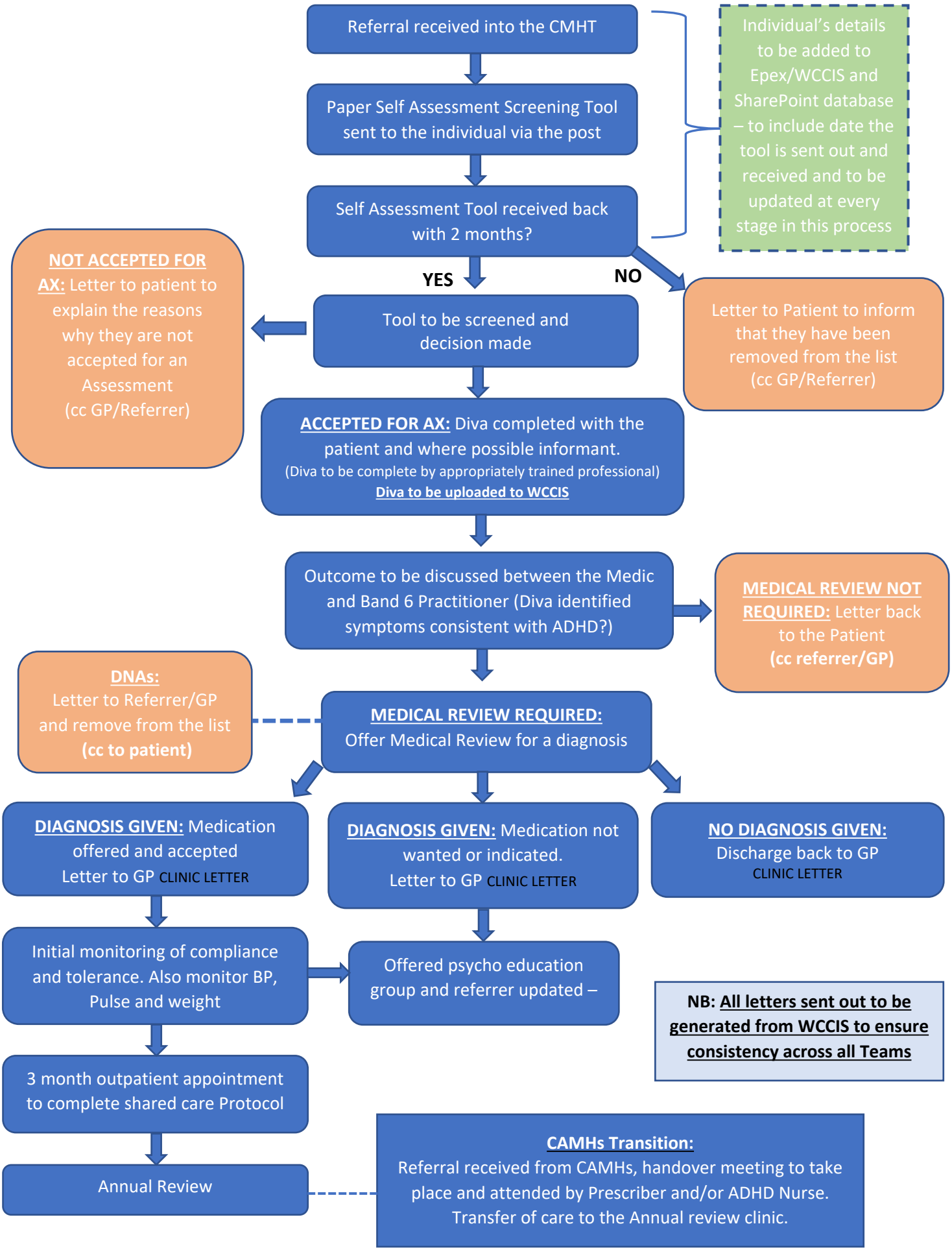
The proposal was discussed at the CHC Planning meeting on 31 May 2022 and received support in principle. It was then subsequently considered by the CHC Executive Committee on the 30th June and, whilst noting their concern regarding the potential development of a waiting list, the proposal was approved. The CHC have also requested a four week period of engagement with the public to launch the service.

Recommendation
The Health Board is asked to approve the development of an interim ADHD diagnostic assessment service, noting the limitations of the service that can be provided within existing resources.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	• Risk of adults not accessing assessment and interventions for ADHD if proposal not supported. • Risk for waiting list for service to develop.
Financial Assessment, including Value for Money	• A bid for four Band 6 practitioners has been included in the WG Mental Health Service Improvement fund bid submitted at the end of May. These posts will support assessments of both ADHD and ASD in adult services. • The annual cost of ADHD medication for most patients is likely to range between £350-£700 per patient depending on dose/brand prescribed.
Quality, Safety and Patient Experience Assessment	• This will result in the provision of an assessment and limited intervention (pharmacological) service for adults across ABUHB with ADHD.
Equality and Diversity Impact Assessment (including child impact assessment)	• Currently being undertaken.
Health and Care Standards	Standard 1: Staying Healthy Standard 2: Safe Care Standard 3: Effective Care Standard 4: Dignified Care Standard 5: Timely Care Standard 6: Individual Care Standard 7: Staff and Resources
Link to Integrated Medium Term Plan/Corporate Objectives	▪ Identified as a priority for development within the Mental Health and Learning Disability Divisional IMTP.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Provides an initial service whilst a long term service model will evolve following Welsh Government review of neurodevelopmental services.
	Integration – Supports a number of other strategic priorities to support the well-being of the local population.
	Involvement – Involvement from the Local Medical Committee and Aneurin Bevan Community Health Council.
	Collaboration – Service model had been developed in collaboration with mental health services, primary care, the Local Medical Committee and Community Health Council.
	Prevention – Service proposal enables the Health Board to move towards the provision of evidence based assessment and interventions for adults with ADHD thus supporting their well-being.

Glossary of New Terms	N/A
Public Interest	Written for public domain

Aneurin Bevan University Health Board
Pathway for Managing ADHD Referrals



Aneurin Bevan University Health Board

Six Goals For Urgent and Emergency Care Programme Plan - Submission to Welsh Government

Executive Summary			
This paper outlines the Health Board's initial "Six Goals for Urgent and Emergency Care" Programme plan. The plan has been submitted to Welsh Government on 30th June 2022 to ensure compliance to the national timeline.			
The Board is asked to: (please tick as appropriate)			
Approve the Report	X		
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Leanne Watkins, Director of Operations			
Report Author: Simon Roberts, Senior Programme Manager, Clinical Futures			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 8th July 2022			
Supplementary Papers Attached: 2			

Purpose of the Report

Provide an update to the Board on Aneurin Bevan University Health Board's Initial 'Six Goals' Programme Plan for endorsement, which outlines the areas of focus for improving Urgent and Emergency Care Services for our population.

Detailed Update

Background

Welsh Government (WG) launched it's 'Six goals for urgent and emergency care' policy handbook on 27 April 2022 (Appendix A). The document sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. It is anticipated that by delivering

each of these goals through collaboration and partnership, optimal patient and staff experience, clinical outcomes and value can be achieved.

To enable delivery of the above, a national six Goals Programme Board has been established to give strategic oversight and assurance for the delivery of Programme objectives. The Board is supported by a Programme integration group which consists of senior responsible officers (SROs) tasked with developing national action plans for each of the Six Goals intended to enable Health Boards and partners to deliver the policy vision.

In addition, four national enabling work-streams have been established to enable delivery of Programme objectives. These will focus on:

- Behaviour change, communications and marketing in urgent and emergency care;
- Digital change, information and technology urgent and emergency care;
- Measurement for improvement and value based urgent and emergency care; and
- Workforce education, development and training in urgent and emergency care.

At Health Board Level, it is expected that a Six Goals Programme Board be established, comprising of all relevant partners and must:

- have a clear and defined role including an investment planning process. The Board will have Programme oversight across the six goals and will be accountable for delivery in addition to triangulation with patient quality, safety and risk (quality assurance).

- be chaired at executive level, with membership representative of the 'whole system', including leads with sufficient seniority, leverage and insight from social care, the Welsh Ambulance Services NHS Trust, primary / community care, mental health and Regional Partnership Boards. Health Boards must also make provision for a representative of the national Six Goals Programme office to join the membership of the local Programme Board.

- ensure appropriate and effective lines of accountability. The Programme Board should report into the Executive Board via the sponsoring executive as chair.

In addition, a detailed Six Goals Programme Plan will be produced for 2022/23. These plans should be in place with a final version approved through the Programme Board by the end of Q1 22/23.

It is expected that there will be regular updates between the Health Boards and partners and the national Six Goals Programme. These updates will include Programme plan progress, risks and issues, and updates on areas where progress is not being made as anticipated.

In response to the above expectations, Aneurin Bevan has completed the initial Programme plan (Appendix B) for submission to WG. The Programme Plan includes:

- Governance structure
- Programme leadership
- Goal Leadership
- Programme objectives by Goal
- Key measures and Current performance

The Programme Plan was developed by the Programme lead through regular interaction with each goal lead to refine the objectives of each goal, agree appropriate metrics that will enable improvements to be measured and agree on the most impactful projects that are deliverable and those that will lead to system improvement. The Projects that make up the Programme are a mix of on-going and some newly established projects. Where possible, key timeline have been included however given the infancy of the Programme there are some projects where that timeline is to be determined following appropriate scoping.

Welsh Government have indicated that two key priorities of programme are implementation of Urgent primary care Centers (UPC) and Same Day Emergency Care (SDEC), The Programme plan addresses each of these areas.

It is anticipated that Goal leads work with the Programme lead to progress each area of work and provide updates on each at the local and national Six Goals Programme boards.

Note that there is considerable inter-dependency on other IMTP priority Programmes such as 'redesigning services for older people' who make up a large proportion of Urgent and Emergency Care attendances. The Clinical futures Programme team will ensure appropriate reporting to ensure programmes have visibility of associated work.

Assessment and Conclusion

Appendix B sets out the Health Board's Initial 'Six Goals' Programme Plan which details the areas of focus that aim to deliver Improvement to Urgent and Emergency Care Services.

Updates to the plan will be provided on monthly basis to the Health Board Urgent and Emergency Care Programme Board. Quarterly updates will be provided to the Board and its Committee's via the IMTP reviews.

The Plan was submitted to Welsh Government on 30th June 2022 as this was the timeline given to Health Boards, timing did not allow for submission to board prior to this.

The Health Board has not yet received feedback from Welsh Government in relation to the Plan however, it will be presented at the next Integrated Quality, Planning and Delivery meeting on 4th August 2022.

Recommendation

Note the contents of the report and endorse Aneurin Bevan University Health Board's Initial 'Six Goals' Programme Plan, which outlines the areas of focus for improving Urgent and Emergency Care Services for our population.

Appendix

A: Six Goals For urgent and Emergency Care Policy Handbook
B: AB Programme Plan

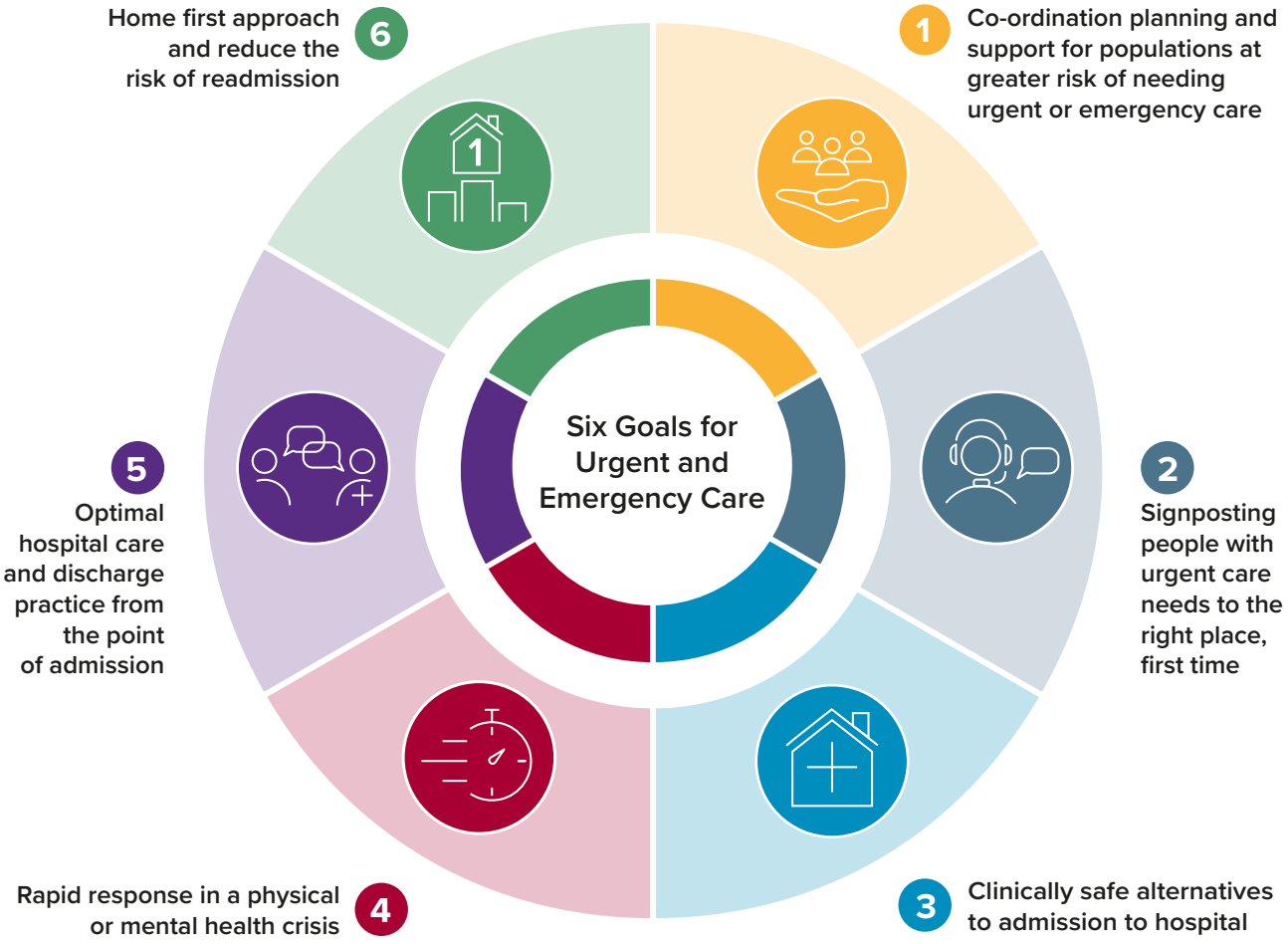
Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the financial benefits are being assessed to ensure value for money.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Six Goals is part of both short and long term strategy
	Integration – It is anticipated that Six Goals will have a positive impact upon the well being of staff and population
	Involvement – Involvement of various internal and external groups is continuous
	Collaboration – Collaboration with various internal and external groups is continuous
	Prevention – Team members have the authority to raise concerns and flag problems
Glossary of New Terms	New terms are explained within the body of the document.
Public Interest	Report to be published.

Llywodraeth Cymru
Welsh Government

Right care, right place, first time

Six Goals for Urgent and Emergency Care

A policy handbook 2021–2026



Contents

Part one	**1**
Ministerial Summary	1
Part two	**10**
Introduction	10
Goal 1: Co-ordination, planning and support for populations at greater risk of needing urgent or emergency care	18
Goal 2: Signposting people with urgent care needs to the right place, first time	22
Goal 3: Clinically safe alternatives to admission to hospital	25
Goal 4: Rapid response in a physical or mental health crisis	29
Goal 5: Optimal hospital care and discharge practice from the point of admission	34
Goal 6: Home first approach and reduce risk of readmission	38
References	41
Appendix 1	42
Appendix 2	44

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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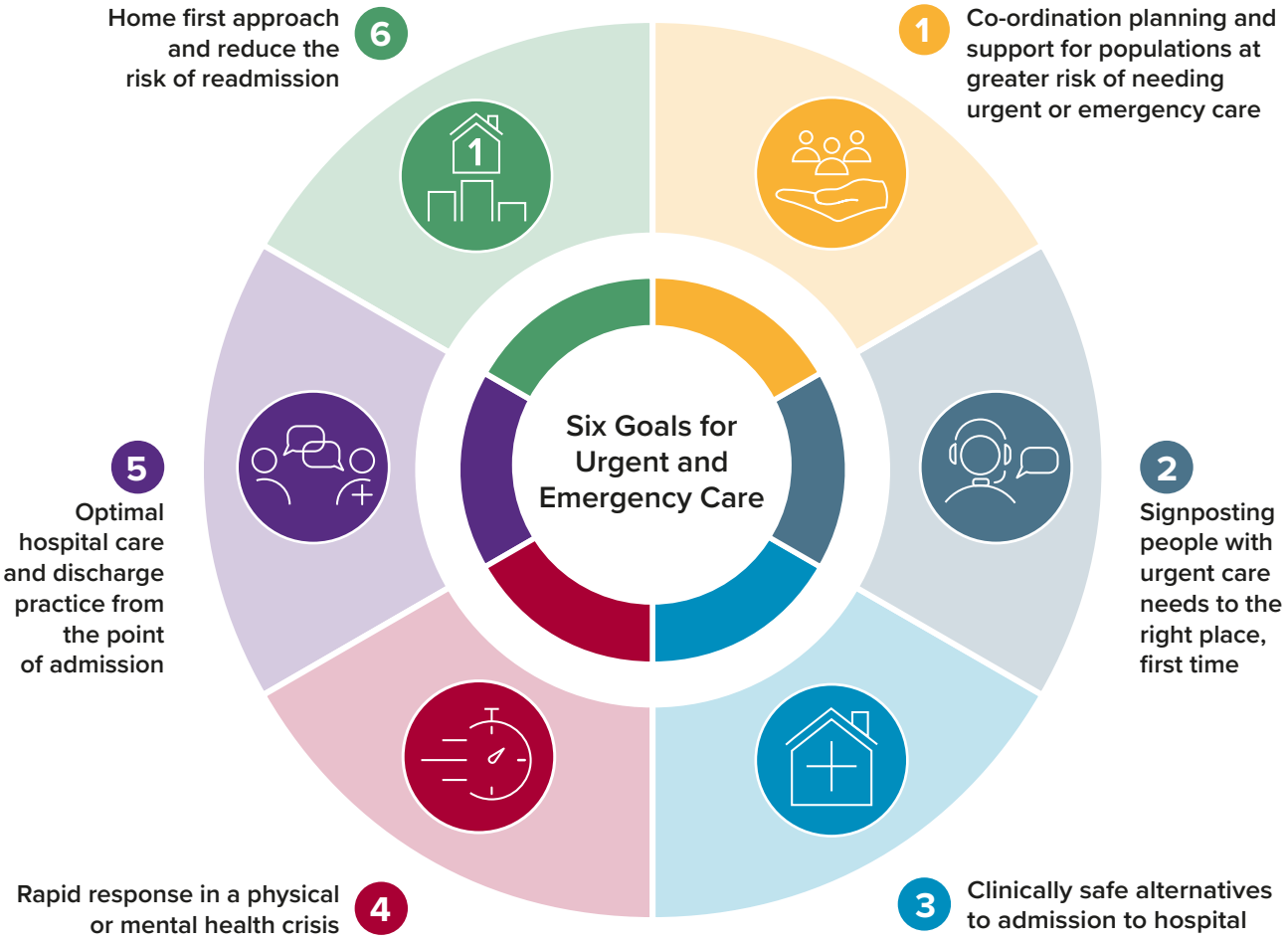
Part one

Ministerial summary

The launch of our Six Goals for Urgent and Emergency Care policy handbook is an important early marker in the delivery of our Programme for Government 2021–2026.

It sets out our expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. This will be achieved through consistent and integrated delivery of six goals for urgent and emergency care (Illustration 1) to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care.

Illustration 1: the six goals for urgent and emergency care



The six goals, co-designed by clinical and professional leads, span the urgent and emergency care pathway and reflect the priorities in our **Programme for Government 2021–2026** to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration.

In developing this approach, **we have listened to *what matters to people* when they want or need urgent and emergency care services**, and the priorities staff passionately feel need immediate attention. In *part one* of this six goals handbook we describe how we intend to meet those expectations through a mix of immediate and longer term priorities progressed nationally, regionally or locally. The priorities, aligned to each of the six goals, should not be considered in isolation as a collection of 'silver bullets' that will enable immediate improvement but as part of a whole-system and integrated approach.

Some of our priorities have medium or longer-term timescales for implementation. This is in recognition of the well-rehearsed challenges faced by health and social care organisations regarding recruitment and retention, and the difficulty associated with managing increasing and complex levels of patient demand. Longer-term milestones also recognise sustainable and effective change cannot be achieved overnight or without focus on continuous learning, sharing and improving.

Our expectation is our priorities are progressed as quickly as possible by Health Boards and partners in the context of the COVID-19 public health emergency, and within the milestones set.

Our previous strategies for improving urgent and emergency care have focused more on services and less on population healthcare. This handbook focuses on strengthening signposting, clinically safe alternatives to admission, rapid emergency care response, good discharge practice and preventing readmission. But through the six goals approach, we also want to tackle inequalities and prioritise new or existing models of care that are proven to work for all populations, ensuring we offer the most value to people, based on what matters to them.

For example, we are committed to improving experience and outcome through greater coordination, support and planning for frail/older people who are at most risk of needing urgent and emergency care. Preventing escalation of care for these populations is a real priority and will be supported through an accelerated (primary care) cluster programme, and a focus on risk stratification and population health management.

We also know certain communities of people of Black, Asian and Minority Ethnic heritages, persons with intellectual disabilities, homeless people, asylum seekers, refugees and migrant communities, Gypsy, Roma and Traveller communities and people with mental ill health experience difficulties accessing urgent and emergency care for a wide variety of reasons. We are committed to further understanding the needs people have, tailoring communication and messaging to enhance understanding of available services and breaking down the barriers that exist to ensure equity of access.

We are also aware that communication is fundamental to accessing the right services first time, and are committed to the principle that people in Wales should be able to live their lives through the medium of the Welsh language if they choose to do so. Our commitment to the Welsh language must be embedded in our efforts to develop and improve our urgent and emergency care services.

Part two of this document provides more information on our strategic approach to enabling improvement. This includes through an additional recurrent £25m to support achievement of the six goals, and establishment of four national enabling work-streams focused on digital change, informatics and technology; behaviour change, communications and marketing; workforce training, education and development; and measurement for improvement and value based urgent and emergency care.

In addition, we will integrate a number of key plans and related national programmes spanning the six goals to enable a seamless and improved urgent and emergency care offer for the people of Wales. This will include connecting programmes relating to end of life care, NHS 111 Wales, 24/7 urgent primary care, same day emergency care, emergency ambulance services, Emergency Departments and the transfer of people from hospital to their communities.

In *part two* we also describe quality statements for each of the six goals. They describe the outcomes and standards individuals should expect when they may need or want urgent or emergency care. If delivered consistently and reliably it will lead to better outcomes and experience for patients and staff alike. Over the course of the Senedd term, we will work with service users and clinical and professional leaders to develop measures of success for each quality statement and hold Health Boards, NHS Trusts, Regional Partnership Boards to account for their delivery.

This handbook focuses on strengthening signposting, clinically safe alternatives to admission, rapid emergency care response, good discharge practice and preventing readmission.

Our immediate priorities, described below, should not be considered in isolation of each other nor without the context of other concurrent action under way through a range of national enabling programmes, as described in part two:

Immediate six goals priorities

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

Health and social care organisations should work in collaboration with public service and third sector partners to deliver a coordinated, integrated, responsive health and care service, helping people to stay well longer and receive proactive support, preventative interventions or primary treatment before it becomes urgent or an emergency.

We will enable this through the following initial priorities:

- Work on Accelerated (Primary Care) Cluster Development will progress as part of the Strategic Programme for Primary Care and set out the planning and delivery framework at a pan-cluster level to support the required collaboration across public, independent and third sector partners.
- For April 2022, early adopter 'Pan-Cluster Planning Groups' will be in place, with 2022/23 regarded as a 'transition year' in preparation for full implementation in April 2023/24. Areas explored via cluster development will include 'virtual wards', homelessness and population health management, all of which contribute to delivery of one or more of the six goals.
- We will continue to meet and learn from people in communities who experience health inequalities, following on from previous Welsh Government consultations and deep dives. We will continue to engage with Black, Asian and Minority Ethnic communities, persons with intellectual disabilities, homeless people, Gypsy, Roma and Traveller communities, asylum seekers, refugees and migrant communities and people with mental ill health.
- People's input will lead to the development of an Urgent and Emergency Care Equalities Plan which will cover all six goals, and seek to address and improve access and outcomes for individuals who experience inequalities and barriers to service access. The plan will be in place **by April 2023** and improvement measures will be discussed through continuous engagement with communities on an annual basis.

Goal 2: **Signposting people with urgent care needs to the right place, first time**

When people need or want urgent care they can access a 24/7 urgent care service via the NHS 111 Wales online or telephone service where they will be given advice and, where necessary, signposted or referred to the right community or hospital-based service, first time. This will be achieved through the development of an integrated 24/7 urgent care service and the delivery of the following initial priorities:

- Urgent Primary Care Centres / services are implemented across Wales, providing a locally accessible and convenient service and offering diagnosis and treatment for urgent care complaints, illness or injury – **by April 2023**.
- Following the completion of the national roll out of NHS 111 Wales in 2021/2022:
  - significantly improve the 111 digital offer and increase use of web or app access, enabling provision of live advice without the need to use the telephone service – **by April 2023**.
  - improve access to urgent dental provision – **by April 2023**.
  - establish a palliative care pathway helping people with life-shortening illness to access a specialist 24/7 after dialling 111 – **by April 2023**.
  - establish a pathway supporting people with emotional health, mental illness and wellbeing issues to directly access a mental health worker 24/7 after dialling 111 (and 'pressing 2') **by May 2023**.
  - develop the 111 Clinical Support Hub at a national and regional level in addition to the wider multi-disciplinary team support for urgent primary care – **by April 2023**.
- Implement a 24/7 urgent care service, accessible via NHS 111 Wales, which can provide clinical or professional advice remotely and if necessary, signpost or refer directly to the right place, first time. This should integrate Urgent Primary Care Centres/services, GP (in and out of hours), and other community services such as community pharmacy, dental and optometry as well as schedule arrival slots in minor injuries units, emergency departments or same day emergency care hospital services – **by April 2025**.
- Each person assessed as having an urgent primary care need will reliably have access to the right professional or service for that need within 8 hours of contacting the NHS – **by May 2026**.

Goal 3: **Clinically safe alternatives to admission to hospital**

People access appropriate and safe care close to home, and with as much continuity of care, as possible. Admission for ongoing care to an acute hospital bed should only occur if clinically necessary. Linked to Goals 1 and 2, and the establishment of an integrated 24/7 urgent care service, Health Boards and partners will achieve this goal through:

- Extension of a national Same Day Emergency Care (SDEC) service across Wales, building on existing Ambulatory Emergency Care (AEC) offerings and consistently reducing the number of people requiring overnight admission for a healthcare emergency – **by April 2023**. Additional Welsh Government funding will be available to Health Boards to deliver this priority; and to the Velindre NHS Trust for an immunotherapy toxicity service and an enhanced ambulatory care service to help prevent admission of people suffering complications of cancers from 2021/2022.
- Implementation of SDEC services so that they support 100% of type 1 emergency departments, allowing for the rapid assessment, diagnosis, and treatment of people presenting with certain conditions, and discharge home same day where clinically appropriate, twelve hours a day and seven days a week – **by April 2025**.
- The Strategic Programme for Primary Care will also develop an effective community infrastructure model for intermediate care, based upon the principles of 'right sizing' available capacity in the community, to help services to meet the needs of local populations. This work will inform planning discussions at pan cluster level.
- There are many well-established crisis cafés, sanctuaries or houses in Wales. The services, provided mainly by the third sector, are effective at supporting people with mental or emotional health issues and offer an alternative to hospital admission or emergency department presentation. We will seek to expand this provision and ensure they address the needs of children and young people as well as adults **by April 2025**.

Goal 4: **Rapid response in physical or mental health crisis**

Individuals who are seriously ill or injured or in a mental health crisis should receive the quickest and best response commensurate with their clinical need – and, if necessary, be transported to the right place for definitive care to optimise their experience and outcome. This should be achieved through the following priorities:

- Deliver safe alternatives to ambulance conveyance to Emergency Departments, which means WAST transport patients there only when that is the right place for their clinical need. This should be done through focused and meaningful collaboration between Health Boards, WAST and their partners.
- This will be supported by the procurement of a new 999 remote clinical triage system in 2021/2022 that will support:
  - More accurate clinical assessment of patients;
  - Ability for clinicians to triage patients remotely increasing 'hear and treat' capacity; and
  - Video and text triage and follow-up advice.
- Increasing ambulance availability to ensure people who access 999 and are categorised as in danger of loss of life or with time-sensitive complaints are prioritised, receive the right kind of rapid response and are transported to the right place for definitive care to optimise their outcomes. Median (average) response times to people in the red and amber categories will improve year-on-year to April 2026.
- Improving ambulance patient handover, ensuring no one arriving by ambulance at an Emergency Department waits more than 60 minutes from arrival to handover to a clinician – by the end of April 2025. The number of people waiting over this period for ambulance patient handover will reduce on an annual basis until that point.
- Consistent delivery of Emergency Department care standards, developed by clinical and professional leads, across all Emergency Departments **by the end of April 2023**.
- Linked to Goals 2 and 3, Mental Health 'single points of access' will cover all Health Board areas and provide rapid 24/7 triage and assessment **by April 2022**.

Goal 5: **Optimal hospital care and discharge practice from the point of admission**

Optimal hospital based care provided for people who need short term, or ongoing, assessment or treatment for as long as it adds benefit to outcome, with a relentless focus on good discharge practice. As a priority:

- Health, and social care, third and independent sector organisations will work together to consistently and reliably deliver our hospital discharge requirements[1] with an immediate focus on reducing the numbers of people staying in hospital longer than 7 days, reducing the risk of harm, optimising experience and providing care in the most clinically appropriate setting.
- There should be additional collective focus on significantly reducing the numbers of people staying longer in hospital than 21 days, to reduce risk of harm; and a renewed focus on reducing the number of people with mental illness or intellectual disabilities receiving long-term hospital care.
- We will establish a three-year transformation plan, **by the end of 2021/2022**, to support delivery of these priorities (and those in goal 6), and enable optimal discharge practice and delivery of Home First principles. Health Boards, NHS Trusts, Regional Partnership Board representatives will co-design the plan focusing on system wide integration.

Goal 6: Home first approach and reduce the risk of readmission

People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes and experience, and to avoid deconditioning. As a priority:

- Health and social care organisations will work together to increase the number of people transferred to the right place following admission to hospital, preferably their usual place of residence, within 48 hours of the decision about the next stage of their care being made.
- The proportion of people leaving hospital on a discharge to recover then assess pathway and with a co-produced personal recovery plan will also increase to help prevent readmission.

1. https://gov.wales/sites/default/files/publications/2020-04/COVID-19-hospital-discharge-service-requirements.pdf

Our priorities should be considered as a suite of interconnected actions and expectations as part of a whole system approach.

In summary, our vision is for greater focus on coordinating support for older, frail people and individuals who have lived experience of discrimination and deprivation. This coordination and support should help people access the right advice or care based on need, enabled by the development of the emerging 24/7 urgent care model.

This model will integrate assessment, signposting and referral from 999 and 111 to a number of health and social care pathways, supporting people to safely remain in their local communities or rapidly access the right type of definitive care to support better outcomes.

When people do have a clinical need to access hospital care, staff will be supported to provide quality care, and individuals will stay in a hospital setting only for as long as is necessary with timely transfer home or to the most appropriate setting for their needs. And, following transfer home, individuals will be supported where they may need it through rehabilitation services and connection to local services to regain confidence and improve outcomes.

We believe a whole system and relentless effort to delivering these immediate priorities and the broader six goals offers the opportunity for Wales to improve substantially our existing urgent and emergency care offer, helping people to get to the right care, in the right place, first time.

Eluned Morgan MS
Minister for Health
and Social Services

Julie Morgan MS
Deputy Minister for
Social Service

Lynne Neagle MS
Deputy Minister for Mental
Health and Wellbeing

Part two

Introduction

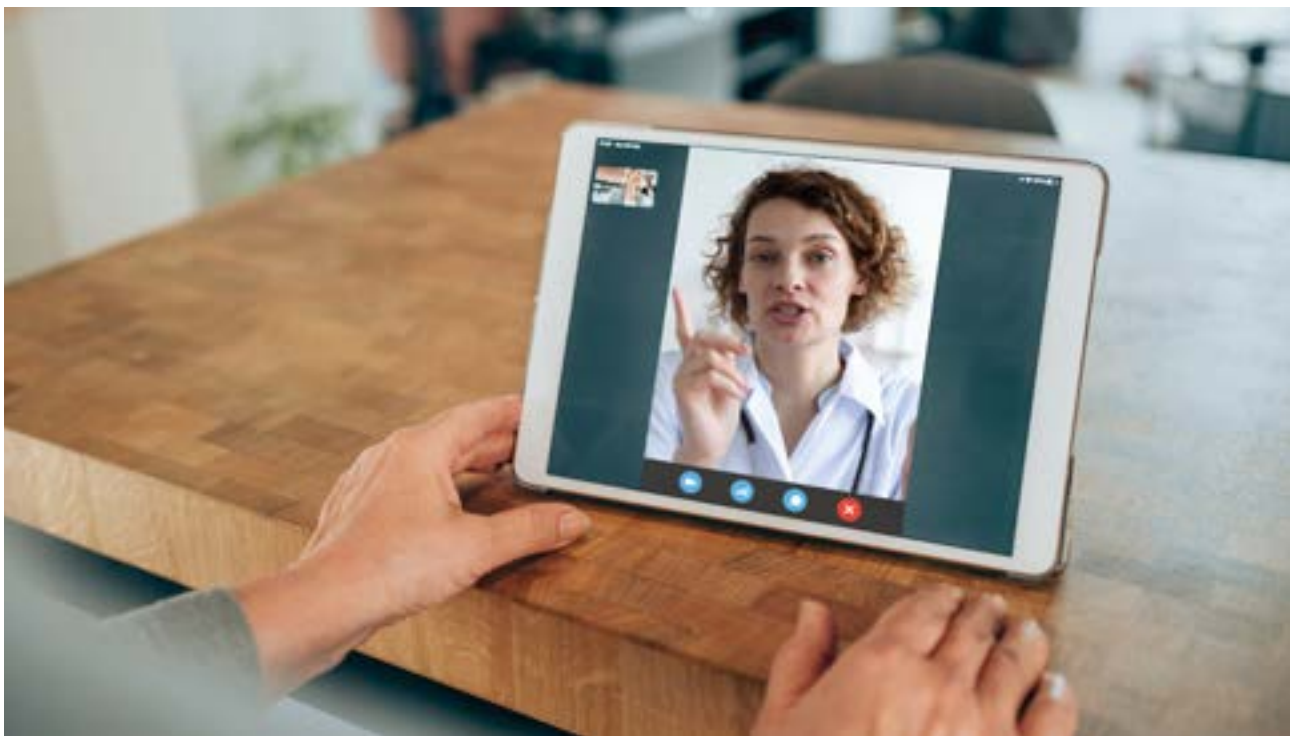
About urgent and emergency care

An urgent or emergency need for advice, care or treatment is not predictable for the majority of people. However, some people are at greater risk of needing urgent or emergency care because of risk factors such as their age, frailty, a long-term condition(s), or other vulnerability; or as a consequence of health inequalities.

'Emergency' and 'urgent care' are frequently used interchangeably, with different perceptions in meaning and a sense of confidence that others have the same understanding.

This can cause confusion with both care providers and the public, and can be detrimental because users of services want a clearer sense of service priorities and clarity in the purpose of different services to ensure they access the right service, first time. Therefore, we have determined that:

- **Urgent care:** means health and wellbeing issues that may result in significant or permanent harm if not dealt with within the next 8 hours.
- **Emergency care:** means health and wellbeing issues that may result in significant or permanent harm or death if not dealt with immediately.



What is the purpose of this six goals handbook?

This handbook describes the Welsh Government's strategic vision for urgent and emergency care, through six policy goals.

The six goals both represent the outcomes we expect for people who need to access urgent and emergency care and also frame a series of 'quality statements' for consistent and reliable delivery by Health Boards, NHS Trusts, Regional Partnership Boards and partners. Successful delivery of the goals and the related quality statements by health and social care systems should enable optimal experience and outcomes for local populations and staff.

The handbook also describes how the Welsh Government will enable the health and care system to achieve the six goals and reliably deliver on the quality statements through targeted funding and supporting national programmes.

Strategic context

Our strategic aim is to prevent unnecessary escalation of care where possible, by providing proactive support, and to enable access to the right care, first time for people who have a need for urgent or emergency care.

This approach aligns with the commitments of A Healthier Wales (2018), the Workforce Strategy for Health and Social Care (2020), the Programme for Government (2021) and the National Clinical Framework (2021), delivering:

A whole system approach where seamless support, care or treatment is provided as close to home as possible:

- Services designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes.
- A system where, people only present at or are admitted to a general hospital when it is essential, with hospital services designed to reduce the time spent in hospital.
- A shift in resources to the community that enable hospital-based care (when needed) to be accessed more quickly.
- The use of digital change and technology to support high quality services.
- A motivated and engaged workforce with the right capacity, capability and confidence.

This document also aligns with the Welsh Governments Together for Mental Health Strategy and supports parity between mental and physical health; and the NHS Decarbonisation Strategic Delivery Plan, supporting reducing carbon with fewer journeys to hospital and care closer to home. This will contribute to improving air quality and individuals' health.

Our vision for urgent and emergency care is also founded on the five ways of working, in the Wellbeing of Future Generations Act. The six goals set out:

- a longer-term vision for designing a seamless urgent and emergency care model along with short to medium term action requiring collaborative planning across health, social care and the third sector to optimise outcomes;
- public involvement, which, has been key to shaping the six goals and will remain fundamental to tackling health inequalities, the delivery of personalised care and the co-design of new models of care;

- a strong focus on preventive activity with the aim of keeping people well and maintaining independence.
- This approach includes schemes that support people to remain safely at home, for example through healthier homes and focus on supporting individuals to manage their health conditions to avoid exacerbations that result in admission to hospital.
- Collaboration and partnership working across key partners in the health and social care system; health boards and trusts, social care, regional partnership boards, and the third sector and beyond to deliver on the system changes required.

We will communicate our priorities for Health Boards, Regional Partnership Boards and NHS Trusts through the NHS Planning Framework and other related strategic documents.

Why do we need to improve delivery of urgent and emergency care?

Managing demand for urgent and emergency care has been challenging for a number of years with increasing pressure on staff in primary and community care services, the ambulance service, emergency departments, hospitals and other essential health and social care services.

This has, at times, resulted in delays for individuals' access to essential services, which can have an effect on their experience and outcomes. The following issues are part of a complex and multi-factorial challenge, compounded by the COVID-19 pandemic (see Appendix 1 for more evidence):

- An ageing population, often with multiple co-morbidities, who have greater need for access to hospital and ongoing care
- Workforce challenges resulting in gaps across the system
- Health inequalities: unwarranted variances in health service access, provision or outcomes between different groups of people. These inequalities are normally understood across four domains:
  1. the socio-economic domain such as income;
  2. the geographic domain such as where the person lives;
  3. specific characteristics domain such as ethnicity or disability; and
  4. the 'excluded groups' domain such as homeless people, migrants, the Traveller communities or asylum seekers.
- An urgent and emergency care system where interactions people have with services - and where they transition following that interaction – is complex
- This complexity is compounded by the interactions with individuals' associated requirements for planned care and the workforce challenges experienced across the health and care sector
- A lack of continuity when individuals transition between services can potentially have a negative impact on the ability of other staff and services to provide timely access and quality care to patients
- Longstanding cultural challenges and an inability to embrace change and move away from outdated practices that add little or no value
- A rise in the numbers of individuals with mental health issues and the complexity and acuity of these issues.

What matters to people who have used urgent and emergency care in Wales?

A survey of people in Wales[2] (Picker, 2020) told us that the most important thing for people when they need urgent or emergency care was to receive the right treatment to manage their illness/injury and prevent future problems.

The findings of the survey align to views of Welsh public when asked about their recent experiences of urgent and emergency care services, with the following consistent themes regarding what matters to them when they need to access urgent or emergency care:

- Being clearly kept informed about their care throughout;
- Having a timely initial assessment, even if this means waiting for treatment;
- Being given medicine to help control pain where necessary;
- Being told how long they can expect to wait for the next stage of their care; and
- Being treated, and to go home, quickly.
- Further, a survey[3] about mental health crisis care of over 1000 individuals in May 2021 found what people most wanted is a quick response, access to support 24 hours a day and to have a caring reassuring person to speak to when in crisis.

What matters to staff involved in the delivery of urgent or emergency care?

Through surveys and engagement sessions about existing challenges and opportunities to improve access to, and delivery of, urgent and emergency care services, frontline staff and professional bodies were clear about the need to focus on four key themes (see Appendix 2 for further detail):

- Getting education and information to the public on access to services right, ensuring there is always a focus on what matters to people.
- A clear, long-term approach to recruitment and retention of the right workforce to manage the right patient demand, and enabling staff to develop while maintaining their wellbeing.
- A clear approach to measuring value, quality, safety, patient and staff experience across the urgent and emergency care pathway; and the use of accurate data to enable 'one version of the truth' supporting better decisions by clinicians, operational and planning teams.
- Harnessing digital change, new technologies and informatics systems that are robust, easy to use and support the delivery of safe, effective care.

2. Picker Institute (2020) Welsh Perceptions of Urgent and Emergency Care
3. Picker Institute Service User Experience of Mental Health Care in Wales

How can we achieve what matters to service users and staff?

The COVID-19 pandemic has enabled new ways of working and an accelerated pace of change, both of which have provided rich learning. We will work with health and care organisations to harness this once-in-a-generation opportunity to continue the work of transforming services to deliver a sustainable, safer, more effective, integrated urgent and emergency care access model.

We want to see a whole-system approach to support people who need urgent or emergency care to access the right care, in the right place, first time. We expect health and care organisations to work with partners to consistently and reliably deliver six goals for urgent and emergency care to optimise clinical outcomes, service user and staff experience and value. At a high level, the six goals are:

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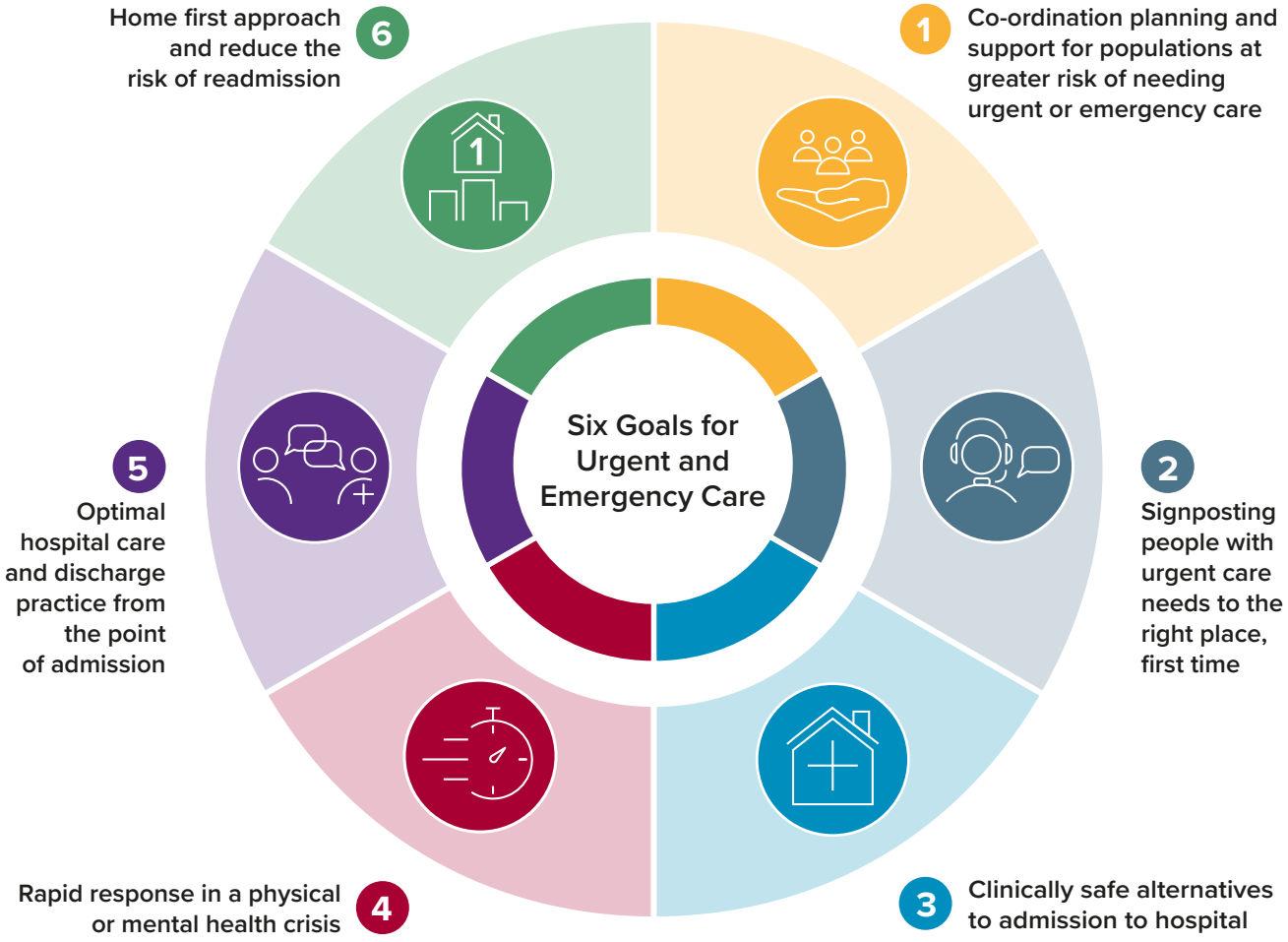


How will the Welsh Government enable the system to deliver the six goals?

The Welsh Government has established a new £25m recurrent fund to support development and sustainable implementation of new models of care that will enable consistent and reliable delivery of the goals. This will be complemented by the Integrated Care Fund (ICF) intended to support delivery of integrated health and social care models of care, and existing annual funding allocated to Health Boards, NHS Trusts and Regional Partnership Boards.

The six goals look across the whole pathway for urgent and emergency care and therefore the role of primary and community care is key. Consequently, there is close working between Welsh Government and national programmes and bodies like the Strategic Programme for Primary Care, the Programme for End of Life Care, the NHS 111 Wales Programme, the Emergency Ambulance Services Committee and others on those areas of alignment that support the delivery of the six goals.

Notably, this includes the development of urgent primary care services and the development of an effective community infrastructure model, all underpinned by accelerated cluster development.

We will establish four national enabling work-streams as part of a national six goals approach to support achievement of the goals. These are:

Digital change, informatics and technology in urgent and emergency care: we will develop a plan with a phased approach combining enabling actions that can be delivered quickly and in the medium term.. We know that not everyone can, or wants to, access online or digital services; therefore, ensuring that any solutions are digitally inclusive is a key priority;

Measurement for improvement and value based urgent and emergency care: a six goals plan will be co-designed with patient groups and clinical and professional leads to enable development of the right service user and staff experience, clinical outcome and value-based metrics to understand and enable improvement against ‘quadruple aim’; and

Behaviour change, communications and marketing in urgent and emergency care: a plan will be developed to identify immediate and medium term actions, aligned to the six goals, to ensure people are better informed of where to turn when they need or want urgent or emergency advice or care. The work of this group will include considerations of language in accessing information and align with our commitments to the Welsh language. This plan will also focus on social movements and making every contact count to optimise experience and outcomes.

Workforce, education, training and development in urgent and emergency care: immediate and longer term opportunities will be identified to support staff to work in modern, multi-professional workforce models. This will seek to enable them to use their skills in line with the prudent in practice principle to deliver the six goals, supported by excellent education, training and development; with the need to support the wellbeing of our workforce central to everything we do.

Funding will also be made available to Health Boards to recruit ‘triumvirate teams’ to drive forward delivery of priorities and form national networks to enable sharing of insight, learning and innovation. These teams will include clinical or professional leadership and analytical support.

What are quality statements?

Each of the six goals in this handbook includes a quality statement that sets out ambitions for consistent and reliable delivery by health and social care organisations across Wales.

They describe the outcomes and standards individuals should expect when they may need urgent and emergency care services, and will inform national oversight of service provision through planning frameworks and the Welsh Government quality, planning and delivery assurance system.

The COVID-19 pandemic and associated challenges make delivery of every element of each quality statement testing and some elements should be considered as aspirational at this stage. However, health and care organisations should work towards consistent and reliable delivery with their partners over the course of this Senedd term.

We will publish more detail on the quality statements and the rationale behind them as part of an evidence framework to support practitioners. We will also keep quality statements under continuous review to ensure the latest available evidence informs our approach, and co-design measures of success alongside service user representatives, clinical, professional and system leaders.

What are the expectations of health and care organisations?

Health Boards, NHS Wales Trusts and Regional Partnership Boards should collaborate with partners to use the six goals as an organising framework, framing action within local urgent and emergency care improvement plans (structured around the six goals) and local Integrated Medium Term Plans (IMTPs).

A framework will be supplied for the development of a Six Goals Plan and associated monitoring, with the expectation that this is used for the key priorities from 2022–23 onwards.

Review and evaluation

This handbook covers the 2021/2022–2025/2026 period and progress towards meeting the intended outcomes of the six goals will be subject to annual review and evaluation.

There will be an initial review of progress, learning, and any challenges to delivery in March 2022 to inform the ongoing development, implementation and operationalisation of the six goals. In line with commitments in a Healthier Wales, consideration of progress by Health Boards against key priorities will align to any new developments regarding 'levers for change'.

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

To help prevent future urgent or emergency care presentations, populations at greater risk of needing to access them should expect to receive proactive support through enhanced planning and coordination of their health and social care needs. This should support better outcomes, experience and value.

Quality statement

- Parents or guardians of children in 'Early Years' settings will be supported to anticipate risks of childhood accidents in the home.
- People eligible to access the Welsh Government's Nest Warm Homes scheme are offered support to improve their resilience and well-being, through improving the health of their homes.
- People living with multiple long-term conditions are offered an opportunity to participate in regular holistic reviews and to co-produce a personalised care plan. This should include an offer of involvement to carers in conversations about care plans. This should cover the carer's own needs to help prevent admission to hospital for the person for whom they have caring responsibilities for non-clinical reasons, in the event of sudden illness for the carer.
- People with frailty syndromes, including those with dementia, are proactively identified by health and social care teams to ensure they receive care by a team of professionals competent to assess and manage individual needs at, or closer to, home.
- Community teams support individuals who are lonely, socially isolated or excluded through social prescribing schemes, awareness of them and encouragement and support for their use.

- People with mental health issues will be supported through early identification and intervention in primary care. They will be empowered to access self-help and community support.
- People with substance misuse issues receive support to reduce their risk of harm through access to advice from the right professional. They can access rehabilitation, recovery services and psychologically informed care.
- Residents of care homes and people known to be at greater risk of falling, are offered proactive support through home safety checks, home adaptations and advice on adoption of healthy behaviours appropriate to their needs.
- People with a progressive life-shortening illness have the offer of agreeing an advance care plan through close collaboration between the person, their families and carers; and the professionals involved in their care to enable them to die in the place of their choice.

Why is this good for service users?

An integrated responsive health and care service will help frail and older people to stay well longer and receive preventative support reducing the risk of escalation to emergency care and admission to hospital. This should also ensure any unmet social need is addressed in the right place, first time. Further, understanding the relationship between socio-economic deprivation, poverty and social injustice with poorer outcomes and unmet need is at the core of delivering goal 1.

As examples, substance misuse and poor quality - or cold - homes present some of the leading risk factors for ill-health and have consequences for both people's outcomes and increased demand on the urgent and emergency care system.

Higher quality, more personalised support for people with substance misuse issues, and on improving safety and warmth of homes will create robust connections and positive outcomes for individuals and deliver greater value. This is particularly prescient given the probable increase in latent risks of poverty and poorer outcomes among people in the community caused by the COVID-19 pandemic, restrictions on life and unemployment.

A selection of other benefits of consistent and reliable delivery of goal 1 include the following:

- personalised care planning enables access to proactive support to remain as well as long as possible;
- advance care planning enables people with life-shortening illness to die in their place of choice; and
- enabling patient-level information to be shared between clinicians and professionals will enable more confident decision making about what is right for the individual, first time, and reduce unnecessary 'handovers' to other services.

How will we support health and social care systems to achieve this goal?

Across Wales, a number of existing services, programmes and projects have been put in place, some of these are tailored to specific conditions or populations. During 2021–22 a stock-take will be undertaken to provide a repository of good practice on which to build a meaningful and coordinated approach for Wales. We will also focus on the following areas:

- The Accelerated Cluster Development work (as part of the Strategic Programme for Primary Care) sets out the planning and delivery framework at a pan cluster level that will support the required collaboration across public, independent and third sector partners. For April 2022, early adopter Pan Cluster Planning Groups will be in place with 2022/23 regarded as a transition year in preparation for full implementation in April 2023/2024.
- Our new national programme for end of life care will provide a renewed and broader focus to palliative and end of life care across health, social care and the third sector. We will also develop a Quality Statement for End of Life Care in conjunction with health, social care, the third sector and our patient engagement leads. The quality statement will drive forward improvements in the quality of care through nationally agreed clinical pathways across all sectors.
- High Impact Service Users: a test of change service will be launched in partnership with a Health Board area and third sector partners in 2021/2022 to explore how the health and social care needs of people who frequently access urgent and emergency care services can be better met.

An evaluation will be undertaken to support the design of a national model which will build on work developed by the Welsh Emergency Department Frequent Attenders Network (WEDFAN).

- The National Data Resource will facilitate timely accessibility of information to healthcare professionals across the system, to ensure an up-to-date, accurate record of individuals' status is available to inform care planning.
- The Welsh Government commitment to improving the safety and warmth of homes will be further progressed, for example with the continuation of the NEST Warm Homes Scheme.
- A 'Hospital to a Healthier Home' scheme, delivered by Care and Repair from 14 hospitals in Wales. This scheme supports vulnerable older people through safe and timely discharge from hospital, and prevents readmission by making their homes safe, warm and more accessible. Care and Repair caseworkers also offer practical support and coordination on issues like benefit entitlements and referral to local community groups to tackle loneliness.
- Welsh Government investment of almost £1m in lifting equipment for care homes continues to ensure that people who experience "non-injury falls" in those homes can be safely lifted and avoid the need for transfer to hospital and potentially admission. The impact of this intervention will be monitored to explore related opportunities in other parts of the health and social care system.
- Through our ePrescribing programme, we will seek to better coordinate, improve and digitise the way patients, clinicians and pharmacists access and manage the provision of medicines across the health system. This will include: patients' access to medicines; prescribing of medication by clinicians; and the assurance and dispensing of prescriptions by pharmacists.
- Programme for Government commitments for implementation of 'integrated health and wellbeing centres' and 'integrated hubs' are also likely to eventually support delivery of this goal.

How will we measure success?

A range of key measures will be developed, such as the frequency of use of care plans and their success in maintaining people at home (a 'Healthy Days at Home' measure is under development) when a crisis occurs.

We should expect to see an increase in time-spent at home by frail and older people, and a reduction in Emergency Department attendances among:

- individuals who are defined as 'high impact users' of services;
- people with substance misuse issues; and
- younger children.

We should also observe a reduction in 999 calls and transfers to hospital from the populations supported by the actions defined in this goal over time.

Goal 2:
Signposting to the right place, first time for people with urgent care needs

When people need to access urgent care they can access a 24/7 urgent care service, accessible via NHS 111 Wales, providing advice online or over the telephone and where necessary are signposted or referred to the right community or hospital-based service, first time.

Service users are involved in shared-decision making and experience coordinated care with clear and accurate exchange of patient level information between relevant health and social care professionals.

Quality statement

People who require urgent care are supported to understand the value of seeking advice through the NHS 111 Wales online platform or telephony service, receiving a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience.

Those who have an urgent health and wellbeing issue that may result in significant or permanent harm if not assessed or treated within the next eight hours, are supported to achieve optimal experience and outcome through urgent primary care services. This will include:

- an initial phone consultation through 111
- signposting to a same day or out-of-hours primary care appointment; or pharmacy, dental or optometry advice
- direct connection to mental health advice
- signposting / referral to an urgent primary care centre; and/or
- signposting / scheduling to an arrival time slot at a minor injuries unit or Emergency Department

Health and care staff have access to a ‘directory of services’ holding comprehensive, accurate and contemporaneous information to signpost or refer people to the right place, first time based on their individual need.

Why is this good for service users?

Signposting people who want or need urgent advice, care or treatment to the right place, first time, taking into account language and communication needs, should help improve service user experience by limiting unnecessary visits to hospital, and reduce the length of time people wait for assessment and treatment when needed.

It should also enable people with serious injuries and illnesses to be assessed and treated more quickly in Emergency Departments, and free-up capacity for GP consultations for people with long term/chronic conditions. In the context of COVID-19, it will also make it safer for service users and staff by reducing crowding in Emergency Departments.

Establishing an accurate, comprehensive, up-to-date and easily accessible 'directory of services' will enable clinicians and health and care professionals to signpost people who need information, advice or assistance to the right place, first time and could also be made available to the public

How will we support health and social care systems to achieve this goal?

We will roll-out the NHS 111 Wales on-line and free to call telephony service nationally by the end of 2021/2022. This will help 100% of the Welsh population to answer questions about their symptoms, 24 hours a day and seven days a week.

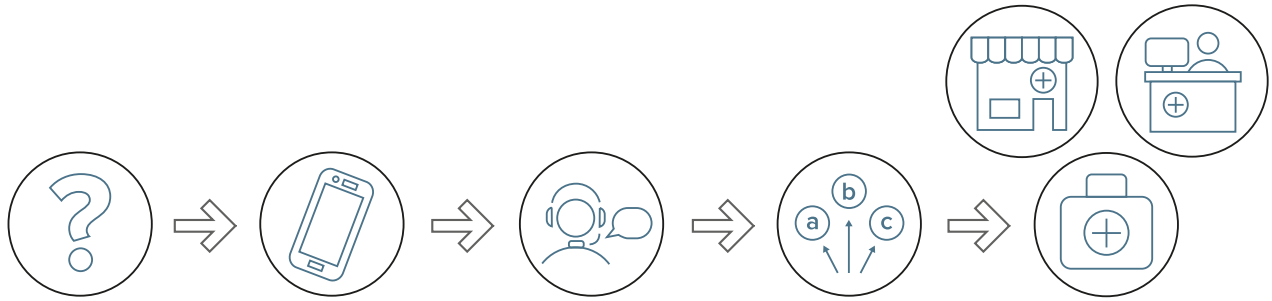
The 111 service provides information on self-care advice and how people can access medication – including repeat prescriptions. It also provides support to individuals or their carers who want or need urgent advice from a range of practitioners, including GPs, pharmacists, dentists, specialist nurses and other clinicians.

In 2021/2022, as part of the development of an integrated 24/7 urgent care service, we will also:

- Enhance accessibility to a range of symptom checkers via the NHS 111 Wales website.
- Accelerate plans to increase clinical capacity to provide remote assessment and advice via 111 and in ambulance control centres, enabling people to be signposted, referred or scheduled in to a slot in the right place, first time.
- Enable individuals with mental health issues to be connected to a trained mental health worker as soon a possible who can connect them to local support or crisis services as well as provide telephone triage, assessment and interventions.
- Continue to establish urgent primary care centres and services, providing a locally accessible and convenient service offering diagnosis and treatment of many of the most common reasons people access GP in and out-of-hours, 999 and Emergency Department services.

The 111 and emerging urgent care service model is illustrated in diagram 1:

Diagram 1 – the NHS 111 Wales model



Helping people to choose

Providing correct information for patients to make an informed decision when accessing urgent care

Accessing 111

Provide a range of options for 111 users to access services, including a digital first approach.

Remote assessment

Provide over the phone assessment and advice to prioritise clinical requirement.

Streaming Options

Streaming the patient to the correct service in a timely manner should care be required. This could include self-care, pharmacy, booking an appointment slot or out of hours GP.

Destination Outcomes

Patient outcome from accessing service. Ensuring the right care is received at the right place, first time.

How will we measure success?

Meaningful metrics are under development to enable a full understanding of how successfully the urgent care system is in respect of signposting people to the right place, first time and in relation to staff and patient experience. The types of metrics used initially will include:

- National 111 standards.
- Analysis of destination outcomes of 111 calls.
- The volumes of presentations at Emergency Departments for low acuity/minor complaints.
- Service user experience and satisfaction surveys.
- National performance reporting for urgent primary care centres will be launched using an agreed minimum dataset alongside formal evaluation of the first phase to support further development and delivery of the model in phase two.

Goal 3:
Clinically safe alternatives to hospital

People with urgent or emergency care needs can access appropriate and safe care close to home, and with as much continuity of care, as possible. Admission for ongoing care to an acute hospital bed should only occur if clinically necessary.

Quality statement

People with urgent or emergency care needs can access appropriate and safe care close to home, and with as much continuity of care, as possible. Admission for ongoing care to an acute hospital bed should only occur if clinically necessary. Community based nurses, allied health professionals and GPs should have timely access to GP and / or specialty advice and guidance to support safe decisions about a person's urgent or emergency care needs. This includes helping them to remain at home; receive timely follow-up care after accessing the ambulance service or accessing the right hospital setting, first time.

People who are assessed for bed-based intermediate 'step-up' care are given clear advice about the support the service will be able to provide and, if accepted for intermediate care, start the service within two hours of referral in line with NICE guidance[4].

People who have a clinical need for a hospital-based urgent or emergency face-to-face assessment, diagnostics and/or treatment are always considered for management on an (ambulatory) same day emergency care pathway.

4. https://www.nice.org.uk/guidance/NG74

Older/frail people, and people nearing the end of their lives, will be assessed quickly at the front door or adjacent to the Emergency Department with decisions on their care acted upon by a multi-agency team. This should include a system that is able to respond to peoples' specific needs to prevent unwanted or unnecessary admission to hospital, focus on maintaining nutrition and hydration, mobility, communication and control.

Individuals will have available, outside of normal working hours, crisis cafés or sanctuaries in their local communities which will provide compassionate safe support for those in mental health crisis.

Why is this good for service users?

Reducing avoidable emergency admissions improves the quality of life for people with long term and acute conditions and their families, as well as reducing pressures upon the resources of local hospitals.

This will be achieved by maximising the use and availability of remote clinical assessment to people who dial 999, and for community practitioners who are at scene with a service user through access to specialty advice and guidance lines. This seamless access to advice from specialty clinicians can support practitioners to make informed decisions about the right setting/service for the needs of an individual helping to reduce unnecessary admissions to hospital.

Increasing referrals of people with urgent or emergency care needs or in mental health crisis to suitable alternative services locally enables people both to have their needs meet closer to home and more swiftly, and release ambulance and other professional or clinical capacity to respond to those individuals who require a rapid response. This should also reduce pressure on primary care services and enable more focus on supporting people with chronic conditions.

Reducing pressure in emergency departments and on hospital capacity will help to reduce 'crowding' and the related risk of harm, including risk to poor experience caused by long ambulance patient handover delays and the risk of hospital acquired infection. This should in turn improve patient and staff experience, and clinical outcome.

Delivering 'same day emergency care services', better mental health liaison services and acute frailty services at the front door of hospitals can enable people referred to or presenting at hospital with relevant conditions to be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

How will we support health and social care systems to achieve this goal?

- We will work with organisations to ensure they implement same day emergency care (SDEC) services so that they support 100% of type 1 emergency departments, allowing for the rapid assessment, diagnosis, and treatment of people presenting with certain conditions, and discharge home same day where clinically appropriate, twelve hours a day and seven days a week – by April 2025. This will be supported by around £10m new recurrent revenue investment, and around £6m in capital funding for equipment and estate changes. This will include just under £1m recurrent funding for three years to support ambulatory emergency care and immunotherapy services delivered to people suffering from complications of cancer by Velindre NHS Trust.
- The Strategic Programme for Primary Care will oversee development of a number of 'step-up' intermediate care pathfinders towards design of a consistent national step up model. This is part of wider work to develop an effective community infrastructure model for or Intermediate Care based upon the principles of 'right sizing' community services. This, alongside the development of urgent primary care services, starts to build a wider range of primary and community care services, the planning of which will be undertaken at pan cluster planning level as set out in the Accelerated Cluster Development work.

- Establish and embed access to 'speciality advice and guidance' telephone lines to immediately link health care and allied health professionals with specialist advice to deliver appropriate action based on a person's needs. This may include alternatives to referral and admission to hospital where clinically safe.
- The Emergency Ambulance Services Committee will oversee a delivery plan that will include focus on rapid delivery of alternative pathways and community-based solutions to safely reduce avoidable conveyance to emergency departments.
- We will work with organisations to review and, where necessary improve, mental health liaison services, NHS crisis services for adults and children, community crisis cafés.

How will we measure success?

Measures to determine how successful the health and social care system has been in enabling people to to safely avoid admission to hospital are under development.

Affiliated work to develop a measure of the 'time spent at home' by older /frail people' is underway through the Strategic Programme for Primary Care.

The resolution of the challenges experienced by Health Boards in recording and reporting same day emergency care activity will be a priority for 2021-22 to support measurement for improvement, and will include measures of service user experience.

Goal 4:
Rapid response in a physical or mental health crisis

The fastest and best response provided for people who are in imminent danger of loss of life; are seriously ill or injured; or in mental health crisis.

Quality statement

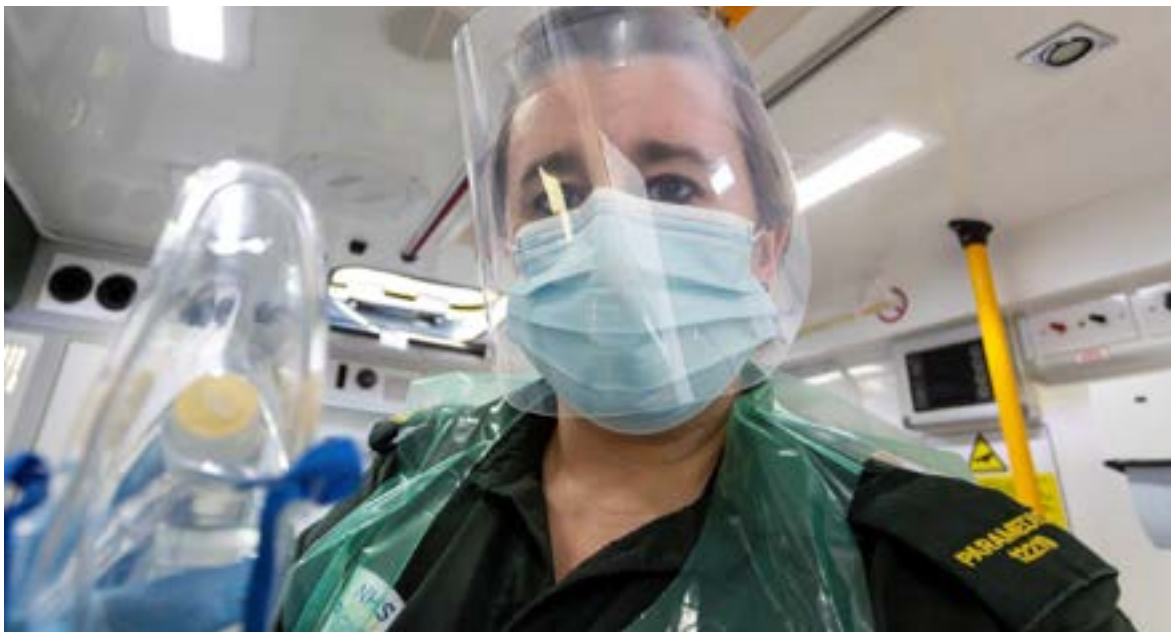
People with mental health and emotional distress will receive a coordinated response from services across the urgent and emergency care pathway. This should seamlessly link:

- in-hours and out-of-hours primary care
- emergency ambulance services
- Emergency Departments
- Police
- mental health liaison
- NHS crisis services; and
- Crisis cafes and sanctuaries.

People dialling 999 with non-time critical presentations are referred to alternative community, mental health single points of access or direct access hospital pathways, or safely discharged over the telephone following a secondary clinical assessment.

People who have dialled 999 for an emergency ambulance and are in imminent danger of loss of life or limb, have a time sensitive injury or illness or require palliative care receive the fastest and best type of response commensurate with their clinical need. They are transported/referred to the best direct access pathway based on clinical need, as quickly as possible.

- Defibrillators are readily available and accessible to the public who are aware defibrillators are easy to use and can do no harm.
- Those arriving by ambulance at a hospital facility should be transferred safely from ambulance clinicians to the care of hospital clinicians in order of clinical priority and always in a timely manner (an hour at most).
- People who have accessed care in an Emergency Department (and the wider hospital) will find suitable environments and proactive processes to greet them. On arrival, there will be quick identification of whom the patient is, why they have attended and, following triage, what the next step in their care should be. Wherever possible, this will occur within 15 minutes of arrival, with an assessment by a senior decision maker complete within an hour.
- People suffering with acute complications of cancer or its treatment are able to bypass the Emergency Department, where appropriate, and quickly access an acute oncology service for appropriate specialist input to facilitate urgent assessment and rapid initial management.
- Ambulance clinicians will develop necessary end of life assessment and support skills to deal with difficult conversations, administer appropriate medications and support family/carer concerns.
- When people are ready to leave the Emergency Department, there will be effective arrangements in place to provide continuity of care with the minimum of delay, including returning home with support and timely admission to a hospital bed, when that is the right next stage in the person's care.



Why is this good for service users?

Emergency ambulance services, mental health crisis response and Emergency Departments are a core and essential part of the urgent and emergency care system. Delivering the best possible, quickest and most appropriate response for people who are in physical or mental health crisis is a priority to optimise survival rates and clinical outcomes.

However, emergency care is not always delivered by health practitioners and we can improve outcomes for people in cardiac arrest through involvement and engagement with the public.

The UK average shows less than 10% of people survive a cardiac arrest for which the major determinant of outcome is time to treatment. The sooner effective Cardio Pulmonary Resuscitation (CPR) is started, the better the chance of survival because for every minute delay, a person's chances of survival fall by 10%[5]. If a defibrillator is readily available, people are six times as likely to survive[6].

A timely initial response and referral to the right place, first time for a number of other time sensitive complaints – such as stroke, STEMI (a type of heart attack) and fractured neck of femur (hip) can also result in improved clinical outcomes in addition to a more positive experience. Evidence from the 'Amber Review' (2018) has shown getting people to the right ward, first time, has beneficial outcomes and that people should be seen by a senior clinical decision maker as soon as possible.

Timely handover of care from ambulance clinicians to hospital clinical staff improves service user experience[7], and improves ambulance availability for other people awaiting a response in the community.

A mental health and/or welfare crisis describes any situation in which an incident related to public safety or individual welfare prompts a call to emergency services and is linked to a person's mental health or wellbeing. The person may be:

- at immediate risk of harming themselves or others;
- an immediate risk of being unable to adequately care for themselves or be cared for within existing support structures, or function safely in the community; and
- where there is an identified trigger or vulnerability associated with their diagnosed mental health condition, or other social, emotional or clinical situation.

The individual in crisis will benefit from a rapid, flexible, person-centred response from health services, tailored around strengths and assets available individually or within the family unit which encourages long term self-management.

5. British Heart Foundation Data cited by Welsh Ambulance Services Trust (2019)
6. References: *Welsh Ambulance Services Trust (2019) – Innovative App a potential game changer in cardiac survival across Wales* https://www.ambulance.wales.nhs.uk/Default.aspx?gcid=1557&pageId=2&lan=en
7. Amber Review: A Review of Calls to the Welsh Ambulance Service Categorised as Amber (2018)

How will we support health and social care systems to achieve this goal?

- A national programme has been established to explore how NHS and fire and rescue services (FRS) services can work effectively and collaboratively to increase response capacity for individuals in the red (immediately life threatened) category.
- Increasing CPR education and investment in defibrillators to optimise outcomes from out of hospital (OOH) cardiac arrest. £2.5m of Welsh Government funding has been allocated over the next three years to enable Save a Life Cymru to raise awareness about the cardiac arrest chain of survival and fund new educational and training resources, including improving public access to defibrillators
- Establish 'call-to-door' measures for time sensitive complaints like stroke to enable improvement.
- The Emergency Ambulance Services Committee will oversee an increase in available response capacity to enable improvements in responsiveness for people with time-sensitive complaints. A delivery plan will also identify actions to safely reduce conveyance of people to Emergency Departments and establish improvement plans for each Health Board area. A long term strategy will be established for remote clinical support, with the procurement and implementation of an enhanced clinical assessment system for the 999 clinical contact centres
- A 24/7 mental health single point of contact in each Health Board will offer triage, assessment, support and signposting those with an emotional or mental health need. The service will be staffed by trained and compassionate mental health professionals. Although this service will focus on promoting self-resilience and health coaching it will also offer brief interventions and, if necessary, access to secondary mental health services.
- Electronic Patient Clinical Records (ePCR) that enable access to medical history and medicines to facilitate electronic handover and transfer of key information into a person's hospital and GP records will be implemented in 2021/2022.
- Nationally and clinically designed Emergency Department care standards and operational arrangements for ambulance patient handover and clinical triage will be implemented by Health Boards, supported through the Emergency Department Quality and Delivery Framework programme.
- We have implemented an 'Emergency Department Wellbeing and Home-safe' service, delivered by the British Red Cross at all Emergency Departments in Wales. This service aims to improve both patient flow and the patient experience at Emergency Departments. British Red Cross staff are present throughout the day in departments, providing support to members of the public and supporting, where appropriate, individuals to return home. The service aims to resettle and connect people with other community services once they have returned home from hospital.
- We are working with St John Ambulance Cymru to trial support vehicles for people who have experienced mental health crisis and need rapid transport to the right setting for further assessment or care. The service has exceeded 400 journeys since implementation in February 2021 and negated the need for emergency ambulance journeys for those conveyed. The average response time of the vehicles is currently around one hour which prevents continued patient anxiety and distress and permits other mental health professionals and police officers from having to wait very long periods on scene. This project has been expanded from covering south West Wales to all of Wales from September 1 2021. This service will be evaluated and if it improves patient experience and outcomes then this, or a similar service, will be procured and placed on a sustainable footing from 2022.
- Quality statements published for the care of the critically ill[8], stroke[9] and heart conditions[10], and should be considered alongside each of the six goals.

8. https://gov.wales/written-statement-quality-statement-care-critically-ill https://gov.wales/care-critically-ill-quality-statement
9. https://gov.wales/quality-statement-stroke-html
10. https://gov.wales/quality-statement-heart-conditions-html

How will we measure success?

For emergency ambulance response, the Emergency Ambulance Services Committee delivery plan and its associated milestone and outcome measures will form the basis for measuring progress and improvement in subsequent years.

Measures will include ambulance availability and achievement of national and internal targets. Outcome measures for service users will be developed along with satisfaction/experience measures. In particular, it will be expected that there will be a reduction in long waits not covered by response targets.

In regard to care in Emergency Departments, existing work on experimental measures developed through the Emergency Department Quality and Delivery Framework will be extended to consider service user experience and timeliness of continuity of care for people who need to be admitted to hospital.

For mental health, the interventions and support given to a person experiencing a crisis of their mental health should be based on the values of empowerment and promote and protect social inclusion, community integration, hope, positive identity and meaningfulness.

We would expect to see a reduction in numbers of people attending emergency departments and contacting ambulance and the police services through 999 for non-emergency mental health issues. We would also expect to see a reduction in high intensity users of 999 and GP services for emotional health issues.

Goal 5:
Optimal hospital care and discharge practice from the point of admission

Optimal hospital based care is provided for people who need short term, or ongoing, assessment or treatment for as long as it adds benefit to outcome, with a relentless focus on good discharge practice

Quality statement

People admitted to hospital should be treated consistently and reliably in line with the expectations of health, social care, third and independent sector partners in Wales as described in Welsh Government Hospital Discharge Requirements guidance.[11]

People admitted as an emergency to a hospital setting should:

- Be reviewed by an appropriate consultant as soon as possible after admission. This should be no later than 14 hours from the time they were admitted to hospital. Frailty assessments should be completed where required on admission.
- Should have a reconciled list of their medications within 24 hours of their admission.
- Be fully involved in and informed of plans for their treatment, recovery and discharge from hospital. They should have answers to four key questions on a daily basis: what is the matter with me? What is going to happen to me today? When am I going home? What is needed to get me home?
- Have a structured patient handover during transitions of care, with a focus throughout on return to home as soon as they are clinically fit to leave.
- Have a patient care plan that includes active intervention to avoid deconditioning, maximise recovery and support independence throughout their hospital stay.
- Have access to rehabilitation regardless of condition and ward to which they are admitted; available immediately upon admission, or as soon as the person is medically able to participate to accelerate recovery and reductions in side effects.

11. https://gov.wales/sites/default/files/publications/2020-04/COVID-19-hospital-discharge-service-requirements.pdf

Frail and vulnerable people, including those with disabilities and mental health problems of all ages, should be managed assertively but holistically (to cover medical, psychological, social and functional domains) and their care transferred back into the community as soon as they are medically fit, to avoid loss of ability to self-care.

The person's consultant is responsible for deciding when they are clinically ready to move on from an acute phase of their care, and agrees an 'individual clinical criteria for discharge' to enable return home even if the consultant is not present.

People who are eligible for discharge through Non-Emergency Patient Transport Services will receive safe, timely and comfortable transport to and from their destination, without detriment to their health. They are treated with dignity and have their religious and cultural beliefs respected. Where people are at a hospital ward or department, the Health Board will ensure they are ready to leave at the time they notify the transport provider of readiness to travel.

Why is this good for our service users?

While admission to a community or acute hospital bed is the right thing for some people, evidence has shown that many people who are older and living with frailty or co-morbidities leave hospital less mobile and independent than when they were admitted. Many also lose confidence and the ability to care for themselves very quickly, when they are away from their familiar surroundings.

When hospitalisation is required, treating individuals' acute symptoms promptly and then enabling them to be supported back to their own home is vital. Delivering an optimal hospital stay in which people stay no longer than necessary and are discharged home, or to the most appropriate setting for their needs, at the earliest safe opportunity improves experience and outcomes and avoids deconditioning as a result of an extended hospital stay.

How will we support health and social care systems to achieve this?

We have issued national hospital discharge service requirements for health, social care, third and independent sector partners. We have also issued supporting guidance – SAFER guidance[12] that should optimise outcomes if delivered consistently and reliably. SAFER comprises the following five principles:

- **Senior review:** all patients are to have a senior review before midday.
- **All patients** and their families will be involved in setting an Expected Discharge Date.
- **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards.
- **Early discharge:** More than 33% of patients will be discharged from inpatient wards before midday on their day of discharge.
- **Review:** a systematic multi-disciplinary team review, is undertaken, including patients and their families, for those with extended lengths of stay (>6 days) with a clear 'home first' mind-set.

The SAFER concept is proven to have benefit for individuals and the wider hospital system. Where implemented effectively by well-led teams and communicated clearly to staff enabling them to fully understand all elements, hospitals have seen real benefits to patient outcomes and staff satisfaction. Hospital crowding reduces, Emergency Departments decongest, mortality falls, harm is reduced and staff feel less pressured.

A new transformational programme has also been established to support the effective delivery of goals 5 and 6, and will incorporate support for the delivery of the quality statements within these two goals including the implementation of hospital discharge requirements and SAFER patient flow guidance – or a version that works well at a local level - supported by strong multi-professional working. Initial action will focus on:

- Developing a demand and capacity model.
- Establish what a "good day" looks like, via a modelling tool for each acute and community hospital in Wales to inform plans and capacity requirements.
- Developing a three-year Transformation Plan to describe how hospital care for people admitted as an emergency, discharge practices and 'Home First' principles will be optimised, including key milestones and outcomes.

12. https://nccu.nhs.wales/urgent-and-emergency-care/safer/

The plan, which will be developed by health and social care teams, will focus on delivering improved quality and patient safety. It will focus on system-wide integration and seek to deliver the capacity required as per the modelling undertaken and will include:

- policy changes required (if any)
- commissioning changes required (if any)
- service changes required
- workforce requirements
- efficiencies/Investment required
- digital enablers; and
- stakeholder, public engagement and communication.

How will we measure success?

Our national hospital discharge service requirements and the SAFER concept provide a clear framework against which progress can be measured through indicators for each principle. We will also co-design, with clinicians and professionals, key metrics to measure system flow against which delivery and performance will be measured. These metrics will be patient safety and outcome focussed.

Goal 6:
Home first approach and reduce risk of readmission

People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes and experience, and to avoid deconditioning.

Quality statement

People who require additional support on discharge should be transferred from hospital onto the appropriate 'discharge to recover then assess pathway' (usually back to their normal place of residence) within 48 hours of the treatment of their acute problem being completed.

Integrated health and social care teams should respond in a timely manner to ensure support systems are safely in place to respond to a person's needs on discharge. Effective care coordination must be in place to ensure that, once recovery and assessment is complete, transfer to onward care arrangements is timely and seamless.

Programmes are in place to help people develop the knowledge, skills and confidence to manage their physical and mental health, access the support they need, make any necessary changes and be better prepared for any deterioration or crisis.

All patients on mental health or learning disability wards with admissions longer than 90 days must have a clear discharge plan in place. All patients cared for in specialist services outside of NHS Wales will have a repatriation plan in place.

Why is this good for our service users?

We have actively developed a Discharge to Recover then Assess (D2RA) model since 2018, recognising that the acute hospital setting does not provide a suitable environment for recovery and assessment for ongoing needs. D2RA is an active recovery model, with the 'Home First' ethos at its heart, and is designed to:

- focus on what matters to the individual, maximising recovery and independence
- minimise exposure to in-patient infection risk and avoid deconditioning; and
- provide a seamless transfer to longer-term support in the community if required, using a strengths-based approach and reducing over-prescription of statutory services 'to be on the safe side'.

Successful implementation will improve outcomes for service users and support effective 'whole system flow', enabling optimal hospital care for those who need it.

How will we support health and social care organisations to achieve this goal?

- Investment of monies from the Integrated Care Fund has pump primed and continues to support the implementation of D2RA pathways across Wales. Consistently delivering the four D2RA pathways[13], in alignment with *What good looks like* guidance, will facilitate timely discharge from hospital. It will also support individuals to remain safely at home in their communities, potentially avoiding future admissions.
- Health, social care, third and independent sector partners across Wales are actively engaged in implementing the D2RA pathways and a comprehensive interagency programme of work is in place to support implementation with three key areas of focus:
  1. Right Community Services (developing and right-sizing the infrastructure required to deliver the model)
  2. Right Mind-set and processes (the culture shift and training required to further embed the Home First/D2RA ethos into hospital discharge processes and beyond); and
  3. Continuous Improvement (monitoring, evaluation and shared learning).
- The National Rehabilitation Framework[14] identifies areas where people may need support to tackle lost confidence and independence and reduced activity and social connections. Rehabilitation services can help by providing personalised physical or mental care and support to enable people to reduce anxiety or regain lost skills, confidence or condition from reduced activity and fitness regimes, or lost social contact, employment and relationships.
- We are funding a two year HEIW delivered programme of work described in the Allied Health Professions (AHP) Framework: 'Looking Forward Together.' Part of the programme includes funding two Clinical Fellows, a National Clinical Rehabilitation lead and a Clinical Public Health Lead to engage the profession, review and update to The National Rehabilitation Framework, develop quality statements and drive transformation.

13. https://gov.wales/hospital-discharge-service-requirements-COVID-19
14. https://gov.wales/rehabilitation-framework-continuity-and-recovery-2020-2021-html

How will we measure success?

A reporting mechanism to capture data against five key D2RA measures, providing baseline data pan Wales for the first time, is currently under development. In addition to this quantitative evaluation, a qualitative review will be undertaken via self-assessment against the principles and standards set out in the 'what good looks like' guidance for D2RA.

The five key measures seek to understand how health, social care, independent and third sector organisations are working together to increase the number of people transferred to the right place following admission to hospital, preferably their usual place of residence, within 48 hours of the decision about the next stage of their care being made. They also focus on how successful teams are at increasing the proportion of people leaving hospital on a discharge to recover then assess pathway, and with a co-produced personal recovery plan. This is also expected to increase to help prevent readmission.

This approach will be used to monitor and evaluate progress with implementation of the D2RA model on an ongoing basis to support continuous improvement and evolution of the model, in response to learning in practice.

References

Amber Review: A Review of Calls to the Welsh Ambulance Service Categorised as Amber (2018)

British Heart Foundation Data cited by Welsh Ambulance Services Trust (2019)

Picker Institute (2020) Welsh Perceptions of Urgent and Emergency Care

Welsh Ambulance Services Trust (2019) Welsh Ambulance Service NHS Trust – *Innovative App a potential game changer in cardiac survival across Wales*[15]

Beyond the call (2020) A national review of access to emergency care services for hose experiencing mental distress and/.or welfare concerns

15. https://www.ambulance.wales.nhs.uk/Default.aspx?gcid=1557&pageId=2&lan=en

Appendix 1

Challenges for urgent and emergency care

An ageing population, often with multiple co-morbidities, who have greater need for access to hospital and ongoing care

- The population over 65 is projected to grow by 27% by 2040[16].
- Admissions for over 85s increased by 9.8% between 2013/14 and 2019/20.
- Over 70s account for around 51% of ambulance incidents to receive a response[17].
- The majority of people in hospital and using community services is over 75[18].
- 35% of over 70-year-olds experience functional decline during hospital admission (compared with a pre-illness baseline); for people over 90 this increases to 65%[19] resulting in poorer outcomes and increased likelihood of further admissions.
- The numbers of people with dementia in the UK are predicted to rise by up to 35% by 2025 and 146% by 2050[20].
- 60% of people admitted to hospital as an emergency have one or more long-term health conditions such as asthma, diabetes or mental illness[21].

Workforce, training and education challenges and opportunities

As with the whole system the challenges are:

- fewer people of working age, and an ageing workforce
- greater demand for both flexible working patterns and part-time working to reflect a desire for work/life balance
- skills shortages in some specialist areas, with vacancies in some professions and gaps in medical training rotas being a common occurrence in Wales
- remote and rural challenges with respect to training, recruitment and retention.

In line with the Workforce Strategy for Health and Social Care the opportunities are:

- increased interest in NHS and public sector careers as a result of the pandemic, with a projected growth in healthcare education and training numbers for the next 5 years
- opportunity to develop new 'prudent in practice' workforce models with associated opportunities for career development to train, attract and retain the Welsh health and care workforce
- accelerated move to digital training and new ways of agile working in a digital service as a result of the pandemic

16. Source: Stats Wales
17. Source: WAST
18. Source: Patient Episode Data for Wales (PEDW)
19. Source: NHS Improvement data cited in CHS Healthcare (2019)
20. Alzheimers' Research UK Dementia Statistics Hub
21. Health Foundation (2018) Briefing: Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions

- new education and training developments to support new service models. Encouraging multi-professional working, skills development and extended practice
- underpinned by a strong wellbeing offer and compassionate leadership.

A complex system

- The urgent and emergency care system and the interactions people have with services – and where they transition following that interaction – is complex.
- A lack of continuity when individuals transition between services can potentially have a negative impact on the ability of other staff and services to provide timely access and quality care to patients.
- The complexity of the urgent and emergency care system is compounded by the interactions with individuals' associated requirements for planned care and the workforce challenges experienced across the health and care sector.

Longstanding cultural challenges

- 60% of assessments and/or therapy could take place out of hospital; the remaining 40% could have been completed in parallel with other steps[22] (Newton, 2017).
- 40% of emergency admissions of care home residents could be avoided[23].

A whole system response is required to overcome these challenges. Primary, community, social, ambulance and hospital care services must work seamlessly together to provide the right care, first time to support the best possible experience and outcomes for people who need urgent or emergency care.

What matters to people who have used urgent and emergency care in Wales?

A survey of people in Wales[24] (Picker, 2020) told us that the most important thing for people when they need urgent or emergency care was to receive the right treatment to manage their illness/injury and prevent future problems.

The findings of the survey align to views of the Welsh public when asked about their recent experiences of urgent and emergency care services, with the following consistent themes regarding what matters to them when they need to access urgent or emergency care:

- being clearly kept informed about their care throughout;
- having a timely initial assessment, even if this means waiting for treatment;
- being given medicine to help control pain where necessary;
- being told how long they can expect to wait for the next stage of their care; and
- being treated and to go home quickly.

22. Newton Europe (2017) Why not home? Why not today?

23. Source: Improvement Analytics Unit (NHS England and Health Foundation) 2019

24. Picker Institute (2020) Welsh Perceptions of Urgent and Emergency Care

Appendix 2

Feedback from staff involved in the delivery of urgent or emergency care

Views were sought from frontline staff and professional bodies through surveys and engagement sessions about existing challenges and opportunities to improve access to, and delivery of, urgent and emergency care services:

"Despite ongoing education the public do not always take advantage of the full range of services available to them – there is still a concept of being 'cheated' amongst many people if you do not get to see a doctor in hospital who prescribes you something when you are ill."

"There should be a shared and existing knowledge of a person so we don't need to keep repeating the same stories over and over and more support in the community for people to stay at home. A more holistic approach is needed – no point healing me after a fall if I still have no way of living at home safely"

"Allowing people to discuss their individual worries, values and preferences for their care could significantly improve people's experiences of care at end of life."

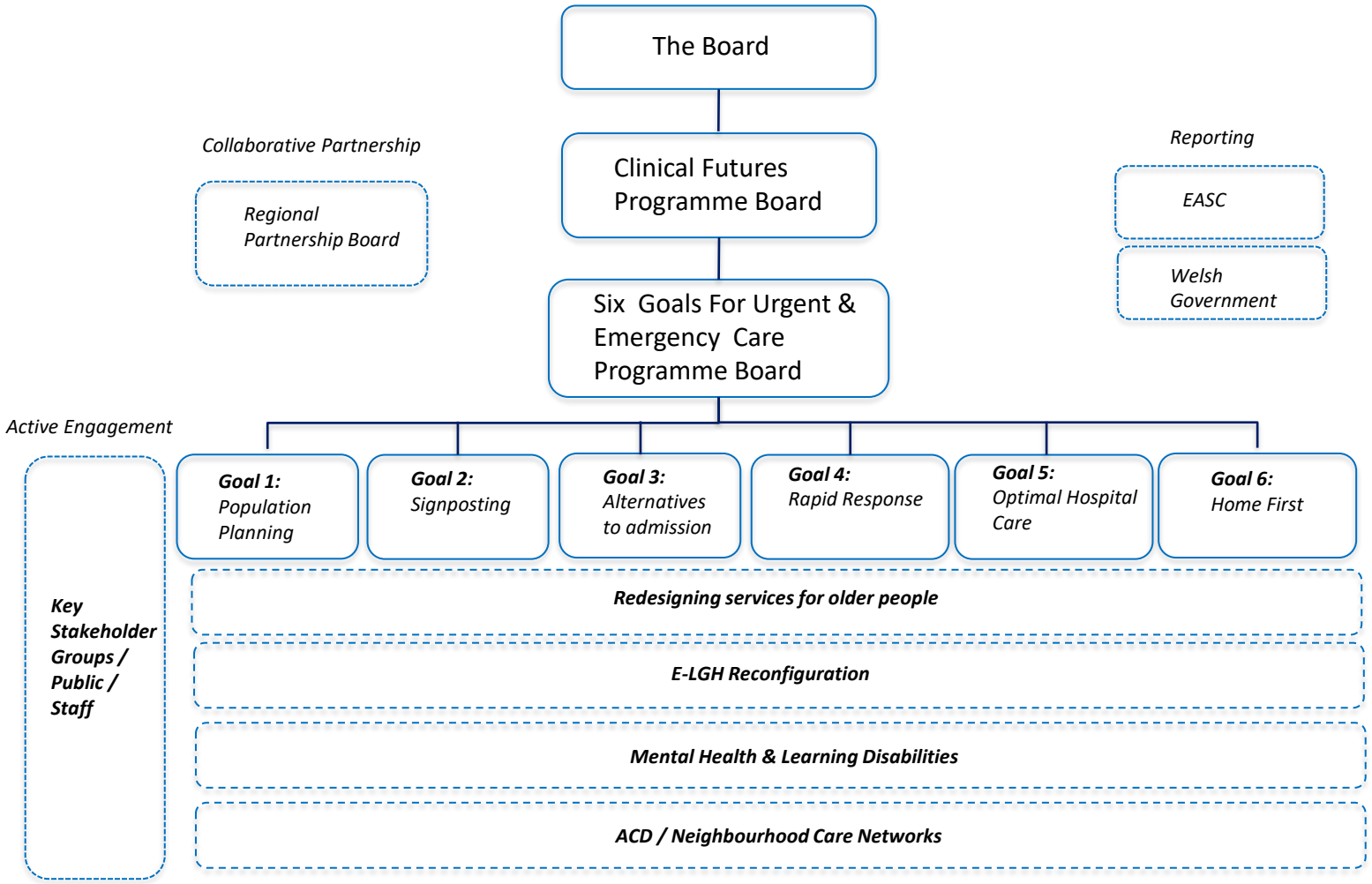
"There is a lack of patient flow through the hospital meaning it is difficult to give necessary treatment to the most needy, including elderly patients. 'Exit Block' then occurs when patients cannot be moved in a timely manner to a hospital ward because of a lack of available hospital beds. There is insufficient workforce in the right areas to match demand and a lack of future planning for the workforce."

"The majority of discharge services largely operate during the working week and are scarce during the weekends because of a lack of community capacity to support people at home."

"Health Boards should develop more reliable and rapid ways of primary care accessing expert clinical advice from secondary care physicians to enable patients to be stabilisedin the community. When patients do present in the unscheduled care system, early review by a specialist is invaluable. Admissions should be triaged as early as possible to ambulatory and non-ambulatory streams in both medical and surgical specialties"

Six Goals Programme Plan
June 2022

Six Goals Programme Governance



- *The Six Goals programme board represents ad evolution from the former 'Urgent Care transformation board'*
- *Collaborative Partnership via the Regional Partnership Board is critical to success*
- *Six Goals has interdependencies with a number of other IMTP priority programmes in Particular 'Redesigning services for older people'*
- *Six Goals requires significant engagement with key stakeholder groups, the general public and staff via local and national communications teams*
- *The Programme Board membership includes Local Authority, WAST and Delivery Unit partners*

Six Goals Programme Leadership

Programme Leadership

Role	Lead
Executive Co-Chair	Leanne Watkins
Executive Co-Chair	Chris O'Connor
SRO	Neil Miles
Programme Lead	Simon Roberts
Clinical Lead	TBC
Regional Analytics	TBC
Local Analytics	Ben Carini
Local Analytics	Jennifer Keyte

Goal Leadership

Goal	Management Lead	Clinical/Professional Lead
1: Population Planning	**William Beer,** Assistant Divisional Director, PCC	**Dr Graeme Yule**, NCN Lead
2: Signposting	**Rebecca Pearce**, Senior Programme Manager, UPC	**Dr Alice Groves** Clinical Director, UPC / **Dr Alun Walters** Clincal Director, Primary Care
3: Alternatives to Admission	**Paul Underwood,** General Manager Urgent Care	**Dr Paul Mizen**, Divisional Director, Urgent Care
4: Rapid Response	**Steve Bonser**, Transformation Lead, facilities	**Dr Alastair Richards** , Clincal Director, ED
5: Optimal Hospital Care	**Sandra Mason**, Assistant Director, PCC	**Sue Pearce** , Divisional Nurse, Unscheduled Care
6: Home First	**Mel Laidler**, General Manager PCC / Social Care Lead (TBC)	**Collette Kiernan,** Clinical Director , Therapies

- *Triumvirate funding not yet received*
- *A social care lead has also been proposed to enhance partnership approach*

Six Goals Programme Highlight Report
June 2022

Goal	Goal Priorities	Short Term Next Steps
1. Population Planning & Prevention	High intensity users, High Risk Adult Cohort (HRAC), Falls prevention/pathways,	- Review the service structure and support for High Intensity Service Users (HISU) - Segment the HISU Data
2. Signposting	Urgent Primary Care Centres redirections GP+, Integrated Front Door model, 111 Option 2, WAST Remote support	- Review the clinical criteria for 111 referrals to Emergency Department (ED) - Scoping exercise for UPC at GUH
3. Safe Alternatives to Admission	Same Day Emergency Care (SDEC) (GUH/eLGH/Specialities), Scheduled slots, Flow centre, Virtual advice	- SDEC Phase 1 launch August 22 - Scheduled MAU slot pilot June 22 - Begin process for FC staffing model review
4. Rapid Response	Handover, EDQDF, Physician Response Unit, Mental Health Crisis response, E-triage / Symphony, ED Referral Improvement	- Review other HB handover processes and role profiles - Engage WAST and if required develop PRU business case
5. Optimal Hospital Care	Discharge pathways, Safer principles, MDT Board rounds, system flow, Amber CEPOD	- Attend the DU led discharge workshop and Schedule local workshop - Refine the requirements for Amber CEPOD business case
6. Home First	Front Door Therapy services, Commissioned service for Medically Fit for Discharge (MFFD), Step closer to home, D2RA ethos, Direct Access pathways, home first	- Progress Front Door Therapies SBAR - Progress CFFD close to home options appraisal

Summary Position

- First Board held on 21st June
- Positive engagement across partnership
- Initial Programme Plan submitted to WG 30th June
- Follow up review on IQPD 4th August
- Care needed to manage governance of cross linking programmes i.e RSOP
- Broader Comms plan to follow (Local and National)
- Working with putting it right team to include patient experience feedback

Six Goals Programme Plan – Goal 1 Population planning, prevention

Overall Objectives:

- Reduce high intensity use of UEC
- Identification of high risk adults
- Develop sustainable methods of early intervention
- Improve falls pathways

Goal Leadership:

- Will Beer
- Dr Graeme Yule

Measurable Outcomes:

- Reduction of high intensity use
- Number of early intervention contacts
- Reduction in number of attendances due to falls

Project	Status	Timeline	Risks
High Intensity Users	- Share learnings from key contributors - Re-energize work to identify those users and develop intervention steps - Business case for a 'corporate service'	TBC	- Multi agency approach
High Risk Adult Cohort	- Initial work started in Blaenau Gwent and Torfaen, with Third sector support - Aim to measure outcomes and agree forward plans - Links to Redesigning services for Older People (RSOP) Programme	TBC	- Requires significant partnership - Difficult to measure outcomes
Falls Prevention / Pathways	- Pathway under review –links to RSOP programme	TBC	- Requires significant partnership - Difficult to measure outcomes

Projects under other governance:

- Preventing unintended Injuries – Public Health
- Promoting health Ageing Activities – Public Health
- Social Prescribing
- Substance misuse

Investment Requirements:

Six Goals Programme Plan – Goal 2 Signposting

Overall Objectives:

- Devlopment of UPCC
- Increase number of UPC contacts
- Develop 111 pathways
- Increase public awareness

Goal Leadership:

- Dr Alice Groves
- Dr Alun Walters
- Rebecca Pearce

Measurable Outcomes:

- 111 Call Volumes / Abonnement rate
- UPCC Contacts
- Re-directions
- GMS activity

Project	Status	Timeline	Risks
Public Communications and Engagement	- Linking to Nye Bevan Champions forum (Third Sector) - Linking to large local employers - Start local and national messaging campaign	- On-going - Pre-Winter 22	
Urgent Primary Care Centres (UPCC)C 24/7 Development	- In-hours Primary Care escalation - Re-directions review of outcomes - GP+ (Access to diagnostics etc) - Ensuring pathway consistency	- On-going - TBC	- Continued Recruitment - Different ways of working
Integrated Front Door model	- Neville Hall Implement Feb 22 (Possible future development) - YYF established - RGH continued work on-going - Scoping Exercise for UPCC at GUH	- Implemented - On-going - August 22	- Organisational structure
Think 111	- Develop working group to review TOR and risk associated with criteria - Development of MH services via option 2	- August 22 - TBC	- Clincal risk (Direct to ED Criteria)
WAST Remote Support	- Initial process Commenced May 22 - Professional support out of hours	- On-going - On-going	

Projects under other governance:

- 111 Programme
- GMS / NCN signposting – ACD

Investment Requirements:

Six Goals Programme Plan – Goal 3 Safe Alternatives to Admission

Overall Objectives:

- Develop secondary care SDEC services
- Develop additional channels to deliver specialist advice
- Find a sustainable model for the flow centre
- Increase the proportion of scheduled demand

Goal Leadership:

- Paul Underwood
- Dr Paul Mizen
- Kate Fitzgerald

Measurable Outcomes:

- Assess-out Rate
- FC Admission avoidance
- % Referrals to SDEC from FC
- % Referrals to SDEC from ED
- % Referrals to a schedule slot

Project	Status	Timeline	Risks
SDEC GUH & eLGH	- SDEC GUH Phase 1 Go-live August 22 (Acute Med/Gen Surgery GP Referral) - SDEC GUH Phase 2 (Acute Med/Gen Surgery ED Streaming) - YYF Staffing SBAR Submitted for 22/23	- August 22 - Early 2023 - TBC	- ACP Staffing / CEPOD Capacity - ACP Staffing / CEPOD Capacity - Funding Required
Speciality SDEC	- Respiratory Ambulatory Care Unit (RACU) Established – funding required to sustain - Speciality Utilization of SDEC GUH Footprint	- Implemented - 2023	- Continued RACU funding
Scheduled AMU Slots	- Pilot planned in June 2022	- June 22	- Status of D1 West
Flow centre Development	- New Pathways – Including over 75 Pilot and maintenance of existing pathways - Staffing Model – Board Level discussion required for the next phase	- August 22 - TBC	- Clinical Risk review required
Virtual Advice	- Build on existing Virtual service offering i.e Cardio - Consultant connect utilization - Develop and share a directory of services	- 2023	- Speciality Capacity

Projects under other governance:

- Health Pathways – ACD
- EFU / Rapid Access Clinics – RSOP
- Right sizing primary / community Care - ACD

Investment Requirements:

- SDEC Staffing at YYF
- Sustaining RACU Services

Additional comments:

- SDEC Workshop 19th July

Six Goals Programme Plan – Goal 4 Rapid Response

Overall Objectives:

- Reduce Ambulance handover time
- Develop admission avoidance processes i.e PRU
- Implement improvements to referrals process
- Ensure sustainable Mental health crisis response

Goal Leadership:

- Dr Alastair Richards
- Steve Bonser
- MHLD Representative TBC

Measurable Outcomes:

- ED waits > 12 hours
- Bed available from Request
- Triage time
- Time to be seen by first clinician
- Ambulance lost hours
- Handover > 1 hour

Project	Status	Timeline	Risks
EDQDF (Handover etc)	- HALO role under review - Review of SBUHB role profiles - Escalation and action card development	- On-going	- Flow limitations - Parameters of local variation - PM Role
Emergency Department (ED) Referrals Process Improvement	- Task and finish group to be established	- Sept 2022 (pilot)	- Referral governance
Physician Response Unit Business Case	- Staffing has been modelled, requires joint priority discussion between HB and WAST	- TBC	- Vehicle availability
Consultant Rapid Assessment	- Requires investment in Medical staffing & Assessment space	- On hold	- Medical staffing - Assessment Space
Triage Improvement	- EDQDF Measures - Patient & Family communication	- On-Going	
Mental Health Crisis response / Sanctuary	- Peer mentors in place, Sanctuary in place from crisis team	- On-Going	

Projects under other governance:

- Clinical Triage – WAST
- Hear and treat – WAST
- Inverse model – WAST

Investment Requirements:

- Symphony / E-triage
- PRU Service
- PM Role

Six Goals Programme Plan – Goal 5 optimal Hospital Care

Overall Objectives:

- Reduce the number of people staying longer than 7 days
- Development and embedding of standard ways of working
- Clarity of pathways and roles & responsibilities

Goal Leadership:

- Sue Pearce
- Sandra Mason

Measurable Outcomes:

- Occupancy levels
- 7/10/21 Day LOS
- Discharge rate
- Net Bed turnover

Project	Status	Timeline	Risks
Discharge Pathways	- Scoping Session and assessment of bottlenecks - Criteria led path and measurement methods	- Sept 2022	- Consistency of delivery
Safer Principles	- Re-energizing, re-communicating - Work to adopt and embed	- TBC	- Cultural element of change
MDT Board Rounds	- Scoped at GUH, leverage across site (s) - Standardization / SOP	- TBC	- Sustainability
System Flow	- Pathways (1/2/3) embedding - Staff Hand book - Senior Review of 7/ 10 / 21 day LOS	- 2022	- Staff turnover
Roles & Responsibilities	- Clarity of 'swim lanes' - Delegation and Coordination - Discharge / Ward Team	- 2022	
CEPOD Amber capacity	- Develop options appraisal for additional capacity to support SDEC and improve SAU Patient experience	- 2022	- Additional funding - Impact to S/C lists

Projects under other governance:

- Community Hospitals Workstream - RSOP

Investment Requirements:

Additional comments:

- DU Workshop 5th 6th July

Six Goals Programme Plan – Goal 6 Home First

Overall Objectives:

- Embed D2RA as an Ethos
- Develop Home first service
- Provide clarity of community service offerings

Goal leadership:

- Mel Laidler
- Collette Kiernan
- Local Authorities – TBC

Measurable Outcomes:

- % of patients discharged with reablement support
- % of patients intercepted at front door
- Accessibility of community services
- Awareness of D2RA ethos and home first services
- Rapid access service admission avoidance

Project	Status	Timeline	Risks
Rapid Access service – RSOP	- Workshop end of June to define what this service should look like and deliverability	- TBC	
Front Door Therapy services	- SBAR for 5 day service front door GUH, to link with home service, BC to be submitted - Plan to develop to 7 day / 12 hour service	- 2022	- Investment required
Home First Service	- Vision and sustainability - Scope and model	- 2023	- Funding risk - Limited POC (Stop/Start nature)
Direct Access Pathways	- Transitioning community beds to direct access	- on-going	- Bed availability
D2RA as an Ethos	- Cultural element of work to embed as an ethos	- TBC	
Commissioned service for CFFD	- Working in partnership to provide a service - Identify Exec to link with LA's - Expand step closer to home pathways (HollyWard, slow stream medicine model)	- TBC	- Requires partnership approach

Projects under other governance:

- Community Hospitals Workstream – RSOP

Investment Requirements:

Additional comments:

- DU Workshop 5th 6th July

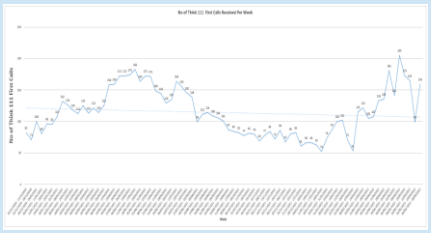
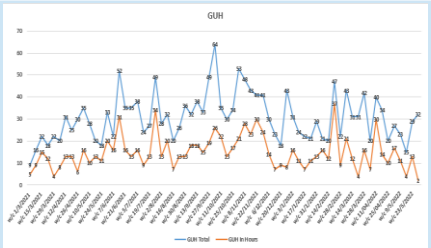
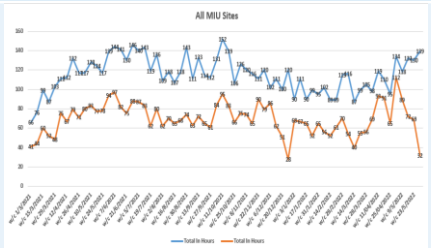
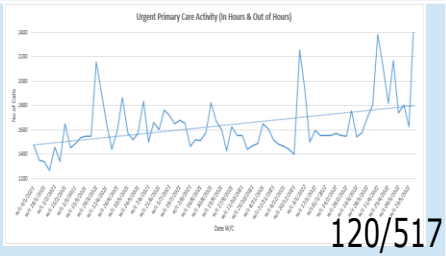
Six Goals Performance Monitoring

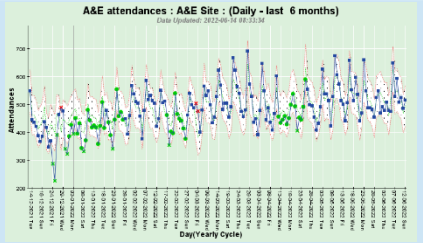
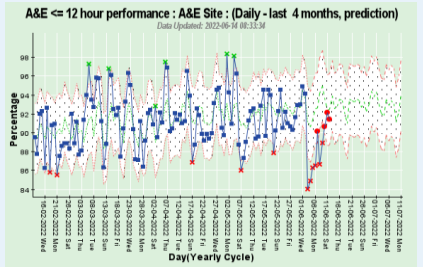
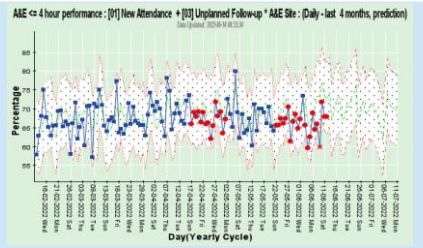
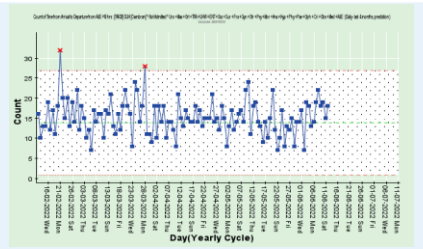
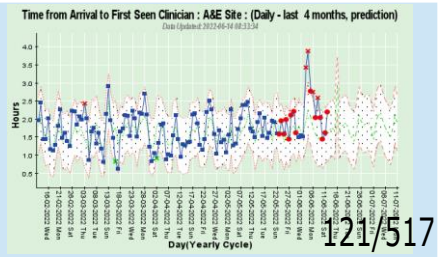
Key Highlights

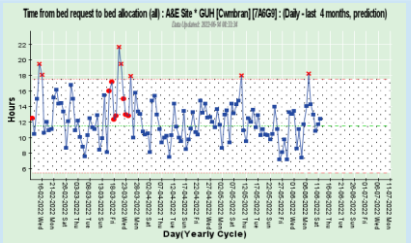
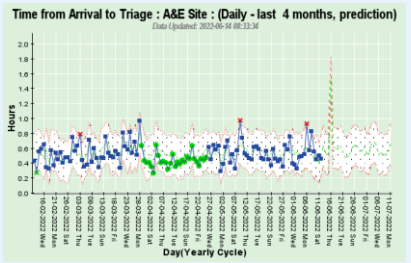
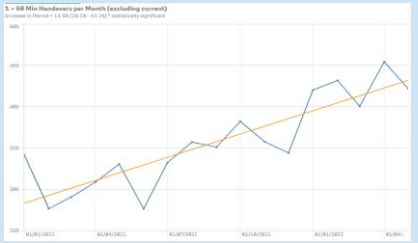
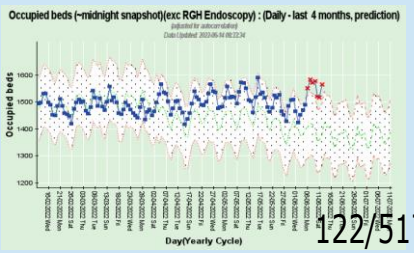
- *111 Call volumes and UPCC contacts generally increasing*
- *Total attendances to ED (GUH) average 260 per day, with peaks in excess of 300 per day which where we see extraordinary system pressures and peaks in associated KPIs i.e 4 hour performance / Ambulance handover*
- *Occupied beds with over 21 day length of stay generally increasing out of expected range. Currently across the Healthboard this count stands at 620 beds*
- *Number of patients on complex DTOC list increasing significantly in both acute and community*

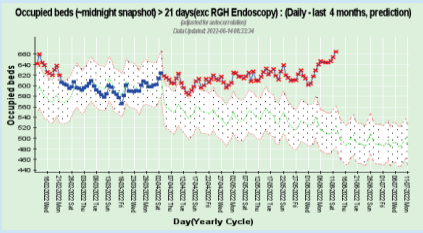
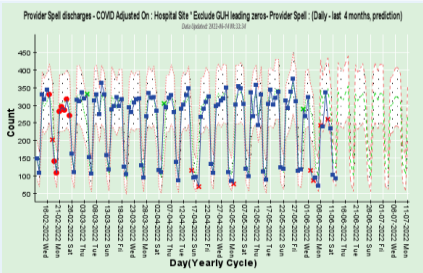
Note

- *Goal 1 measures to be agreed, focusing on HISU, interventions and falls*
- *Goal 3 measures to be reported following the launch of SDEC at GUH along with assess-out rates*

Goal	Key Metric	Target	Mar22	Apr22	May22	Signal	Signal explanation/ Comment	Chart/Graph
2	Think 111 calls (both in and out-of-hours)	↑ Increase	459	622	778		Improvement in the number of call during May.	
2	111 calls abandoned	↓ Reduction	9.2%	10.2%	5.4%		Significant reduction in abandonment rates	111 Call Abandonment rate (pan Wales) September2021 31.9% October 2021 36.3% November 2021 21.5% December 2021 19.3% January 2022 10.8% February 2022 4.6% March 2022 9.2% April 2022 10.2% May 2022 5.4%
2	Redirections from GUH (Count of both in and out-of-hours) *Right place, first time ethos*	↓ Reduction	139	151	104			
2	Redirections from MIU (Count of both in and out-of-hours) R*ight place, first time ethos*	↓ Reduction	453	473	544			
2	UPCC Consultation / Treatment (monthly totals)	↑ Increase	7,283	8,674	8,301			

Goal	Key Metric	Target	Mar22	Apr22	May22	Signal	Signal explanation/ Comment	Chart/Graph
4	ED Attendances (all sites/daily avg)	↓ Reduction	517	477	526		Increasing trend since Jan.	
4	<12 hours %	↓ 100%	91.7%	91.7%	91.9%		Following projection and seasonal trend.	
4	<4 hour %	↓ 100%	67.2%	68.5%	67.2%		Below forecasted levels since 22nd May	
4	Waits in ED over 16 hours	↓ Reduction	472	447	432			
4	Time to be seen by first clinician never above 2 hours	↓ 95%	1.7 hours	1.5 hours	1.8 hours		Above forecasted levels since 22nd May	

Goal	Key Metric	Target	Mar22	Apr22	May22	Signal	Signal explanation/ Comment	Chart/Graph
4	Time for bed available from request - 8 hours	↓ 95%	12.6 hours	11.5 hours	11.5 hours		Sustained performance during May.	
4	ED Triage Time	↓ 0.25 hours	0.6 hours	0.5 hours	0.5 hours			
4	Ambulance Handovers >1 hour	↓ Reduction	40.1%	45.5%	42.2%		Overall increasing trend. 42.2% of handovers >1 hour in May 22.	
4	No more than 70 Ambulance hours lost in a day (daily average)	↓ 95%	87 hours	89 hours	89 hours			
5	Occupied Beds monthly av	↓ Reduction	1486	1498	1511		Out of range and following forecasted seasonal trends.	

Goal	Key Metric	Target	Mar22	Apr22	May22	Signal	Signal explanation/ Comment	Chart/Graph
5	LOS over 21 days	↓ Reduction	593	607	619		Out of range and not following forecasted seasonal trend	
5	Ave Daily discharges	↑ Increase	264	234	247			
6	Average daily DTOC Patients on Complex List - Acute	↓ Reduction	100	98	155		New complex list system commences in May. Therefore some discrepancies may show when comparing prior to May.	N/A
6	Average daily DTOC Patients on Complex List - Community	↓ Reduction	111	116	136		New complex list system commences in May. Therefore some discrepancies may show when comparing prior to May.	N/A

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th July 2022 Agenda Item: XX

Aneurin Bevan University Health Board

Integrated Medium-Term Plan (IMTP) 2022/25 Quarter 1 Progress Report

Executive Summary

The purpose of this paper is to provide the Board with a progress report against the Aneurin Bevan University Health Boards Integrated Medium Term Plan (IMTP). This report summarises the Health Boards progress during Quarter 1, bringing together these following key components:

- Outcomes Framework
- Performance Report
- A review of the planning scenario
- Clinical Futures Priority Programme progress

The Board is asked to:

- Note the progressed achieved during Quarter 1
- Note the revised forecasts set out in the supporting Minimum Data Set

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

Executive Sponsor:
Nicola Prygodzicz (Director of Planning, Digital and IT)

Report Author:
Chris Dawson-Morris (Deputy Director of Planning)

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: 15th July 2022

Supplementary Papers Attached: Integrated Medium-Term Plan (IMTP) 2022/25 Q1 Outcomes Report. Supporting Minimum Data Set (MDS). Performance Dashboard.

Background and Context

The IMTP for 2022 to 2025 sets out the vision for the organisation, that is to improve population health and reduce health inequalities experienced by our communities. In order to achieve this vision, the IMTP focusses on 5 life course priorities.

Outcomes and Performance Framework
With the IMTP vision and 5 life course priorities in mind, the Health Board has developed a set of supporting outcomes and associated indicators that helped focus understanding of how well they were doing in these areas. Indicators have been included that cover the full spectrum of what the organisation understand the health system to be, and what can be realistically measured at the moment. The aim is to provide information and measurement at a system and population level to support the understanding of progress against the IMTP. Alongside this the report provides a high-level overview of activity and performance at the end of May 2022, with a focus on delivery against key national targets included within the performance dashboard. The update focuses on the areas of RTT, Diagnostics, unscheduled care access, cancer, and Mental Health.

Priority Programme Progress
The IMTP set out key priorities, which, based on the understanding of the system, will deliver the biggest impact and improve the sustainability of the health and care system. By their very nature, these key strategic priorities are complex, system wide and the programmes of work are designing to implement these changes during the course of the IMTP. This report provides an update against the key milestones and progress made against each of the key priorities.

IMTP Planning Scenario
Working with a data partner, the organisation adopted a dynamic planning approach to understand the potential demand, risks and capacity requirements of the system. Working with each clinical team by speciality using real time data, realistic workforce assumptions, emerging experience of how patients are returning to their services and known system constraints, the health board developed a clear understanding of predicted demand on the system and the capacity needed against what is available. This report provides an update against what was planned, what took place and forward projections.

This information has supported refreshed profiles includes in the updated Minimum Data Set for Quarter One, this is required to be submitted to Welsh Government as part of the IMTP process.

Assessment and Conclusion

Quarter 1 has continued to see sustained pressure on our services as the Health Service comes out of pandemic measures and manages Covid pressures alongside recovery and day to day service delivery. Our planning assumptions have been tested and are in line with expected outputs, it is positive that the position has not deteriorated in this period given the wider factors described.

During Quarter 1 the Health Board delivered:

- ✓ Increased levels of GMS activity with more face-to-face activity
- ✓ Improved Performance in Primary Care Mental Health and sustained position in performance for psychological therapy services
- ✓ Maintenance of Urgent Care performance in a challenging climate
- ✓ Improved access to elective, urgent and essential services

- ✓ Increased capacity for new outpatient appointments
- ✓ Transfer of the vaccination scheme from emergency planning to business as usual, with an interim arrangement to support roll out to the younger age groups
- ✓ Same Day Emergency Care building complete, ready for launch in Quarter 2
- ✓ Secured capital funding for new Endoscopy and Breast Units
- ✓ Maintenance of ambulatory services models

This is the first production of a quarterly report in this format and feedback is welcome on the report.

Recommendation
The Board is asked to: • Note the progressed achieved during Quarter 1 • Note the revised forecasts set out in the supporting Minimum Data Set

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report highlights key risks for delivery against the IMTP
Financial Assessment, including Value for Money	The delivery of the outcomes framework, key performance, delivery against the planning scenario and risk management is a key part of the Health Board's service and financial plans.
Quality, Safety and Patient Experience Assessment	There are no adverse implications for QPS.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no implications for Equality and Diversity impact.
Health and Care Standards	The Health and Care Standards underpin the IMTP and Quarterly reports.
Link to Integrated Medium Term Plan/Corporate Objectives	This is a Quarterly report against the Integrated Medium Term Plan and the key organisational priorities informed by our detailed understanding of how our system operates.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The IMTP demonstrates an integrated approach to working across the Health Board and with partners and combined both short and long term goals.
Glossary of New Terms	Any new terms are explained as they occur within the document.
Public Interest	This report has been written for the public domain.

Aneurin Bevan University Health Board

IMTP

Integrated Medium-Term Plan

2022/25

Q1

1. INTRODUCTION

This report summarises the Health Board's progress for Quarter 1 against the Integrated Medium-Term Plan (IMTP), bringing together reporting on Outcomes, Performance, Priority Programmes and a review of the underpinning planning scenarios.

The Health Board has remained under sustained pressure transitioning from the winter period; Covid-19 bed occupancy has continued at a sustained level (around 10% of the pandemic peak) and sickness levels across all clinical teams has continued to present challenges in maintaining consistent services across primary and secondary care.

However, there have been performance improvements as the organisation aims to return to pre-pandemic levels of service and to deliver service transformation. Despite these challenges, we have tested our planning assumptions set out in the IMTP and they are in line with expected delivery.

In Quarter 1 the Health Board delivered:

- ✓ Increased levels of GMS activity with more face-to-face activity
- ✓ Improved Performance in Primary Care Mental Health and sustained position in performance for psychological therapy services
- ✓ Maintenance of Urgent Care performance in a challenging climate
- ✓ Improved access to elective, urgent and essential services
- ✓ Increased capacity for new outpatient appointments
- ✓ Transfer of the vaccination scheme from emergency planning to business as usual, with an interim arrangement to support roll out to the younger age groups
- ✓ Same Day Emergency Care building complete, ready for launch in Quarter 2
- ✓ Secured capital funding for new Endoscopy and Breast Units
- ✓ Maintenance of ambulatory services models

The current urgent care pressures and challenges faced by the social care system have impacted upon service recovery, and the organisation has not therefore seen the step change required to significantly revise the forecasts of planned activity for Quarter 2. This is a realistic position based on the Health Board's current performance, staff sickness rates, the number of patients delayed but medically fit for discharge and current continued management of Covid-19 in our Hospital and Primary Care settings. We have therefore refreshed the forecast taking in to account the constraints of the current system.

There are areas of risk within the following pathways that will need attention over the next quarter and which have been included in our plans:

- Eye Care
- Single Cancer Pathway
- Continued medical and community bed pressure
- Sustainability of Primary Care access

The Health Board will remain alert to further waves and potential new variants of Covid-19, which may affect the organisation's ability to tackle backlogs of demand for planned care services.

Structure

This report is structured across three sections as follows:

Outcomes Framework and Performance Summary – This section reports against the life cycle priority outcome measures. It provides population and system outcomes measures to support understanding of IMTP delivery.

Progress of Clinical Futures Priority Programmes– This section reports on the progress of the Clinical Futures Programmes set out in the IMTP.

Planning Scenarios- This section reports against the planning scenarios as set out in the Minimum Data Set of the IMTP.

2. OUTCOMES FRAMEWORK – QUARTER 1

The vision set out in the IMTP 2022-2025 is to:

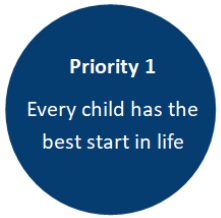
> Improve population health and reduce the health inequalities experienced by our communities.

In order to achieve this vision, the IMTP focuses on 5 life course priorities. With this in mind, the Health Board has developed a set of supporting outcomes and associated indicators that help focus understanding of how well the organisation is doing in these areas. Indicators have been included that cover the full spectrum of what we understand the health system to be, and what the organisation can realistically measure at the moment. The aim is to provide information and measurement at a system and population level to support understanding of progress. In January 2022, the Welsh Government wrote to the Health Board to set out Ministerial Priority Delivery Measures. This contained 34 measures, and all measures with Monthly or Quarterly qualitative data are provided in this report. Subsequently on 30th June 2022, the Welsh Government published the NHS Wales Performance Framework for 2022 to 2023. This framework sets out a greater movement towards outcome-based measurement. Many of these measures are included in this report and will be further reflected in quarter 2 as data and reporting processes become available.

The Outcomes Framework will be updated quarterly and, depending on data availability, the latest data is reported for each indicator. This is the first production of these measures and development is still required. The timescales for indicators vary according to the data source. Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. The 'No Data' category is used where the indicator is in development.

A total of 43 indicators have been identified and of those, 36 have been measured with the remaining 7 currently in development. Of these indicators, 14 measures have shown improvements against their baseline including 2 measures that have met or sustained their target. A total of 14 indicator values have deteriorated and 8 are statistically similar. A breakdown of the type of change by priority can be seen in the table below:

Type of change	P1 - Every child has the best start in life	P2 - Getting it right for children and young adults	P3 - Adults living healthily and aging well	P4 - Older adults are supported to live well and independently	P5 - Dying well as part of life	Total
Improved	2	2	6	2	2	**14**
Similar	2	2	3	0	1	**8**
Deteriorated	3	1	7	3	0	**14**
No data	1	2	1	1	2	**7**
Total indicators	**8**	**7**	**17**	**6**	**5**	**43**



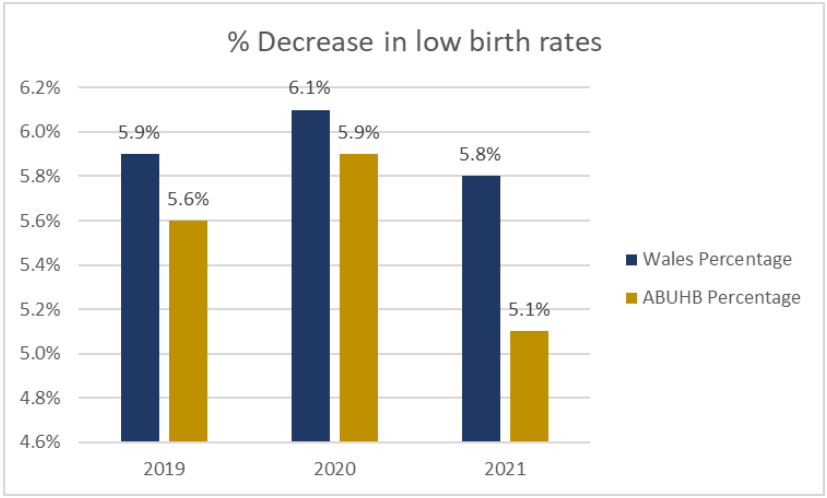
Early childhood experiences, including before birth, are key to ensuring improved health outcomes. The Health Board's IMTP committed to working with partners to take forward actions and activities that have a positive impact on the first 1000 days of life. The table below sets out three core outcomes to be achieved in this area. Alongside identified measures, this information is used to target actions and identify priorities for the organisation.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 1 - Every child has the best start in life	Improving Good Health in Pregnancy	Decrease in low birth rates	5.6%	4%	2021	5.1%	Improved	Decrease in indicator over the last 3 years. Significantly lower than the all Wales average.
		Decrease in smoking status at birth	16%	10%	2021	13.7%	Improved	Significant decrease between 2020 and 2021.
		Decrease in stillbirths	Indicator to be developed				No data	Indicator to be developed
	Optimising a child's long term potential	Increase update in mothers breastfeeding (any breastfeeding)	59.2%	65%	Q3 2021/22	57.1%	Deteriorated	Decrease in indicator over the last 3 quarters and significantly lower than the welsh average.
		Increase of eligible children measured and weighed at 8 weeks	62.5%	60%	Q3 2021/22	52.3%	Deteriorated	Continued decrease in indicator.
		Increase of eligible children with contact at 3.5 years pre-school	64.4%	60%	Q3 2021/22	59.6%	Deteriorated	Decrease in indicator, however, remains significantly higher than the welsh average.
	Increasing childhood immunisation and preventing outbreaks	Percentage of children who received 2 doses of the MMR vaccine by age 5	91%	95%	Q3 2021/22	90%	Similar	Indicator value has remained stable.
		Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	96%	95%	Q3 2021/22	97%	Similar	Indicator value has remained stable and target has been met.

Good progress has been made against the first outcome **'Improving good health in pregnancy,'** with observed improvements in both the **'decrease in low birth rates'** and **'smoking status at birth'** indicators. Most notably, there was a significant decrease in low birth rates between 2020 and 2021, with the Health Board showing noteworthy improvements compared to the Welsh average.

Deterioration in the outcome **'Optimising a child's long-term potential'** was reported at both a Health Board and all Wales level across all three indicators. The **rate in mothers breastfeeding** was reported at 57.1% during Quarter 3 2021/22 compared to the Welsh average of 62.7%. This will be an area of focussed action for the division in the next quarters.

The indicator value has remained stable and similar for the **'Increasing childhood immunisation and preventing outbreaks'** indicators, demonstrating sustained strong performance.



Priority 2
Getting it right for children and young adults

Our Outcomes:

Improve mental health resilience

Support being a healthy weight

Improve healthy lifestyle behaviours

Nurturing future generations is essential for our communities. There is strong evidence that healthy behaviours in childhood impact throughout life; therefore, targeting actions to improve outcomes in these areas has a long-lasting impact on delivery. Young Adult mental health is a Ministerial priority area with CAMHS a focus in the national performance framework.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 2 - Getting it right for children and young adults	Improve Mental Health Resilience in Children and Young adults	Improvement in the mean mental health wellbeing score for children	Indicator to be developed				No data	Indicator to be developed.
		Decrease in 4 week CAMHS waiting list	95%	80%	Q1 2022/23	98.3%	Improved	Sustained and improved compliance against indicator target. Target met.
		Decrease in neurodevelopmental (SCAN) waiting list	80%	80%	Q1 2022/23	47.3%	Deteriorated	The indicator value has continued to decline since July 2021 due to a significant (103%) increase in demand. A recovery plan is in place to attain target by end of year.
	Support being a healthy weight	Increase in children age 5 of a healthy weight	73.1%	80%	2017	74.9%	Improved	Indicator has shown continued increases since 2006.
		Increase in adolescents of healthy weight	Indicator to be developed				No data	Indicator to be developed.
	Improve healthy lifestyle behaviours	Increase in the percentage of children (aged 2-7 years) who are active for at least 1 hour seven dats a week	62%	70%	2020	63%	Similar	Indicator value has shown signs of improvement.
		Increase in the percentage of children who eat vegetables every day	67%	70%	2020	68%	Similar	Indicator value has shown signs of improvement.

Further progress has been made against the **'Improve Mental Health Resilience'** outcome in terms of the **'4-week CAMHS waiting list'** indicator, which has demonstrated sustained compliance and improvement. However, there has been a deterioration in the **'decrease in neurodevelopmental (SCAN) waiting list'** due to a significant (103%) increase in demand. A recovery plan is in place to attain this target by the end of the year.

Access to services is a focus of the national performance framework. At the end of May 98.3% of **patients were waiting less than 28 days for a first appointment**. The implementation of the SPACE wellbeing (development of single point of access, multi-agency panels) which is operational in all five local authority areas has continued to have a positive impact on access to services.

As referenced in the above table, the **level of acceptance of Neuro Development referrals** has increased by 103% since the relaunch in April 2021. This increase in demand and, the impact of the easing of COVID-19 lockdown and the restarting of face-to-face appointments resulted in a backlog of follow up appointments for the children

undergoing a neuro-developmental assessment and has inevitably delayed the conclusion of the assessments. The recovery plan will involve closer working with Local Education teams, with the help of our Schools In Reach, School Nurses, the Locality Community support services and School staff to help schools produce a tailored school setting support plan.

The '**Support being a healthy weight'** outcome has observed improvements in the **increase in children age 5 of a healthy weight** indicator. This has continued to increase, year on year, since 2006.

Whilst the indicator values have remained similar, there have been signs of improvement in the **'Improve healthy lifestyle behaviours'** outcome and this will be monitored closely. This is a measurement area where as well as health interventions, social determinates have an impact upon behaviours and outcomes. The development of the Health Board as a Marmot Region will support our understanding in this area and the targeting of actions such as the organisation's Food Communities Programme.

Priority 3

Adults in Gwent live healthily and age well

Our Outcomes:

Our ambition is for citizens to enjoy a high quality of life and to be empowered to take responsibility for their own health and care. A significant number of measures fall within this area, particularly in relation to maximising an individual's time. The outcomes and performance set out below underpin the work of the priority programmes and in particular the work of the 6 Goals for Urgent and Emergency Care, Planned Care and Mental Health. The progress for these can be found in Section 3.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 3 - Adults living healthily and aging well	Maximising an individuals time	Reduction in the number of patients waiting more than 36 weeks for treatment	32202	0	Q1 2022/23	32959	Similar	Indicator value has increase during Quarter 1, following the trend oberserved over the last 12 months.
		Reduction in the number of patients waiting for a follow-up outpatient appointment	113107	69268	Q1 2022/23	114624	Similar	Small increase but similar to baseline.
		Increase in Urgent Primary Care Consultations/Treatments	6969	10000	Q1 2022/23	8336	Improved	Significant and continued increase in rate since 2021. On track to meet target.
		Increase in Think 111 calls	493	800	Q1 2022/23	673	Improved	Significant improvement in indicator value since Autumn 2021. On track to meet target.
		Reduction of handovers >1 hour	737	0	Q1 2022/23	793	Deteriorated	Trend reported in the increase in value since 2021. Indicator is breaching target.
		Reduction in patients never waiting in ED over 16 hours	417	0	Q1 2022/23	445	Deteriorated	Continued increase in indicator value. Rate has increased by 6.7% from baseline.
		Reduction in time for patients to be seen by first clinician	1.6 hours	2 hours	Q1 2022/23	1.8 hours	Deteriorated	Continued increase in indicator value. Rate has increased by 12.5% from baseline.
		Reduction in time for bed allocation from request	11.5 hours	8 hours	Q1 2022/23	11.9 hours	Deteriorated	Continued increase in indicator value. Rate has increased by 3.5% from baseline.
	Adults living healthily and aging well	Increase in adults active at least 150 minutes a week	53.0%	60%	2019/20	55%	Improved	Increased and continued improvement rate (1% year on year). Indicator value is consistently performing higher than the all Wales average.
		Decrease in the % of adults smoking	19%	15%	2019/20	18%	Improved	Decreased in indicator value, although remains higher than the all Wales average.
		Decrease in the number overweight or obese adults (BMI over 25)	65%	50%	2019/20	65%	Similar	No change observed.
		Increase in working age adults in good or very good health	69%	80%	2020/21	74%	Improved	Significant improvement in indicator value (+7.2%) from 2019/20 and 2020/21, however, value remained lower than the all Wales average.
		Increase uptake of National Screening Programmes	Indicator to be developed				No data	
	Improved mental health resilience in adults	Increase in Mental Health Well-being score for adults	50.3%	55	2018/19	50.5%	Similar	Small increase in value.
		Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	80%	90%	Q1 2022/23	78%	Deteriorated	Indicator value has decreased from baseline by -2.5%.
	Maximising cancer outcomes	Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	56.9%	75%	Q1 2022/23	53.4%	Deteriorated	Indicator value has consistently decreased over the last 12 months.
		Increase in 5 year cancer survival	51.0%	60%	2014-2018	58%	Improved	Significant improvements in rate reported over the last 10 years.

Maximising an individual's time

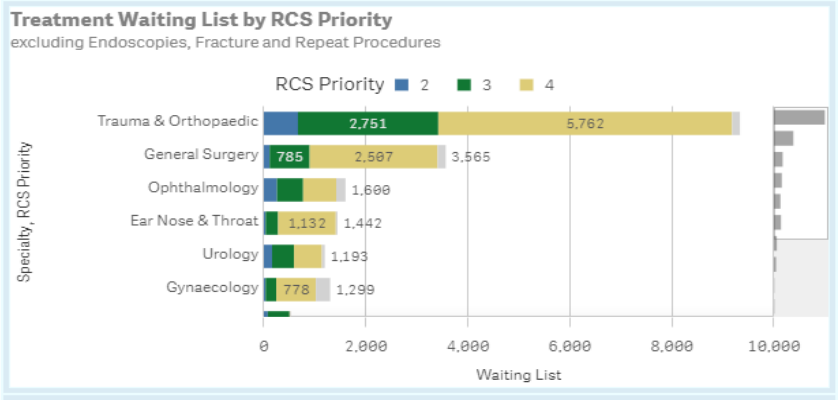
Time-based waiting measures form a large element of the Minister's Priority Delivery Measures. In this framework, a smaller number of core measures have been selected to represent key areas of delivery as proxy measures of effective use of an individual's time. However, as part of the organisation's forecast performance against the core Ministerial measures, the table below shows actual performance in Quarter 1 against the plan.

Measure	Target	Forecast			
		Mar-22	APR	MAY	JUN
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by 2024	8,946	6,514	6,029	5,813
	Planned		8,722	8,457	8,346
Number of patients waiting more than 36 weeks for treatment	Improvement trajectory towards a national target of zero by 2026	32,720	33,177	32,959	33,570
	Planned		32,120	30,500	29,900
Percentage of patients waiting less than 26 weeks for treatment	Improvement trajectory towards a national target of 95% by 2026	58.00%	61.20%	61.40%	62.10%
	Planned		58.00%	58.00%	58.00%
Number of patients waiting over 104 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 104 week waits by July 2022	1,884	1,462	1,362	1354
	Planned		1,800	1,764	1,728
Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 52 week waits by December 2022	9,975	8,925	9,147	9,381
	Planned		9,700	9,579	9,380
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	A reduction of 30% by March 2023 against a baseline of March 2021	17,910	18,787	18,402	19,055
	Planned		17,845	17,583	17,255
Number of patients waiting over 8 weeks for a diagnostic endoscopy	Improvement trajectory towards a national target of zero by March 2026	2,986	3,528	3,515	3,247
	Planned		2,752	2,345	2,155
Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of 75%	65.00%	57.00%	53.00%	
	Planned		65.00%	65.00%	65.00%

Maximising an Individuals Time- Planned Care

Maximising an individual's time is a core element of planned care. Whilst performance is not yet achieving target delivery against the plan, it has been sustained in quarter 1, with continued improvement in **treating the longest waiting patients**. Sustaining this performance is an achievement given the continued impact of Covid-19, high staff sickness rates and urgent care and system-wide pressures. There are approximately 18,700 waiting beyond 36 weeks are at the new outpatient waiting list stage.

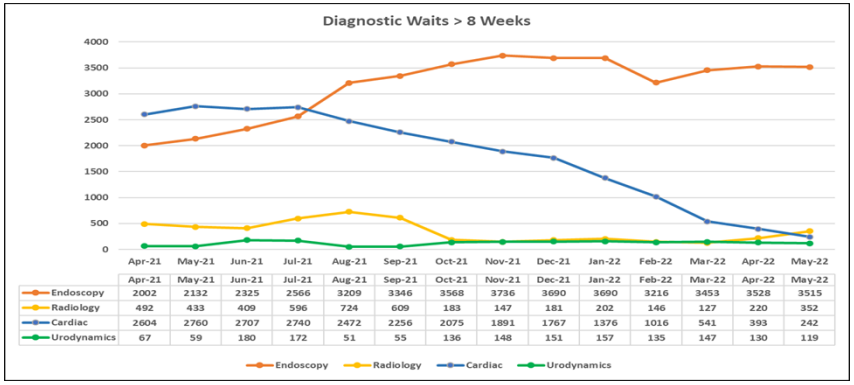
Therefore, improvement in outpatient performance is essential to make the most of individual's time and is a core focus of the Planned Care Programme set out in section 3.



In relation to treatments, the Specialties have maintained the principle of undertaking activity defined by clinical prioritisation, rather than a time-based approach; this enables timely care for the most urgent patients and clinically-led decision making. This will have an impact on RTT waits in some services, however there is evidence that services are balancing urgent patients and the patients who have waited the longest.

Maximising and Individuals Time- Diagnostics

The diagnostic element of the pathway is an essential area to understand performance and future patterns. Only Endoscopy is included in the national measures, however it is important to understand the total position. Services have increased capacity for all patients; the overall over 8-week position rose slightly in May 2022, with 4,228 waiting over 8 weeks compared with 4,271 in April but fell in June to 3,871. As seen in the graph on the right, cardiology has seen significant improvement, driven by use of an insourcing company to deliver additional echo capacity.



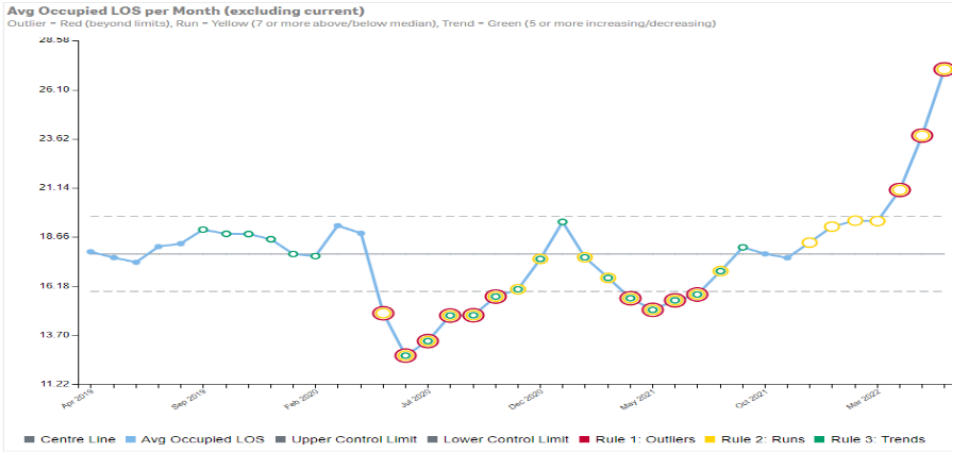
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Endoscopy	2002	2132	2325	2566	3209	3346	3568	3736	3690	3690	3216	3453	3528	3515
Radiology	492	433	409	596	724	609	183	147	181	202	146	127	220	352
Cardiac	2604	2760	2707	2740	2472	2256	2075	1891	1767	1376	1016	541	393	242
Urodynamics	67	59	180	172	51	55	136	148	151	157	135	147	130	119

Further key areas in diagnostics:

- The increase in the number of colorectal cancer referrals has increased the wait for more routine diagnostics
- Continued insourcing of additional endoscopy capacity has supported a decrease in the 8-week backlog
- Availability of staff is affecting delivery through core theatres; the service anticipates that with service improvement and additional insourcing capacity, the 8-week breach position will improve over the next few months
- Radiology diagnostics continue to recover well. The main backlog is in MSK ultrasound, although performance continues to be higher than other parts of Wales.

Maximising an Individuals Time- Urgent Care

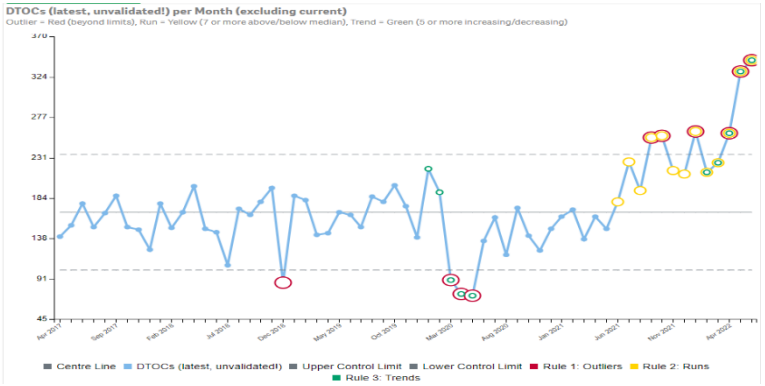
The urgent care system continues be under significant pressure both nationally, regionally and locally, making delivering timely care challenging. This is in the context of significant workforce challenges, increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and minor injury units, increased acuity linked to post lockdown impact, increased bed occupancy for emergency care and high levels of delayed discharges linked to significant social care workforce challenges. All of this is also in the context of ongoing presentations of patients with covid-19 and the need to maintain appropriate streaming of patients and increasing levels of elective work as part of the recovery programme.



This pressure on the urgent care system has resulted in patients staying in hospital for longer. The **average length of stay** for patients admitted as an emergency is at its highest point recorded since before April 2017.

Attendance at the Health Board's Emergency Departments (ED) had been increasing since the start of February 2021. This increasing trend changed in December, January and February as it does every year, but a sharp increase in attendances was seen in March and then May with 16,120 attendances compared to 13,051 in February and 13,132 in January.

In June 2022, 793 patients waited over 60 minutes to the transferred to the ED from the Ambulance compared to the previous two months where May position reported 847 and 794 in April. The **4 hour compliance** deteriorated slightly in June 2022 with performance at 71.4% compared with 74.2% for May 2022 and 76.4% in April. The Health Board continues to achieve the highest 4 hour performance for all Welsh Health Boards with a major Emergency Department.

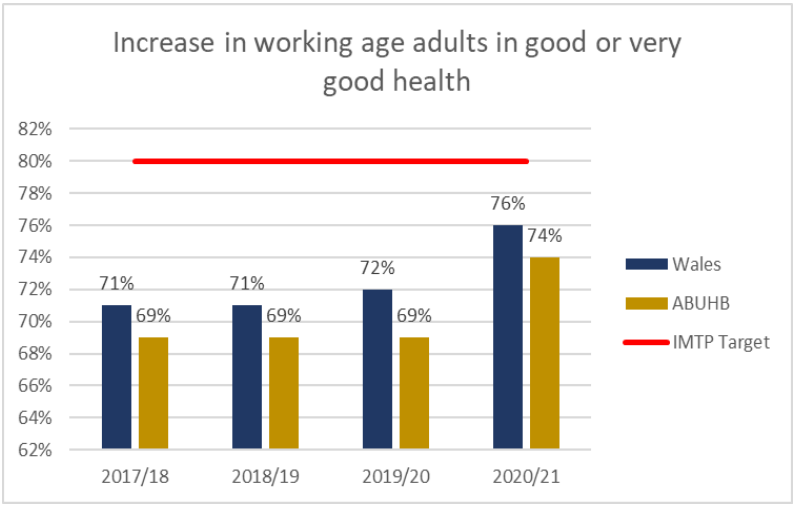


Maximising an individual's time means supporting them in the right place of care, which is often their own home. Prior to the COVID-19 pandemic, there were typically 160 patients per day who had their **discharge or transfer of care delayed**. Since July 2021, this number has only been below 200 once, and on 4 occasions, has been in excess of 250. The position at the end of May is 330 per day and with the pressure across the health and care system, this number may increase in the coming months. As set out in section 3, this is a core element of focus for the Redesigning Services for Older People Programme.

Adults Living Healthily and Aging Well

The outcome '**Adults living healthily and aging well'** has seen improvements across a number of indicators, most notably in the **increase in working age adults in good or very good health**. The rate significantly increased between 2019/20, however this still remains below the Welsh average.

A similar score was reported for the **mental health well-being of adults** in the Health Board, although a small increase has been observed contributing to the progress towards the achievement of the improved mental health resilience in adults outcome.



Improved Mental Health Resilience in Adults

Access to mental health care services is of equal importance to physical healthcare services and there are a range of measures that provide further details on performance in this area and support the organisation's understanding of future delivery.

In relation to Primary Care Mental Health:

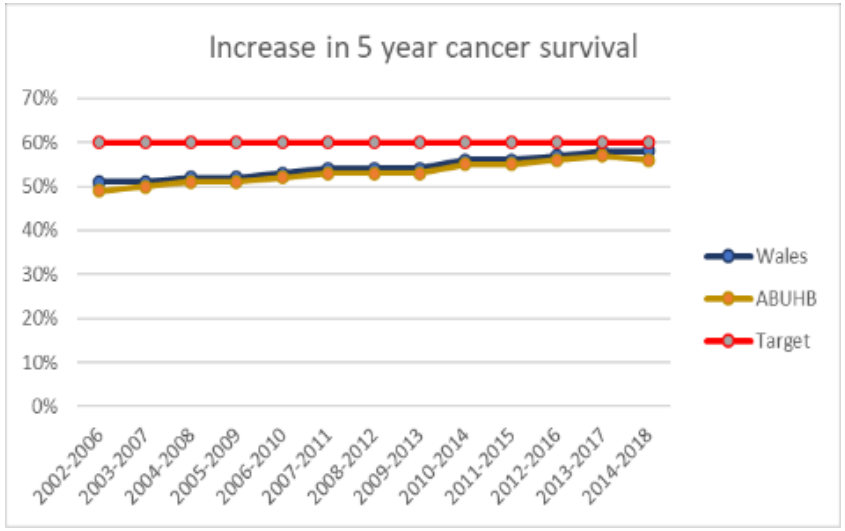
- Performance against the 80% target improved in May 2022 (latest validated position) to 82.7% compared with 65.6% in the previous month. The position for intervention remains below the target with position slightly improving from 11.2% to 14.6% between April and May 2022
- The continued deterioration in intervention performance is due to the service focusing on the assessment in line with Welsh Government guidance, to ensure that all patients receive the initial assessment with a registered mental health practitioner
- The recovery plan continues to be aimed at reducing waiting lists for therapeutic treatments. Though waiting lists for counselling and low intensity intervention have reduced to some extent, it is unlikely that that the target can be achieved in the short term

Psychological Therapy:

- A sustained position in performance is reported for psychological therapy in Specialist Mental Health Services, with 72% of patients waiting less than 26 weeks for treatment at the end of May 2022, compared with 69.3% in April 2022, against a target of 80%
- Performance is calculated based on combined compliance for Adult, Older Adult and Learning Disabilities (LD) services. However, the Older Adult service has consistently achieved performance levels above 80% with 90.2% in May
- With regards to Adult Services, the service has plans to continue to improve performance and reduce long waiters
- The Adult service has consistently improved and achieved 68.7% in May compared with 57% in May 2021.

Maximising cancer outcomes

There has been significant improvement in the rate of **5-year cancer survival** reported over the last 10 years and is on track to meet the target. However, the compliance against the **62-day target** for definitive cancer treatment has continued to deteriorate from 56.9% to 53.4% over the last 12 months and is breaching the target. This is in part driven by increases in demand relating to suspected cancer referrals in the first 2 months of the quarter and has continued to exceed 2,500 referrals per month. The rapid sustained demand this year is continuing to have an onward impact on performance creating capacity challenges throughout the pathway both in the Health Board and for those patients requiring surgery at tertiary centres.



This high demand is not evenly distributed across tumour sites. Those tumour sites that have seen the biggest increases have subsequently struggled to achieve against the 62-day pathway target. Most notably, the huge Lower GI demand seen throughout the year has been sustained. Urology is also seeing very high demand which is affecting the timeliness at the start of the cancer pathway.

This variation is a demonstration of the fragility of the Single Cancer Pathway and the need for sustained and consistent deliverable capacity.

To turn the position around in the face of sustained high demand will require a concerted effort to create additional capacity. Transforming Cancer Services is a Clinical Futures Priority Programme and further action is set out in section 3.

Priority 4

Older adults are supported to live well and independently

Our Outcomes:

Prevention and keeping older adults well

Delivering care closer to home

Reducing admissions and time spent in hospital

Supporting Adults to live well and independently is core to the Health Board's Plan. We know we need to deliver improvement for this section of the population in our service offer. Redesigning Services for Older People is a Clinical Futures Priority Programme.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 4 - Older adults are supported to live well and independently	Prevention and keeping older adults well	Increase in older people in good health	Indicator to be developed				No data	Indicator to be developed.
	Delivering Care Closer to Home	Increase in Rapid Response within 4 hours	38%	50%	Q1 2022/23	35%	Deteriorated	Decrease in indicator value over the last 12 months across all 4 Local Authority areas (excludes Monouthshire).
		Reduction in the number of short stay patients (<7 days)	12%	5%	Q1 2022/23	11%	Improved	This indicator has improved since 2021/22.
		Reduction in average LOS case load	39.9 days	30 days	Q1 2022/23	52.7 days	Deteriorated	Significant increase (32%) in indicator value.
	Reducing admissions and time spent in hospital	Increase in Admission avoidance (month)	71	100	Q1 2022/23	68	Improved	An improvement in the indicator value across all 4 Local Authority areas (excludes Monmouthshire).
		Decrease (from 65 - 55%) in LOS over 21 days	56%	45%	Q1 2022/23	60%	Deteriorated	Increases in the indicator value since 2021/22.

The **'Delivering Care Closer to Home'** outcome has seen a deterioration in 2 indicator values. **Rapid response within 4 hours** has decreased across all 4 reported Borough areas (data excludes Monmouthshire) from 38% to 35%. There has also been an increase reported in the **average length of stay of case load**. This is most notable in Blaenau Gwent and Newport Boroughs.

There has been a positive increase in **hospital avoidance** witnessed across all 4 Boroughs (data excludes Monmouthshire) contributing to the achievement of the **'Reducing admissions and time spent in hospital'** outcome. The '**reduction in number of length of stays over 21 days'** indicator value has deteriorated and an increase from 56% to 60% has been observed, with now over 600 patients in hospital with a length of stay greater than 21 days.

Older people, including those receiving acute care, active treatment including rehabilitation and those who are waiting to move to the next phase of their pathway occupy over 430 beds in our acute system, up to 50% of these people are designated fit for discharge. This is a core area of focus for action through the Redesigning Services for Older People Programme. This is an area of improvement to be driven in partnership through the Integrated Service Partnership Board and Regional Partnership Board

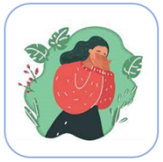
structures, through partners creating a more resilient care home sector, enhancing our Rapid Response Model, developing more integrated teams, enhancing access to hot clinics, providing single points of access and direct admissions pathways are all part of action plan to deliver improvement in this area.

Priority 5

Dying well as a part of life

Our Outcomes:

Improved end of life care experience



Improved planning and provision of end of life care

The IMTP sets out the commitment to continuously improve what we do to meet the need of people of all ages who are at the end of life. The measures represent indicators to support the organisations understanding of how it is delivering in this area to support the population to die in their place of choice and have access to good care.

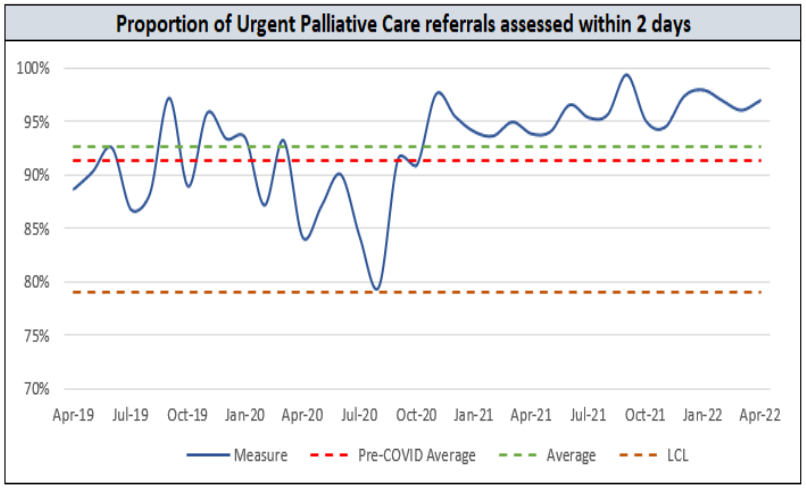
Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Latest data available	Indicator value	Change over the last time period	Latest findings
Priority 5 - Dying well as part of life	Improve care at end of life	Decrease in the % of hospital as a place	53%	40%	2022	50%	Improved	Decrease reported over the last 3 years.
		Increase in compliance of issuing of Medical Certificates within 5 days	81%	90%	Q1 2022/23	80%	Similar	The reported rate is similar to baseline value and therefore current performance levels have remained. Target to be amended from 5 to 7days.
		Reduction in compliants	Indicator to be developed				No data	Indicator to be developed.
	Improved planning and provision of end of life care	Increase in propotion of Urgent Palliative Care referrals assessed within 2 days	91%	100%	Q1 2022/23	97%	Improved	Signficant improvement in the indicator value since July 2020 and on track to meet target.
		Increase in the number of Advanced Care Plans in place	Indicator to be developed				No data	Indicator to be developed.

The dying well as part of life priority has seen a number of improvements and sustained performance against the outcome and indicator values. The reported rate of the indicator **'Increase in compliance of issuing of Medical Certificates within 5 days'** has been sustained. The legal timescale and target is due to increase to 7 days to accommodate the Medical Examiner service when statutory. Overall, 95.4% of cases are completed within 7 days.

For the **'Improved planning and provision of end of life care'** outcome, there has been a significant increase in the proportion of **Urgent Palliative Care referrals assessed within 2 days** since July 2020.

Whilst the indicator of Advance Care Planning isn't yet in place, action is underway across the Health Board establish ACP champions in each specialty and enhance ACP training for teams.

Further outcome measures and indicators are being developed nationally and this priority will evolve to incorporate the relevant outcomes.



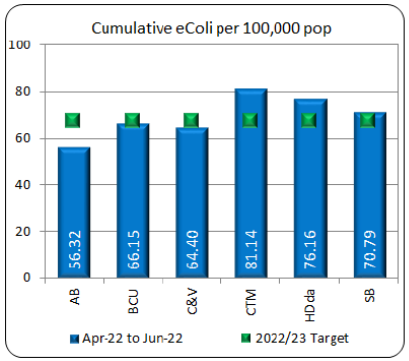
Key Enablers

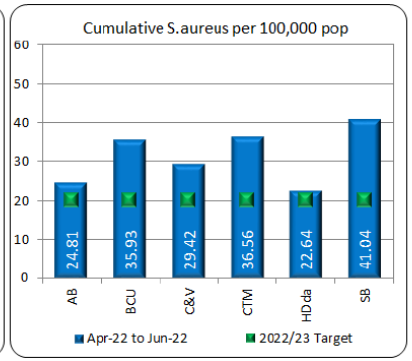
Quality and Safety

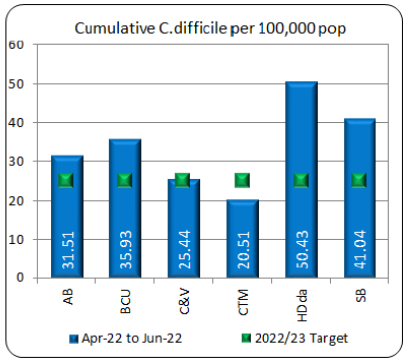
The Welsh Government priority measures include two reporting areas related to the **number and confirmed cases per 100,000 of bacteraemia cases**. In Quarter 1 there has been an **increase in C difficile** and in June there was a total of 33 cases across the Health Board, with a provisional Health Board rate of 37.13 per 100,000 population. Analysis indicated of the 33 cases, 18 related to hospital acquired infection resulting in 3 ward outbreaks of which genotyping has indicated local cross infection.

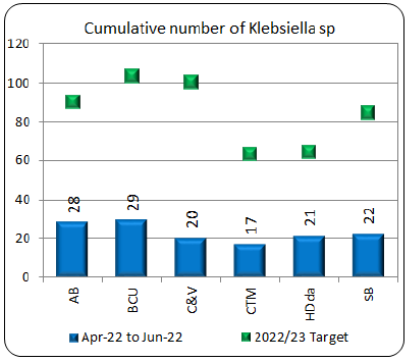
In response, an extraordinary meeting was convened, and a rapid C diff implementation plan was developed, attached for information with ongoing monitoring via governance meetings. Key messages, environmental cleaning, hand washing, prudent antimicrobial prescribing, mattress checking, prompt isolation of symptomatic patients and standard precautions are in place. In addition, a proactive HPV clean has commenced across our hospital settings and PSAG boards promoting MDT working for the management of C diff and other infections advocated.

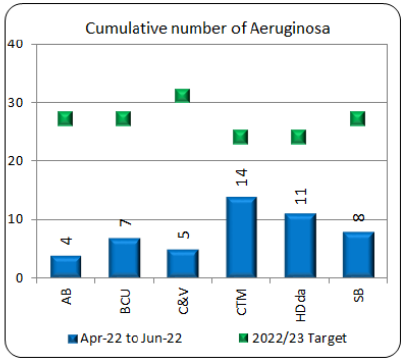
In relation to **MRSA,** there was a provisional rate of 24.17 per 100,000 population, which is above the Welsh Government reduction expectation. In June there were 9 cases compared to 12 in May. **E coli** provisional rate is 60.08 per 100,000 population.







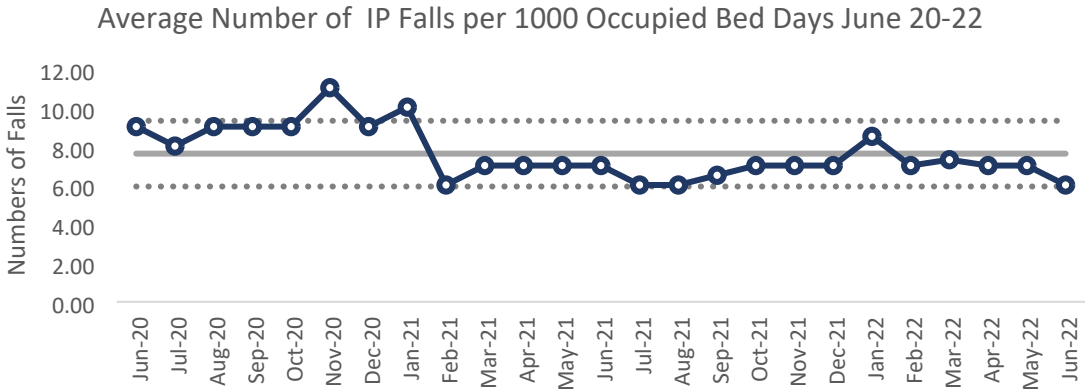


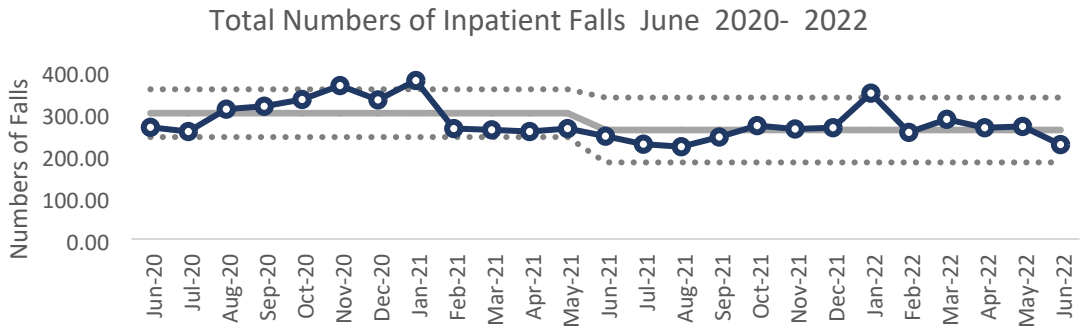


Falls

Data associated with Inpatient (IP) falls management continues to be monitored over a two-year rolling period of analysis to provide assurance in the recognition of any changing trajectories or statistical variation in the numbers of falls incidents. Q1 has demonstrated a position in which the average number of falls per 1000 occupied bed days (Chart 1) remains aligned to or is below the national average of 6.8. Apart from January 2022, a sustained position of improvement has been seen.

The total numbers of Inpatient falls (chart 2) for the same period looks to demonstrate a similar trajectory. 94% of the falls incidents reported are categorised as no or minimal harm.





Workforce

In relation to the Ministerial measures, two indicators for workforce were included in the Minimum Data Set as required for the IMTP submission. The table to the right sets out actual performance against the plan with the latest validated position. Sickness absence reporting does not include covid related sickness and medical exclusion and as that is not classed as sickness absence this brings the average percentage for the quarter to nearly 8%.

An Agency reduction plan is now in place to support the development of a sustainable workforce to support improvement against the agency spend.

		Forecast March 22	April	May	June
Agency spend as a percentage of the total pay bill	12 month reduction trend	8.20%	9.20%	10.00%	9.20%
	Planned		8.20%	8.20%	8.20%
Percentage of sickness absence rate of staff*	12 month reduction trend	6.50%	6.90%	6.10%	
	Planned		6.50%	6.50%	5.50%

Outcomes Framework Summary

Further detail on the individual outcome measurements is provided in Appendix 1. Overall, the indicators show that the Health Board is making some progress in key areas. Improvements in actions to support children in the first 1000 days of life with reductions in low birth weight babies and reductions in smoking amongst pregnant mothers. Vaccinations performance also remains high, meaning we are providing vital protection to our population.

Wider social determinants impact on outcomes, therefore the measures chosen are a mixture of those which represent the Health Board's impact on the population and specific system outcomes. Progress in measures such as improved healthy weight in children are positive indicators of the population which will be supported by Health Board activities and indicators of future impact of conditions.

In relation to our adult population, progress is mixed. In longer term outcomes, we are making progress in cancer survival and improved Mental Health resilience. However, in relation to making the best use of an individual's time, progress is challenging due to the urgent care and post pandemic pressures in our system. This demonstrates the importance of our Clinical Futures programmes in focussing upon urgent care, planned care and services for older people. Similarly, in relation to supporting people to live well in the community, the system is holding too many patients in hospitals, and this is a key focus area for our population.

Many of the metrics are still very much process measures and more work is underway to look at more outcome based measures and their reporting timelines. These will include areas such as mortality, stroke outcomes, hip fractures and heart failure.

3. IMTP PRIORITY PROGRAMME QUARTER 1 UPDATE

The IMTP set out key priorities based on the understanding the system and what will deliver the biggest impact and improve the sustainability of services for the local communities.

The Health Board delivers these priorities through a Programme Management structure via its Clinical Futures Programme Team. By their very nature, these key strategic priorities are complex, system wide and the programmes of work we are designing to implement these changes will be realised incrementally over the life of this three-year plan and beyond. Notwithstanding this, progress against each priority for quarter 1 are shown below.

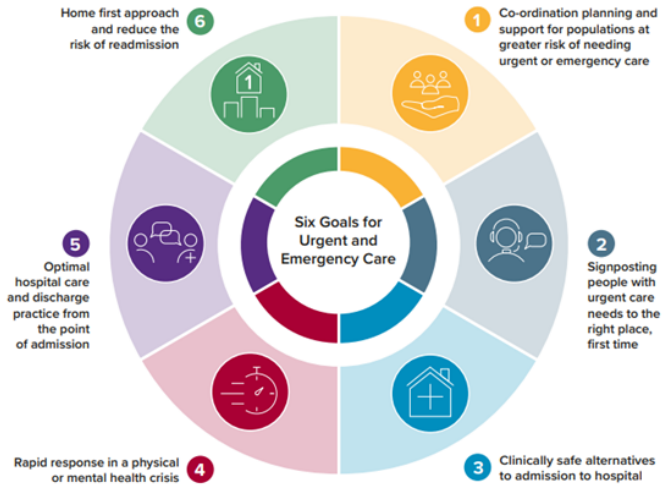
1. Urgent and Emergency Care Improvement (6 Goals)

Why is this a priority?

Prior to the pandemic, the situation in Emergency Departments was increasingly difficult, with demand soaring and the percentage of people being seen within the four-hour target reaching an all-time low over the 2019/20 winter. Since the start of the pandemic, ED attendance decreased significantly which led to performance improvements. Since lockdown eased, demand has steadily risen, and a greater number of people with serious problems are presenting themselves in our urgent and emergency care system.

Last July (2021) Welsh Government launched a plan to deliver urgent and emergency health care in the right place, first time in Wales. This plan provides a framework for our approach to improving urgent and emergency care. The 'six goals for urgent and emergency care' are:

1. Coordination, planning and support for people at greater risk of needing urgent or emergency care
2. Signposting to the right place, first time
3. Alternatives to hospital admission
4. Rapid response in a physical or mental health crisis
5. Optimal hospital care following admission
6. Home-first approach and reduce risk of readmissions have rocketed



Progress:

A revised programme structure aligned to Six Goals improvement has been established with clinical and managerial leadership roles for each of the 6 Goals. This ensures leadership of our system from those across all services both within the health Board and with partner agencies.

Specific achievements in Q1 include:

- A '6 Goals' action plan has been developed and submitted to Welsh Government
- The development and capital implementation of the Same Day Emergency Service (SDEC) unit at the Grange University Hospital (GUH)
- Developing alternatives to unplanned hospital attendance through the Royal Gwent Hospital MAU hot slot pilot
- A review of the approach to supporting High Impact Service Users (those who use emergency care frequently where other services are available) has been undertaken
- The ability for our Urgent Primary Care service to more easily and directly support patients waiting for Ambulance Services and provide alternatives to hospital attendance
- Revisiting patient flow between hospital sites and the discharge pathway from GUH

There are a broad range of actions for the next quarter and key actions include**:**

- Implementing Phase 1 of SDEC at GUH from August 2022
- Revised patient categorisation and pathways at GUH
- System access review and action plan
- Hot clinic and rapid access to specialist advice implemented and developed
- 6 Goals communications plan implemented for staff, partners and public
- Pilot of over 75s assessment via eLGH
- Flow Centre sustainable staffing review
- Recruitment to front door therapies roles
- Commence implementation of additional General Surgery theatre capacity linked to SDEC
- Agree strategic direction for the Physician response unit (PRU)
- Creating bed equivalent opportunities in partnership with social care through the 1000 bed days programme

2. Enhanced Local General Hospital

Why is this a priority?

The Enhanced Local General Hospital structure was established when the GUH opened in November 2020. The roles of the Royal Gwent (RGH) and Neville Hall (NHH) Hospitals changed to be more similar to Ysbyty Ystrad Fawr (YYF). The eLGH model provides local emergency care services, outpatients and diagnostics, planned care day case and inpatient surgery and medical inpatient beds on all 3 sites. They hold key roles in providing direct emergency care and supporting patients who have received emergency and inpatient care at the GUH but who are not yet ready for discharge due to ongoing care needs including rehabilitation. In addition, each eLGH is developing specialist Health Board wide or regional services roles, for example the Breast Care Unit at YYF and the proposed developments of local cancer services at NHH.

This workstream considers the role of the eLGH sites and oversees capital developments for both major schemes and the utilisation of existing spaces and service alignment/location. In addition, the remit has been expanded to consider the future acute medical model for the eLGH sites and options for long term sustainability of service delivery.

Some areas of Progress include:

- Establishment of Acute Medicine workstream
- Approval of the YYF Breast Unit Capital build and completion of the Satelite Radiotherapy Unit FBC and submitted to WG
- Stabilisation of junior medical staffing acute medicine model with collaboration from HEIW and a revised rota for the August 2022 intake

There are a broad range of actions for the next Quarter including:

- Service modelling and development of options for sustainable acute medicine service delivery
- Continued work on the NHH cancer services capital business cases
- Agreement on utilisation of unallocated capacity at NHH against the key priority areas particularly around day case, endoscopy and Ophthalmology opportunities

3. Redesigning Services for Older People

Why is this a priority?

The importance of getting things right for older people has been reinforced through our dynamic planning approach. It shows, in the starkest of terms, the cost to our system because the offer to older people falls short of what is needed to support them to live well and independently. As we emerged from the direct impacts of COVID-19 emerged, older people including those receiving acute care, active treatment including rehabilitation and those who are waiting to move to the next phase of their pathway occupy over 430 beds in our acute system, up to 50% of these people are designated fit for discharge.

The system urgently needs further transformation to ensure that older people can access evidence based clinical interventions that respond to their needs, in the context of what matters to them and ensuring that the care they receive helps prevent dependency now and later in life.

Some Key ares of Progress include:

- Key stakeholders have been brought together to set out a framework of early intervention, including locality structures, defining core offer of frailty and formalisation of hot clinics that when implemented will provide a viable alternative to hospital admission for many older people.
- Establishment of 4 key workstreams
    - WS1: Early Intervention - focussed on our GP and Frailty services, building on the integrated approach and interface with local authority and third sector partners to provide proactive and preventative care and services to support people to live well at home
    - WS2: Hot Clinics – develop a service that provides rapid assessment, diagnostics and treatment or ambulant patients with inpatient admission only occurring where there are clear further secondary care requirements.
    - WS3: Community Hospitals – Graduated care, developing the pathways and types of bed required in our Community Hospitals.
    - WS4: Early Supported Discharge - MDT approach to enable people to get home or closer to home as quickly as possible.

- Workshop held on 20th June to bring together workstreams 1&2 focussed the evolution of the CRT service, and in particular the Rapid Response service and hot clinic provision, with solutions thinking on the theme "working collectively as a health and social care system, how can we improve the efficiency and effectiveness of support provided to frail, elderly people to enable them to stay at or close to home, where it is safe to do so?"

There are a broad range of actions for the next Quarter key actions include

- WS1&2: Following the workshop, a proposal is being developed for phase one of programme delivery to:
  - Determine enablers for rapid response services to increase capacity and extend operations to provide care for more people in the community.
  - Develop Emergency Care at Home model to support people at home, including out of hours, across all areas.
  - Map the existing Hot Clinic provision across ABUHB to develop a navigable pathway for Health Care Professionals to understand the offer of the various clinics and how/when/where to refer.

  The above proposal will be developed in the first few weeks of Q2 with, once approved, delivery planned across Q2&3.
- WS3: Developing a front door model (GUH) for medically fit patients who require therapies input, using Direct Transfer Pathway to community hospitals.
- WS4: Align work with Goal 6 of Urgent Care programme to ensure joined up approach across the Health Board, providing the Frailty input and perspective.

4. Neighbourhood Care Network Development Programme (Accelerated Cluster Development)

Why is this a priority?

The Primary Care Model for Wales set out how primary and community health services will work within the whole Public sector system to deliver Place-Based Care. Collaborative work is at the core of this bringing together local health and care services to ensure care is better coordinated to provide care closest to home and promote the wellbeing of people and communities.

Progress:

A core programme team has been established and includes the Clinical Director for Primary Care, Workforce, Finance, Planning and Clinical Futures Programme support to develop a local programme plan to deliver a regional response to the nationally set ministerial milestones. The focus to date has been two fold:

1. undertaking the core briefing and engagement work for setting up the professional collaboratives, and;
2. undertaking the readiness assessment exercise and closing the required actions.

There are a broad range of actions for the next Quarter key actions include:

- Agree programme deliverables and milestones
- Establish fortnightly NCN Development sessions
- Recruit to the NCN Office (including business support, workforce transformation, data analyst and service improvement expertise) to increase capacity and capability for NCN led population based planning and service delivery
- Engage with RPB and Integrated Service Partnership Boards regarding the latter adopting the function of the Pan-Cluster-Planning Groups
- Individual Professional Collaboratives will begin to be established within each borough footprint for GMS, Community Pharmacy, Optometry, Community Nursing, Allied Health Professionals (AHPs) and potentially social services and these are represented on the cluster / PCPG. (Subject to contract reform, Dental Professional Collaborative are expected to be established by March 2023)

- Professional Collaborative (where established) will begin to respond to published population needs assessments (such as RPNAs due to be published in April 2022) and identify their service gaps and developments in response to Welsh Government planning guidance

5. Planned Care Recovery

Why is this a priority?

During the pandemic, services had to be paused to respond to the immediate demands and challenges of COVID-19 and capacity has been reduced by infection prevention and control requirements. As a result, the number of people waiting – and the time people are waiting – for planned care services are now longer than ever. This position is further exacerbated by those who did not access health care during the pandemic and in addition to the backlog of patients known to the services there is a potentially significant cohort of 'unreferred demand'.

In April 2022, Welsh Government published the 'Transforming and modernising planned care and reducing waiting lists' plan to encourage focus on key areas. These are: transforming outpatient services; prioritising diagnostic services; early diagnosis and treatment of suspected cancer patients; patient prioritisation to minimise health inequalities; those waiting a long time; building sustainable planned care capacity; and improving communication and support. These national objectives are in line with those identified in our IMTP, and continue to endorse our focus on these key areas of recovery.

Urgent and planned services are interconnected and a sustained higher need for emergencies will continue to constrain capacity for planned care work.

Progress:

- Formal Programme structure has been put in place with an Executive Lead and Senior Responsible Officer agreed, workstream leads approached, and monthly Programme Board initiated in July
- Specialty Outpatient Plans received and signed off by Divisions
- Communications to patients on the waiting list sent
- Scoping underway of programme and workstreams, particularly informed by existing activity and WG prioritisation – and how these are structured within the overall Planned Care Programme
- Key areas already progressed within the organisation aligned to the Planned Care Programme - Outpatient Transformation, MSK, and Ophthalmology
- Planned Care Programme workshop took place on 17th June 2022, extensive discussion on ways forward, and draft principles were agreed that will inform and shape the programme.
- Development of key metrics to support activity, RTT and beyond
- Future state Theatres model designed to maximise utilisation of our estate has been agreed
- Waiting list cohort projections remodelled
- Development of ABUHB Health Pathways programme approach

- Linking with key programmes – particularly Cancer, Urgent Care (6 Goals), eLGH Reconfiguration
- Combined action plan response to GIRFT and NCSOS reports completed

There are a broad range of actions for the next Quarter which include:

- Further increase outpatient activity and implement transformation change i.e. virtual clinics, patient-initiated follow-up/see on symptom
- Focus on delivery of agreed trajectories for 52 week and 104 week cohorts
- Sign off of key measures and targets to provide focus to Programme Board
- Develop capacity increase options for theatres for specialties with significant backlogs .e.g MSK and Ophthalmology, as well as focusing on ensuring appropriate capacity is maximised.
- Theatre Collaborative re-initiated
- Delivery of Regional Ophthalmology plan and cataract service backlog reduction programme
- Commencement of Health Pathways programme in line with nationally procured software solution
- Scoping up and development of Diagnostics programme
- Patient Activation and Access workstream initiate

6. Maximising Cancer Outcomes

Why is this a priority?

Cancer outcomes need to be improved. The Single Cancer Pathway, supported by Optimal Cancer Pathways for individual tumour sites, provides the roadmap to shorten diagnostic and treatment pathways once a person is suspected as having cancer. The Cancer Strategy, Delivering a Vision 2020-2025 sets out the broader context with prevention, early detection, patient experience, living and dying with cancer, cancer research and access to novel therapies also key components of the approach to transforming cancer services for our population.

Whilst it is too early to be able to measure the impact of successive pandemic waves on morbidity and mortality for cancers, there is concern that a reluctance by patients to attend primary care and hospital, together with the temporary suspension of national screening programmes and longer waiting times for diagnostic tests and treatment will result in patients presenting at a later stage in their cancers which will make improving cancer outcomes more challenging.

Planned Care and Cancer Services are interconnected; it is the same workforce, accessing the same diagnostic and treatment capacity.

Progress:

- Operational model for managing cancer services is under review and includes all Health Board teams involved in cancer care delivery, to maximise resource and outputs to better meet demand
- Corporate Cancer team nearing full compliment, improving the alignment between strategic, corporate and operational activity
- Local components of the Regional Acute Oncology Service (AOS) Phase 1 model are being implemented, with additional AOS nursing being appointed to increase capacity to meet the needs of our patients and develop a bespoke service for the ABUHB healthcare system
- Workshops developing the business justification case for the Nevill Hall Hospital Cancer Centre are being progressed, and also for the proposed Radiotherapy Satellite Cancer Centre

- Implementing Optimal Cancer Pathways will be progressed for Breast, Colorectal & Urology MDTs; the initial priority will be the Breast MDT, linked with the Breast Unit
- Cancer Clinical Reference Group is being established with the inaugural meeting September 2022
- Commencement of developing the strategic vision for cancer care delivery within the Health Board, as part of the broader regional model – setting out the journey that cancer needs to travel, incorporating the capital investments being made into the system
- Linking with other key programmes of activity to ensure read across; Planned Care Recovery (including Elective Capacity, Diagnostics and Outpatients), eLGH Reconfiguration, Urgent Care (6 Goals)

There are a broad range of actions for the next Quarter key actions include**:**

- Demand and capacity mapping and modelling, incorporating predicted demand to align resources against
- Continued review of operational delivery and development of improvement plan
- Developing roles to support workforce to deliver – such as Pathway Navigators
- AOS recruitment to complete and model developed, moving towards Phase 2 of the programme, including working with SDEC model
- Increased linkages with new Clinical Support Services Division and Diagnostics programme to improve access and optimise support available
- Linking with Planned Care Recovery – focus on theatre allocation, and NHH Day Surgery activity
- "C the Signs" roll out, supportive technology to assist in the early detection of cancer
- Prehab and recovery workstream workshop to instigate activity
- Start on site for NHH Radiotherapy Unit subject to Welsh Government approval
- Review of commissioning position for tertiary services provided for Health Board residents by other organisations
- Annual Report completed

7. Public Health Protection and Population Health Improvement

Why is this a priority?

COVID-19 has shown a spotlight on the inadequate level of preparedness for the challenges faced by our population, our workforce, and our services. The level of ambition for Public Health Protection (including preparedness for managing infectious outbreaks, contact tracing, protecting most vulnerable populations and workforce, effective surveillance and higher vaccination uptake must be stronger.

As a population health organisation reducing health inequality and improving health is at the core of everything we do. Our long-term ambition to reduce demand for healthcare is fundamental to a sustainable system of care. This can only be achieved through systematic, population scale interventions that target the underlying causes of poor health, such as lifestyle choices and socio-economic deprivation, and the uptake of screening to improve early detection and optimal treatment of disease.

Progress:

- GTTPS and the Testing Service have transitioned to support the new Welsh Government requirements with respect to testing and contact tracing of those most vulnerable to the effects of Covid. As of 1st July, The Health Board and Caerphilly County Borough Council are the lead organisations for GTTPS.
- 91.6% of all eligible patients in an older adult care home and 85.3% of patients aged 75 years + have received a spring booster
- Learning from Covid and Monkeypox is informing the development of the Public Health Incident Plan

- Monkeypox pathways for patients have been developed and vaccine programme for has commenced for those at highest risk of transmission utilising the limited vaccine supply currently available.
- The Health Inclusion team supported by clinical leads from GTTPS and the Testing workforce have supported the Ukrainian refugees initial health screening process.

There are a broad range of actions for the next Quarter key actions include:

- Agree a new workforce and finance plan for the Testing Service in light of WG communication.
- Finalising symptomatic admission pathway at GUH with testing team due to support.
- Complete spring booster offer to those who were unable to attend appointment and secure mass vaccination centres for the Autumn/Winter.
- Develop a more sustainable workforce plan to support the Ukrainian refugees health screening and support.

8. Mental Health Transformation

Why is this a priority?

Throughout 2021 we set out and discussed our proposals to Transform Mental Health Services with our population. The detrimental impact of COVID-19 on the mental health and wellbeing of our population has been significant. Demand is likely to exceed capacity threefold over the next three to five years with significant increases in conditions such as severe anxiety under pression and disproportionate impact on individuals with existing mental health conditions. Demand for mental health services is sharply increasing and we need to find ways of supporting people earlier within the community to better support crisis prevention and recovery.

The vision is to provide high quality, compassionate, person-centred mental health and learning disabilities services, striving for excellent outcomes for the people of Gwent. There are 2 transformational Programmes (Whole System, Whole Person Crisis Support Transformation and Complex Needs) that will deliver this vision. There are multiple projects that sit under both Programmes including:
111 press 2, review of Primary Care Mental Health Services, in patient ward remodelling, reviewing complex needs pathways, strengthening crisis assessment and home treatment services, improve transport for patients in crisis.

Through a single point of access, we will develop services through a variety of sanctuary service (in Emergency Department and community), shared lives, acute inpatient provision, housing tenancy and support, mental health support for first aiders, crisis assessment, home treatment and liaison and Support House.

Links with other workstreams are: Inpatient Improvement Urgent Care – ED

Progress:

- Welsh Government have reviewed the Outline Business Case for a Specialist Inpatient Unit (SISU) providing a series of recommendations and actions to enable us to progress this to a Full Business Case
- A Complex Needs Community of Practice established, with a local event recently held
- Ty Cynnal support house has been open for 6 months, and continue to offer support to people
- Recruitment of staff for 111 (mental health point of contact roles) has been completed
- Welsh Government SIF funding has been secured for Hiraeth forensic community services transition house
- Increased access to Suicide First Aid and Zero Suicide Alliance training

- Continued to develop a new psychological wellbeing practitioner workforce in primary care
- Expansion of Shared Lives for Mental Health (older adults- part of recovery plan as alternative to admission as part of whole person, whole system crisis programme)- WG SIF bid submitted- awaiting confirmation of funding
- Expansion of MAS provision; 4 ANPS employed to support timely assessment & diagnosis and to support earlier intervention as will in reach to care homes. Also a Band 7 practice facilitator started in June to enhance clinical skills to support robust and empowered decision making.
- Enhanced OAPL (older adult psychiatric liaison) service- WG SIF bid submitted to support permanent expansion of operational hours of 8am-8pm Mon-Fri and 9am-5pm Sat/Sun. Weekday service will cover all general acute and community hospitals. Weekend support will be for general acute with telephone advice to other sites.
- Programme manager recruited to lead implementation of LD Community Services Review outcomes

Next Quarter:

- Develop the SISU OBC and associated service planning and transformation work, including the benefits realisation plan via external consultancy organisation. Continue to develop action plan in response to WG feedback on SOC
- Continue to roll out Connect 5 and the use of a locally developed App to further evaluate training
- Commission "Mindfulness for Everyday" sessions
- Tackling the waiting list backlog for primary care intervention by recruiting start workers and practitioners
- Implement extension of shared lives for older adults
- Refresh overarching mental Health strategy and divisional estates strategy
- Secure funding for ED sanctuary service to continue into Q3/Q4
- Commence 111#2 test of change & start recruitment of staff for 24/7 model
- Continue work to enhance liaison model

9. Decarbonisation (Net Zero)

Why is this a priority?

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

Progress:

- Formal Programme structure established.
  - Terms of Reference
  - Governance structure
  - Workstreams and workstream leads
- Funding applications received (5) 3 short listed with 2succesful bids totalling the full £60k available this financial year for Decarbonisation improvement schemes
- Estates workstream is well established, colleagues are working closely with Finance and the Clinical Futures PMO.

- 1st phase of SusQI sustainable health care training has been completed through ABCI funding and delivered through the centre for sustainable health care.
- WG renewable energy study has been completed on GUH,YAB,NHH these are our priority sites based on WG National mapping exercise. This report has just been received.
- Continued progress on the ReFit programme with the tender specification and contract documents being developed

Next Quarter:

- Implementation of action plan
- Workstreams to commence in August 2022
- Alignment of the 46 Welsh Government Initiatives with the Programme workstreams
- Investigate further funding opportunities for this financial year
- The net-zero Carbon report to Welsh Government is due on the 09th September 2022, which will include carbon footprint information for buildings, fleet, procurement, waste plus other aspects of the decarbonisation programme metrics.
- Evaluation and next steps from the renewable energy study recently received from WG.
- ReFit tender and contract to go to market to procure a service provider who will work with AB & WG to design and deliver an efficiency and renewable energy solution.

10. Agile Working

Why is this a priority?

Welsh Government have developed an approach to agile working following the need to work differently through the recent Covid 19 Pandemic. Based on service needs, providing a variety of options for employees on where, and how they want to work. It means offering mixed-use spaces with a variety of services, workspaces, and environments. More modern agile workspaces are not just about working from home, hot desking and sharing office space, but changing the cultural mind-set and ensuring working environments support break-out spaces to encourage communication, providing areas for impromptu meetings and collaborative work.

Key Drivers

- Length of lease of existing premises
- Utilise HB property in preference to Lease property - better value.
- Utilise available capital for long term benefit instead of annual revenue spend.
- Vacate substandard current Health Board owned accommodation as a precursor to supporting the Estates Strategy and rationalisation of older estate where there is no future use envisaged.
- Opportunities to centralise staff into fewer buildings.
- Maximise the use of buildings that are good environments to work in that have good IT connectivity, parking and promote staff wellbeing and retention.
- An incremental approach to releasing estate to reduce frequent moves of staff bases.
- Reduced claims on travel expenses
- Reduced carbon footprint/emissions on both fuel and building utilities
- Improved staff well-being, morale, and productivity/efficiency
- Alignment with the Socio-economic Duty 31 March 21

Welsh Government Future Workforce Model

The Welsh Government have stated that they would like to see a workplace model where staff can choose to work in the office, at home or in a hub location and are exploring options for a network of remote working hubs in towns and communities which will:

- allow people to work nearer to where they live
- allow individuals to work together in their local community
- provide a space for those who cannot or do not want to work from home

Progress:

- Agile space at GUH now completed.
- Progress made at Grange House with next steps to review the gym as an opportunity to re-purpose the space into either an agile working area or well-being working area.
- Mapping work at St Woolos around the staff and the requirements for space in the future had been completed and being assessed.
- Agile Programme Manager in the Workforce and OD Division due to start in August will allow a dedicated resource to the programme.
- Small task group set up conducting an audit on all accommodation reviewing leases of what is up for renewal and what is flexible.
- The 365 Desk Booking System had been received by the programme, this is currently being monitored for practicalities and effectiveness by the management team at Caerleon House. Outcomes will be reported at future board reviews.
- Caerleon House 8 agile spaces created within the open plan area with all ICT equipment in place, with an additional 3 meeting rooms that can also be utilised, the booking of this facility is now live on the internet.
- Facilities staff survey has identified those staff that can work agile / Home working with an additional proposed number of staff who could also work agile.
- Facilities & Estates agile sub-group now set up and reporting into the Senior Management Board for scrutiny and reporting purposes.
- Accommodation group ToR now in place with future meetings planned over the coming months.
- The car sharing portal is now live on the system and can be accessed by all those staff who wish to sign up to the process, this also links with the Zero Carbon programme delivery.

Next Quarter

- Finding the space opportunities to create 5 additional agile working Hubs across the organisation.
- Evaluating the new agile hub at Caerleon House in Newport
- Reporting on the outcome of those staff that are now working agile within the facilities division & extending the work to other divisions
- Focus on the STW/RGH agile delivery plans.
- Further development of the online booking system for spreading the agile Hub space opportunities to other sites/estates.

Summary

Whilst there is progress across all priority programmes, some are more advanced than others with much of the progress in Quarter 1 focused on getting the structures and governance in place. Quarter 2 should expect to see greater emphasis on delivery and more robust plans that can assess the opportunities to support the financial challenges and the key metrics to measure success and impact.

4. IMTP PLANNING SCENARIO – QUARTER 1

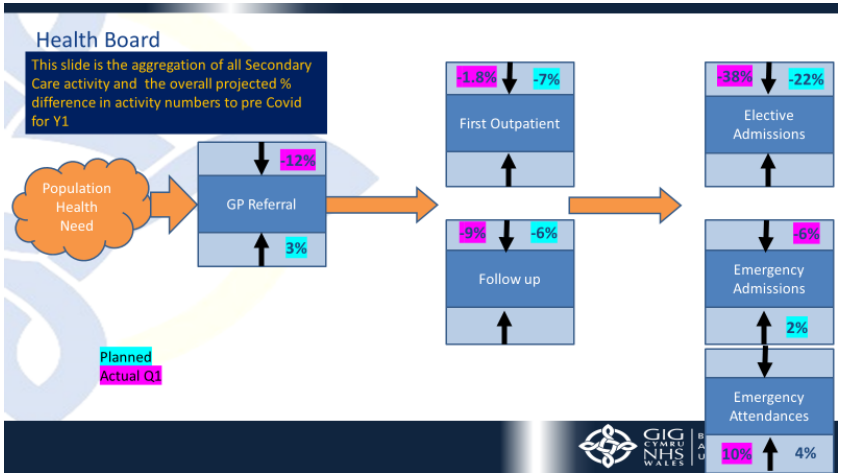
As part of the IMTP submission the organisation was required to submit a Minimum Data Set (MDS) outlining a profile of activity for the year alongside forecast performance and workforce information. This information has been updated for the first quarter and a full data set presented in the refreshed MDS at Appendix 3.

As set out in the IMTP the Health Board adopted a dynamic planning approach for secondary care to understand the potential demand, risks, and capacity requirements of the system. Working with each clinical team by specialty using real time data, realistic workforce assumptions, emerging experience of how patients are returning to their services and known system constraints for our IMTP we had a clear understanding of:

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

The Planning scenario has, in aggregate form, largely followed as predicted by the services and their scenarios.

- Referrals are back to within pre Covid range and have not yet overall seen the increase predicted.
- Overall, there have been positive increases in the numbers of first outpatients delivered across all services.
- This increase in first outpatient performance is expected to be sustained and based on the trajectory we have reforecast and improvement in the numbers of outpatient appointments in line with the improvement programmes.
- Elective inpatient activity remains below the forecasted scenario, due to the staffing and covid pressures, therefore existing forecasts have not been adjusted in line with current operational plans, these need to be reviewed at Q2.
- Bed occupancy is in line with forecast with utilisation for non-protected areas running at 95% - 97%.



MDS Changes Q 2-4

The Q1 review reflects the organisation is planning appropriately for activity and are broadly in line with the planning scenario. The following changes have been made to the forecasts in the MDS:

Improvements:

- Improvement projected in the March 2023 out turn for the numbers of 104 week waiter for treatment from 6500 to 2383
- Improvement projected in the March 2023 out turn for the numbers of 104 week waiters for a first out patient appointment from 1600 to 538
- Increases in the numbers of face to face and virtual outpatient appointments overall increase of 18% against the original forecast

Areas where reductions are projected:

- Cancer performance expected to sustain at 50-55%% compliance rising to 60% by the end of the year against original forecast of 60% rising to 70% due to the backlog of patients to be treated
- Endoscopy, the re - forecast will be revised in Q2 however due to the urgent and suspected cancer demand the routine forecasts are likely to be revised down

Areas to look at in Q2

- A and E attendances - attendances were above forecast in Q1
- Elective inpatient and Daycase activity against the planning scenario, these were below forecast in Q1 due the urgent care pressures and staff sickness, these will be review reviewed in Q2

With continued pressure on our urgent care system, sustained levels of staff sickness due to Covid it is positive as this position could have deteriorated further. In Planned Care each specialty as part of day to day operational planning continue to review capacity and opportunities to address the backlog with the ability to scale up further if workforce and funding becomes available. The current forecast takes into account the current position and most likely scenario.

Waiting lists

The Health Board has been making progress in the reduction in the volume of patients waiting for planned care treatments and outpatient appointments , with numbers reducing for the last seven months. There has already been progress in bringing down the longest waiting patients in the first quarter of the year. There has been a full review of the waiting list, cohorts, our rate of current additions and un referred demand scenario (this was the consideration of patients who did not come forward during the pandemic but may now enter the system). Services continue to review their plans focusing on treating those that have waited the longest whilst balancing the urgent and prioritised work. As noted in the report whilst this influences RTT performance it is in keeping with treating the patients with the greatest clinical need first.

As part of the Quarter 1 refresh of the Minimum Data Set, there are improvements forecast for those waiting over 104 weeks for treatment the organisation has decided to retain the forecast performance for the 52 weeks to new first outpatient appointment measure as set out in the original IMTP submission. The forecast position was

remodelled based on existing organisational performance and suggested that performance would deteriorate from this original profile, in particular in the final quarter of the year. However significant work is underway to support improvement in outpatient performance.

The review sees progress in addressing the numbers waiting but it is clear from the model there is not currently capacity to treat our urgent patients, improve cancer compliance, respond to the acuity presenting and achieve the target performance for these measures. It is also noted based on the current referral levels, the focus on urgent and long waiters, there is a risk of greater wating list growth due to the profile and will mean the Year 2 position may be even more challenging without changes in activity.

Unreferred Demand

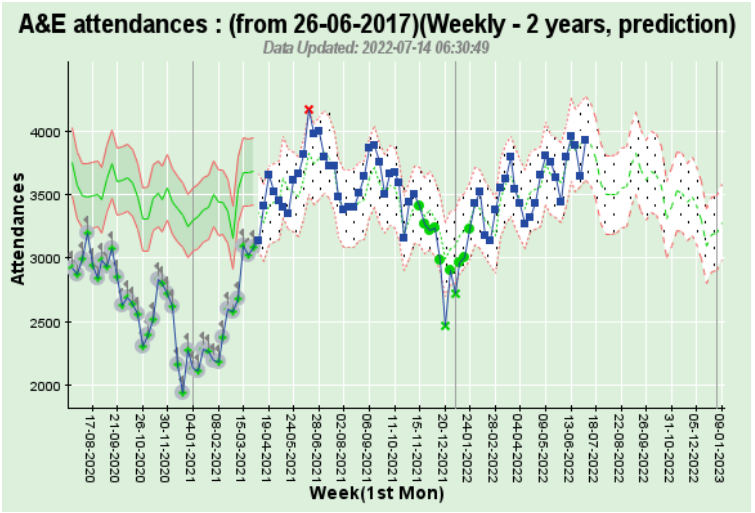
The planning scenario in the IMTP was predicated on unreferred demand presenting during Year 1 of this planning cycle. We have factored this scenario into our demand and capacity assumptions on a specialty by specialty basis. It is too early to start to draw any firm conclusions on the presentation of unreferred demand, for Q1. Overall the numbers forcasted have not been observered, however there are increases in emergency activity, and increased referals for Geneneral Surgery and Gastroenterology. This suggest patients who did not get referred in during the pandemic are now presenting in our emergancy care system.

Cancer

The Cancer forecasts for the numbers of referrals and patients starting treatment are in line with the forecasted planning scenario. The Single Cancer Pathway compliance has deteriorated against forecasted performance this quarter. There is a recovery programme of work in place to improve this position, however it is prudent to reforecast the yearly profile at this point. The expected compliance is expected to be maintained at around 50% -55% with an aim to reach 60% by the end of the year and a best-case scenario if the diagnostic pathway capacity issues are resolved in year.

Urgent Care

The Q1 forecasts were slightly below the actual activity for A and E attendances. The forecasts remain within the planned range however should be noted any small increase in demand is a significant challenge on an already pressured system. The forecasts will be reviewed again in at the end of Q2. Emergency admissions are in line with forecasted and the forward projections will not be amended.

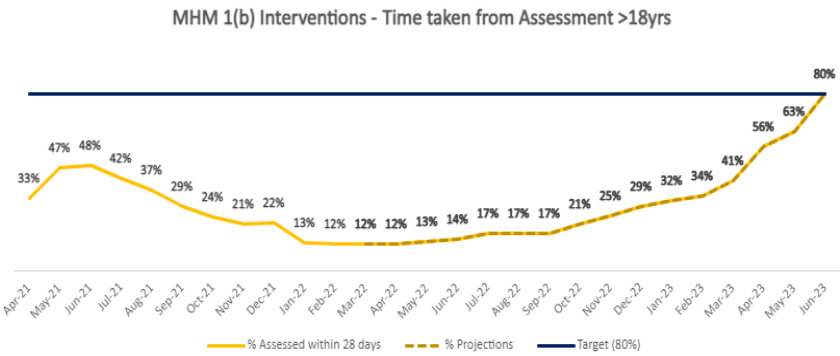


Adult Mental Health Projections

There is ongoing work to align with the Delivery Unit measures and forecasting with the MDS. The following forecasts have been projected by the Division:

- Part 1a, psychological therapies, is in line with target and expected to continue with current level of achievement

- Part 2 expected to reach target level within the year and 1b interventions has a clear plan to meet the 80% target by March 2023.



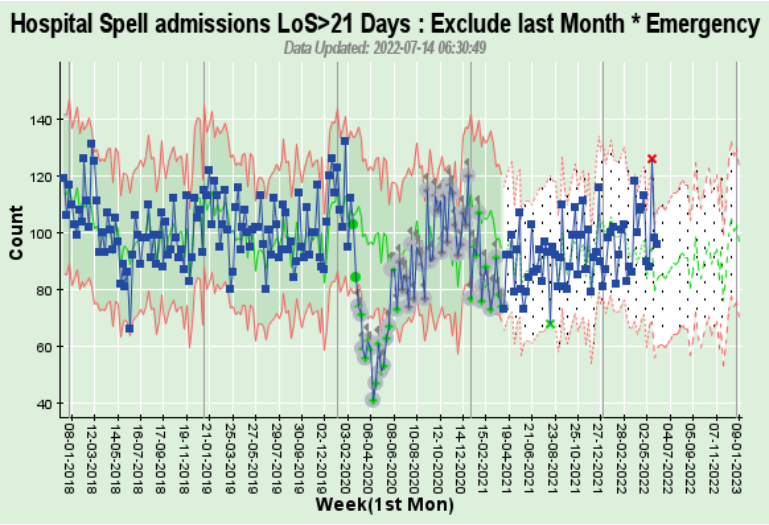
Primary Care:
The MDS does not truly represent the demand and capacity picture for Primary Care and the following is noted which should be reviewed in Q2 and could influence the forecasted projections.

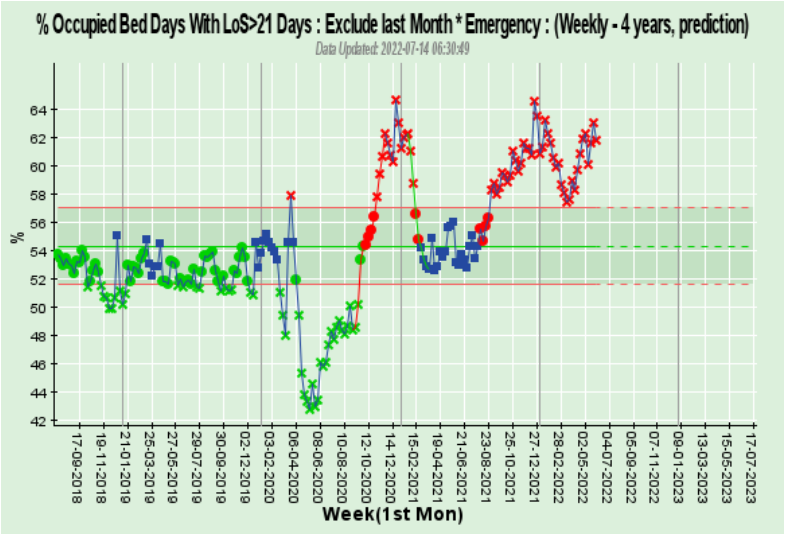
- GMS activity levels increased with more face-to-face activity. activity has stabilised however as noted in the report the stability of GMS has deteriorated and this is expected to effect activity levels over the next 6 months.

- This is a similar picture for Pharmacy with increased workload in community pharmacies. There has been a notable increase in Q1 in the suspension of services impacting on the ability access advice and support locally.
- Significant increase utilisation of the Common Ailments Scheme after exercises to increase awareness and capacity within the service.
- GP referrals for urgent assessments via Rapid Response, Emergency Departments or Assessment Units has returned to pre-pandemic levels.
- Community hospitals are continuing to operate with maximum surge capacity open, this continued position has not been descaled as forecast.
- There is an evident increase in the average length of stay in community hospitals and a reduction in overall discharges
- The greatest proportion of bed days lost for patients with complex needs awaiting discharge from hospital are associated with allocation of social workers (Newport in particular),
- GP referrals for speciality outpatient services have returned to almost normal levels in a number of specialities.
- Trauma & Orthopaedics fewer referrals now being made directly to this specialty. It is important to note at this point it unknown if this is due to alternative pathways or reduction because of the waiting lists leading to delayed access to assessment.

Bed Plan

The bed plan has followed the overall expected occupancy levels and demand patterns but not at a specialty level. During Q1, the Medicine Division were running at 97% utilisation against their bed plan and Community Division 103% Both Medicine and Primary Care Division are operating above forecasted and expected levels. Our Care of the Elderly service occupancy was in line with forecast and continues to drive the need for additional inpatient capacity which present associated workforce challenges. Whilst the numbers admitted who stay over 21 days is following the similar pre Covid patterns the % of occupied bed days remains out of range.





Summary

This is the first production of this report seeking to draw together the Health Boards progress drawing on outcome, performance and priority programme information. This report attempts to provide information to support the organisation understand the progress it is making against the IMTP and enable effective decision making looking to future quarters of activity.

There is more work to do to develop this report, greater outcome-based measurement is required and a range of information to support fuller understanding of quality and experience will be developed.

Overall, there has been progress in this quarter in the face of a challenging environment. The organisations understanding of its system and plans remains robust and the priorities decision made in the IMTP remain vital areas of focus looking to the next three quarters of the year.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board 27th July, 2022 Agenda Item: XX

Aneurin Bevan University Health Board

Planned Care Delivery

Executive Summary

The challenge in recovering planned care activity was set out in the Health Boards IMTP for 2022 to 2025. Alongside the production of the Health Boards IMTP the Welsh Government published 'Our programme for transforming and modernising planned care and reducing waiting lists in Wales' in April 2022. Within the National Programme the Welsh Government have set a series of ambitious targets for Planned Care Services, notably:

- Eliminate the number of people waiting longer than two years in most specialities by March 2023 (104 Week to all stages of treatment)
- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (52 weeks to new first outpatient appointment)

This paper provides an overview of our approach and priorities for Planned Care Recovery in the Health Board aligned to the Welsh Government plan and focusses specifically on our delivery against these two measures, projected activity towards the targets and actions we are taking to ensure efficiency and productivity in our services.

In May 2022, the Auditor General published 'Tackling the Planned Care Backlog in Wales' a commentary on the position regarding patient waits. The report contains 7 key actions the auditor identified as essential to tackle the waiting list backlog, this paper also sets out at a high level how the Health Board is responding to these recommendations with a more detailed report on this to come back to a future Board session and through the Finance and Performance Committee.

The Board is asked to ENDORSE the approach and priorities for Planned Care Recovery, as set out within this paper, including:

- the Developments in Planned Care
- the Trajectories against the national ambitions

The Board is asked to:	
Approve the Report	X
Executive Sponsor: Leanne Wood	
Report Author: Chris Dawson-Morris	
Date of the Report: 27/07/22	
Supplementary Papers: • ***Audit Wales Review: Tackling the Planned Care Backlog in Wales*** **https://www.audit.wales/publication/tackling-planned-care-backlog-wales**	

Purpose of the Report

The Planned Care Programme was identified as a priority programme in the 2022/25 IMTP approved by the Board in March 2022 and subsequently approved by Welsh Government. The Planned Care Programme brings together existing programmes, as well as key new workstreams identified through our IMTP alongside those set out by Welsh Government in the national programme plan. This paper seeks to inform and provide assurance to the Board of overall progress and prioritisation of this agenda and updates against the two specific National Planned Care Ambitions.

- Eliminate the number of people waiting longer than two years in most specialities by March 2023 (104 Weeks to all stages of treatment)
- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (52 weeks to new first outpatient appointment)

The Auditor General's publication 'Tackling the Planned Care Backlog in Wales' contains seven actions;

- Clear national vision and supporting investment
- Strong aligned system leadership
- Renewed focus on system efficiencies
- Build and protect planned care capacity
- Manage clinical risk and avoidable harms
- Enhanced Communication with patients

The Health Boards Planned Care programme addresses these actions and information on this is provided later in the paper.

Background and Context

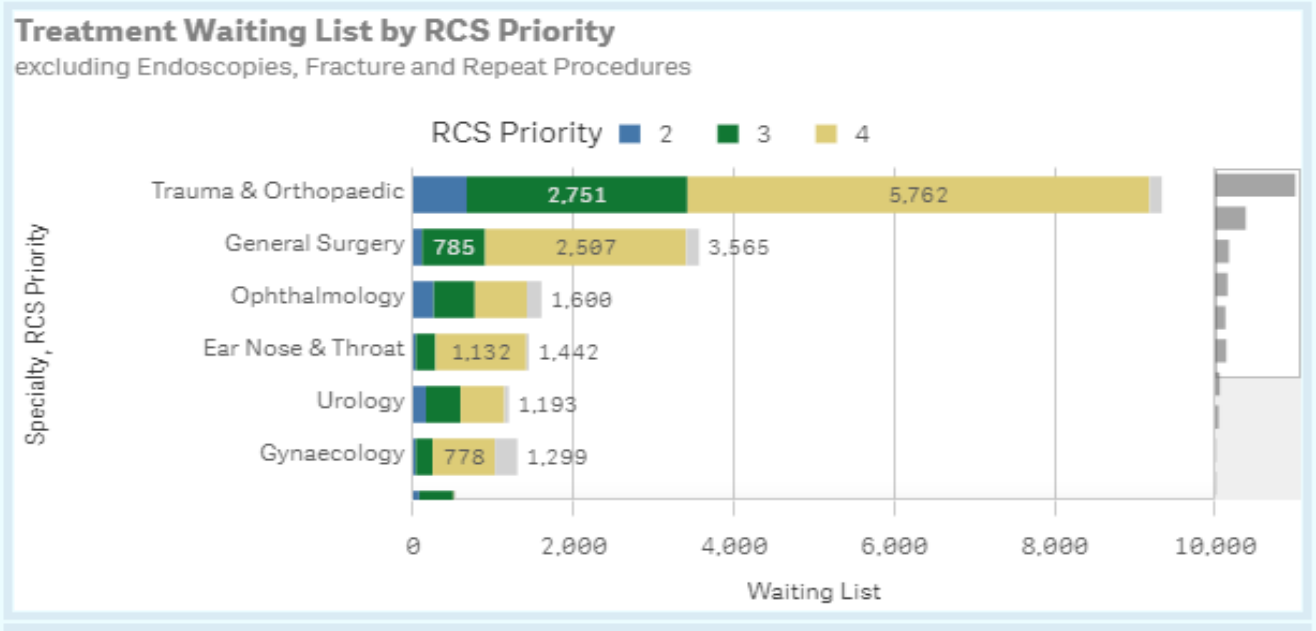
The Health Board has been making progress in the reduction in the volume of patients waiting for planned care treatments, with numbers reducing for the last seven months. However, the total number of people waiting to be seen and / or treated is at exceptional levels due to the pandemic

The below table is a breakdown of waiters by stage and time and it is the totality of this demand that the organisation has to plan for, this is the latest validated point at May 2022.

Week Bands	1 Outpatient WL	2 Diagnostic	2 Therapy	3 Follow Up	4 Daycase WL	4 Inpatient WL	Grand Total
0 to 25	48,462	2,602	152	4,171	8,385	2,435	66,207
26 to 35	10,138	624	18	779	2,098	799	14,456
36 to 51	9,589	480	22	342	1,701	1,191	13,325
52 to 103	7,817	558	64	636	2,364	2,166	13,605
104 +	1,330	298	19	185	2,234	1,963	6,029
Total	**77,336**	**4,562**	**275**	**6,113**	**16,782**	**8,554**	**113,622**

Within this there remains significant backlogs for treatments with the majority of these in Trauma and Orthopaedics categorised as stage 4 against the Royal College of Surgeons (RCS) priority criteria (Procedures to be performed <3 months).

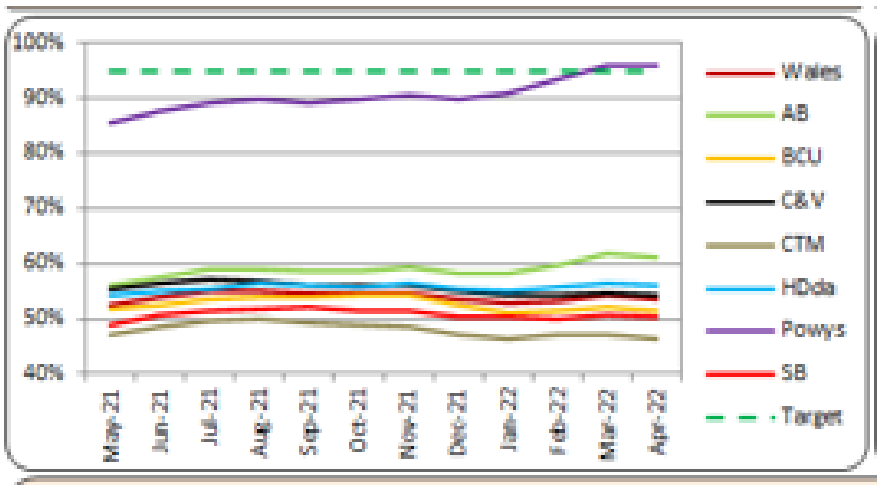
May 2022:



Procedures are still being undertaken on a priority basis based on the RCS criteria and there is no national guidance to move to a treat in turn approach which would see long waiters prioritised.

Capacity for Planned Care has increased across the organisation as Infection Prevention and Control measures have been eased. Although there is variation by specialty the number of elective inpatient admissions have increased to the highest level since the pandemic began, elective inpatient admission activity for May represented 72% of pre-pandemic levels. Day case activity also increased in May to 90% of pre-covid activity. This will increase further in coming months with the alignment of sites and there is information further in the paper on developments and plans for capacity and transformation. However there remains a challenge in the capacity available for planned care, with workforce restrictions, displacement of urgent need and the availability of beds due to urgent care pressures. There is a constant need to balance system risk across urgent care presentations and planned treatment based on clinical prioritisation and need.

In relation to other Health Boards, the organisation has one of the lowest numbers of people waiting in most metrics relating to referral to treatment times (with the exception of Powys). Aneurin Bevan University Health Board and Powys Teaching Health Board are the only organisations to have seen improved RTT performance in the last 12 months. The graph below represents performance against the 26 week RTT position.



To support the organisation in delivering against the national programme, the Health Board has set in place clear governance approaches with the Planned Care Programme established as a core priority. Formal Programme structures have been put in place with an Executive Lead and Senior Responsible Officer agreed, workstream leads in place, and a monthly Programme Board initiated in July.

As set out in the Board paper in June, the Planned Care Programme has agreed the following principles to guide the organisations work:

- Reducing Health Inequality will be core to decision making
- Sustainability of service delivery for the long term
- Focussing on clinical need in prioritisation
- Maximise an individual's time, both citizens and staff
- Intelligence led decision making, with a common and shared understanding of delivery
- System based decision making

The Health Boards Planned Care Programme is structured around 5 core areas of work;

1. Outpatients
2. Elective Capacity
3. Diagnostics
4. Patient Information and Active Waiting
5. Pathways

Outpatients
This area of work will build on the existing programme. Each service area has developed a clear service specification for outpatients with a check and challenge approach to ensure consistency and consideration of options such a Patient Initiated Follow Up and See on Symptom where appropriate.

Elective Capacity
This area of work is considering the model for allocation and utilisation of theatre capacity to ensure the most efficient and equitable use of resources. It will also establish a Theatres Collaborative to support service efficiency and organisational design, this will utilise improvement methodology around practice in theatres.

Diagnostics
This area of work will initially undertake a benchmarking exercise around diagnostics capacity and access in the organisation. This will inform opportunities for service gaps and potential develops of community diagnostic centres and Endoscopy expansion working with partners across South East Wales.

Patient Information and Active Waiting
This area of work will build on existing progress in outpatients to develop simple access points for patients for information about their waits and what to do during the waiting period. This area of work will also develop more consistent approaches to Prehabilitation, benchmarking existing provision and exploring opportunities to ensure patients are supported to be as fit as possible physically and mentally for treatments in order to maximise outcomes.

Pathways
As set out in the IMTP we have prioritised pathway programmes of work in MSK and Ophthalmology for a focus of improvement in 2022/23. This area of work will also explore the potential implementation of tools to support more consistency in referral processes and utilisation of pathways.

Importantly the delivery of planned care is not just about focusing on the numbers, we know there is an individual story for each person waiting for an outpatient appointment or definitive

treatment. Therefore, whilst the organisation increases activity it is also important we maintain focused on core principles of supporting patients. It is also important that sustainable solutions are delivered in addressing the needs of our communities, delivering the services our population needs will not be achieved by focusing on short term solutions alone.

Assessment and Conclusion

The following section provides an assessment to support Board members understanding of our deliverability against the national ambition and actions to maximise efficiency with a specific focus on:

- Eliminate the number of people waiting longer than two years in most specialities by March 2023 (104 Weeks to all stages of treatment)
- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (52 weeks to new first outpatient appointment)

Demand for new outpatients has increased since the start of the year with referrals back to pre-covid range. Whilst clinicians are prioritising based on clinical urgency this means the capacity for long waiting patients is restricted.

Although the cancer pathway is counted separately to other outpatients for performance reporting the organisations capacity plans must balance across all services. Suspected cancer referrals in the first 2 months of 22/23 have continued to exceed 2,500 referrals per month, with a 12.4% increase in referrals in Q1, however this varies by speciality and the overarching figure masks significant increases in other areas. Patients on these pathways must be seen and treated within the Single Cancer Pathway target of 62 days. This again limits the capacity available for long waiters for non-cancer referrals. The current urgent care pressures also need to factor into the system capacity for planned care. As can be seen in the RTT position new outpatients represent the highest volume with 18,700 currently waiting over 36 weeks.

As part of the Quarter 1 refresh of the Minimum Data Set, the organisation assessment has resulted in maintaining the forecast performance for this measure as set out in the original IMTP submission. The forecast position was remodelled based on existing organisational performance and the 52 week cohort which indicated that performance would deteriorate from this original profile, in particular in the final quarter of the year. However as set out below significant work is underway to support improvement in outpatient performance.

			March '22	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 52 week waits by December 2022	March IMTP Forecast	9,975	9,700	9,579	9,380	9,200	9,000	9,000	9,100	9,200	9,300	9,300	9,300	9,300

At present the organisation is not forecasting it can achieve the Welsh Government target, this is a scenario which will and can change. However, it must be noted there is risk in delivery of outpatients. As demonstrated above balancing across the demands of cancer, urgent care and planned activity is essential.

Aggregated projections at organisational level hide specific risks at specialty and sub speciality level. Whilst the target can be achieving across many specialties there are areas where the cohort of patients who may breach 52 weeks is large and beyond current capacity, such as in urology, ophthalmology, ENT and particular orthopaedic specialties. The level of risk that is planned to be

managed across these specialties through additional activity or new approaches is in the region of 3,000 by December 2022.

All activity that can improve outpatient delivery, increase capacity, and change practice will be needed to create opportunities to meet new outpatient demand.

The Outpatients Improvement Programme continues to build on the new ways of working and modernisation which was established through necessity after surge 1 of the pandemic. This includes the outpatient improvement measures outlined by the National Planned Care Programme Board, with key targets regarding risk-management of long waiting follow-up patients.

The outpatient programme focuses on driving improvement and change. The key to sustainability is the ability to modernise its delivery through for example, maximising non- face to face consultations via telephone, video, group consultations, attend anywhere, virtual consultations or assessments and advice only. Embedding new processes such as See on Symptom (SoS) and Patient Initiated Follow-ups (PIFU), streamlining pathways and use of technology. All specialties have now reviewed their outpatient models.

The focus has been on the 52+ week new Outpatient waiting list clinical assessment process which will establish whether long waiting patients still require their appointment along with a clinical assessment. There is a robust process in place which has been underpinned by Welsh Government and which ensures that the patient and referrer are notified if a patient has indicated that they wish to be removed from the waiting list. This process is being rolled out to contact those patients who have been waiting over 36 to 51 weeks. Some other initiatives include determining where future services can be delivered, a communication strategy to keep in touch with patients who are on Health Board waiting lists, exploring new ways of working through technology, for example, a specialist advice system, whilst ensuring that there are close working links between Primary, Community and Secondary Care. The benefits of the programme will be an outpatient service that is designed around the needs of the patient, that access to services is timely and that patients are fully engaged in their treatment, promoting a culture of self-help.

Dermatology

The Dermatology Directorate has a "Psoriasis Direct" in place providing a Patient Initiated Follow Up pathway for Psoriasis patients. The scheme allows Psoriasis patients to contact the CNS and seek advice or an appointment when their skin flares.

The team have also established an advice only system to enable clinicians to give written advice to both the patient and the GP without the patient needing to be seen in clinic or non-face to face in 2021/22 8236 were supported through this route.

Treatments

The Specialties have maintained the principle of undertaking activity defined by clinical prioritisation rather than a time-based approach; this enables timely care for the most urgent patients and clinically led decision making. This will have an impact on RTT waits in some services however there is evidence that services are balancing urgent patients and patients who are waiting the longest.

Measure	Target	Forecast Mar 2022		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by 2024	8,946	Q1 Refresh	6,514	6,029	5,813	4,485	3,962	3,618	3,251	2,899	2,719	2,222	2,059	2,383
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by 2024		IMTP Forecast	8,722	8,457	8,376	8,200	8,044	8,000	8,500	8,700	8,900	8,900	8,900	8,900

As part of the Quarter One refresh the organisation has revised the treatment forecast for patients waiting two years. This represents a significant improvement on the forecast included in the March IMTP submission. Partly this reflects an improved starting position at the start of the financial year but also further progress by teams to deliver activity to target the longest waiting patients.

This does not mean the organisation will hit the target on this trajectory and there is a need for focused action. As with outpatients the aggregated projections mask challenges at specialty level. Across the majority of specialties long waiters have already been treated, with ENT, Orthopaedics and Urology contributing to the remaining long waiting patients.

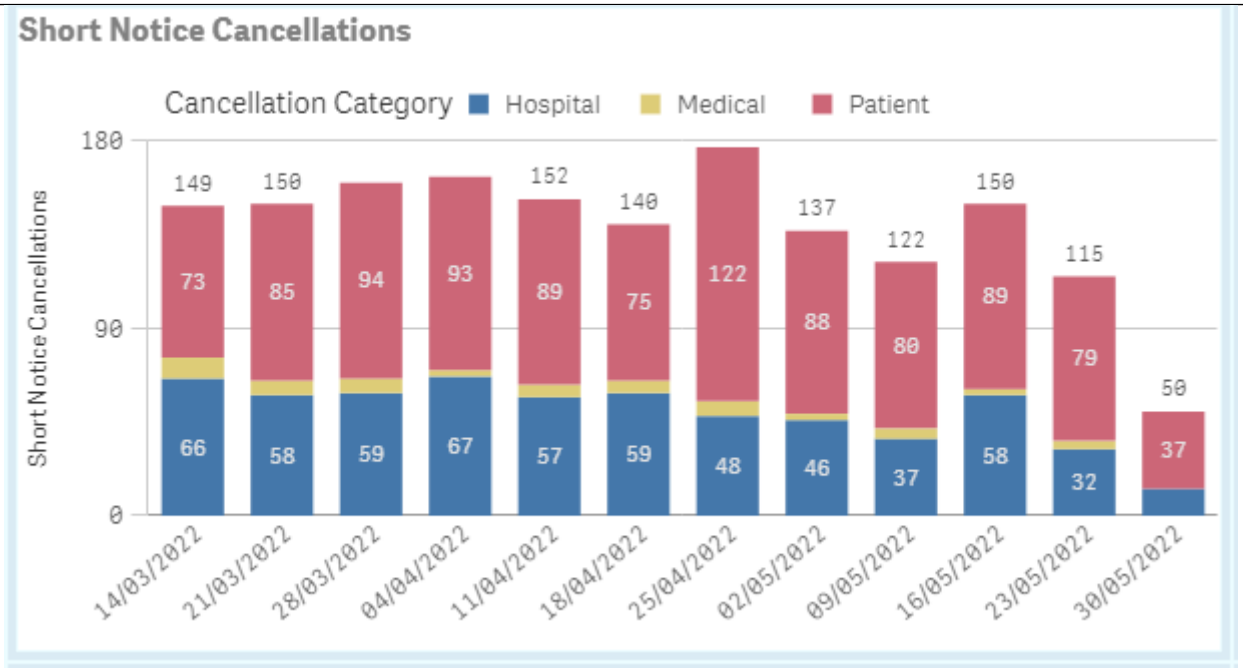
The organisation through the planned care programme is seeking to increase capacity and ensure the service is as efficient as possible. The programme has recently remodelled the opportunity to allocate theatres in a more efficient way which could increase the number of theatre sessions by 50 a week offering additional opportunities for capacity to be utilised.

New ways of working are being trialled for example MDT triaging for Orthopaedics. 4,110 referrals have been triaged to date with an average of 56 referrals reviewed per session and subspecialities have sessions weekly.

- 17% of referrals are being directed to non consultant led pathways – and the orthopaedic advanced professional will see these patients.
- 4% are being rejected and
- 7% are being directed to non consultant led pathways.

This results in a total of 28% which are being triaged away from traditional consultant led pathways with 21% going off the Directorate's waiting lists. The annual impact could be over 300 additionally funded clinics removed from plans with further plans to increase this.
This is just one example of the activities teams are undertaking to ensure efficiency.

There are a number of patients who decline the offer of treatment due to the pandemic or pre-admission Covid isolation requirements and prefer to remain on the waiting list. The breakdown of cancellations is shown below with patient cancellations making up the majority of cancellations each week. The actual numbers of cancellations each week are slightly less than pre-pandemic levels which were approximately 160 per week, but as a rate compared to activity, the numbers are similar. The number of short notice cancellations attributed to Covid-19 issues is minimal compared with the overall numbers. This is another opportunity to improve efficiency.



The Health Board continues to commission elective treatments and outpatients with St. Joseph's Hospital and ophthalmology treatments with Care UK, although the contract with Care UK expired at the end of June 2022. Opportunities continue to be explored with for additional capacity, along with other outsourcing / insourcing opportunities and regional working.

The scale of the challenge is significant and the focus will be on the individuals behind each number. The information and activation programme for those waiting will be crucial to provide support to those who will be waiting longer than they should. The organisation also recognises the pressure on staff, additional work that will need to be undertaken to deal with the significant backlog which may also still be affected by the implications of the current pension/tax issues for some of the Health Board's medical staff as well as individual choices to rebalance work and home life.

Auditor General Actions

The Auditor General's report 'Tackling the Planned Care Backlog in Wales' contained a series of actions and as set out in the paper the Health Board has established a clear programme of work to address these areas. A brief high level overview of progress against the actions is summarised in the table below with more detailed assessment against this report being progressed and reported to the Finance and Performance Committee.

Auditor General Actions	Health Board Position
Clear national vision and supporting investment The Welsh Government's plan to transform and modernise planned care and reduce the backlog should be supported by frameworks with ambitious goals and milestones to recover and transform planned care. The plan should be informed by a realistic assessment of the capacity that is likely to be available to achieve these. It must be supported by an investment strategy which includes a more strategic and longer-term approach to capital funding to facilitate the required changes to NHS estates needed for planned care recovery.	Welsh Government have published a National Planned Care Plan and allocated £170m to NHS Wales to support implementation. The Health Board Planned Care Programme is balancing ambition and realism as set out in this report with a key focus on optimising the Health Board estate opportunities for sustainable planned care services whilst addressing the backlogs.

Strong and aligned system leadership A system is needed that translates national vision into local action, recognising that the previous national programme board arrangements had limited success. Clinical and managerial leadership within organisations needs to be aligned around a common purpose and lessons learnt from how the NHS and its partners responded to COVID need to be transferred to help tackle the longer term planned care challenges.	The Health Board has refreshed its Planned Care Programme and agreed a set of principles to provide clear and common purpose. The Programme is supporting teams across the system to have a structured approach to addressing the challenges in planned care. A relaunch workshop took place on 17th June with colleagues across the system and a local Planned Care Programme Board has been established to oversee this work.
Renewed focus on system efficiencies Using existing resources to best effect should be a key priority. This will mean doing things differently by improving existing processes and systems. It will also mean doing different things and rethinking how, where and from whom patients get the advice and treatment they need. Constraints associated with infection prevention and control will need to be factored in but a focus on prudent healthcare principles and key efficiency measures should be maintained. Opportunities to make best use of new digital technologies need to be secured and ways of speeding up diagnostic tests explored.	Efficiency is a core element of the programme across outpatients, theatres and diagnostics. Actions are already being taken to improve efficiency and further examples are provided in the paper. Opportunities identified by benchmarking, audit, innovation and stemming from intelligent understanding of our system are supporting decision making. A number of digital projects are also underway as part of this programme.
Build and protect planned care capacity Additional capacity is undoubtedly going to be needed in the short term and clear plans are going to be needed to identify where this is going to come from. The extent to which planned care capacity can be protected from emergency care pressures should also form part of national and local planning. The Welsh Government frameworks should support health boards to prioritise emergency care at times of great pressure but must also help them to balance the needs of patients waiting for planned care. Some health boards have made progress in creating dedicated facilities for elective work which have seen some success. Whilst it may not always be practical or the best use of resources to physically separate facilities, the system does needs to think differently about how it protects planned care. A more collective approach to capacity planning across health board boundaries is going be needed alongside a critical review of the number of staffed beds required in the system. This will also include a need for effective workforce planning at local, regional, and national levels.	The implementation of the Clinical Futures System has already delivered benefits in providing segregated space for Planned Care, most notably in the Royal Gwent Hospital and Nevill Hall Hospital. This is being further enhanced with development of the post anaesthetic care unit to allow further procedures to take place at the site. We are also working with Health Boards in South East Wales to consider options to work collectively with solutions for Opthamology, Orthopaedics and Diagnostics.

Manage clinical risks and avoidable harms Management of the planned care system will need to shift to one that is based on the clinical need of patients rather than how long they have been waiting. Performance monitoring should be based around recommended lengths of waits for different categories of clinical priority with a focus maintained on minimising the extent to which patients' conditions deteriorate whilst they are waiting. There needs to be a particular focus on monitoring the condition of patients who face long waits for their first outpatient appointment. The role that general practice can play in prioritising and managing patients waiting for treatment also needs to be considered.	Procedures are still being undertaken on a priority basis criterion, with clinical review of risk in both new and long waiting patients. There is currently no national guidance to move to a treat in turn approach which would see long waiters prioritised. The Health Board has been developing communication mechanisms with long waiting patients to ensure treatment is still required and ensure up to date clinical information to inform prioritisation
Enhanced Communication with Patients Building on existing mechanisms, NHS bodies will need to ensure they are communicating effectively with patients about the likely time they will need to wait, how to manage their condition whilst they wait and what to do if their condition worsens or improves. Given the numbers of patients waiting, NHS bodies will need to ensure that they are investing sufficient resources into patient information and communication.	This is a fundamental part of our Planned Care Programme. Building on existing progress in outpatients to develop simple access points for patients for information about their waits and what to do during the wating period. This area of our programme is also developing more consistent approaches to Prehabilitation, benchmarking existing provision and exploring opportunities to ensure patient are supported to be as fit as possible physically and mentally for treatments in order to maximise outcomes.

Recommendation
The Health Board is fully committed to making improvements in planned care delivery. The ambitions set out in the Welsh Governments Planned Care Plan and the Auditor Gerneral actions provide a clear focus to support decision making in the organisation. Whilst our current planning scenario forecast does not yet meet the Ministerial ambition on the two specific targets we have a clear understanding of the requirements in our system to get close to the target. Our Planned Care Programme will support us in driving forward the actions to improve efficiency and activity further. The organisation is also committed to openly and transparency engaging with those waiting about realistic expectations and how they can be as fit as possible when they receive treatment.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report highlights key risks for delivery against the IMTP
Financial Assessment, including Value for Money	The delivery of the key performance, delivery against the planning scenario and risk management is a key part of the Health Board's service and financial plans.
Quality, Safety and Patient Experience Assessment	Monitoring patients is important to avoid adverse experience whilst waiting
Equality and Diversity Impact Assessment (including child impact assessment)	In this reporting there is no impact. However reducing inequality is identified as a principle of the Planned Care Programme
Health and Care Standards	The Health and Care Standards underpin the IMTP and Quarterly reports.
Link to Integrated Medium Term Plan/Corporate Objectives	This links to the performance profiles set out in the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The IMTP demonstrates an integrated approach to working across the Health Board and with partners and combined both short and long term goals.
Glossary of New Terms	Any new terms are explained as they occur within the document.
Public Interest	Disclosed

Aneurin Bevan University Health Board
2022/23 IMTP
Delegation of Revenue Budgets - Quarter 2 Update

Executive Summary

This paper sets out and updates the revenue funding allocations available to the Health Board for 2022/23 to be used to delegate budgets, including:

- Confirmed funding allocations,
- Anticipated allocations, supported by Welsh Government guidance or policy letters,
- Anticipated allocations for exceptional cost pressures as described by Welsh Government guidance, and
- Anticipated allocations for national and local transitional Covid allocations aligned to Welsh Government and Finance Delivery Unit financial planning principles, where there remains a risk around securing this funding.

The assumed income level (c.£1.65bn) is used to support the proposed approach to delegating funding for the 2022/23 financial year within total available resources, including a quarterly approach to setting and reviewing the delegation of budgets, recognising that a flexible and practical approach to financial planning and delivery is required.

The 2022/23 IMTP financial plan identified £26m savings and £19m cost mitigation and avoidance to enable a budget break-even position.

It should be noted that significant risk remains with regards to securing funding for exceptional and Covid cost pressures (as indicated in the WG letter dates 14th March 2022) especially given the de-escalation correspondence received from Welsh Government in May 2022.

The Board is recommended to:

- agree the levels of anticipated funding to support the financial forecast,
- confirm the delegated quarter 2 budget arrangements,
- note the non recurrent nature of these budgets, and
- note the risk associated with the Exceptional and Covid anticipated funding.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	√
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Decision	
Executive Sponsor: Rob Holcombe, Interim Director of Finance, Procurement & Value	
Report Author: Suzanne Jones, Interim Assistant Director of Finance	

Report Received consideration and supported by :			
Executive Team		**Committee of the Board**	
Date of the Report: 13th July 2022			
Supplementary Papers Attached: Appendix 1 - Statutory Financial Duties Appendix 2 – Glossary			

Purpose of the Report

Prior to the beginning of the financial year the Health Board set a revenue budget in accordance with its Standing Financial Instructions (SFIs), allocating resources based on delivering the priorities within the 2022/23 to 2024/25 Integrated Medium Term Plan (IMTP).

As we continue to move through the Covid pandemic, with de-escalation now required, recovery, service and workforce plans continue to be flexed to meet service demands. The delivery of savings required is paramount and is dependent on the service changes planned as part of delivering the IMTP priorities.

It is proposed that the Board continues to review revenue budgets alongside associated funding and spend plans on a quarterly basis.

This paper outlines to the Board the current anticipated funding / income position and the updated budget setting arrangements at the start of quarter 2 to the Board, establishing:

- Revenue budgets to be delegated for the 2022/23 financial year from quarter 2 onwards, and
- Those budgets to be held in reserve – both in terms of anticipated income at risk, planned commitments and any contingency (uncommitted reserve).

Background and Context

1.0 Financial Governance

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

The 2022/23 IMTP financial plan identified £26m savings and £19m cost mitigation and avoidance to enable a budget break-even position.

The Health Board's approach to producing a financial plan for 22/23 financial year has been to produce a financial plan comprising three component parts appreciating the on-going uncertain and complex environment:

1. Core plan – based on service/workforce baselines that reflect Covid de-escalation, cost and savings assumptions and aligned to core funding,

2. Exceptional cost pressures – these relate to the impact of the increased National insurance contributions, the impact of Real living wage for social care as well as the impact of increased energy prices.
3. Covid
    a. national response plan – incrementally adjusted to reflect reasonable spend plans and align with available Covid funding allocations, and
    b. local response plan – incrementally adjust to reflect Welsh Government definitions and secure funding in line with de-escalation measures as appropriate and to enable the necessary service and workforce plans.

As at month 3 the Health Board is expecting a full year funding for Covid of £76.4m of which £4.6m has been received and £71.8m is anticipated. In addition, the Health Board is anticipating £22.9m of exceptional items funding.

The Health Board has received funding for the following National responses to Covid:-

- Costs as a result of lost GDS income - £2.3m
- Nosocomial Covid investigation - £0.75m
- Enhanced flu - £1.517m

The Health Board is anticipating full year funding for the following National responses to Covid:-

- Mass Vaccination Programme - £9m
- Trace and Protect (TP) - £6m
- Testing - £6.51m
- Personal Protective Equipment (PPE) - £3.65m

The Health Board is anticipating funding for the following exceptional cost pressures as at month 3:-

- National Insurance contributions - £4.61m
- Real living wage for social care - £2.15m
- Increased energy prices - £16.1m

In addition, the Health Board has a number of local Covid transitional programmes for other pandemic response measures such as:-

- maintaining enhanced cleaning standards,
- supporting the NHS local response plans,
- surge capacity in relation to Covid positive and recovering patients, and
- increased acuity of patients.

In the context of the Covid pandemic and the exceptional cost pressures surrounding the formulation of budgets, this paper proposes delegation of these items (where possible) using Divisional forecasts coupled with the most recent information available. A further update will be provided at the September 2022 Board meeting, on the assumption that there will be more certainty regarding the de-escalation measures for Covid, spending requirements, available funding, and delivery of savings including the mitigation of financial risks for ABUHB.

Funding from WG is anticipated and as such the funding proposed to be delegated to Divisions may need to be adjusted in future months (i.e clawback) to ensure reconciliation with the funding received. This risk lays with the budget holder. In addition, Divisions must aim to mitigate and de-escalate from Covid status and reduce costs wherever possible in line with WG guidance.

Type	Covid-19 Specific allocations - June 2022	£'000
HCHS	Testing (inc Community Testing)	6,508
HCHS	Tracing	6,000
HCHS	Mass COVID-19 Vaccination	9,000
HCHS	PPE	3,654
HCHS	Cleaning standards	2,491
HCHS	Extended flu	1,517
HCHS	Long Covid	887
HCHS	A2. Increased bed capacity specifically related to C-19	9,971
HCHS	A3. Other capacity & facilities costs	7,174
HCHS	B1. Prescribing charges directly related to COVID symptoms	280
HCHS	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	15,043
HCHS	D1. Discharge Support	8,685
HCHS	D4. Support for National Programmes through Shared Service	0
HCHS	D5. Other Services that support the ongoing COVID response	2,131
Dental	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS income	2,308
HCHS	Nosocomial investigation and learning	753
	Total Covid-19 Allocations (confirmed and anticipated)	**76,402**

Type	Exceptional items allocations - June 2022	£'000
HCHS	Energy prices increase	16,100
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,154
	Total Exceptional items allocations (anticipated)	**22,860**

2.0 Budget setting principles

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

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

1. For established services, plans should demonstrate:
   - How service and workforce plans will be delivered within agreed resources?
   - How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales' and reduce socio-economic disadvantage?

- Efficiency and productivity improvements which achieve (or aim to achieve) excellence.

2. Addressing the underlying financial position – service and workforce plans which demonstrate 1. (above) should be funded appropriately before considering new investments,
3. Savings plans should demonstrate delivery before approving new funding or reinvestment,
4. Where savings have been identified for new service proposals plans should demonstrate:
   - Fit with the Clinical Futures strategic direction of ABUHB,
   - If they are approved priorities,
   - How service and workforce plans will be delivered within agreed resources?
   - How care will be provided which optimises outcomes for patients and makes best use of available resources aligned to the principles of 'A Healthier Wales?', and
   - Efficiency and productivity improvements which achieve (or aim to achieve) excellence,
5. Pay awards to be funded in line with Welsh Government allocations, and
6. If funding becomes available or there is a level of savings achievement greater than the IMTP then the Board should consider and establish an appropriate contingency reserve, considering the significant level of financial risk within the IMTP.

In addition to these principles the Health Board has a duty to consider the requirements of 'Wellbeing and Future Generations Act', socio-economic principles, the 'Foundational Economy' and the Decarbonisation agenda.

3.0 Allocations & Income

Based on the above principles and assumptions, this paper sets out the level of revenue funding available for 2022/23. It also takes account of the nature of some of the funding allocations, including directions from Welsh Government in the use of specific funding allocations. Table A outlines the total allocations and net expected income for 2022/23 as at 30th June 2022 (Month 3), totalling £1.65bn.

Table A – 2022/23 Allocations and Income

Funding as at 30th June 2022	£'000s
Confirmed Allocations	1,428,067
Anticipated Allocations	120,753
Other 'Central' Income	104,802
Total	**1,653,622**

Anticipated allocations include items which are:

- typically funded every year (albeit non-recurrently),
- considered likely (low risk), and
- have agreement from Welsh Government.

Whilst not all Health Board allocations have been confirmed, based on the overall Welsh Government budget and advice to the Health Board from Welsh Government, the Finance Delivery Unit (FDU), it is considered reasonable to assume funding to cover ABUHB Covid costs for the year of c.£76.4m. This includes National Priorities which are separately funded as well as specific items listed in section 1 which have been received in-year.

Increased costs in year have continued to enable the Health Board services to operate in a 'covid safe and compliant' manner, noting the Covid de-escalation correspondence in May 2022. These service requirements do not directly correlate to the number of Covid positive and Covid recovering patients in hospital.

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

Covid response
The Welsh Government has confirmed funding for the National Covid responses but have only confirmed a value for the Tracing element.

Correspondence has been received regarding testing funding in June 2022 which requires further discussion given the value is lower than forecast expenditure (£4.07m anticipated allocation). The Director of Therapies, who is leading this area of work, is liaising with WG regarding the level of funding available, therefore, only the confirmed value is proposed to be delegated at this stage.

The Welsh Government has not confirmed funding for all local Covid responses as well as other National elements such as Mass Vaccination and PPE but have conveyed the expectation that these are time limited to reflect the changing Covid status. It is however recognised that services still need to ensure the safety of staff and patients. The overall value for Covid response costs is c.£76.4m of which £71.8m is anticipated.

Exceptional Cost Pressures
The Health Board has anticipated funding and included costs for the volatile energy increases, the increase in the national Insurance contributions from employers and the real living wage costs for externally commissioned staff. These are estimated to be c. £23m and the Health Board is expecting to work with WG to find a solution to these costs. Given the volatility in energy prices whilst the current forecast value will be delegated, this will be reviewed and updated to reflect the latest forecasts from NWSSP on a monthly basis.

The Health Board is expected to manage these costs in liaison with WG with a view to 'de-risk' these elements in future forecasts.

Table B sets out the remaining anticipated revenue funding allocations assumed as part of setting budgets this year. **It is important to note the significant level of non-recurrent funding that has been both confirmed and anticipated this year to support spending plans.**

Table B – Anticipated allocations

	STATUS OF ISSUED RESOURCE LIMIT ITEMS		Recurring (R) or Non Recurring	Total Revenue Resource Limit
	HCHS £'000	GMS £'000	(NR)	£'000
DEL Non Cash Depreciation - Baseline Surplus / Shortfall	298		NR	298
DEL Non Cash Depreciation - Strategic	21,122		NR	21,122
DEL Non Cash Depreciation - Accelerated	483		NR	483
DEL Non Cash Depreciation - Impairment	0		NR	0
AME Non Cash Depreciation - Donated Assets	342		NR	342
AME Non Cash Depreciation - Impairment	(13,929)		NR	(13,929)
Total COVID-19 (see below analysis)	71,824	0	NR	71,824
Energy (Price Increase)	16,100		NR	16,100
Employers NI Increase (1.25%)	4,606		NR	4,606
Real Living Wage	2,154		NR	2,154
(Provider) Substance Misuse & increase	3,184		R	3,184
(Provider) SPR's	112		R	112
(Provider) Clinical Excellence Awards (CDA's)	298		R	298
Technology Enabled Care National Programme (ETTF)	1,805		R	1,805
Informatics - Virtual Consultations	2,813		R	2,813
I2S DHR Phase 2 (£143k) & Omnicell (£425k)	(568)		R	(568)
Carers Funding	191		R	191
National Nursing Lead Community & Primary Care	53		NR	53
National Clinical Lead for Falls & Frailty (£26k) & Primary & Comty Care (£113k)	139		R	139
National Allied Health Professional (AHP) Lead for Primary and Community Care	85		R	85
Accelerated cluster development programme	200		R	200
AHW:Prevention & Early Years allocation 20/21	1,171		R	1,171
Healthy Weight-Obesity Pathway funding 21-22	550		R	550
Community Infrastructure Programme	180		R	180
C19 Support for Post Anaesthetic Critical Care Units (PACU)	904		R	904
WHSSC - National Specialist CAMHS improvements	139		R	139
Same Day Emergency Care (SDEC)	1,500		R	1,500
PSA Self-management Programme (Phase 1 & 2)	114		R	114
OP Transformation-Dermatology Specialist Advice and study day	26		R	26
Digital Priority investment fund (DPIF)	500		R	500
Strategic Primary Care - additional posts	113		R	113
Learning Disabilities-Improving Lives	64		R	64
Nurse Operation lead pump-prime funding 22-23 (18mths)	68		R	68
WHSSC All Wales Traumatic Stress Quality Imprmt (ANEHFS 13 21/22)	159		R	159
Children & Young People MH & Emotional Wellbeing (ANEHFS 16 21/22)	200		R	200
Support all age Mental Health - Tier 0/1 provision (ANEHFS 22 21/22)	200		R	200
Memory Assessment Services - Gwent RPB (ANEHFS 37 21/22)	565		R	565
EASC/WAST Improvements in MH Emergency Calls (ANEHFS 54 21/22)	51		R	51
WHSSC - Impl of National Specialist CAMHS Improv. (ANEHFS 90 21/22)	131		R	131
NHS Pay enhancement Band 1 to 2 - 3% uplift 21-22 (ANEHFS 21/22)	152		R	152
Mental Health - additional resources 22-23	1,364		NR	1,364
GMS Refresh		1,603	R	1,603
Welsh Risk Pool	(4,118)		R	(4,118)
Urgent Primary Care	1,400		R	1,400
Primary Care 111 service	623		R	623
End of life Care Board	112		R	112
PSA self-management Programme Platform development	465		R	465
Outpatient Treatment Centre project costs	101		R	101
Real Living Wage	658		R	658
Dementia Action Plan-Age Cymru National advocacy project	445		NR	445
Total Anticipated Funding	**119,149**	**1,603**		**120,753**

As per iterations in 2021/22, the resource allocation proposals only consider those funding allocations which have been confirmed by Welsh Government or where it is reasonable to anticipate funding allocations. Should further resources be made available, then these will be delegated in line with the budget setting principles agreed by the Board and the priorities set out in the IMTP, described in section 2.0 above.

4.0 Value, Efficiency & Savings assumptions

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

ABUHB is now developing a refreshed approach to re-engage the whole organisation in re-focussing on efficiency and taking a prudent healthcare approach to both daily front line decisions and corporate programme level. This was reported to the Finance and Performance Committee (FPC) on the 6th July.

The 2022/23 IMTP identified a savings requirement of £26m and cost risks of £19m that would need mitigation and management.

Four key elements of the sustainability approach are identified and a summary of how the approach is being operationalised and implemented is included.

The 4 key elements include:

- People Focussed
- Support to drive transformational change
- Autonomy & Accountability
- Monitoring & reporting & holding to account

These are operationalised through an organisation and system wide set of actions, including:

- System & Financial Planning
- Governance compliance
- Financial Sustainability focus
- Programme Approach to Transformation
- Identification & delivery of Efficiency Opportunities

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

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

At the IMTP stage, cash releasing opportunities for 2022/23 were assessed as circa £26.5m noting the considerable level of risk associated with these schemes with regards to implementation. The IMTP also assumed a level of cost avoidance and further Divisional 'house-keeping' plans to mitigate a wide range of lower-level investments. Following further review of the national and local Efficiency Frameworks there are additional opportunities, greater than the £26.5m, which would give the Health Board further opportunity to deliver a sustainable financial plan. However, all opportunities need to be

analysed and progressed to increase cash releasing savings, productivity improvements and improve health outcomes within available resources.

2022/23 ABUHB priority programmes are as follows:-

- Urgent Care Transformation,
- Redesigning Services for Older People (COTE) incl. COPD,
- Enhanced Local Hospital Network,
- Planned Care (MSK, Outpatient transformation, Regional Planning, Diagnostics, Maximising Elective Capacity),
- Health Protection and Population Health Improvement,
- Cancer services,
- Accelerated Cluster Development incl. HRAC, Diabetes
- Mental Health & Learning Disabilities,
- Decarbonisation,
- Agile working,
- Variable Pay
- Procurement non-pay,
- Medicines Management, and
- CHC.

It should be highlighted that there is a considerable level of risk to these savings assumptions which may affect the level of achievement and the ABUHB financial forecast.

5.0 Reserves

In line with the Health Board's resource allocation principles, Health Board reserves are held by the Board, which as Accountable Officer the CEO can delegate. Some items held in reserves are a 'holding' point as the use is either directed by Welsh Government, confirmed by Welsh Government or generated from internal funding found to cover a specific commitment. The following reserve commitments, in Table C, are held by the Board.

Table C – Reserves as at June 2022/23

Confirmed or Anticipated	R / NR	Description	22/23	Proposed delegation	Revised 22/23
Anticipated	NR	Mental Health Service Improvement funding 22-23	1,363,823	(1,363,823)	0
Anticipated	NR	Real Living Wage Bands 1&2	658,000	(658,000)	0
Anticipated	NR	Urgent Primary Care	1,400,000	(1,400,000)	0
Anticipated	NR	Primary Care 111 service	623,000	(623,000)	0
Anticipated	NR	End of Life Care Board	112,000	(112,000)	0
Anticipated	NR	C19 Response-Cleaning Standards	2,490,900	(2,490,900)	0
Anticipated	NR	C19 Response-Increased bed capacity	9,970,600	(9,970,600)	0
Anticipated	NR	C19 Response-Other Capacity & facilities costs	7,174,200	(7,174,200)	0
Anticipated	NR	C19 Response-Prescribing charges - Covid symptoms	279,800	(279,800)	0
Anticipated	NR	C19 Response-Increased workforce costs	15,043,100	(15,043,100)	0
Anticipated	NR	C19 Response-Discharge Support	8,685,100	(8,685,100)	0
Anticipated	NR	C19 Response-Other Services that support the ongoing COVID response	2,131,300	(2,131,300)	0
Anticipated	NR	Exceptional-Incremental National Insurance	4,606,000		4,606,000
Anticipated	NR	Exceptional-Incremenntal Real Living Wage	2,154,000	(2,154,000)	0
Anticipated	NR	Exceptional-Increase in Energy Costs (net of baseline costs)	16,100,000	(16,103,000)	(3,000)
Anticipated	NR	C19 National-Covid PPE	3,654,000	(3,322,000)	332,000
Anticipated	NR	C19 National-Covid Testing	6,508,000	(4,070,000)	2,438,000
Confirmed	NR	Value Based Recovery balance	1,083,000		1,083,000
Confirmed	NR	Value Based Recovery balance - return of MSK slippage		141,000	141,000
Not applicable	NR	Recovery of pay budget relating to VERS	56,421		56,421
Not applicable	NR	Other (inc.B1&2 enhancement alloc)	698,443	(622,000)	76,443
Total Reserves			**84,791,687**	**(76,061,823)**	**8,729,864**

6.0 Proposed quarter 2 updated budget delegations

In line with the Board's resource allocation principles, it is proposed that the following delegations should be approved for the 22/23 financial year **non-recurrently** based on the current income and spend forecasts.

The proposed budget delegation will transfer the following elements of Covid funding to the relevant Division(s):-

- £4m Covid Testing as per WG correspondence in June 2022,
- £2.5m Cleaning Standards,
- £3.3m PPE linked to Divisional forecasts, and,
- £45.8m Local Covid transitional costs forecast for 2022/23,

The proposed budget delegation will transfer the following elements of Exceptional item funding to the relevant Division(s):-

Anticipated (Exceptional cost pressure) Welsh Government Funding**;**

- £16.1m increased energy prices as per month 3 Divisional forecast, and
- £2.2m incremental real living wage for social care contracts,

Further elements of funding that are proposed to be delegated from reserves relate to the following:-

- £1.4m Mental Health Service Improvement funding,
- £0.7m Band 1 and 2 real living wage funding,
- £1.4m Urgent Primary Care,
- £0.623m 111 first funding,
- £0.112m End of life Care Board, and
- £0.6m further Powys income reduction adjustment
- (£0.14m) return of MSK slippage to reserves from F&T division

It should be noted that all these delegations may require adjustment, clawback, if anticipated allocations are not fully received. The local Covid response plans require review and amendment; therefore it should be noted that these allocations may be subject to change in future months.

As a result of the delegations described, the following elements will remain in reserves for 2022/23 pending further information and adjustment:-

- £4.6m Incremental National Insurance increase,
- £2.5m Balance of Covid testing forecast costs pending discussion with WG,
- £0.3m Balance of PPE funding pending updated forecast expenditure,
- £1.2m Value based recovery balance pending prioritisation of schemes, and
- £0.1m balance resulting from revenue to capital transfer for IT costs

Pay uplifts and IMTP Investments

There remain Board and Executive recurrent decisions that are unfunded and will need to be considered should any funding become available, for example water risk management, microbiology business case, backlog maintenance and transfer lounges operational posts

(not an exhaustive list). These recurrent commitments are contributing to the risk of deficit in 2022/23, if these are not mitigated then they will increase the underlying deficit going in 2023/24. Nationally agreed wage awards for the Health Board are assumed to be funded through Welsh Government allocation increases.

Risks & Opportunities (funding related)

- Uncertainty related to the Covid pandemic and its service, workforce and financial implications in the short, medium and long term.
- Uncertainty regarding funding for both local and national Covid schemes from WG.
- Uncertainty regarding funding for exceptional cost pressure items from WG.
- Uncertainty regarding levels of other anticipated allocations.
- Pay award and any new changes to Terms & Conditions will be funded by WG separately,
- No indication of funding for the implications of the Ukraine crisis and Monkeypox disease from WG and have therefore not been factored into this assessment.

7.0 Contingency

Residual reserves post budget delegation are £8.73m and are summarised in table D as follows:-

Table D – remaining reserves post budget delegation

Reserves post delegation (M4 -22/23)	£'000s
Increased National Insurance	4,606
Covid-19 PPE balance	332
Covid-19 testing balance	2,438
Value Based recovery	1,224
IT revenue to capital balance	130
Total	**8,730**

These reserves are likely to be committed and are therefore **not** a contingency.

The Health Board annually considers the level of contingency (or uncommitted reserves) to support the organisation as part of delegating budgets. Evidence from other organisations indicates that a contingency of between 2% and 5% would be desirable.

The level of financial risk, including savings required, to deliver financial balance during 2022/23 is significant and greater than it has been previously, however, **there is no contingency available.** As per section 5, it is assumed that the remaining elements of funding in reserves will be either adjusted and/or delegated once further information is received for future months.

Given the level of risks involved in the IMTP, it is recommended that if funding becomes available a contingency reserve is established to manage cost risks to support financial balance in 2022/23. Utilisation of this contingency reserve will be considered as part of the quarterly budget delegation paper for quarter 3.

8.0 Proposed Budget Delegation

Based on the principles and rationale, set out in this paper, including reserve commitments and contingency, the following budgets have been updated and are proposed for quarter 2 of the 2022/23 financial year:

Table E – Proposed Delegated Budgets

The Divisional Table below identifies the proposed budget delegations with revised budgets shown.

Proposed Delegated Budget as at 30th June 2022. Includes Non Recurrent Funding.	Annual Budget 22/23 Quarter 1	Allocations to be delegated (non-Covid / Exceptional)	Local Covid-19 response	National Covid-19 response	Exceptional items	Other Commitments	Annual Budget 22/23 Quarter 2
Operational Divisions:-							
Primary Care and Community	258,411	2,188	9,319	353	-	-	270,271
Prescribing	99,190	-	-	-	-	-	99,190
Community CHC & FNC	63,411	-	6,528	3	1,354	-	71,296
Mental Health	101,461	1,422	1,454	37	800	-	105,174
Director of Primary Community and Mental Health	311	-	-	-	-	-	311
Total Primary Care, Community and Mental Health	**522,784**	**3,610**	**17,301**	**393**	**2,154**	**-**	**546,242**
Scheduled Care	219,870	165	3,307	2,887	-	-	226,229
Urgent Care	33,452	42	7,361	626	-	-	41,481
Medicine	98,729	147	6,664	330	-	-	105,870
Family & Therapies	117,745	31	371	244	-	(141)	118,250
Estates and Facilities	78,205	114	8,919	83	16,103	-	103,424
Director of Operations	5,440	4	1,623	-	-	-	7,067
Total Director of Operations	**553,441**	**502**	**28,245**	**4,170**	**16,103**	**(141)**	**602,320**
Corporate / Exec budgets:-							
Finance & Performance	6,622	-	-	-	-	-	6,622
Workforce & OD	6,734	-	-	-	-	-	6,734
Nurse Director	5,116	-	-	-	-	-	5,116
Chief Executive and non officer members	37,547	-	-	-	-	-	37,547
ABCi	713	-	-	-	-	-	713
Planning & Digital/ICT	29,235	43	35	848	-	-	30,161
Therapies Director	2,017	-	-	1,981	-	-	3,998
Board Secretary	901	-	-	-	-	-	901
Public Health Director	18,614	-	-	-	-	-	18,614
Medical Director	4,612	2	34	-	-	-	4,648
Litigation	852	-	-	-	-	-	852
Total Corporate Divisions	**112,963**	**45**	**69**	**2,829**	**-**	**-**	**115,906**
Specialist Services							
WHSSC	135,502	-	-	-	-	-	135,502
EASC	36,179	-	-	-	-	-	36,179
Total Specialist Services	**171,681**	**-**	**-**	**-**	**-**	**-**	**171,681**
External Contracts							
External Commissioning - LTAs'	82,425	-	160	-	-	622	83,207
External Commissioning - Access Plans'	500	-	-	-	-	-	500
Total External Contracts	**82,925**	**-**	**160**	**-**	**-**	**622**	**83,707**
Capital Charges	32,042						32,042
Total Capital Charges	**32,042**						**32,042**
Total Delegated Position	**1,475,836**	**4,157**	**45,775**	**7,392**	**18,257**	**481**	**1,551,898**
Reserves	**84,792**	**(4,157)**	**(45,775)**	**(7,392)**	**(18,257)**	**(481)**	**8,730**
Total Health Board Budget	**1,560,628**	**-**	**-**		**-**	**-**	**1,560,628**

Recommendation

This paper sets out the principles and proposed approach to delegating funding at the start of quarter two for the 2022/23 financial year within total available resources (£1.65bn), including a quarterly approach to reviewing and adjusting the delegation of budgets,

recognising that a flexible and practical approach to financial planning and delivery continues to be required.

The Board is recommended to:

- agree the level of anticipated funding to support financial balance,
- confirm the delegated quarter 2 budget arrangements, and
- note the risk associated with the Covid and exceptional cost anticipated funding.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks to achievement of the Health Board's statutory financial duties are identified in this paper, of particular risks are the level of recurrent savings required to manage within allocated resources & the impact of Covid.
Financial Assessment, including Value for Money	This paper provides details of the proposed updated budget delegation for 2022/23 financial year, based on agreed principles and the Health Board's IMTP subject to further amendment.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	The delegation of budgets is based on the IMTP priorities agreed by the Board. On the basis that relevant impact assessments have been undertaken in agreeing these priorities, then further assessments have not been considered necessary.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the budgetary framework and delegation proposal which supports and the Health Board's IMTP for 2022/23 to 2024/25, including allocation of resources to support agreed priorities.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** refresh of the IMTP 3 year plan and future longer term strategy including foundational economy principles. **Integration** – investment plan recognises Clinical Futures and wider Partnership arrangements and internal & external pathway system integration. **Involvement** – Board and Executive team have considered wider priorities. **Collaboration** – Board approved IMTP includes reference to partners and wider stakeholder initiatives and joint working initiatives. **Prevention** – Prevention initiatives are part of budget plans as a priority.
Glossary of New Terms	Provided
Public Interest	Written for the public domain

Appendix 1

Statutory Financial Duties

1. Expenditure should not exceed aggregate funding over a period of 3 financial years, and
2. Prepare a plan (in line with point 1) which improves the health of the population and is approved by Welsh Government Ministers.

Ref: NHS (Wales) Act 2014

Extract from the LHB's Standing Financial Instructions (SFIs)

"Prior to the start of the financial year, the Director of Finance will…prepare and submit budgets for approval and delegation by the Board. Such budgets will:

1. *Be in accordance with the aims and objectives set out in the Integrated Medium Term Plan and medium term financial plan…,*
2. *Accord with Commissioning, Activity, Service, Quality, Performance, Capital and Workforce Plans, and*
3. *Be prepared within the limits of available funds."*

Appendix 2

Glossary

IMTP	Integrated Medium Term Plan
SFI's	Standing Financial Instructions
EASC	Emergency Ambulance Services Committee
WHSSC	Welsh Health Specialised Services Committee
GMS	General Medical Services
FYE	Full Year Effect
FDU	Finance Delivery Unit
GDS	General Dental Services
GUH	Grange University Hospital
CF	Clinical Futures
LD	Learning Disabilities
LTA	Long Term Agreement (contracts between NHS bodies)
ICF	Intermediate Care Fund
RAG	Red / Amber / Green Savings Rating
WG	Welsh Government
PIP	Health Board's Pre Investment Panel
CHC	Continuing Health Care
FNC	Funded Nursing Care
RTT	Referral to Treatment
WCCIS	Welsh Community Care Information System
NICE	National Institute for Clinical Excellence
AWMSG	All Wales Medicines Strategy Group
RPB	Regional Partnership Board
SLC	Speech, Language Communication
CAMHS	Children & Adolescent Mental Health Services
NCN	Neighbourhood Care Network
AOF	Annual Operating Framework
RGH	Royal Gwent Hospital
YYF	Ysbyty Ystrad Fawr
DOSA	Day Of Surgery Admission
COTE	Care of the Elderly
NWSSP	NHS Wales Shared Services Partnership

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th July 2022 Agenda Item: 3.5

Aneurin Bevan University Health Board

Draft Arts in Health Strategy 2022 - 2027

Executive Summary

The Arts in Health Strategy 2022 – 2027 provides the context for Art in Health within Aneurin Bevan University Health Board (ABUHB), and indicates how best practice can be embedded throughout the Health Board, addressing health inequalities through built environments and participation of staff and patient communities.

The Board has been asked to note and make comments on the draft version previously.

Following this, amendments have been made and the strategy is now being submitted to the Board for ratification and approval.

This will lead to a process of the Health Board adopting the strategy, including publishing through the Health Board website and creating a landing page within the intranet and providing opportunities for people to find out more about how they can be involved, sharing best practice and supporting the inclusion of these ways of working where appropriate.

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

Executive Sponsor: Peter Carr, Executive Director of Therapies and Health Science

Report Author: Sarah Goodey, Arts Development Manager and Eleanor Davis, Arts in Health Project Officer

Report Received consideration and supported by :

Executive Team	✓	**Committee of the Board [Committee Name]**	

Date of the Report: 27th July 2022

Supplementary Papers Attached: The full, draft Strategy document is attached as Appendix 1

Purpose of the Report

To present the final draft of the ABUHB Arts in Health Strategy, explaining the background and process followed to develop it. The report seeks Board approval to publish and implement the strategy.

Background and Context

This strategy has been developed in a context of a growing body of evidence from within Wales, the UK and further afield including research by WHO that recognises the benefits that arts and culture can make to addressing both physical and mental health. In 2014 the UK Department of Culture, Media and Sport researched the social impact of culture on communities and found evidence that the arts and culture are beneficial to both mental and physical health; specifically that arts and culture can be used directly to improve clinical outcomes and indirectly to support reintegration into society. This was followed by the UK All-Party Parliamentary Group on Arts, Health and Wellbeing publishing Creative Health: The Arts for Health and Wellbeing (2017) which includes a wealth of information about the benefits of working with the arts.

Significantly, in 2017, the Welsh NHS Confederation and Arts Council of Wales developed a Memorandum of Understanding (MOU) to share best practice, research and evaluation and celebrate the difference that arts in health activities can make. The MOU was supported with the creation of the Arts in Health Strategic Capacity 3 year fund (2020-23: ACW), which has enabled ABUHB to access funding for the post of Arts in Health Project Officer.

The process of creating the Arts in Health Strategy has drawn on principles of co-production and has included a wide number of staff throughout the Health Board through the Creative Forum, chaired by Peter Carr, Executive Director of Therapies and Health Science.

Assessment and Conclusion

This strategy document has been co-produced with the ABUHB Creative Forum and the Arts Development Team and outlines how best practice can be embedded across the Health Board.

Building on the success of the Art for the Grange programme with Studio Response and the ongoing work of Gwent Arts and Health (GARTH), this Arts in Health Strategy proposes a broad and inclusive approach to applying creative practice within healthcare delivery. This encompasses working within the built environment and capital development and by engaging with and involving patient, staff and the wider community in projects that provide for creativity and to contribute to high quality, meaningful artworks.

As a model of best practice, Arts in Health is able to support a sense of well-being through contributing to positive environments, participatory opportunities, raising participant and patient voice; working with internal and external partners and creating an evidence base of good practice within the Health Board.

Support for the Arts in Health Strategy by the ABUHB Board ensures the conditions for an increasingly strategic approach to Arts in Health with ABUHB, for Arts and Health to become embedded, and to be a key consideration in new builds and refurbishments and when considering opportunities for patient, staff and community involvement. This more strategic approach to Arts in Health allows the Health Board to maximise the possible benefits from this diverse practice alongside existing provision.

It is important that adequate governance is in place to oversee the delivery of the objectives and to provide assurance that we can maintain momentum throughout its duration. Delivery of the strategy will be coordinated within the Health Board Planning

Team with the agenda and strategy sponsored by Peter Carr, Executive Director Therapies and Health Science. An annual progress report will be provided to the Health Boards Executive Team and the Strategic Partnership Planning and Wellbeing Committee of the Board. We have established a Creative Forum which has provided important contributions to the development of this strategy. The Creative Forum will continue to provide a role in delivery by harnessing involvement and participation across the Health Board and with key external partners.

Recommendation
The Board is asked to note the background and process followed to develop this draft strategy document, to note its content and approve its publication and implementation.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no new risks identified with implementation of this strategy, or links to the risk register.
Financial Assessment, including Value for Money	Arts related schemes and projects will need to secure funding to proceed, whether as part of an agreed capital investment or from non-recurring project funding. Only those arts related schemes and projects that have secured funding will proceed. Typically, arts related schemes and projects have been funded as part of a capital scheme investment or from external project funding (such as the Arts Council funding) or charitable funds (such as those secured by GARTH). This strategy presents no immediate financial risks to the Health Board.
Quality, Safety and Patient Experience Assessment	The strategy is underpinned by evidence that the arts and culture are beneficial to both mental and physical health; specifically that arts and culture can be used directly to improve clinical outcomes and indirectly to support reintegration into society. Individual arts projects will be assessed in terms of the anticipated benefits.
Equality and Diversity Impact Assessment (including child impact assessment)	Individual arts projects that are delivered will be subject to equality and diversity impact assessments as required.
Health and Care Standards	This strategy is not directly aligned to any specific health and care standard.
Link to Integrated Medium Term Plan/Corporate Objectives	The benefits for health and wellbeing from arts in health, as described in this strategy, have the potential to be realised across the life course and by all services, in support of the IMTP delivery.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The range of approaches and activities outlined in the strategy will contribute to the Health Board's approach to the Well Being of Future Generations Act.

Glossary of New Terms	No new terms have been identified.
Public Interest	The strategy will be published in the public domain

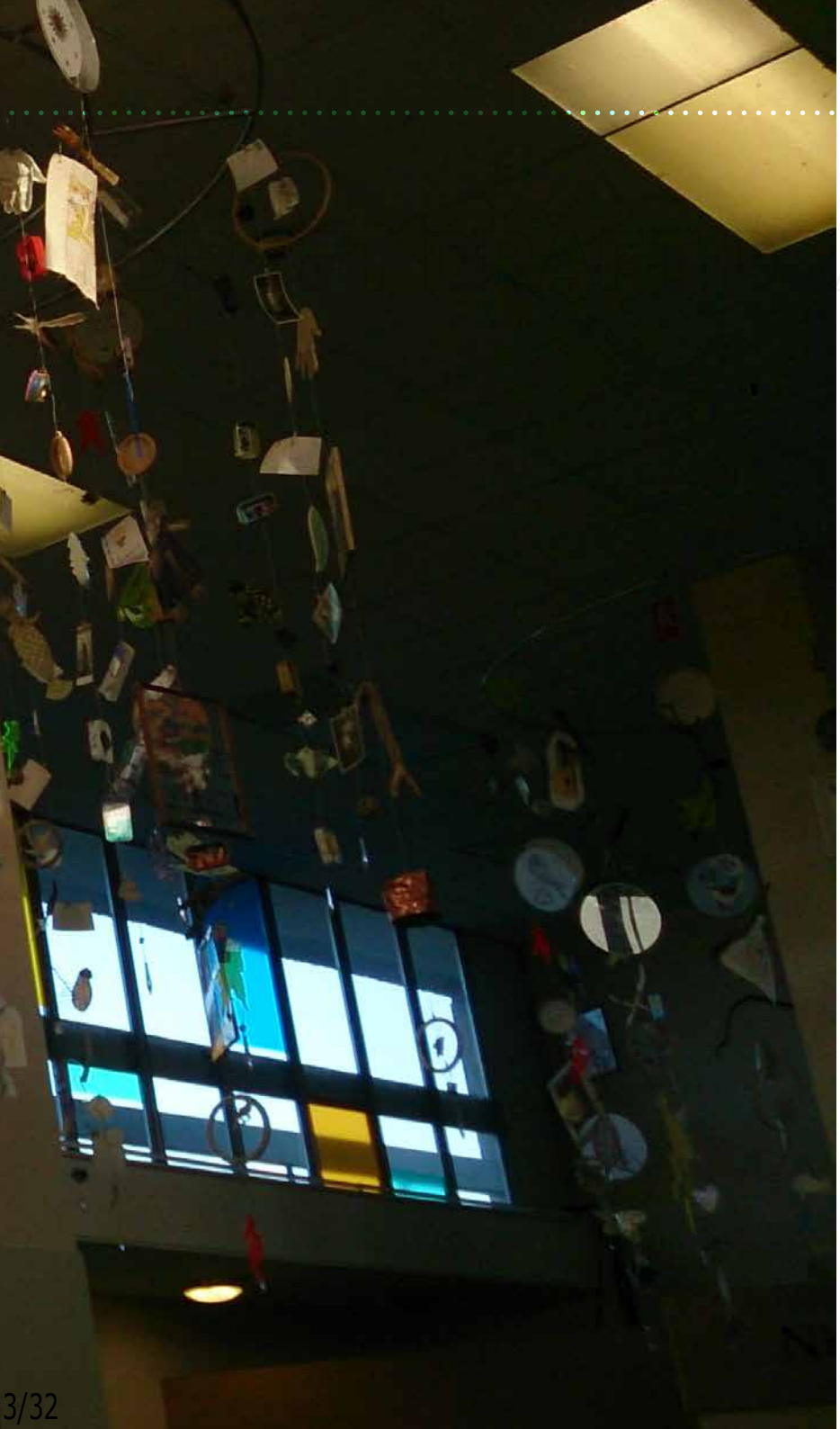
Arts in Health Strategy

For arts and creativity to support and improve the health and well-being of our patients, communities and staff

Aneurin Bevan University Health Board

2022–2027

Contributors: ABUHB Creative Forum, Peter Carr, Eleanor Davis, Chris Dawson-Morris, Sarah Goodey and Arian Howells



CONTENTS

Introduction	3
Context	4
Our Vision & Strategic Objectives	15
Governance & Delivery	22
Resources	23

Cover Page: Catrin Jones, *From the Mountains to the Sea*
Photography by Phillip Roberts, as part of Grange Arts Programme commissioned and curated by Studio Response.

This page: The 'Aerial' installation in Main Outpatients, designed by Tessa Waite and made up of individual elements made by community members – in partnership with GARTH and PEAK (formally Arts Alive)

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

garth Gwent Arts in Health

Cyngor Celfyddydau Cymru Arts Council of Wales

Our Vision

For arts and creativity to support and improve the health and well-being of our patients, communities and staff

Our Strategic Objectives

1. To identify and enable opportunities to maintain positive, welcoming, nurturing and energising **environments** for delivering healthcare that reflect the cultures and communities that they serve.

2. To deliver a consistent programme of quality and evidence-based **participatory arts** projects in primary, secondary and community health care settings.

3. To ensure that staff are supported and confident in using arts & creativity in **the workplace.**

4. To develop and expand existing **internal** and **external partnerships** with individual practitioners, arts in health organisations and other providers.

5. To gather **evidence, evaluate** and to establish (internally) – and contribute to (externally) – the national arts in health **research** field.

6. To identify sustainable **funding and resources** for arts in health projects from within the HB.

1. INTRODUCTION

Peter Carr

Introducing this Arts in Health Strategy is a privilege; art has the power to raise smiles, begin conversations and connect communities. The evidence for the role of the arts in delivering benefits to health, wellbeing and care is now well known therefore this strategy takes us beyond making the case for arts in healthcare, and into implementing a programme of action to harness this evidence base.

Deborah Aguirre Jones, Synapse
As part of Gofalu Grange Caring Connections part of Grange Arts Programme commissioned by Studio Response

Our overarching ambition as a Health Board is to reduce the health inequality experienced by our communities, the current 16 year gap in healthy life expectancy between our most and least deprived communities is unacceptable. Arts in Health will play an important role in helping us address this challenge.

Through creating nurturing environments, enabling participation of communities in conversations about health and wellbeing, creating unique partnerships with our communities to give voice to those experiencing poverty as well as supporting our staff to thrive through improving wellbeing, the Arts can play a significant role in achieving the ambition of the organisation.

Importantly, as an organisation our strategy makes clear that we operate a partnership-first approach, and through using a creative approach we can open dialogues and enable engagement with our communities along with a wide range of creative partners to work together for the benefit of our communities.

Creativity is powerful, and it is a power that we must make full use of in healthcare. We want this strategy to enable our organisation to harness this potential, and we would encourage everyone who reads this strategy to join us in promoting Arts In Health as a powerful tool in delivering for our communities.

2. CONTEXT

"The creative impulse is fundamental to the experience of being human … The act of creation, and our appreciation of it, provides an individual experience that can have positive effects on our physical and mental health and wellbeing."

(p 10, All-Party Parliamentary Group on Arts, Health and Wellbeing Inquiry Report, 2017)

2.1 Arts in Health: Wales and the UK

Arts in Health within Aneurin Bevan Unviersity Health Board takes place within a context of a growing body of evidence from within Wales, the UK and further afield including research by World Health Organisation that recognises the benefits that arts and culture can make to addressing both physical and mental health.

The Welsh Government has demonstrated its commitment to Arts and Health through their ongoing research and support of Arts Council of Wales Arts Arts in Health Capacity Fund. Wales has a number of key networks supporting this work including Wales Arts Health and Well-being Network (WAHWN), the Cross Party Group on Arts and Health and the network of Arts in Health Coordinators across each of the health boards.

In 2014 the UK Department of Culture, Media and Sport researched the social impact of culture on communities and found evidence that the arts and culture are beneficial to both mental and physical health; specifically that arts and culture can be used directly to improve clinical outcomes and indirectly to support reintegration into society.

This was followed by the UK All-Party Parliamentary Group on Arts, Health and Wellbeing publishing Creative Health: The Arts for Health and Wellbeing (2017) which includes a wealth of information about the benefits of working with the arts.

Significantly, in 2017, the Welsh NHS Confederation and Arts Council of Wales developed an Memorandum of Understanding (MOU) to share best practice, research and evaluation and celebrate the difference that arts in health activities can make. The MOU was supported with the creation of the Arts in Health Strategic Capacity 3 year fund (2020-23: ACW), which has enabled our organisation to access funding for the post of Arts in Health Project Officer.

Research conducted by Arts Council Wales in 2018 reiterated the benefits of arts and culture

finding 'that creative arts therapies have been applied to a broad range of physical and mental health issues including post-traumatic stress disorder, autism, chronic illnesses, dementia, neurological disorders, brain injuries and physical disabilities to improve patients' well-being and quality of life.'

The Well-being and Future Generations Act (2015) requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change. Aneurin Bevan University Health Board is one of the 44 public bodies required to consider The Well-being and Future Generations Act in its decision making.

Our Arts in Health Strategy integrates the five ways of sustainable working as outlined in the act including considering long term needs, integration, involving people, collaboration and prevention. We make a particular contribution to Objective 4: A Healthier Wales and Objective 6: A Wales of Vibrant Culture and Thriving Welsh Language.

2.2 Art in Health: Our Health Board Priorities

Our organisation is committed to delivering our five priorities through the Arts in Health Strategy. We know that actively integrating arts and creativity within our approach to healthcare will have a positive impact on the full life course of our population.

We are dedicated to keeping the population healthy through health promotion, health recovery and health prevention. Our Arts in Health Strategy demonstrates how we can support all stages of our Clinical Futures Plan towards a sustainable healthcare system for our Health Board population.

'Staying healthy' is one important element, and our recent activities have included *Mums and Poetry Writing* project supporting families who are experiencing adversity, '*I'm thinking of you*' a social media project connecting young people and families during the first lockdown

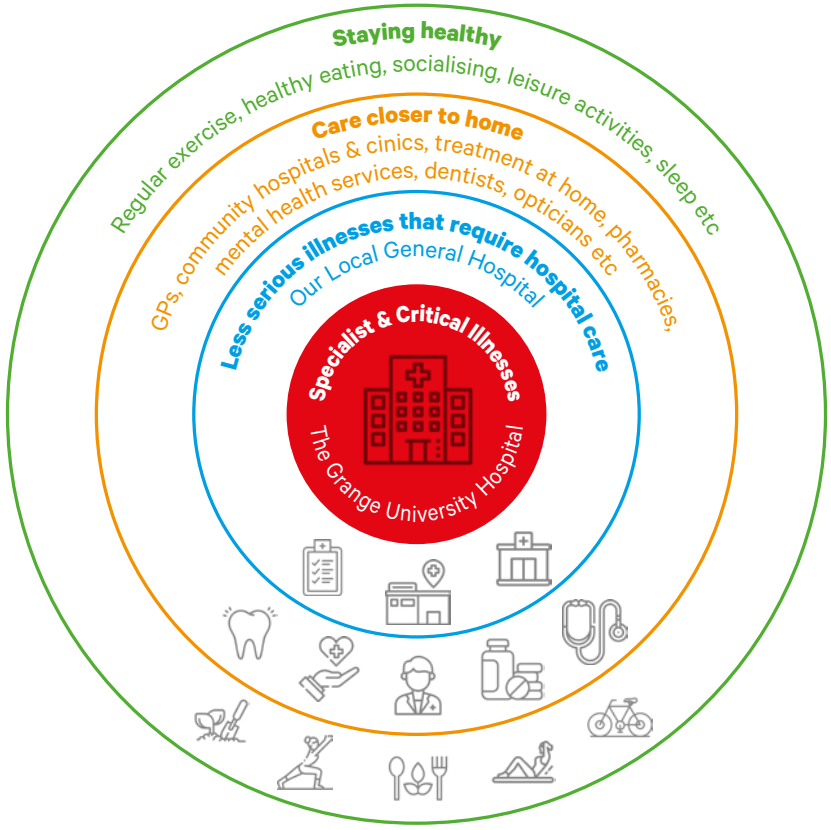
(May-July 2020), dance and movement activities, and developing creative initiatives to support bereavement.

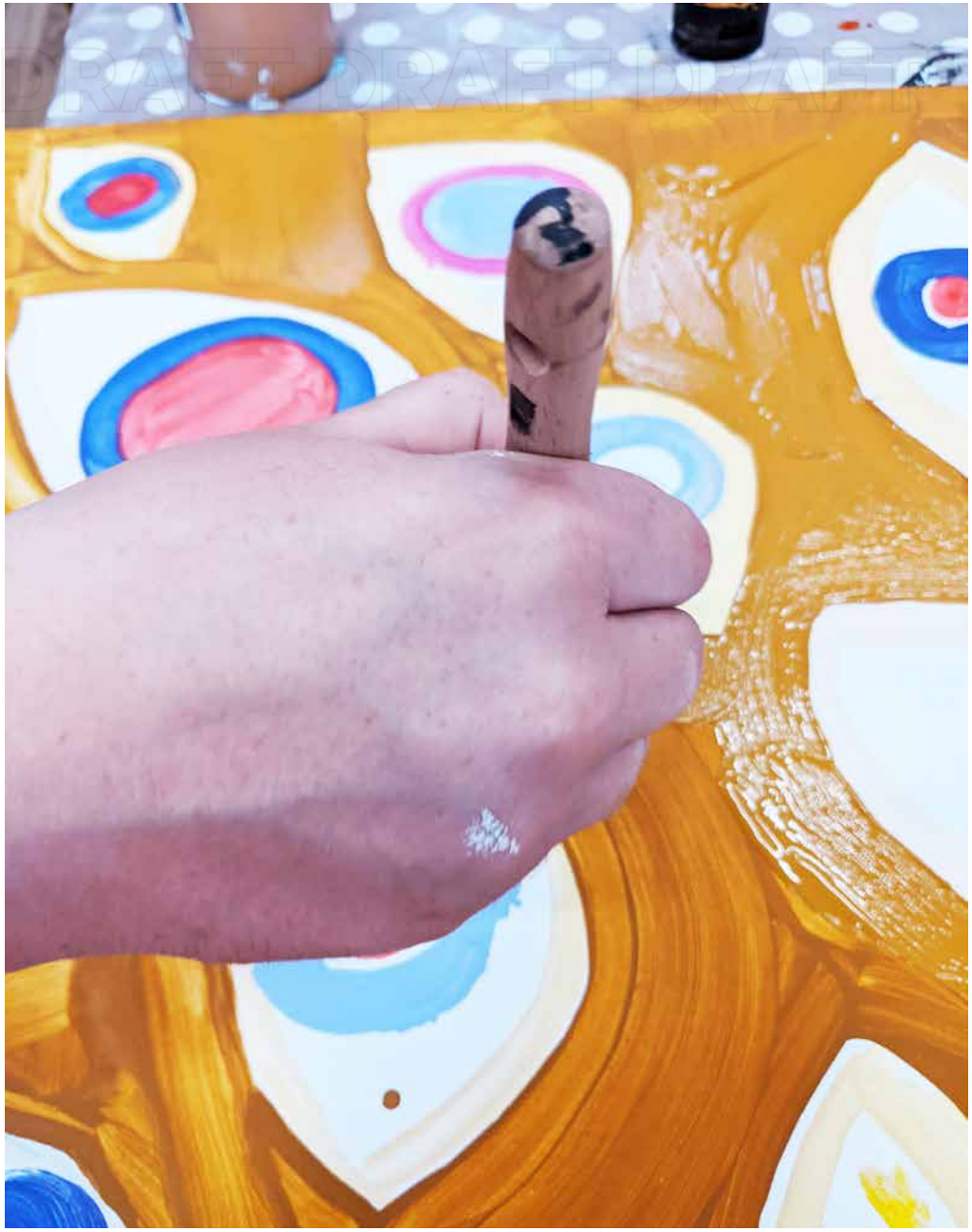
Of equal importance is how we use arts and creativity to support patients and staff across Health Board sites. We enhance patient experience through access to live music and performance programmes, creative writing and supported reading, and participatory arts activities that encourage conversation, strengthen relationships and support patient voice in discussions about recovery.

We improve our healthcare environments through creative projects involving patients and staff, and our landmark Specialist Critical Care Centre – Grange University Hospital, which has had a deep consideration for how the arts can contribute to a positive healing space – both inside and out – embedded from its inception.

Our work with clinical specialisms such as child psychology and cytology also highlight the impact that Arts In Health can make across the entire healthcare model by supporting teams to deliver their core objectives, improve their environments, and maintain wellbeing through textiles and singing projects amongst others.

Our Arts in Health Strategy is a framework for how we can increasingly support our community's health needs more holistically. It is an illustration of how we are continuing to work towards our priorities as a health board and it supports delivery at all stages of our Clinical Futures model.





Visual Arts Project with young people from MyST Torfaen and artist Ben Connors as part of Iceberg Creative Arts Programme

3. CURRENT PROGRAMME

The Arts in Health programme reaches across a variety of clinical specialisms, across sites and into our community. The programme is supported through a range of partnerships and schemes including: Gwent Arts in Health, Arts Council of Wales, Capital Development Programmes), Nesta, Baring Foundation and ABUHB Charitable Funds.

There is a long history of Arts In Health projects and activities within ABUHB and our communities, primarily delivered in partnership with Gwent Arts and Health (GARTH), an independent charity formed in 2004 to meet an organisational need identified by the previous Glan Hafren Trust and Nevill Hall Trust who had supported several Artists in Residence and creative arts programmes in the 1990s. GARTH continues to work in partnership with the Health Board and other organisations to support the Arts In Health programme (www.garth.org.uk).

Our programme is delivered by the Arts in Health team who work alongside clinical teams and executives, to devise, deliver and commission bespoke projects that involve a wide range of specialist practitioners including public arts consultants, artists, musicians, poets, writers, photographers, performers as required.

3.1 Enhancing our physical environments

The Arts in Health team is well-established in working with directorates across the organisation to create significant and meaningful interventions contributing to positive healthcare environments within the Health Board estate; from small-scale interventions such as staff-designed privacy screening *The Art of Cytology* to the flagship *Arts for the Grange* at The Grange University Hospital.

The Grange University Hospital Arts Programme is extraordinary in its breadth and scale. It takes in not only public and clinical spaces, but also staff-only and bereavement areas, the grounds and the wider community to support patients, visitors and staff on their journeys through the hospital. Ambitious thinking about what public art in a healthcare environment can be is revealed in the variety of projects, from wall installations, photography, painting and drawings to sound works, interactive play worlds, sculpture, gardens, architectural glass and steel, and more. A companion website, (www.artforthegrange.com), also ensures that engagement with artworks can continue beyond the building.

Rainbow Project
Photography by Phillip Roberts, as part of Grange Arts Programme commissioned and curated by Studio Response

Synapse, Gofalu Grange | Caring Connections
Photography by Eleanor Davis as part of Gofalu Grange | Caring Connections

The programme was delivered by external consultants Studio Response, part of which was *Gofalu Grange* – a social engagement project delivered by artists Davis & Jones, where staff and communities were invited to take part in creative activities that resulted in artwork that was included in the Hospital (www.gofalugrange.co.uk).

> *"Art for the Grange, one of the most ambitious integrated health projects in Wales, has been carefully curated by public art commissioners to embed creativity into the new Grange University Hospital in Llanfrechfa, south Wales, with high-quality work that inspires and succours." Emma Price, Studio Response*

3.2 Delivering in our healthcare settings

The Arts in Health team work within our hospitals and healthcare settings to deliver a varied and rich programme of activity that involves patients and staff as participants, audience and innovators. From regular live music sessions in Outpatients and Ward settings (Music While You Wait), to performance, arts and crafts and creative writing for acute settings, we aim to enhance the patients' and staff experience of our wards and shared spaces. We deliver changing exhibition programmes at Nevill Hall Hospital and the Grange University Hospital, and support staff in commissioning works for their specific areas.

We encourage participation from the whole team, ward or hospital community in our projects, and in Spring 2022 we are working with teams from the Clinical Research Centre, Day Surgery and Ophthalmology (Royal Gwent Hospital) to enhance their surroundings, as well as inviting all patients and staff to create their 'Windows on the World' at St Cadoc's Hospital to enhance the main building in a project that aims to support staff wellbeing and build cohesion after a long period of isolation for many.

3.3 Working with our communities

The Arts in Health team is continually exploring new ways of supporting the work of the Health Board within its communities, creating links with external partners to deliver

Top: Willow Heart Weaving Workshop with Community & Acute Mental Health Patients & Staff at Talygarn Unit, County Hospital led by Willow Artist Amanda Rayner

Staff observed that: "One of our inpatients who has been struggling quite a lot on the ward, to see him produce such a lovely piece to give to his daughter was magical."

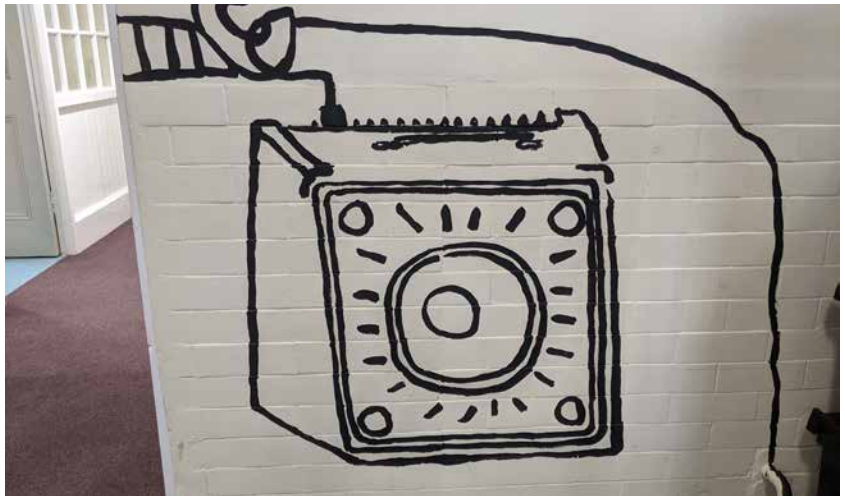
Below: Usk Art Group with their artwork in Nevil Hall Hospital Main Outpatients

Top: Gofalu Grange | Caring Connections, Cyanotypes
Photography by Phillip Roberts, as part of Grange Arts Programme commissioned and curated by Studio Response.

Left: Patients from Adferiad Ward (St Cadoc's Hospital) creating landscapes for Windows on the World patient and staff project

Top Right: Visual Arts Project with young people from MyST Torfaen and artist Ben Connors as part of Iceberg Creative Arts Programme

Bottom Right: Supported creative activities offered alongside memorial services



high-quality participatory arts activities contributing to improved mental health and well being. Current projects include the work with Child Psychology, and *Galaru* – a partnership project testing creative methods of supporting bereavement in isolation.

The Iceberg Arts Programme is an innovative approach weaving the arts and creativity into the work of CAMHS and Child Psychology. Working with organisations dedicated to supporting the mental health and well-being of children, young people and families, the programme has commissioned artists to work with participants to create art installations, music projects, social media virtual postcards, logos, poetry, spoken word and to explore how teams can better communicate their core messages.

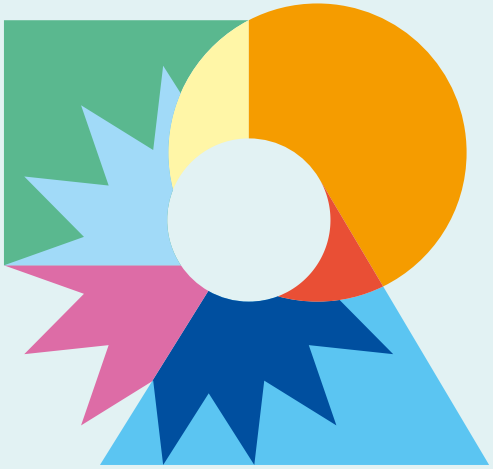
Galaru – working with creativity to support bereavement – is an evidence-based partnership project between the Health Board Person-Centred Care and Partnerships team, the Chaplaincy team, Head4Arts and GARTH which

My heart beats fast,
As the waves crash,
The memories of the water over my head.
Fear takes over.
My children look on,
Filled with hope, with excitement.
The first step is the hardest,
Their look now mirrors mine.
What was excitement, has been replaced,
Instead the look of full on anguish.
I'm projecting my fear on to them.
I need to show them,
Fears should be faced.
I take a deep breath,
Close my eyes,
And with that step.
I'm in! I've done it!
No longer afraid to immerse myself.
Like a weight has been lifted.
I no longer need to be afraid,
I can overcome anything.
Fears don't define me.

Mum, participant, poet
Mums and Poetry with Families First Blaenau Gwent and poet Clare e Potter as part of Iceberg Creative Arts Programme

Kiran Guye, Clinical Psychologist, Gwent Child and Family Community Psychology says of the project:

> *'Our hopes were to offer a space for parents to build hope and see themselves and others as 'more than' the single story others have told about them or they've told themselves... Parents developed lots of powerful writing including poems and eported that they enjoyed the project and this helped with their confidence around literacy skills and mental health."*



Young people from Gwent Child and Family Psychology creating a new logo with Jono Lewarne, City Edition Studio as part of Iceberg Creative Arts Programme

Mums and Poetry with Families First Blaenau Gwent and poet Clare e Potter as part of Iceberg Creative Arts Programme

Bereavement Journal commissioned by Galaru and created by artist Francesca Kay distributed to staff, patients and community members

has delivered mindful and creative activities for individuals and teams to consider loss, and has designed and tested a Bereavement Journal for distribution to staff and community members whose natural grieving processes have been disrupted by COVID restrictions.

3.4 Working alongside Arts Therapies

Arts in Health sits alongside the clinical practice of Arts Therapies, supporting each other where possible and sharing similar values regarding the positive impact of working creatively.

Arts Therapies are an established and important clinical specialism delivered and supported across many departments within the health board. They are referred psychological therapies for people with specific needs, the majority taking place in therapeutic spaces. Arts therapists have to qualify in their profession in order to practice, and are working within multidisciplinary teams for the most part.

Arts in Health offers a different range of experiences, often focusing on process and being part of enhancing patient wellbeing, engagement, sharing and building creative visions. There are potential therapeutic outcomes but these are often not the primary aim focus of the work. Artists are commissioned to work to specific briefs devised and will have expertise in a particular area.

Arts Therapists and Arts in Health staff worked together in winter 2021/22 to provide safe singing sessions in person and through virtual forums which staff could access throughout ABUHB for half an hour each week. Both a wellbeing and health improving activity; a sense of community was established through sharing seasonal and uplifting songs in English and Welsh, and contributing to events for Welsh Language Music Day with the Welsh Language team.

Left: Screen shot of the Christmas Subg featuring staff from the Maa Vacination Centre Ebbw Vale

Right: Oli Wilson-Dickson & Jamie Smith perform to Sycamore Ward patients and staff

4. OUR VISION & STRATEGIC OBJECTIVES

"For arts and creativity to support and improve the health and wellbeing of our patients, communities and staff."

1. To identify and enable opportunities to maintain positive, welcoming, nurturing and energising **environments** for delivering healthcare that reflect the cultures and communities that they serve.

2. To deliver a consistent programme of quality and evidence-based **participatory arts** projects in primary, secondary and community health care settings.

3. To ensure that staff are supported and confident in using arts & creativity in **the workplace.**

4. To develop and expand existing **internal** and **external partnerships** with individual practitioners, arts in health organisations and other providers.

5. To gather **evidence, evaluate** and to establish (internally) – and contribute to (externally) – the national arts in health **research** field.

6. To identify sustainable **funding and resources** for arts in health projects from within the HB.

Vinyl prints from silkscreen painting installed as privacy screening in the Colposcopy Clinic. From 'The Heart of Cytology', a creative project to support staff wellbeing through transition.

4.1 The Built Environment

Objective: To identify and enable opportunities to maintain positive, welcoming, nurturing and energising **environments** for delivering healthcare that reflect the cultures and communities that they serve.

> *"Creating beautiful environments – physical or psychological – that promote healthy working relationships between staff, patients, health and health care."*

How will we deliver?

- We will support projects that enhance positive environments for health and wellbeing, including physical spaces indoors and outdoors.
- We will promote creative approaches to engagement with service users, staff and stakeholders to capture lived-experience feedback and aspirations that can contribute to fit-for-purpose environments.
- We will include arts expertise in the outset of capital build and reconfiguration programmes to ensure that their potential to support health and wellbeing is maximised.
- We will include opportunities for community participation in art commissions for our healthcare environments.
- We will maintain the legacy of existing art works and programmes, ensuring the cultural connections to communities.

4.2 Participatory Arts and Creative Activities

Objective: To consistently deliver a programme of quality and evidence-based **participatory arts** projects in primary, secondary and community health care settings.

"Seeing the joy in being alive ... giving people functionality, advocacy, ownership, hope, closure, relieving pain"

How will we deliver?

- We will create opportunities for service users and patients to take part in participatory arts projects on a formal and informal basis, supporting population health and contributing positively to the 5 ways of wellbeing (WFGA).
- We will deliver a programme of staff focussed creative activities to support wellbeing as part of our People Plan.
- We will work with the Arts Therapies team to promote and share artwork from clinical practice where appropriate.
- We will build a platform to support the potential of arts and creative activities within social prescribing.
- We will maintain and develop our current exhibition & performance programme.
- We will deliver creative experiences for patients and staff to work together through high quality arts provision and opportunities; offering a democracy of experience where everyone is an artist.
- We will work with principles of co-production to ensure that projects respond to people's needs and create opportunities to amplify our patient's voices and their stories.

Cyanotype Workshops with Caroline Stealey, Llanfrechfa Grange Walled Garden

Images made with community members in open workshops, then selected and used for interiors in the Hospital

'The Heart of Cytology' was a 12 week creative project that supported staff wellbeing through transition for the Cytology team (bottom), and new artwork, which included privacy screening (top), was welcomed by the Colposcopy team (RGH / NHH) who had chosen their favourites for display.

4.3 Arts In the Workplace

Objective: To ensure that staff are supported and confident in using arts & creativity in **the workplace.**

"We need to give permission and encouragement for creativity; the introduction of new ways of working to support health; to encourage curiosity"

How will we deliver?

- We will provide staff with appropriate tools and resources to help them in the delivery of their creative projects including sharing best practice examples of Arts in Health projects.
- We will maintain and develop the Creative Forum as a regular, all-access, learning and network session to share news and developments in Arts in Health, enabling partnerships across all disciplines and agencies in support of arts and health.
- We will ensure that there is equal access to arts opportunities by sharing information about current activity within the health board and creating a recognisable Arts in Health identity.
- We will create a network of Arts Champions who are able to offer peer to peer insight into the potential and benefits of working with participatory arts practice.

4.4 Internal and External Partnerships
Objective: To develop and expand existing **internal** and **external partnerships** with individual practitioners, arts in health organisations and other providers.

"Arts & creativity run alongside everything we do, in all sorts of ways ... it's about being human"

How will we deliver?

- We will work in partnership with local and national organisations to deliver shared objectives.
- We will continue to work in partnership with Gwent Arts in Health in the funding and delivery of a range of arts in health projects.
- We will work to advocate for the Arts in Health sector and necessary resouces with Arts Council of Wales, Welsh NHS Confederation, University of South Wales and other partners.
- We will work on national arts, health and wellbeing initiatives with other health boards and Wales Arts Health and Wellbeing Network.

Top Left: St Woolos staff Mary Hopkins and Tina Veeter examine Elizabeth Anne Gardener's artwork 'The Unknown Soldier'

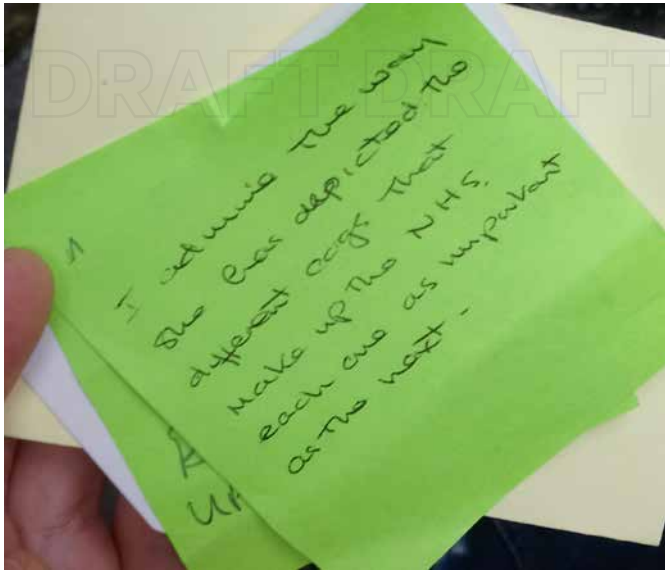
Top Right: Visual Arts Project with young people from MyST Torfaen and artist Ben Connors as part of Iceberg Creative Arts Programme

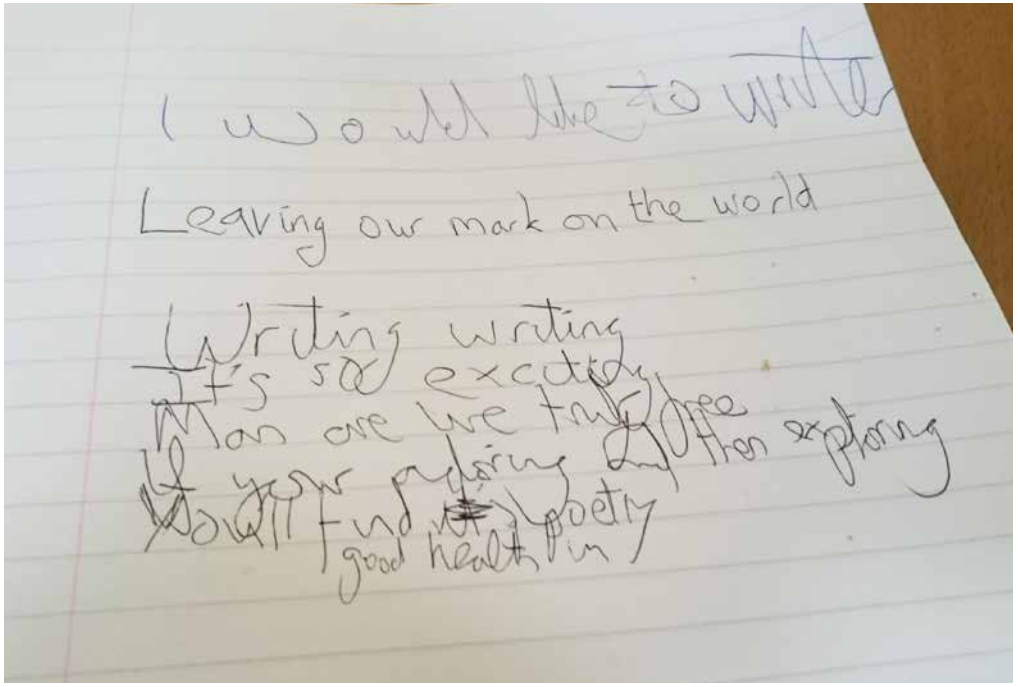
Bottom Right: Sense making with Gwent Child and Family Psychology and artists Gill Ha and Deborah Aguirre Jones as part of Iceberg Creative Arts Programme

Top left: Visitor feedback in response to USW students artwork

Top Right: Retired NHS staff share stories with USW students in preparation for their 2019 project at St Woolos.

Bottom right: An example from Healing Words: Creative writing for positive mental health with patients from Talygarn Ward, County Hospital.





4.5 Evidence, Evaluation & Research

Objective: *To gather evidence, evaluate and contribute to the national arts in health research field.*

> *"Recognition and use of theoretical relationship between occupation, creativity and health across the system"*

How will we deliver?

- We will ensure that evidence, and evaluation and Benefits Management and Benefits Realisation are built into all projects.
- We will contribute to building the evidence base for arts in health practice within the Health Board and wider context.
- We will ensure that patient voice is a key part of all evaluation working with principles of co-production in devising how participants are represented within a project context.

4.6 Funding and Resources

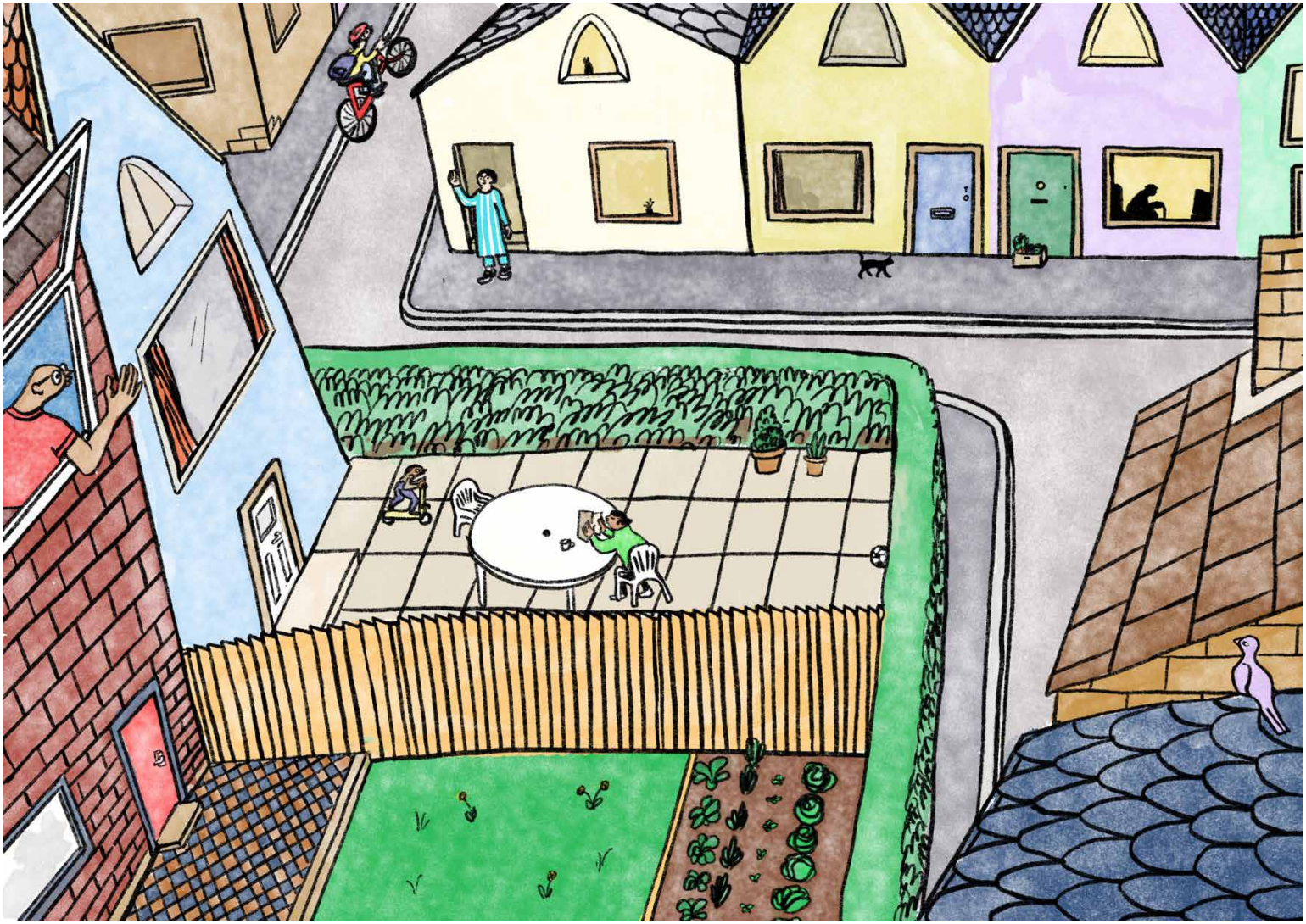
Objective: To identify sustainable **funding and resources** for arts in health.

"We must optimise access and integration of the arts and creative practice as a golden thread woven through our culture and facilities, enhancing holistic care and wellbeing for patients, carers and colleagues"

How will we deliver?

- We will identify a sustainable funding model in partnership with ABUHB Charitable Funds
- We will continue to seek funding when available from national programmes administered by the Arts Council of Wales and other bodies to support specific arts in health projects.
- We will consider other fundraising streams of activity which may also serve to raise awareness of Arts in Health practice within and external to the Health Board.
- We will consider income generating opportunities.
- We will match fund appropriate projects when required by external funders.

Young people create artworks artists Becca + Clare as part of I'm thinking of you – a social media project during the first lockdown as part of Iceberg Creative Arts Programme



George Manson's artwork for I'm thinking of you – a social media project during the first lockdown as part of Iceberg Creative Arts Programme

5. GOVERNANCE & DELIVERY

This strategy sets out our ambition and a clear set of actions to realise. It is important that adequate governance is in place to oversee the delivery of the objectives in the plan, and to provide assurance that we can maintain momentum throughout its duration.

It is also important not to overburden teams with governance; this strategy needs a '*Yes, and* ...' culture where we back our enthusiasts, champion ideas and enable creativity to flourish. Delivery of the strategy is everyone's business and we all have a role to play in its delivery.

In order to support delivery we have a number of enablers in place. Coordination sits within the Health Board Planning Team and the Strategy is sponsored by Peter Carr, Executive Director Therapies and Health Sciences.

An annual progress report will be provided to the Health Boards Executive Team and the Strategic Partnership Planning and Wellbeing Committee of the Board.

We have established a Creative Forum which has provided important contributions to the development of this strategy. The Creative Forum will continue to provides a role in delivery being:

- A place to share good practice and open to all
- A place for enthusiasts to meet and gain peer support
- Information sharing on grants, programmes and developments
- A place to test ideas
- A place for learning, reflection and practice

We have an Arts Development Team to support the organisation in delivering this strategy, the role of the team is to:

- Maintain current and ongoing programmes of work where appropriate
- Respond to and support patients, Health Board staff and the wider community in the development of creative projects that meet one or more of our Arts in Health Objectives
- Initiate and maintain partnerships and co-productive relationships that enable the delivery of the Arts In Health Strategy
- Share best practice models of arts in health within the Health Board and contribute to external dialogues and initiatives

Deborah Aguirre Jones, Paper Hospital
As part of Gofalu Grange | Caring Connections part of Grange Arts Programme commissioned by Studio Response

RESOURCES

POLICIES & REPORTS

Creative Health: The Arts for Health and Wellbeing
UK All-Party Parliamentary Group on Arts, Health and Wellbeing: www.culturehealthandwellbeing.org.uk

Arts and Health in Wales: A Mapping study of current activity (Arts Council of Wales)
https://arts.wales/sites/default/files/2019-02/Arts_and_Health_Volume_1_0.pdf

Welsh NHS Confederation: Advancing Arts Health and Wellbeing
www.nhsconfed.org/resources/2020/11/advancing-arts-health-and-wellbeing

Well-being of Future Generations (Wales) Act 2015 www.futuregenerations.wales/about-us/future-generations-act/

WHO: What is the evidence on the role of the arts in improving health and well-being? A scoping review: www.culturehealthandwellbeing.org.uk

Iceberg Creative Arts Programme Year 1 Report
https://wahwn.cymru/knowledge-bank/abuhb-iceberg-arts-report

***I'm thinking of you* Case Study**
https://wahwn.cymru/knowledge-bank/itoy

ARTS IN HEALTH ORGANISATIONS & NETWORKS

I'm thinking of you
Instagram @imthinkingofyou_cymru

Wales Arts, Health & Wellbeing Network (WAHWN)
www.wahwn.cymru

Arts & Health South West
www.ahsw.org.uk

London Arts & Health Forum
www.londonartsandhealth.org.uk

Arts Culture Health & Wellbeing Scotland
www.achws.org

Arts Care Northern Ireland
www.artscare.co.uk

Arts & Health Ireland Arts & Health
www.artsandhealth.ie

Culture, Health & Wellbeing Alliance
www.culturehealthandwellbeing.org.uk

JOURNALS & ACADEMIC SCHOOLS

The Arts Council England website lists several Arts In Health Journals and publications: www.artscouncil.org.uk/useful-resources/academic-journals-and-resources

University South Wales www.usw.ac.uk
MA Arts Practice (Arts, Health and Wellbeing)
BA (Hons) Creative and Therapeutic Arts

University of Bangor School of Health Science
www.bangor.ac.uk/research/themes/human-sciences

Manchester Metropolitan University
Arts for Health: www.artsforhealth.org/

Wales School for Social Prescribing Research (WSSPR)
www.wsspr.wales/

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

garth Gwent Arts in Health

Cyngor Celfyddydau Cymru
Arts Council of Wales

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Date: 27th July 2022 Agenda Item: 3.6

Aneurin Bevan University Health Board

MSK Transformation Programme

Executive Summary

Musculoskeletal (MSK) Transformation was identified as an IMTP key priority in 2019/20. An Executive led Programme Board was established to review the end-to-end MSK pathway and the initial community, therapy based tranche of work was agreed by the Executive Team and Board (Audit, Finance and Risk Committee) in April 2021. MSK Transformation, across the entire pathway (primary, community and secondary care) remains an IMTP key priority for 2022/23, with the intention of progressing further tranches of transformation work in the next 12 months.

A refreshed programme management approach was adopted in late December 2021 to strengthen the whole pathway approach to improving the service

There are four key workstreams:

1. Community Therapy
2. Outpatients
3. Elective Surgery
4. Post-operative care

The business case developed for a Community Therapy MSK Pathway (Works-stream 1) of the Programme resulted in the Executive Team agreeing a £1.8m investment on 9th December 2021. Work-stream 1 focusses on a pathway to deliver evidenced based, upstream, self-referral, self-management and community therapy support. The investment is being made from a recurring Value Based Health Care fund, supported by Welsh Government.

Workstreams 2 and 3 have been established building on the GIRFT (Getting it Right First Time) review of elective orthopaedic services in Wales and the NCSOS (National Clinical Strategy for Orthopaedic Services) work. An improvement action plan has been established for those workstreams.

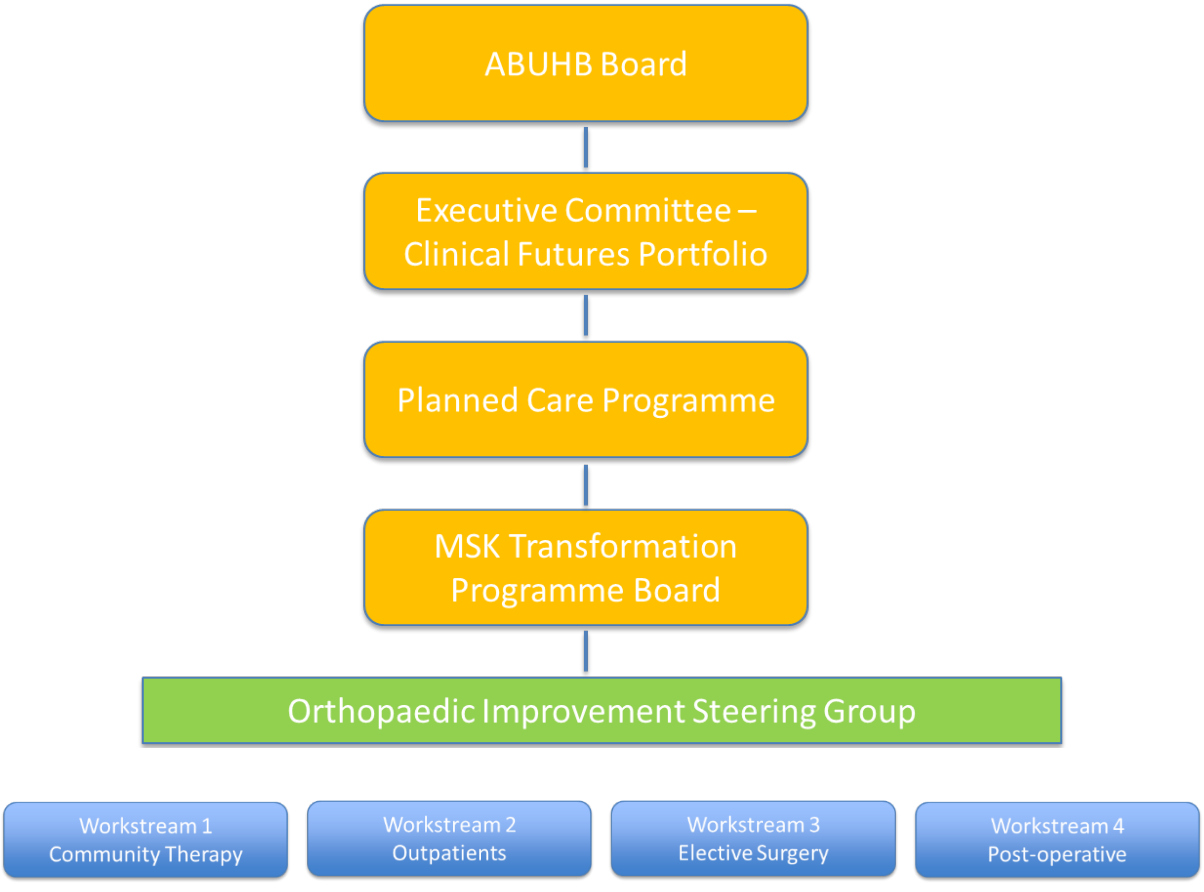
The purpose of this paper is to provide the Board with an update on progress to date on the overall Programme and all workstreams. This includes the preparatory work by the MSK Programme Board for starting the implementation of the community therapy pathway, with the management of deliverables, metrics and benefits, as well as implementation considerations, such as implementation issues and risks are being managed. Based on this preparatory work, the paper seeks approval to proceed with

implementation of Work-stream 1, following the decision by the Executive Team to allocate the £1.8m investment.			
The Committee is asked to: (please tick as appropriate)			
Approve the Report	✓		
Discuss and Provide Views	✓		
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Peter Carr, Executive Director of Therapies and Health Science			
Report Author: Peter Carr, Executive Director of Therapies and Health Science			
Report Received consideration and supported by :			
Clinical Futures Programme Board		**Committee of the Board [Public Partnerships & Wellbeing Committee]**	
Date of the Report: July 2022			

Background and Context

Planned Care Recovery has been added as a priority programme of the Clinical Futures Programme as part of the 2022/23 IMTP. A key component of this programme is the MSK Pathway programme. That whilst previously existing as an organisation priority has taken on additional focus given the deterioration of waiting times as a consequence of the COVID-19 pandemic

The programme structure is as below:



The programme had previously existed as a Health Board pathway programme but progress on the whole pathway improved had stalled I part due to the pandemic.

Work stream 1 Update

The Community Therapy pathway remodelling group used a value and clinical evidence base to review and redesign the community therapy elements of the MSK pathway to one of upstream management to improve outcomes, equity of access, waiting times for therapy assessment and efficiency in the community therapy MSK service delivery. Informed by national and international evidence, the MSK Transformation Programme Resource Group, working with the Community Therapy pathway remodelling group, anticipated that the redesigned pathway will provide the following benefits:

Primary Care:

- Reduction in waiting times for MSK specialist therapy advice and provide faster, equitable access to MSK services across ABUHB through self-referral to a therapy clinical triage hub, and access to a supporting patient information website,
- Support GPs by reducing their workload by redirecting MSK related demand of approximately 186,000 annual contacts across Gwent, (**at a calculated worth of the direct cost of a GP appointment of about £2.9m**), to the therapy triage hub. To note, that GPs will still have their direct referral route to secondary care specialist services (for example Orthopaedics, Rheumatology) according to the referral criteria agreed by those specialties – this will not be changed.
- Evidence has shown that approximately 40% of people self-referring or being referred by a GP to a community based, clinical triage hub can be managed successfully into self-care and self-management, without requiring further specialist interventions.

Secondary Care Specialist 1st Outpatient:

- Increase the probability that secondary care, specialist services have only appropriate referrals (according to the criteria agreed by those specialties) by providing alternative options in the community for those patients who don't fit the criteria, thus adding an additional safeguard to prevent inappropriate secondary care referrals.
- Minimising the risk of deterioration and chronicity for patients referred onto an orthopaedic waiting list or providing additional care and treatment options that might help patients whilst they wait.

Therapies:

- Avoiding inappropriate referrals to MSK community therapy services through utilisation of 'what matters' approach, by promoting self-management and self-care - signposting people to community, local authority and third sector services, where appropriate, to support self-management of their MSK conditions.
- Avoiding inappropriate diagnostic scan requests from GPs (calculated benefit worth of **minimum £88k**) - through the expansion of the integrated ultrasound delivery model and diagnostic pathway implementation by MSK Therapy teams.
- Research also shows the role of point of care diagnostic MSK ultrasound is a key feature of clinical triage and early diagnosis through **a shift in the delivery of care** from the acute setting into the community setting.

Patient Outcomes:

- Improving:
  - equity of access pan Gwent,
  - ease of access to MSK specific information and self-help support, and
  - access to self-referral option at persons' convenience.
- Improve patient experience (PREMs) by using the hub to manage the 'Your NHS Experience' questionnaire, to inform service improvements.
- Improve collation and measurement a baseline set of PROMs for all persons accessing the MSK hub – to facilitate full Value mapping of the system and support service development.

Workforce – retention and recruitment

- Improve opportunity for therapy career progression and workforce succession planning, to meet future progressive needs of the MSK pathways.
- Allow further development of therapy posts, for example, assistant practitioner, minor injury practitioner.
- Development of innovative roles, for example, MSK clinical sonographer.

Urgent Primary Care (UPC)/ Minor Injuries Unit (MIU):

As part of the scoping work undertaken for the MSK community therapy pathway redesign, the developing Urgent Care work stream lead clinicians also approached the Therapy Directorate to help manage the demand into UPC and MIU units for MSK pain and disorders (not related to accident or injury). The inclusion of this service provision fits within the end-to-end MSK pathway redesign, and is suitable for inclusion within the community/primary care therapy section of the pathway. Management of this activity away from the front door clinical staff has a calculated benefit worth of **circa £250k**.

Key Performance Indicators (KPIs)

The following key performance indicators have been developed for Workstream 1.

Value Measure - Patient Experience					
Aims & Measure	**Baseline**		**Expected Change**	**2019/20 Performance**	**Target Performance**
Patient Experience	PROMs		↑	WIP	
Website	Hit Rate/Survey				
Telephoney Responsiveness					
Waiting Times	To 1st contact				
		Physiotherapy	↓	16 Weeks max; 8 week med	8/52 Routine
		Podiatry	↓		8/52 Routine
		Acute (Routine OP)	↓	? Weeks	14/52 Routine
Adult Weight Management - new PH interventions: Commercial Weight Management	75% of patients lose weight, with 30% of participants who complete the intervention losing 5% of their initial weight			WIP	Impact of the PH intervention on people with MSK conditions will result from testing of pilot 2021/22
				WIP	
				WIP	

Primary Care Setting					
Aims & Measure	**Baseline**		**Expected Change**	**2019/20 Performance**	**Target Performance**
Short term: GP to Therapy Referrals	Referrals	MSK Triage	↑	33%	60%
Medium to long term: Therapy assessment - 1st	Referrals	Self-referrals	↑	25%	80%
Diagnostic requesting compliance	Non compliant requests	Rejected requests	↓	%	5%

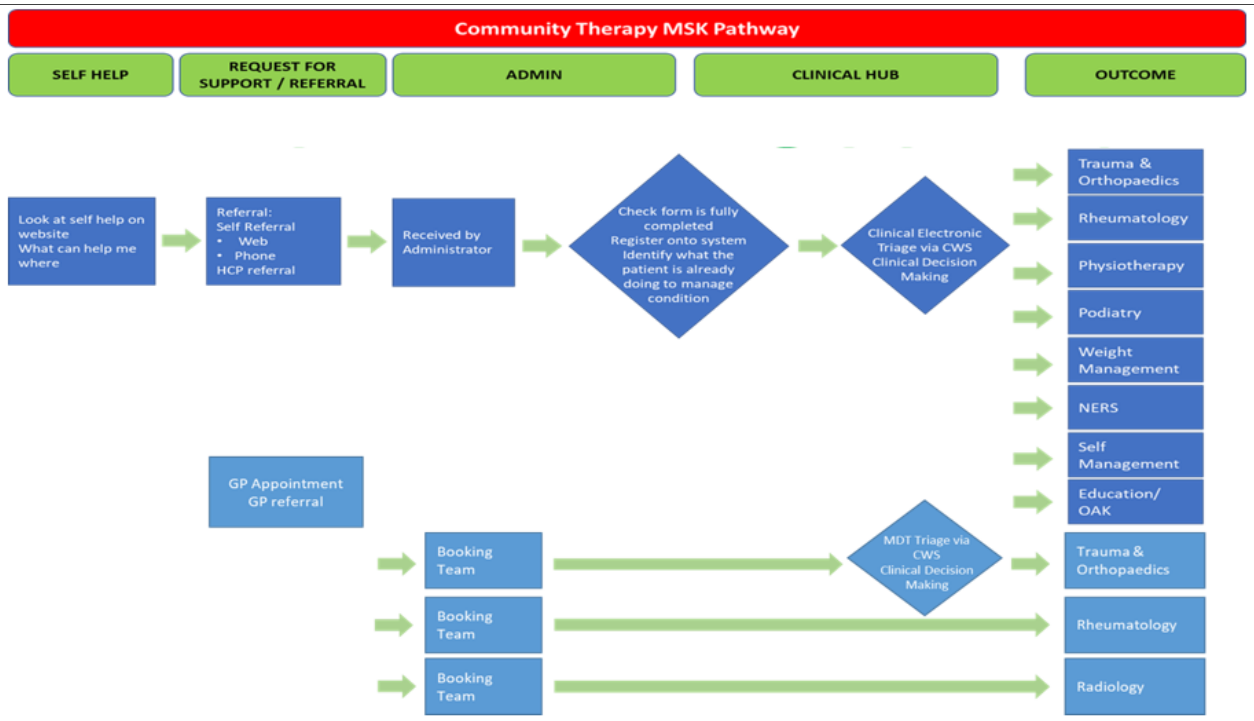
Acute Care Setting					
Aims & Measure	**Baseline**		**Expected Change**	**2019/20 Performance**	**Target Performance**
Referral Redirection (other than listed for treatment from 1st appointment)	1st contact referrals	Orthopaedics	↓	71%	40%
Surgical conversion rates (Listed for treatment)	From 1st appointment	Orthopaedics	↑	29%	60%
Follow up Patterns - convert to nurse/therapy management	FUP appointments	Orthopaedics	↓	1.78:1 FUP:N ratios	1.35:FUP:N ratios
	Shifting from Consultant FUPs where appropriate	Nurse/Therapy	↑	WIP	FUP:N ratios

Community Care Setting					
Aims & Measure	**Baseline**		**Expected Change**	**2019/20 Performance**	**Target Performance**
MSK Service Development of direct access to therapies (based on DACs)	Equity across boroughs	wte/population per borough	↓	Range from 0 to 2wt	Range will have zero difference
		slots/population per borough	↓	Range of 0 to 3,780	Range will have zero difference
Associated Therapy MSK service activity	Assessments/Attendances	Activity per population	↑	115,615 news/Fups	Right sizing as per new modelling
Therapy ROTT (removed other than treatment) rate	Physio	Mainstream	↓	18% (4,809)	
	Podiatry	Mainstream	↓	14.3% (612)	
	MSKI	MSKI	↓	53% (3,100)	

The KPIs will provide monitoring and assurance of the new service and performance and patient quality and safety measures. They will be monitored weekly by the service and reviewed on a monthly basis via the Programme Board.

Proposal

The redesigned Community Therapy MSK Pathway is shown below. It should be noted that in developing this model the Community Therapy pathway remodelling group has liaised with and listened to GPs, NCNs, and the LMC. Importantly, it has also ensured that GPs are still able to refer directly to secondary care services (such as Orthopaedics, Rheumatology) using existing, agreed pathways.



Recognising that much of the above improved value/ opportunities will not result in cash releasing funding, but also recognising that investment in an upstream therapist triage service is good value for money, additional resources were required to facilitate the upstream redesign in the community therapy pathway. A bid of £1.8m (summary below), was approved by the Executive Team to support this transformational change, noting that although the mathematical workforce calculators developed for the business case used tested activity data sets, the calculator applied several untested demand and capacity assumptions. It is recognised that these assumptions will need to be reviewed at the end of Year 1.

Summary Table – Resource requirements for the Community Therapy MSK pathway redesign:

	Year 1	Year 1 FYE	Year 2	Year 2 FYE	Year 3	Year 3 FYE
	WTE	£m	WTE	£m	WTE	£m
Sub Total Revenue - MSK Hub clinic staff	29.00	1.191	Test modelling assumption - how 12% of current GP MSK contacts (364,000) would translate into patient numbers - to be reviewed post Year 1			
Sub Total Revenue - Integrated ultrasound delivery model	2.00	0.112				
Sub Total Revenue - support staff	2.50	0.143				
Sub Total Revenue - MIU/ UPC	6.00	0.329				
TOTAL REVENUE - STAFF		1.775				
Total Revenue - non staff		0.080				
Total Revenue		1.855				
Capital - Ultrasound Machine		0.094				
	Based on 186,000 GP MSK contacts - 6% of current GP workload		Based on 364,000 GP MSK contacts - national average of 12% of total workload			

* Dependent on timing of recruitment

Activity

Modelled Annual Volume of patient contacts that would have been seen by a GP, assuming contacts convert into number of patients accessing early intervention & signposting (Est annual MSK related GP contacts = 364,648)		**185,617**
		509 Per day
Modelled Annual Volume of additional patients that will also require Telehealth*		**18,562**
Modelled Annual Volume of additional patients that will also require Clinical 'Triaged' (f2f)		**371**
Estimated Maximum Annual Volume of patients managed out of UPC/ MIU*		**13,477**
Maximum number of patients seen each shift:		**37**
		per shift or day

Issues and risks associated with Implementing the redesigned Community Therapy MSK Pathway

Whilst the Executive Team agreed in December 2021 to allocate the £1.8m investment to the redesigned Community Therapy MSK Pathway, it recognised that there were concerns about implementation being raised by stakeholders across both primary and secondary care services. In response, the Executive Team instructed a pause on recruitment of the posts into the redesigned therapy pathway, so that issues and risks could be explored further. Since December 2021, Executive led discussions with the relevant stakeholders have taken place, including the re-establishment of the MSK Transformation Programme Board, supported by the newly established Programme Management Office (PMO).

The re-establishment of the Programme Board was important to address concerns about ensuring appropriate clinical governance and oversight of the transformation work. The Programme Board is led by a Clinical Executive (Executive Director of Therapies and Health Science) and includes in its core membership Clinical Directors from each of the stakeholder clinical specialties (Primary Care, Orthopaedics, Rheumatology, Therapies). This arrangement will ensure a shared clinical governance framework with multidisciplinary review of any clinical concerns, for workstream 1 and future workstreams. The Programme governance also seeks to ensure that Programme sub-groups include and engage the relevant stakeholders in an appropriate and proportionate way. Participation in this Programme will be challenging, as it is for all busy clinicians but the Programme Board has set clear terms of reference with a commitment to organise meetings with appropriate notice and coordinated best fit with clinician availability. There is an expectation on each stakeholder specialty represented to ensure that appropriately senior colleagues, with delegated authority, are identified as deputies, so that meetings can go ahead and the pace of the Programme maintained. The Programme Board is now meeting monthly.

In terms of engagement with Primary Care, the pathway and outline plan for implementation has been endorsed at the NCN Leads Meeting and by the Executive

Director of Community and Primary Care, in addition to Primary Care representation on the Programme Board and all relevant sub-groups.

There was clearly a concern coming from the assumptions and understanding of the impact that this redesigned community therapy pathway will have on secondary care services activity, especially in the context of the pandemic recovery work. The MSK Transformation Programme Board has been able to confirm that whilst the overarching Programme mandate is about optimising the entire end to end MSK pathway, this particular tranche of work is concerning the community therapy element and will be responding to new community demand.

A number of concerns were raised by the Orthopaedic Directorate to the Programme Board about the detail of the implementation of the Community Therapy pathway. There are a number of particular concerns raised summarised as:

1. Investment benefits
2. Secondary care service volumes and increased activity concerns
3. Waiting times implications for patients accessing the Community Therapies pathway who go on to require secondary care
4. Workforce concerns re additional recruitment and impact on secondary care therapy resources
5. Community diagnostics concerns

There was a perception that the investment agreed by the Executive Team for the Community Therapy MSK Pathway was predicated on reducing activity in Orthopaedics (including waiting list initiatives) in order to pay for this investment. The MSK Transformation Board has been able to clarify that this is categorically not the case. The business case did not assume a reduction in Orthopaedic waiting lists. The benefit identified was a potential improvement in the conversion from 1st Orthopaedic outpatient appointment to procedure. This benefit is described as a calculated worth, not a saving, as this is the benefit to the efficiency of the Orthopaedic Directorate i.e. potentially these outpatient slots could be utilised by a patient that needs to see an orthopaedic surgeon.

Since the re-establishment of the MSK Transformation Programme Board, the Health Board has participated in the Orthopaedics Getting it Right First Time (GIRFT) review, which is being used to now inform the Programme's next tranches of work, looking at secondary care outpatients, elective surgery, and post operative care. These tranches of work will look at addressing the current waiting times and backlog, much of which is a legacy of the pandemic. There is no doubt that the transformation of the community therapy pathway can only help and support this secondary care transformation work by expanding community-based therapy options that have historically been underprovided or difficult to access.

Through discussion it became clear that a misunderstanding had developed that the existing referral routes from primary care into secondary care specialist services for MSK conditions would be changed. This is not the case and was not the brief of the remodelling group. This position has been clarified and confirmed by the MSK Transformation Programme Board, though further work has been requested to sign off the referral criteria and guidance for 'red flag' secondary care referrals, which should resolve this issue fully.

It will be the responsibility of the Work-stream 1 Implementation Group to monitor the interface between the community pathway and secondary care to respond to any unintended consequences of implementation so that they can be quicky resolved.

It was also apparent that misunderstanding had also emerged in part due to the naming applied to this tranche of work. In response, the Programme now refers to Programme Work-streams, with Work-stream 1 being clearly and consistently named as the Community Therapy MSK Pathway. Future branding of this community service will be considered by the Workstream 1 Implementation Group as it moves into full implementation. Also related to branding, Workstream 1 has designed a dedicated website to support self-management and provide information for the community about how to access the community therapy MSK service; the website branding has the ABUHB logo and was developed in collaboration with the ABUHB communications team to ensure alignment.

Concern had been raised by secondary care clinicians about the application of Point of Care, therapy led, diagnostic ultrasound as part of this community therapy pathway, despite it already being an established model in ABUHB and other parts of the UK, with a strong evidence base. This concern appears to have emerged due to lack of awareness of this model already established in community therapy services and lack of awareness about the scope of practice that therapy professionals are able to undertake. The clinical protocols have been approved by the ABUHB Ultrasound Governance Committee (which has representation from Radiology) and the Clinical Standards and Policy Group. In avoiding onward referral for secondary care diagnostics, patients receive care closer to home as part of their community therapy assessment (one stop shop). This is considered a very prudent (cost effective) model of care and excellent for patient experience. Clinical outcomes and patient experience will be monitored and reported though the Workstream 1 Implementation Group.

Similarly, concern has been raised by secondary care clinicians about the role in the pathway of therapy First Contact Practitioners (FCPs), particularly about the governance for these roles and referring protocols. Currently GPs allow self-referral to FCPs, and they themselves refer to FCPs. Also, secondary care services (Orthopaedics and Rheumatology) accept referrals from these FCPs. The future community pathway adopts this same, agreed referral arrangement but expands its capacity to allow greater equity of access across Gwent. Also, as with the current pathway, the future community pathway will not 'intercept' direct referrals from GP to secondary care, with current referral pathways remaining.

There has been detailed consideration of the workforce risks and broader system impact if recruitment of community-based Therapy posts attracts staff from existing secondary care services (particularly in relation to Physiotherapists). It was agreed to review the proposed job descriptions and management arrangements to ensure that there is sufficient flexibility that allows rotation across the system to manage this risk. It has been a useful discussion to better understand that community-based therapy professionals are largely distinct from secondary care professionals attracting candidates with different interests. During the discussion on this matter, it has also become apparent that other Health Boards in Wales, and Trusts in England, are actively and aggressively recruiting into community-based therapy MSK roles, to the extent that therapists from our Health Board are applying for these roles whilst we have recruitment on pause. Recognising that recruitment to

these therapy roles is competitive, Workstream 1 Implementation Group have prepared an attractive and dynamic recruitment campaign, including a social media campaign. Endorsement of the Community Therapy MSK Pathway by the Board will also mean ABUHB is perceived by candidates as a progressive and transformative place to develop a therapy career.

The community therapy MSK pathway and service will be required to comply to Welsh Government waiting times reporting and meet required performance; this had been raised as a concern but has been clarified by the MSK Transformation Programme Board. Performance monitoring systems will be put in place as the pathway is implemented.

The MSK Programme Board will continue to monitor these concerns through the development of the Workstream 1 Implementation Plan.

A log of issues and risks (concerns) is monitored and kept up to date by the Workstream 1 Implementation Group, which has responsibility for implementation of the Community Therapy MSK pathway, including resolving and managing existing and emerging concerns. The Workstream 1 Implementation Group is a sub-group of the overarching MSK Programme Board with accountability for implementation. Key to successful implementation of the Community Therapy MSK pathway will be evaluation of impact and outcomes; it is proposed to establish rapid improvement cycles as part of this evaluation, especially during the first year, to allow immediate correction and adjustment of the pathway as it is implemented to allow maximum benefit. The implementation evaluation will be reported to the Programme Board.

As described in this paper, funding has been agreed by the Executive Team and commencement of implementation is subject to satisfactorily addressing concerns that have subsequently emerged. With Board approval the implementation of the Community Therapy MSK pathway will commence fully in August 2022.

Workstreams 2 & 3 Update

Recognising the breadth of the pathway, the Programme Board will support the work for the rest of the MSK pathway to take place in four workstreams, as shown in the Programme structure below:

The Orthopaedic Improvement Steering Group, led by the Director of Operations, is currently scoping the work that will sit within Work-streams 2 and 3. As already indicated in this paper, this work will be informed by the National Clinical Orthopaedic Strategy (NCOS) and Getting it Right First Time (GIRFT) review.

There are a total of 87 actions across both reports so work is needed to consolidate and prioritise. The key themes emerging are:

- Quality & Patient Safety
- Restart & Recovery
- Regional Working
- Trauma Service
- General/other

The first meeting took place in June 2022 and the action plan was accepted but it was acknowledged that rationalisation was required to reduce duplication/overlap and focus attention for improvement.

In terms of programme structure, reporting and governance, the Orthopaedic Improvement work (covering workstreams 2 and 3) will report into the MSK Transformation Programme Board. This is due to the interdependencies that exist in the patient pathway across the whole system. A workstream Terms of Reference has been developed and adopted by the steering group.

Recommendation
The Board is asked to: • Note progress with delivering the MSK Transformation Programme; • Consider the information provided in this paper about Work-stream 1: the Community Therapy MSK Pathway, the investment agreed by the Executive Team and the emerging issues and their resolution, and support proceeding with full implementation from July 2022. • Note the development of the consolidated action plan to inform elective surgical service improvement via workstreams 2 and 3 in response to the two National reviews of orthopaedic services in Wales. • The paper seeks approval to proceed with implementation of Work-stream 1, following the decision by the Executive Team to allocate the £1.8m investment.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The Programme maintains it own risk register for items related to programme change. The programmes aims to resolve risks related to long waiting times for access to orthopaedic care on the HB risk register.

Financial Assessment, including Value for Money	This approach presents no immediate financial risks to the Health Board. Workstream 1 is subject to Welsh Government VBHC funding. Workstreams 2-4 will consider the operational efficiency and opportunity for improvement within existing resources and any available recovery funds from Welsh Government for outpatient and inpatient treatment.
Quality, Safety and Patient Experience Assessment	The MSK Pathway programme is underpinned by extensive evidence gathering and national guidance/policy including expert approaches The Programme board retains the clinical oversight of any changes with membership from a number of clinical groups
Equality and Diversity Impact Assessment (including child impact assessment)	E&DIAs will be completed for all changes proposed and developed by the Programme
Health and Care Standards	This is not directly aligned to any specific health and care standard.
Link to Integrated Medium Term Plan/Corporate Objectives	The MSK Pathway Programme is a key pathway programme as part of the Planned Care Recovery IMTP Priority Programme
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The range of approaches and activities outlined in the strategy will contribute to the Health Board's approach to the Well Being of Future Generations Act.
Glossary of New Terms	No new terms have been identified.
Public Interest	Any service change will be assessed for requirements for engagement and consultation.

Aneurin Bevan University Health Board

REQUEST TO CLOSE NORTH ROAD BRANCH SURGERY – TROSTNANT LODGE MEDICAL PRACTICE

Executive Summary

Purpose

The purpose of this paper is to inform the Board of the recommendation of the Branch Surgery Closure Panel, where an application for the closure of North Road branch surgery was considered – the branch surgery of Trosnant Lodge Medical Practice.

Background

On 6th April 2022, the Health Board received a request from Trosnant Lodge Medical Practice, Pontypool, Torfaen North, to close their branch site North Road Surgery, Croesyceiliog, Torfaen North.

All branch surgery requests are subject to consideration under the process for 'Considering Branch Surgery Closure Applications' (Appendix 1).

The formal Branch Surgery Closure Process was implemented, including patient engagement.

Assessment

A Branch Surgery Closure Panel convened on 5th July 2022, to consider the business case and supporting information, results from the patient engagement and equality impact assessments. The practice were also invited to present their case for closure.

The Panel considered the results of the patient engagement and acknowledged the impact the branch surgery closure could have on some patients. The Partners presented a compelling case for closure, detailing their current sustainability issues, including workforce difficulties, future viability, and their overall aim to provide safe, effective, and timely care to their patients.

These factors were considered by the Panel, and it was agreed that by consolidation of service provision on one site would support Trosnant Lodge Medical Practice to provide the safe delivery of care and support the future sustainability of the practice. The practice application to the close the branch surgery.

Recommendation

The panel recommends that the practice application to close the branch surgery is approved.

The Board is asked to approve the content of the report.

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

Executive Sponsor: Chris O'Connor, Interim Executive Director of Primary, Community and Mental Health

Report Author: Angela Williams, Service Development Manager and Victoria Taylor, Head of Primary Care

Report Received consideration and supported by :

Executive Team	**X**	**Committee of the Board [Committee Name]**	

Date of the Report: 14th July 2022

Supplementary Papers Attached:

Appendix 1 – GMS Branch Closure Process
Appendix 2 – Patient Engagement Report
Appendix 3 – Business Case
Appendix 4 – Equality Impact Assessment

Purpose of the Report

The purpose of this paper is to inform the Board of the recommendation of the Branch Surgery Closure Panel, where an application for the closure of North Road branch surgery was considered – the branch surgery of Trosnant Lodge Medical Practice.

Background and Context

Trosnant Lodge Medical Practice is a 3 GP Partner practice with a registered list size of 7,282 as of 1st April 2022. The practice is currently providing 23 GP sessions and 4 GP equivalent sessions via their Advanced Nurse Practitioner. Based on the list size the practice should be providing a minimum of 36.4 GP equivalent sessions, a shortfall of 9.4 sessions.

Over the last 2 years, due to two GP Partner retirements, the practice has had a reduction of 13 GP sessions.

North Road Surgery is the branch site of Trosnant Lodge Medical Practice. Open for 5 mornings per week, 8am – 1pm each day it is based in Croesyceiliog, Cwmbran. The branch site is located 4 miles away from the main site.

The practice has requested to close the branch surgery to consolidate services onto one site to maintain safe, sustainable GMS services in the longer term.

Trosnant Lodge Medical Practice occupies purpose-built premises built late 1980s / early 1990s and is working towards compliance with the Equality Act 2010. The main site can cope with increased capacity and has an adequate waiting area, a car park, and there is additional free parking surrounding the building, which is not subject to parking restrictions by the local council.

The main site is designed to cater for the needs of their patients and provides a full range of services including chronic disease management, child health surveillance, immunisations, investigations, and sexual health clinics. The main site has 5 GP consulting rooms and 2 treatment rooms. Not all GP/clinical rooms at the main site are currently used due to staff working across the 2 sites.

There are 3 pharmacies in Pontypool Town Centre approximately 0.3 miles away from the main surgery premises. Additionally, other local pharmacies collect directly from Trosnant Lodge Medical Practice. The practice has stated that the pharmacy local to North Road Surgery would continue to provide a collection/delivery service from the main site if the application were approved.

At the start of the pandemic, the practice reduced the services at the branch site due to constraints on the premises. The current service is nurse led with routine GP appointments arranged at Trosnant Lodge Medical Practice. As such, patients have become accustomed to attending the main site in Pontypool. Additionally, services such as spirometry, coils & implants, minor surgery and vaccinations are only provided from the main site.

The practice is not seeking to remove any patients, reduce services or revise their boundary as part of this application.

Case for closure

Trosnant Lodge Medical Practice has cited a number of difficulties which has led to their decision to apply to close the North Road Surgery and these are documented below:

1. Maintaining a safe and sufficient service provision: The practice has an insufficient number of clinical staff to cover both sites due to ongoing recruitment difficulties, and over the last 2 years there has been a reduction of 13 GP partner clinical sessions per week.
2. The longstanding senior partner retired in January 2020 and the practice was unable to recruit a replacement GP; therefore, an Advanced Nurse Practitioner was recruited.
3. Working on one site would support wider multi-disciplinary team (MDT) working.
4. Another partner unexpectedly gave notice to retire from the partnership, and subsequently left the practice March 2022.
5. A reduction from 5 GP partners to 3 over the last 2 years has created significant challenges for the practice, particularly when covering 2 surgery sites.
6. The practice has had an advert out for a salaried GP with flexibility on sessions for over 2 years and have been unsuccessful to date.
7. The surgery has tried various means of employing a GP including advertisements on NHS Jobs, Welsh Locum GP's, Facebook, and other sites. The practice has also become a training practice, has actively approached regular locums, and more

recently approached a recruitment agency. However they remain unsuccessful in recruiting a GP.

8. Closing the branch would enable the practice to better utilise their resources and enable them to have a greater range of clinical expertise available under one roof, enhancing patient care and safety and provide better continuity of care.
9. Many patients residing in Croesyceiliog already travel to Trosnant Lodge Medical Practice to be seen, as currently there is limited GP provision available in North Road Surgery due to changes made during the pandemic.
10. A survey carried out by the Oakleaf Group on behalf of ABUHB in March 2019 has highlighted multiple issues with both surgery premises.
11. North Road Surgery was categorised as 'Condition C' in 2019 with significant and moderate improvements required, total £58,819 and a recent valuation of the building has shown that it is only worth £85,000. These changes would therefore cost over 69% of the current value of the building.
12. Trosnant Lodge Medical Practice was categorised as 'Condition B' in 2019 with significant and moderate improvements required, total £14,205.
13. The partners have already begun implementing some of the proposed changes to Trosnant Lodge Medical Practice such as new flooring, seating covers, a new boiler, decorating and they have recently submitted an improvement grant for 2022/23 to convert 2 admin rooms to clinical rooms. They have also submitted an improvement grant for 2023/24 to install an electric entrance door and alterations to a patient toilet to make compliant with the Equality Act.
14. The practice is currently having to rely on locum GPs to provide core services to their registered population.
15. The practice has engaged locum GPs; however they often have a minimal effect in supporting the practice as they will often place restrictions on the number of patients they will treat and the additional work they will undertake such as bloods results, letters, on call etc. This also impacts on continuity of care.
16. Many locums will not work alone at the branch site due to safety concerns of working alone at an unfamiliar surgery. By condensing services from one site the practice feels these issues would no longer exist and locum staff would be able to support the team and make the working day safer and more efficient for both staff and patients.
17. The practice feels that having one site will help attract/retain new GPs to the practice with the aim of converting to Partners for succession purposes.
18. The GP Partners are seriously concerned about how they will continue to provide any service should the application to close the branch site be unsuccessful and this would potentially result in a contract resignation.
19. By supporting the application, the partners feel this would provide resilience in the partnership, mitigating the strain of delivering services across 2 sites, whilst managing the current challenges

Assessment and Conclusion

As part of this process, an 8-week patient engagement exercise was undertaken between 23/04/22 until 17/06/22, with a questionnaire issued to all registered patients of 16 years and over (6,090 patients, equating to 83.6% of the patient list). The Health Board

received 1,305 responses, giving a response rate of 21.4%. Due to the current pandemic, it was agreed with Aneurin Bevan Community Health Council that drop-in sessions held at the practice would not be appropriate in this instance.

The patient questionnaire asked whether patients attend the main and branch site and if so, how often, what mode of transport they used and if they have any specific difficulty in accessing the main surgery, Trosnant Lodge. It also offered them an opportunity to add any additional comments (Appendix 2).

From the results, the following key factors were considered:

Do not attend main site and would have difficulties due to lack of transport and/or mobility

269 patients stated they do not usually attend the main site, and of these, 227 indicated that they would have difficulty attending the main site, mainly due to public transport, lack of transport, affordability of taxis and mobility issues. The majority of these respondents reside within Croesyceiliog and are within walking distance of the branch site.

Depending on where the patient resides, there are 5 other local GP practices with open lists that accept registrations from patients residing in Croesyceiliog. Some of these surgeries are closer than the branch surgery, which could result in a reduction in travel.

There is also community transport scheme:

Age Connects Torfaen - Transport to Health

The service for older people 50+ enables Torfaen residents to have easy access to safe, reliable, and accessible transport to access medical appointments. To enable the service to become self-sustainable a charging policy is in place and residents will be given a price on making an enquiry about the service to help cover costs.

Age Connects Torfaen has two adapted vehicles, accommodating wheelchairs or mobility aids. Their drivers are Dementia Friends and have a vast experience of supporting vulnerable older people.

285 (21.8%) patients felt there would be a negative impact on the main surgery if the branch closed as there would be more people trying to access the main site by telephone and attending for appointments. Also, that there would be an added pressure on staff due to the increase in demand at one site.

The practice is not seeking to reduce the number of appointments available to its registered patients or to reduce staffing levels. All staff and appointments from the branch surgery would be transferred to the main site. The practice anticipates that having the same resources but on one site would allow them to manage patient demand more efficiently and safely and reduce the pressure on staff. This includes appointment availability and telephone access.

Conclusion

The Branch Surgery Closure Panel convened on 5th July 2022 to consider the business case for Trosnant Lodge Medical Practice (Appendix 3). This included supporting

information, responses from the patient engagement and an equality impact assessment (Appendix 2 & 4). The Panel comprised of:

Dr Alun Walters	Primary Care Clinical Director (Chair)
Dr Liam Taylor	Deputy Medical Director/Divisional Director of Primary Care & Networks
Victoria Taylor	Head of Primary Care
Dr Natasha Collins	Gwent Local Medical Committee
Linda Joseph	Aneurin Bevan Community Health Council (Non-Voting)
Eryl Smeethe	NCN Lead, Torfaen North
Cath Gregory	Assistant Head of Service, Torfaen

The practice, (Partners - Dr Laura Hammond, Dr Rachel Collier, and Dr Lisa Cavacuiti), attended the Panel meeting on 5th July 2022 and presented their case for the closure of North Road Surgery. Following the presentation, the Panel raised the following questions to the practice:

Q What is the practice current telephony system and if the application to close is supported, what would the impact on telephone lines be?

A The practice updated their telephony system 2 years ago to a cloud-based system with unlimited lines, therefore the number of lines available will not be reduced if the branch were to close. The receptionists who would be answering calls at the branch surgery can answer the calls at the main site so there will not be any detrimental impact to telephone access.

The Panel was satisfied with the answer.

Q What repeat prescription ordering services will be available for patients residing in Cwmbran/Croesyceiliog if the branch closure was supported?

A Patients have an option to order prescriptions online. The practice has adapted the Luton Model for repeat prescription ordering. For patients unable to order online, the practice has a designated prescribing clerk who holds a list of vulnerable patients who are able to ring the practice via a dedicated line to order their medication.

The Panel was satisfied with the answer.

Q How many locum sessions does the practice rely on?

A Regularly use equivalent to 4 locum sessions each week. Depending on absences and/or clinical need may use more.

The Panel was satisfied with the answer.

The Panel acknowledged the content of the presentation and thanked the practice for attending and answering the questions raised.

The Panel also considered the results of the Patient Engagement and the Equality Impact Assessment.

It was acknowledged by the Panel that the fundamental factor is the sustainability of Trosnant Lodge Medical Practice and being able to provide safe and effective care, delivered by the appropriate workforce.

It was recognised that GP recruitment is increasingly difficult, especially when practices work over multi sites. This can be seen as a barrier to recruitment.

Practices working at scale on one site supports sustainability and the security of working as part of a larger team on a day-to-day basis, which is of particular importance for the new generation of GPs.

Working from one site would also support the development of the practice team. Providing the opportunity to consider the wider skill mix of staff that will enable patients to be seen by the most appropriate health care professional for their needs.

The Panel also reflected on the compelling case presented by the GPs namely the strain of the current workload, compounded by the recruitment challenges, and the continued commitment of the Partners to maintain a safe service for their patients.

The Panel considered the results of the Patient Engagement and acknowledged the impact the branch surgery closure would have on some patients.

The Branch Surgery Closure Panel was satisfied that the location of the bus stops and the availability of public transport to the main site in Trosnant Lodge was satisfactory for the majority of patients, and those patients with difficulties would have a choice to register with 5 other GP surgeries in Torfaen South. Some of these surgeries were closer than the branch surgery, resulting in a reduction in travel.

The Panel was satisfied that the practice would continue to undertake home visits to their registered patients where clinically appropriate, regardless of where they reside.

The Panel was satisfied that adequate arrangements were in place for patients to access their repeat prescriptions via a choice of several local pharmacies who collect/deliver repeat prescription requests direct to the main site in Pontypool and to the patients' home if required, including the pharmacy local to North Road.

The Panel acknowledged that Trosnant Lodge Medical Practice is not the only GP practice experiencing challenges within Torfaen, and recognised that if the application is not supported, the Health Board could potentially receive the GP Partners contract resignation which would have a significant, detrimental effect on the other local practices and patients.

Outcome

Following a comprehensive review of all the above, the Panel recommends that the practice application to close the branch surgery is approved. This was considered and agreed by the Executive Tram on 14th July 2022.

Aneurin Bevan Community Health Council Executive Committee were supportive of the branch closure, subject to appropriate patient communications, including a

comprehensive FAQ document being provided alongside the outcome letter. This would explain the rationale for the decision and include details of the access arrangements for patients, patient options, should they wish to register with an alternative GP Practice, closer to where they reside. This was to address any concerns patients may have as result of the closure.

Following detailed discussions, the Panel agreed the following:

- Branch surgery closure request supported
- Recommendation submitted for consideration Aneurin Bevan Community Health Council Executive Committee 7th July 2022; outcome received 13th July 2022 supporting the closure request
- Recommendation submitted and supported by the Executive Team – 14 July 2022
- Recommendation to Board – 27 July 2022
- Branch to close 30th September 2022

Stakeholders and patients to be notified from week commencing 1st August 2022.

Recommendation
The panel recommends that the practice application to close the branch surgery is approved. The Board are asked to support the recommendation and approve the content of the report.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There is no reduction in service, patients will continue to be able to access GMS services from the main site. A formal engagement process has been concluded and has identified minimal patient impact.
Financial Assessment, including Value for Money	There is no financial risk of withdrawing the Branch Surgery and delivering all General Medical Services from the main sites.
Quality, Safety and Patient Experience Assessment	No reduction in service, relocation of service provision to main site. Patients will continue to access safe services from an appropriate setting
Equality and Diversity Impact Assessment (including child impact assessment)	EQIA undertaken and attached as Appendix 4
Health and Care Standards	Standard 1: Staying Healthy Standard 3: Effective Care Standard 4: Dignified Care Standard 5: Timely Care
Link to Integrated Medium Term	▪ Ensuring safety, excellence, and quality in all our services

Plan/Corporate Objectives	at all times. ▪ Improving the efficiency and effectiveness of our services. ▪ Focusing on prudent and value-based healthcare to ensure clinical value and value for money is improved. SCP 6 – Planned Care SCP 7 – Service Sustainability and Regional Collaborations
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Sustainability of GMS services to ensure patient can access service provision close to where they reside
	Integration – Facilitates integrated working with independent contractors
	Involvement – A patient engagement process was implemented. Stakeholders notified and views sought
	Collaboration – Independent GP Practice, Local Medical Committee and Aneurin Bevan Community Health Council
	Prevention – this will support the sustainability of an independent GP practice and will provide opportunities to recruit, develop the workforce and systems to ensure patients access safe, effective, and timely care
Glossary of New Terms	N/A
Public Interest	Written for the public domain

Aneurin Bevan University Health Board

Vacant Practice Panel GMS Contract Resignation – Glyn Ebwy Surgery

Executive Summary

Purpose

The purpose of this paper is to inform the Board of the Vacant Practice Panel's recommendation following the local and national advertisements in relation to Glyn Ebwy Surgery, Ebbw Vale.

Background

On 24th March 2022, the Health Board was advised by Dr Kunju and Dr Jones of their intention to resign the GMS contract with effect from 30th September 2022.
All GMS contract resignations are subject to consideration under the process for "GMS Vacant Practice Policy" - Appendix 1.
The formal Vacant Practice Process was implemented.

Assessment

A Vacant Practice Panel convened on the 14th April 2022. All of the options detailed in the Vacant Practice Policy were considered by the Panel.
The Panel agreed on the recommendation of options 1, 2 and 3 running parallel, on a full or partial list basis which was approved by the Executive Team.
In order to discuss the vacant practice and the potential impact this may have on the practices within the Neighbourhood Care Network, an urgent sustainability meeting was scheduled with neighbouring practices within Blaenau Gwent West on 20th April 2022. The practice was advertised locally and nationally, with a closing date of 30th May 2022. Unfortunately, the Health Board did not receive any applications.

The Vacant Practice Panel reconvened on 8th June 2022 to consider the remaining options 3 – 6, for the continued provision of GMS services to the patients registered with Glyn Ebwy Surgery.

Option 3: Managed list dispersal with existing neighbouring practices.
Option 4: LHB take on the management and delivery of GMS services.
Option 5: Dispersal of practice list.
Option 6: Fill the vacancy through existing partners.

The Panel agreed on the recommendation of option 5, converting to option 3 in collaboration with the neighbouring practices via an agreed package of support, both financially and non-financially.

Recommendation

The recommendation of the Vacant Practice Panel was that the Glyn Ebwy patient list be dispersed to neighbouring practices, with effect from 1st October 2022. The remaining small number of patients residing outside of the practice boundaries are to be allocated to the GP practice closest to their residence.

Option 5 is the recommendation, with a plan to convert to option 3 in collaboration with neighbouring practices via an agreed package of support, both financially and non-financially.

The Board is asked to note the content of the paper and the recommendation of the Vacant Practice Panel.

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

Executive Sponsor: Dr Chris O'Connor, Interim Executive Director of Primary, Community and Mental Health

Report Author: Angela Williams, Service Development Manager, Deborah Harrington, Contracts Manager and Victoria Taylor, Head of Primary Care

Report Received consideration and supported by :

Executive Team	**X**	**Committee of the Board [Committee Name]**	

Date of the Report: 1st July 2022

Supplementary Papers Attached:

Appendix 1 – GMS Vacant Practice Process

Purpose of the Report

The purpose of this paper is to inform the Board of the Vacant Practice Panel's recommendation following the local and national advertisements in relation to Glyn Ebwy Surgery, Ebbw Vale.

Background and Context

Introduction

The Health Board received a GMS Contract Resignation from Dr Kunju and Dr Jones at Glyn Ebwy Surgery on 24th March 2022. All GMS contract resignations are subject to consideration under the process for "GMS Vacant Practice Policy" - Appendix 1.

Dr Yousuf Kunju has been a GP Partner providing General Medical Services at Glyn Ebwy Surgery since before the new GMS contract was implemented in April 2004. Dr Ian Jones joined the partnership on 3rd September 2012.

Dr Kunju and Dr Jones advised Aneurin Bevan University Health Board on 24th March 2022 of their intention to resign the GMS contract with effect from 30th September 2022.

The Practice provides General Medical Services from a 1990's two storey purpose-built building which is owned by Dr M Y Kunju, and 2 previous GP Partners, within Ebbw Vale town centre and is situated in a residential area, close to the local shops.

The Practice has a list size of 7,221 (March 2022) and their practice boundary covers the council wards of Ebbw Vale North and South, and parts of Beaufort, Badminton, Brynmawr, Rassau, Waun-Lwyd, Sirhowy and Cwm. There are 1,330 patients aged 65 or over, which represents 18.41% of the practice list.

A Vacant Practice Panel convened on the 14th April 2022. The Panel included representation from Gwent Local Medical Committee and Aneurin Bevan Community Health Council, to consider the options available as part of the GMS Vacant Practice Policy and to determine the most appropriate course of action for the future of the practice. All of the options detailed in the Vacant Practice Policy were considered by the Panel.

Option 1: Aim to fill the vacancy through local interest under a GMS contract.

Option 2: Aim to fill the vacancy through national interest under a GMS contract.

Option 3: Managed list dispersal with existing neighbouring practices.

Option 4: LHB take on the management and delivery of GMS services

Option 5: Dispersal of practice list

Option 6: Fill the vacancy through existing partners.

The Panel agreed on the recommendation of option 1, option 2 and option 3 running parallel, on a full or partial list basis which was approved by the Executive Team.

In order to discuss the vacant practice and the potential impact this may have on the practices within the NCN area, an urgent sustainability meeting was scheduled with neighbouring practices within Blaenau Gwent West on 20th April 2022 to enable early discussions in terms of the future of Glyn Ebwy Surgery.

Assessment and Conclusion

The practice was advertised locally and nationally, with a closing date of 30th May 2022. Unfortunately, the Health Board did not receive any applications.

The Vacant Practice Panel reconvened on 8th June 2022:

Dr Liam Taylor	Deputy Medical Director/Interim Divisional Director of Primary Care and Community Services (Chair)
Victoria Taylor	Head of Primary Care
Kay Morris	Business Partner Accountant
Jo Green	Senior Primary Care Manager, GMS
Dr Gareth Oelmann	Gwent Local Medical Committee Representative
Linda Joseph	Aneurin Bevan Community Health Council Representative
Dr Isolde Shore-Nye	NCN Clinical Lead

The Panel considered the remaining options 3 – 6, for the continued provision of GMS services to the patients registered with Glyn Ebwy Surgery.

Option 3: Managed list dispersal with existing neighbouring practices.

Option 4: LHB take on the management and delivery of GMS services

Option 5: Dispersal of practice list

Option 6: Fill the vacancy through existing partners

Each option was discussed and considered fully:

Option 3: The Panel agreed that a local solution would be the best option for patients and the wider community and further meetings would be arranged with the practices to discussion and agree the support required to enable this.

Option 4: It was acknowledged that the Health Board was already experiencing significant workforce challenges with the existing directly managed practices and securing the appropriate additional clinical resource would be extremely challenging. There was also a potential that patients may choose to register with a neighbouring practice, resulting in an ongoing influx of new registrations, which could have detrimental effect on those practices. As a result of this, the Panel agreed that larger allocations of patients to neighbouring practices would support workforce planning and allow the practices to recruit to meet the additional needs of patients.

Option 5: The Panel agreed that the most appropriate option for the ongoing GMS care for the patients currently registered with Glyn Ebwy Surgery would be to disperse the list to neighbouring practices with extreme outliers being allocated to the practice closest to their residence.

The Panel agreed that option 5 should be recommended, with a plan to convert to option 3 in collaboration with neighbouring practices via an agreed package of support, both financially and non-financially.

Option 6: Not applicable in this instance.

The Panel therefore agreed on the recommendation of option 5, converting to option 3 in collaboration with the neighbouring practices via an agreed package of support, both financially and non-financially.

Following Executive Team approval, the next steps were:

- Inform existing contractor of Panel outcome w/c 13th June 2022
- Arrange a further meeting with neighbouring practices w/c 13th June 2022 to progress managed list dispersal and support package
- Agree allocation lists with neighbouring practices w/c 11th July 2022
- Issue stakeholder letters w/c 13th June 2022
- Issue patient allocation letters w/c 18th July 2022

Recommendation
The recommendation of the Vacant Practice Panel is that the Glyn Ebwy patient list be dispersed to neighbouring practices, with effect from 1st October 2022. The remaining small number of patients residing outside of the practice boundaries to be allocated to the GP practice closest to their residence from 1st October 2022. Option 5 is the recommendation, with a plan to convert to option 3 in collaboration with neighbouring practices via an agreed package of support, both financially and non-financially. The Board asked to note the content of the paper and the recommendation of the Vacant Practice Panel.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	▪ The Health Board is required to ensure the provision of GMS services to all patients ▪ It is anticipated that ongoing care for the majority of patients currently registered with Glyn Ebwy Surgery will be secured by neighbouring practices ▪ A small number of outlier patients would be allocated to their closest GP practice
Financial Assessment, including Value for Money	▪ £10 per patients approx. £72,210 ▪ Letters to patients approx. £9,964 ▪ Support package to neighbouring practices, to be determined but estimated circa £250,000
Quality, Safety and Patient Experience Assessment	This will result in alternative provision for GMS services to the patients registered with Glyn Ebwy Surgery, Ebbw Vale
Equality and Diversity Impact Assessment (including child impact assessment)	N/A - All patients will be treated equally
Health and Care Standards	Standard 1: Staying Healthy Standard 3: Effective Care Standard 4: Dignified Care Standard 5: Timely Care
Link to Integrated Medium Term Plan/Corporate Objectives	▪ Ensuring safety, excellence, and quality in all our services at all times. ▪ Improving the efficiency and effectiveness of our services. ▪ Focusing on Prudent and Value-Based Healthcare to ensure clinical value and value for money is improved. SCP 6 – Planned Care

	SCP 7 – Service Sustainability and Regional Collaborations
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Ensures the ongoing provision of GMS services to the patients registered with Glyn Ebwy Surgery, Ebbw Vale, Blaenau Gwent
	Integration – Facilitates integrated working with independent contractors
	Involvement –Involvement from the Local Medical Committee and Aneurin Bevan Community Health Council
	Collaboration – Independent GP Practices and cluster teams. Local Medical Committee and Aneurin Bevan Community Health Council
	Prevention – This will ensure the ongoing provision of GMS services to patients
Glossary of New Terms	N/A
Public Interest	N/A

Aneurin Bevan University Health Board

Vacant Practice Panel GMS Contract Resignation – St Brides Medical Centre

Executive Summary

Purpose

The purpose of this paper is to inform the Board of the Vacant Practice Panel's recommendation and outcome following the advertisement and interviews in relation to St Bride's Medical Centre, Newport.

Background

On 21st March 2022, the Health Board was advised by Dr Natasha Collins of her intention to resign the GMS contract with effect from 30th June 2022.

All GMS contract resignations are subject to consideration under the process for "GMS Vacant Practice Policy" - Appendix 1.

The formal Vacant Practice Process was implemented.

Assessment

A Vacant Practice Panel convened on the 14th April 2022. The panel which included representation from Gwent Local Medical Committee and Aneurin Bevan Community Health Council, considered the options available as part of the GMS Vacant Practice Policy and to determine the most appropriate course of action for the future of the practice. All of the options detailed in the Vacant Practice Policy were considered by the panel.

The Panel agreed on the recommendation of options 1 and 2 running in parallel, on a full or partial basis. This was approved by the Executive Team.

The practice was advertised locally and nationally, with a closing date of 16th May 2022. The Health Board received 6 business cases and 4 progressed to interview.

The Vacant Practice interview panel convened on 25th May 2022. Applicants presented their business case and answered panel questions.

The Panel agreed that whilst there was merit in different areas of all bids, St David's Clinic, Malpas Brook Health Centre, and Bellevue Group Practice all provided strong assurances through their business cases and interview that they had sufficient capacity and clear

robust plans for the integration and continuation of care for the patients currently registered at St Brides Medical Centre.

Based on the outcome of the interviews, patient allocations were recommended. The following reconfigured allocations were registered as bulk transfers as of 28/06/22:

St David's Clinic: a new GMS contract to be awarded to the contractors to deliver GMS care to 4,099 patients residing in Marshfield, Tredegar Park, (proportion including Duffryn), Peterstone, Castleton, Coedkernew and St Bride's Wentlooge, retaining the existing St Bride's Medical Centre premises. The longer-term plan will be to merge this contract with existing contract, delivering care from all 3 sites.

Bellevue Group Practice: to be allocated 1,995 patients residing in Tredegar Park (proportion), Pilgwenlly, Stow Hill, Duffryn and Bettws, these patients would receive their General Medical Services from the main site at Bellevue Terrace or the branch site in Bettws, Newport.

Malpas Brook Health Centre: to be allocated 662 patients residing in Gaer, Rogerstone, Allt-yr-yn, Bassaleg and Shaftesbury, these patients would receive their General Medical Services from Malpas Brook Health Centre at Malpas Road, Newport.

54 patients residing outside of these wards will be allocated to the GP practice closest to their residence and based on existing practice boundaries.

The Panel was satisfied that St David's Clinic, Bellevue Group Practice and Malpas Brook Health Centre all have the ability and clinical capacity to deliver care safely to the patients.

Recommendation

The recommendation of the Vacant Practice Panel was that, with effect from 1st July 2022, St David's Clinic will provide General Medical Services to 4,099 patients from the existing St Brides premises; Bellevue Group Practice will provide General Medical Services to 1,995 patients from their existing premises and Malpas Brook Health Centre will provide General Medical Services to 662 patients from their existing premises. The remaining patients will be allocated to the GP practice closest to their residence.

The Board is asked to note the contents of this report and the recommendation of the Vacant Practice Panel.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	X
Executive Sponsor: Dr Chris O'Connor, Interim Executive Director of Primary, Community and Mental Health	
Report Author: Angela Williams, Service Development Manager, Deborah Harrington, Contracts Manager and Victoria Taylor, Head of Primary Care	
Report Received consideration and supported by :	

Executive Team	**X**	**Committee of the Board [Committee Name]**	
Date of the Report: 1st July 2022			

Supplementary Papers Attached: Appendix 1 – GMS Vacant Practice Policy

Purpose of the Report

The purpose of this paper is to inform the Board of the Vacant Practice Panel's recommendation and outcome following the advertisement and interviews in relation to St Bride's Medical Centre, Newport.

Background and Context

Introduction

The Health Board received a GMS Contract resignation from Dr Natasha Collins at St Brides Medical Centre on 21st March 2022. GMS contract resignations are subject to consideration under the process for "GMS Vacant Practice Policy" - Appendix 1.

Dr Natasha Collins has been a GP Partner providing GMS services at St Brides Medical Centre since 1st September 2018. She became the single-handed contract holder on 1st January 2020.

Dr Natasha Collins advised Aneurin Bevan University Health Board on 21st March 2022 of her intention to from the GMS contract with effect from 30th June 2022.

The Practice has a list size of 6,875 (March 2022) and the practice boundary covers the wards of Tredegar Park, Marshfield, Gaer and Graig. There are 943 patients aged 65 or over, which represents 13.7 % of the Practice list.

A Vacant Practice Panel convened on the 14th April 2022. The panel included representation from Gwent Local Medical Committee and Aneurin Bevan Community Health Council, to consider the options available as part of the GMS Vacant Practice Policy and to determine the most appropriate course of action for the future of the practice. All of the options detailed in the Vacant Practice Policy were considered by the panel:

Option 1: Aim to fill the vacancy through local interest under a GMS contract.

Option 2: Aim to fill the vacancy through national interest under a GMS contract.

Option 3: Managed list dispersal with existing neighbouring practices.

Option 4: LHB take on the management and delivery of GMS services

Option 5: Dispersal of practice list

Option 6: Fill the vacancy through existing partners.

The Panel therefore agreed on the recommendation of option 1 and option 2 running parallel, on a full or partial basis which was approved by the Executive Team.

Assessment and Conclusion

The practice was advertised locally and nationally, with a closing date of 16th May 2022. The Health Board received 6 business cases and 4 progressed to interview.

The Vacant Practice interview panel convened on 25th May 2022:

Dr Liam Taylor	Deputy Medical Director/Interim Divisional Director of Primary Care and Community Services (Chair)
Victoria Taylor	Head of Primary Care
Dr Alun Walters	Clinical Director for Primary Care
Kay Morris	Business Partner Accountant
Dr Neil Statham	Gwent Local Medical Committee Representative
Jemma Morgan	Aneurin Bevan Community Health Council Representative
Linda Joseph	Aneurin Bevan Community Health Council Representative
Leah McDonald	Head of Service, Newport
Dr Sue Thomas	NCN Clinical Lead, Newport West

Applicants presented their business case and answered panel questions.

The Panel agreed that whilst there was merit in different areas of all bids, St David's Clinic, Malpas Brook Health Centre, and Bellevue Group Practice all provided strong assurances through their business case and interview that they have sufficient capacity and clear robust plans for the integration and continuation of care for the patients currently registered at St Brides Medical Centre.

Based on the outcome of the interviews, it was recommended by the panel that the following allocations are applied:

Ward	**Number of Patients**	**Allocated to**
Tredegar Park	3169	St David's Clinic & Bellevue Group Practice
Marshfield	2560	St David's Clinic
Gaer	464	Malpas Brook Health Centre
Rogerstone	194	Malpas Brook Health Centre
Graig	186	St David's Clinic
Pilgwenlly	138	Bellevue Group Practice
Allt-yr-yn	66	Malpas Brook Health Centre
Stow Hill	24	Bellevue Group Practice
Liswerry	22	Liswerry Medical Centre
Others < 20	Approx 50	Closest GP practice

St David's Clinic: a new GMS contract to be awarded to the contractors to deliver GMS care to 4,099 patients residing in Marshfield, Tredegar Park, (proportion including

Duffryn), Peterstone, Castleton, Coedkernew and St Bride's Wentlooge, retaining the existing St Bride's Medical Centre premise. The longer-term plan will be to merge this contract with existing contract, delivering care from all 3 sites.

Bellevue Group Practice: to be allocated 1,995 patients residing in Tredegar Park (proportion), Pilgwenlly, Stow Hill, Duffryn and Bettws, these patients would receive their General Medical Services from the main site at Bellevue Terrace or the branch site in Bettws, Newport.

Malpas Brook Health Centre: to be allocated 662 patients residing in Gaer, Rogerstone, Allt-yr-yn, Bassaleg and Shaftesbury, these patients would receive their General Medical Services from Malpas Brook Health Centre at Malpas Road, Newport.

54 patients residing outside of these wards will be allocated to the GP practice closest to their residence and based on existing practice boundaries.

The Panel was satisfied that St David's Clinic, Bellevue Group Practice and Malpas Brook Health Centre all have the ability and clinical capacity to safely deliver care to the patients.

Conclusion

The Vacant Practice Panel convened on the 25th May 2022 to consider the business cases received.

The Panel was satisfied that St David's Clinic, Bellevue Group Practice and Malpas Brook Health Centre all have the ability and clinical capacity to safely deliver care to the patients.

Following Executive Team approval, the following steps were taken:

- Successful practices informed of outcome and agreed allocations
- Existing practice and staff informed of outcome
- Aneurin Bevan Community Health Council Executive Committee informed of outcome
- Stakeholder letters issued w/c 6th June 2022
- Patient letters issued w/c 13th June 2022
- Patient registration with allocated practices from 1st July 2022

Recommendation
The Board is asked to note the contents of this report and the recommendation of the Vacant Practice Panel.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	▪ The Health Board is required to ensure the provision of GMS services to all patients ▪ It is anticipated that ongoing care for 60% of patients currently registered with St Brides Medical Centre will be secured by St David's Clinic, unless they choose to register elsewhere

	▪ The remaining 40% will be allocated to a neighbouring GP practice
Financial Assessment, including Value for Money	▪ £10 per patients approx. £68,750 ▪ Letters to patients approx. £9,500
Quality, Safety and Patient Experience Assessment	This will result in alternative provider for GMS services to the patients registered with St Brides Medical Centre, Newport
Equality and Diversity Impact Assessment (including child impact assessment)	N/A - All patients will be treated equally
Health and Care Standards	Standard 1: Staying Healthy Standard 3: Effective Care Standard 4: Dignified Care Standard 5: Timely Care
Link to Integrated Medium Term Plan/Corporate Objectives	▪ Ensuring safety, excellence, and quality in all our services at all times ▪ Improving the efficiency and effectiveness of our services ▪ Focusing on Prudent and Value-Based Healthcare to ensure clinical value and value for money is improved SCP 6 – Planned Care SCP 7 – Service Sustainability and Regional Collaborations
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Ensures the ongoing provision of GMS services to the patients registered with St Brides Medical Centre, Newport
	Integration – Facilitates integrated working with independent contractors
	Involvement – Involvement from the Local Medical Committee and Aneurin Bevan Community Health Council
	Collaboration – Independent GP Practices and cluster teams. Local Medical Committee and Aneurin Bevan Community Health Council
	Prevention – This will ensure the ongoing provision of GMS services to patients
Glossary of New Terms	N/A
Public Interest	N/A

Aneurin Bevan University Health Board

Complex and Long-Term Care
Care Home and Domiciliary Care Proposed Provider Fee Uplifts – 2022/23

Executive Summary

The Complex and Long-Term Care Division commissions complex care for individuals who are eligible for Continuing NHS Healthcare (CHC) where a person's primary need has been assessed as health based. Care can be provided within a care home or within a person's home (domiciliary care) and is part of a continuum of care and support that an individual with complex needs requires.

The current paper proposes the uplift in fees for both care homes and domiciliary care for the financial year 2022/23.

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

Executive Sponsor:
- Dr Chris O'Connor, Interim Executive Director for Primary Care, Community and Mental Health

Report Author:
- Hayley Jones – Head of Business and Performance, Complex and Long Term Care Division
- Andrew George – Business Partner Accountant, Complex and Long Term Care Division

Report Received consideration and supported by:

Executive Team	**x**	**Committee of the Board [Committee Name]**	

Date of the Report: 12th July 2022

Supplementary Papers Attached: Letter from Care Forum Wales and HomeCare Association

Purpose of the Report

This report seeks approval for the agreement of 22/23 fee uplifts for care homes and domiciliary care independent providers to be able to continue to commission complex care from the independent sector. The proposed increase in fees is in line with the methodology used in previous years to identify fee uplift as outlined below:

Care Homes - In July 2015, the Executive Board approved a fee methodology to enable delivery of an equitable, transparent, and robust methodology for setting standard care home Continuing NHS Healthcare (CHC) placement fees. The methodology adopted identified three key elements to the standard Continuing NHS Healthcare (CHC) weekly fee structure:

1. The baseline aligned to Local Authority individual residential nursing rates which range from 8-25% across the Gwent Local Authorities for 2022/23.
2. Plus, the NHS Funded Nursing Care (FNC) rate. This rate is set nationally and for '22/'23 is forecasted to be 5.5%
3. Plus, in recognition of the additional care required for a CHC patient when compared to an FNC patient - This was originally calculated to be equivalent to 7 hours of a HCSW per week – forecast 5.5% (22/23).

This methodology has historically been applied since 2015.

Domiciliary Care - In previous years, the fee uplift applied to domiciliary care providers commissioned by the Health Board has been the average percentage uplift of the 5 Local Authority partners, which are all different rates.

Background and Context

From April 2022 there has been an increase in costs for care provided by independent care providers. This increase in costs is due to a number of factors including increases in the following:

- Cost of living (the current Retail Price Index RPI is 11.7%) including rising energy costs
- Real Living Wage (national increase of 6.9%)
- National Insurance contributions (national increase of 1.25%)
- Higher insurance premiums in the wake of the Covid-19 pandemic
- Limited availability of workforce within the health and social care sector increasing reliance upon offering higher financial incentives to fill vacancies and retain staff
- Increased reliance upon agency staff to fill vacancies

These increased costs have resulted in providers requesting additional funding for commissioned care from the Health Board.

During the Covid-19 pandemic additional funding was received from Welsh Government to support independent providers however this was tapered down from 1st October 2021 and ceased 31st March 2022 and there is no indication from Welsh Government that any additional funds will be received by the Health Board to support the sector from 1st April 2022.

The WG COVID-19 funding relief equated to £2.636 million in 2021/22.

Domiciliary Care

The domiciliary care sector has reached critical levels at times due to insufficient staffing. Labour shortages and cost pressures to meet the demands of increased wages are causing issues for providers. Since April/May 2020 there has been a consistent increase in the level of demand for domiciliary care services which exceeds pre-pandemic levels. The market has strived to meet this rise in demand but faces considerable challenges with recruiting and retaining sufficient staff to meet existing packages of care. These issues are not particular to Gwent and replicated across Wales and the UK as a whole.

Across statutory agencies at present within the Gwent region there are approximately 4,000 hours of domiciliary care required for individuals who are currently residing in the community either waiting a domiciliary care package or an increase in care. It is likely providers will select the commissioning agency that pays the highest rate and it is therefore essential that the Health Board provides a fee uplift that is reasonable.

The Complex and Long Term Care Division also commissions support for End of Life patients, in all localities. This provides care to persons already in the community who are eligible for fast-track care, hence avoiding a hospital admission. This provision is also for individuals who are discharged from hospital whose wishes are to have their End of Life care at home. Providers have stated that if a fee increase is not achieved this provision will become unsustainable.

In March 2022 the Health Board received a letter from the Care Forum Wales and HomeCare Association outlining the current challenges within the sector and requesting an increase in fees for HomeCare.

Nursing Homes

Within Gwent there are currently 533 individuals who are eligible for CHC who are residing in care homes. It is noted that patients funded by the Health Board have more complex needs than those funded by the Local Authority (hence the Health Board's inclusive rate of 7 hours of a HCSW to meet the complex needs of the individual). If an appropriate fee increase is not achieved there is a risk that providers will decline admissions from the Health Board Hospital sites in favour of those being funded by the Local Authority as they are less complex. It is also worth noting that patients who have their care funded by the Local Authority can pay top ups to the home for any additional extras they request, this is illegal for individuals in receipt of CHC funding.

The potential financial challenge associated with an increase in care home and domiciliary care fees is acknowledged and in order to support the efficient use of resource and potentially mitigate some of the increase in costs the Complex and Long Term Care Divison are implementing a number of cost improvement savings whilst maintaining quality and safety for patients in receipt of care. These areas include:

- 1:1 provision in Hospitals and Care Homes
- Implementation of the Holiday Policy
- Contribution to the review of the Step Closer to Home model
- 'In house' efficiencies to workforce alignment, including the expansion of the Care at Home Team (CAHT) and allocation of resource to support patient

pathways from hospital who would have otherwise been likely to require high cost placement

- Review of packages of care to ensure needs are being met

Assessment and Conclusion

By utilising the methodology described above the table below summarises the proposed increase in domiciliary rate and care home fees for '22/'23.

Proposed Domiciliary Care Rates & Care Home Fees 22/23

Forecast	£000s	Comment
Domiciliary Care	£ 2,009	Proposed Increase 12.38%
Care Home Fees	£ 3,935	Proposed Increase average 11.77%
	£ 5,944	
Additional Spend	£ 2,305	Increase on IMTP

The original IMTP financial submission for the Division forecasted an additional domiciliary care rate and care home fee increase of £3.639m compared to '21/'22 in order to cover the real living wage, inflationary costs and potential growth. The proposed increase of 12.38% for the domiciliary care rate, and an average of 11.77% for care home fees, equates to £2.305m over the original IMTP submission by the Divison related directly to fee uplifts. This is a cost pressure to the Divisional IMTP (the full effect of the proposed fee increases has been included in the mth 1, 2 and 3 forecast for Complex Care).

When considering the proposed increase in Care Home Fees it should be noted that at this point in time Welsh Government are yet to confirm the increase in NHS Funded Nursing Care and additional care rate and it is possible that the 5.5% forecast increase may be an over or under estimate.

Deviation from previous agreed fee methodologies, could raise the following risks: -

- Providers may choose not to commission with the Health Board or may become unviable with the risk of reducing available options for care across Gwent. Not only would this have a significant impact on patient and carer quality, outcomes and experience the impact on the wider system could potentially be significant with individuals unnecessarily being admitted to hospital or the number of delayed discharges increasing. There are currently 533 individuals eligible for CHC residing in a care home that are at risk of being served notice and potentially require a hospital admission.

- Providers are currently contacting the Health Board requesting an update on fee position. Any delay in agreeing fees may impact on existing providers willingness and ability to either provide new packages of care or maintain existing ones.

- A potential negative impact on the Health Board's ability to work with partners to respond to the current Welsh Government request of increasing beds (or virtual beds) across Wales by 1,000 prior to the Autumn to support anticipated additional pressures within the system.

- Challenge to the Health Board can be expected with potential legal processes and potential reputational damage for the Health Board.

- The Health Board's ability to fund the real living wage for providers would be compromised which is not in line with Welsh Government commitments.

Chair's Action
Given the significant pressures being faced by the Health Board and the increased demand expected over the weekend of the 16/17th July 2022, the Executive Team requested Chair's Action be undertaken to enable the Health Board to confirm and communicate an approved fee uplift with Care Homes immediately in order to encourage Care Homes to actively work with the Health Board to support hospital discharges.

The Chair approved this action on 14th July 2022, collectively with Nicola Prygodzicz, Deputy CEO, and supported by the Executive Team.

Recommendation
The Board is requested to ratify the Chair's Action undertaken to increase fees for both care home and domiciliary care providers as per prior approved fee methodologies with effect from 1st April 2022. The Board is also requested to note that this increase in fees is an additional £2.305m over the original IMPT financial submission and the wider actions being undertaken within the Complex and Long Term Care Division to try and mitigate part of these costs.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are a range of risks related to individuals, the sustainability and stability of the care sector market and the wider system if proposed fees are not supported.
Financial Assessment, including Value for Money	Previously agreed methodology has been used to propose rate and fee increase. Reduced fees could potentially impact ability to commission care with individuals remaining within the acute sector.
Quality, Safety and Patient Experience Assessment	There is a risk individuals may be admitted to, or remain in, hospital due to being unable to commission placements/community care if proposed fees not supported.
Equality and Diversity Impact Assessment	There are no equality, diversity or child impact issues associated with this report.

(including child impact assessment)	
Health and Care Standards	
Link to Integrated Medium Term Plan/Corporate Objectives	The proposed increase in fees is an additional £2.305m over the estimate included within the original IMTP financial submission.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Not applicable to this report**.**
	Integration – Not applicable to this report**.**
	Involvement – Not applicable to this report**.**
	Collaboration – Not applicable to this report**.**
	Prevention – Not applicable to this report**.**
Glossary of New Terms	N/A
Public Interest	No reason not to be available to the public.

Homecare Association

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CARE FORUM WALES

Glyn Jones, Interim Chief Executive
Aneurin Bevan University Health Board
Headquarters
St Cadoc's Hospital
Lodge Road, Caerleon
Newport
NP18 3XQ

1 March 2022

Dear Mr Jones,

Local Health Board fee rates for homecare

First, we want to thank you and your colleagues for all you have done and continue to do to support homecare providers, and those they care for, during these most challenging of times. Your help and commitment are greatly appreciated by our members.

We are writing to urge you to do everything possible to increase fee rates for homecare in your local health board to help to maintain and grow vital homecare capacity and ensure stability of your local market.

Our UK wide calculations, explained below, suggest that providers face increases in wage and non-wage costs of 8-10% in 2022/23. From discussion with members in Wales, we understand that costs in Wales will likely be higher than the UK average due to the level of training requirements and registration that have been introduced by Social Care Wales and the introduction of the Real Living Wage – this could mean cost increases of up to 25%. Failure to increase fee rates sufficiently risks further damage to the supply of homecare, which could lead to further adverse consequences for older and disabled people.

Homecare Association, Sutton Business Centre, Restmor Way, Wallington, Surrey SM6 7AH
T 020 8661 8188 **F** 020 8669 7100 **E** info@homecareassociation.org.uk **W** homecareassociation.org.uk

Providers are also concerned about the future of the £1 per hour uplift that they have been receiving via the Hardship Fund. This has been agreed until the end of the financial year, but pandemic related costs, such as high sickness absence rates and testing costs are continuing against a backdrop of significant workforce pressures. If this funding is removed then these costs will need to be met from other income when fee rates are often already inadequate to cover costs, suggesting a further need for fee rates to increase.

Care Inspectorate Wales' 2021 *National Overview Report – Assurance Checks Children and Adult Social Services* identified that "Based on what we found there is a clear lack of domiciliary support capacity in Wales. We heard the impact of this is care packages being returned to the local authority, increased pressure on unpaid carers, people placed on long waiting lists, and some people going without care and/or staying in hospital longer."

Inadequate homecare capacity is also reportedly leading to an increase in numbers of patients stranded in NHS hospitals in Wales. As the BMA noted in their submission to the Senedd Health and Social Care Committee's Inquiry "Adequate discharge is massively dependent on appropriate services and packages of care being available to support the patients being released from hospital. There has been widespread coverage of a 'crisis' in the care sector in Wales due to an overwhelming lack of staff." Of the measures announced so far to address these issues the BMA note that they "fear they will only go some way towards addressing the scale of the crisis." We concur and continue to call on the UK and Welsh Government to increase social care funding.

Homecare Association survey data in November indicated that workforce shortages continued to worsen at the end of 2021. Employers report that pay, terms and conditions of employment are the main factors driving difficulty in retaining and recruiting staff. Staff costs in homecare are at least 70-80% of total costs, so the fee rates paid by councils and the NHS have a direct impact on wages received by careworkers and on the ability of providers to remain financially viable.

We understand that the Welsh Government have announced additional funding in order to improve careworker pay, with Real Living Wage being the aim.

On 17 December 2021, the Homecare Association published updated UK-wide calculations on the minimum fee rate for homecare required by homecare providers in 2022/23, to enable compliance with employment and care regulations, as well as sustainability of services. The National Commissioning Board Wales are also in the process of updating their Wales specific cost estimates.

The legal minimum wage does not adequately reflect the skill, training and experience required to perform modern care roles, as is recognised by Welsh Government with their Real Living Wage commitment. Due to this and the fact that the minimum wage is uncompetitive in many labour markets, we also calculated fee rates required to allow payment of higher wage rates, including the equivalent of Band 3 in the NHS (2+ years' experience), as advocated by the ADASS.

The UK-wide minimum fee rate for homecare based on the national legal minimum wage is calculated as £23.20 per hour for 2022/23, compared with £21.43 per hour in 2021/22. This represents an 8% increase, driven largely by the increase in statutory minimum wage but also by non-wage inflation. However, if providers are to pay their staff at Real Living Wage for all hours worked we calculate they would need at least £24.08 per hour in 2022/23. This would be a 12% increase on the minimum wage rate of £21.43 per hour in 2021/22. The underpinning assumptions are detailed in our report and are based on national statistics, real-time data from one of the largest national suppliers of electronic monitoring software, and detailed financial data supplied by our members.

Furthermore, initial estimates from the National Commissioning Board Wales suggest that, once Wales-specific training and other costs are taken into account delivery costs at a pay rate of the Real Living Wage could be as much as £26.98 per hour.

Adding to this the scenario that the £1 Hardship Fund grant is withdrawn, COVID related costs, such as testing, vaccine administration and increased sickness absence costs may not be covered. If all these costs are to be met to the same level as they are presently, an hourly rate of £27.98 per hour would be required.

It should also be noted that the costs for shorter visits are not necessarily half of the hourly rate but will be more expensive as overheads, such as travel time, will go up.

Homecare Association

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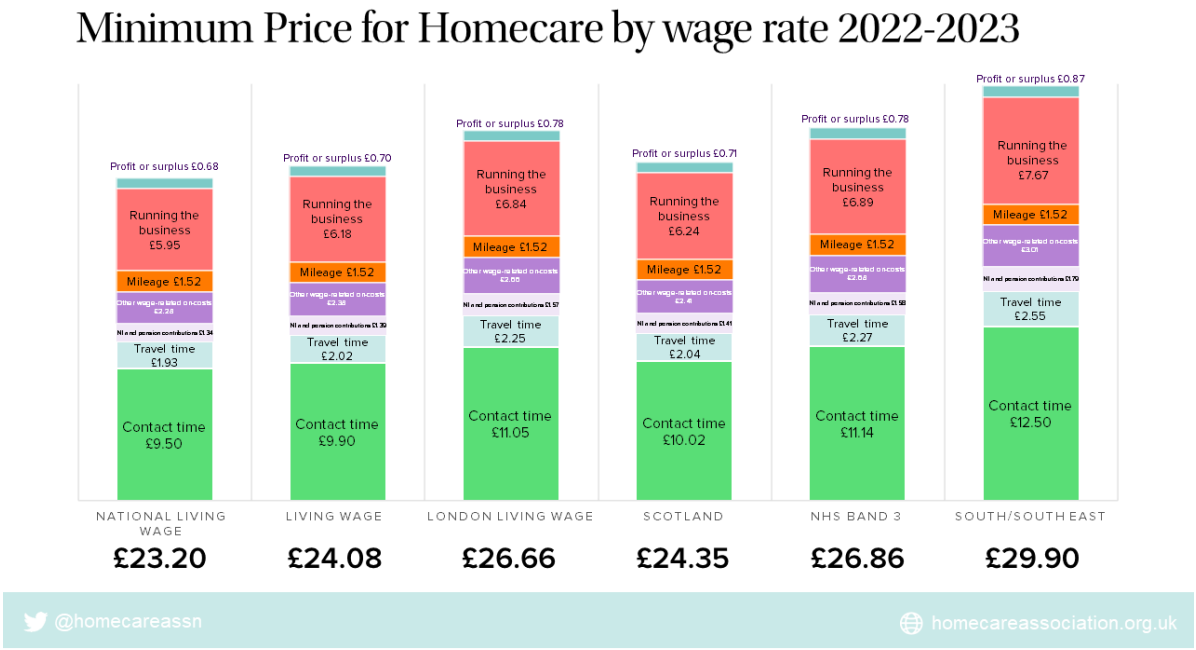
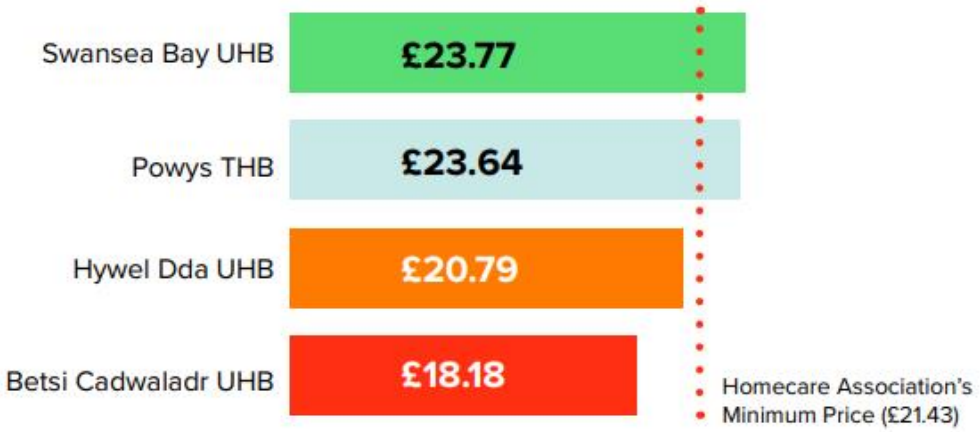


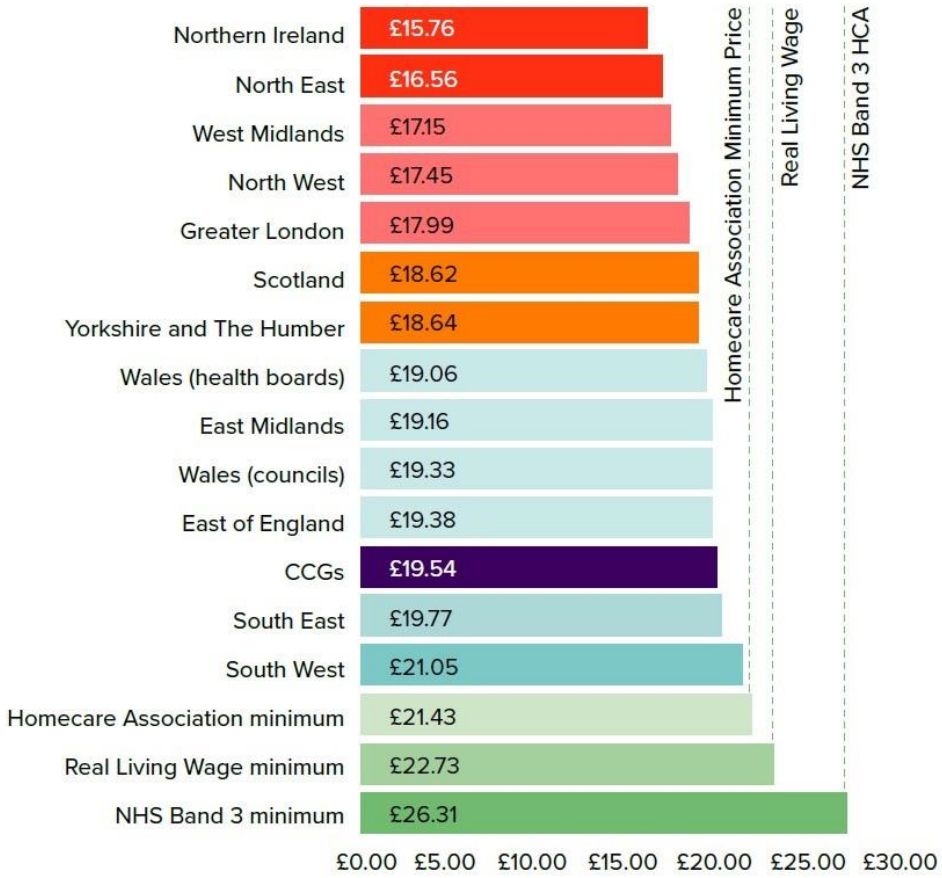
In October 2021, we published our latest Homecare Deficit Report. This detailed the findings of enquiries, made under Freedom of Information legislation, to 340 public organisations across the United Kingdom. We received responses from all 312 organisations that confirmed they purchase homecare from the independent and voluntary sector, delivered to people aged 65 years or above. However, your local health board responded that it was not possible to extract the data that we requested from your system.

Other average fees for health boards in Wales were as follows:

Figure 100. Average hourly prices paid for homecare by Local Health Boards in Wales during the 2021 sample week



We also computed average hourly rates, weighted for the volume of hours purchased, for the UK's government and health regions:



In light of the Real Living Wage announcements and also with the forthcoming preparation of Market Stability Reports in Regional Partnership Boards, we hope that local health boards in Wales will engage with providers to understand their delivery costs.

As recorded in our Homecare Deficit report, only 14% of public organisations in Wales said they had undertaken a recent calculation demonstrating a rationale for the fee rates paid for homecare. This proportion is lower than Scotland, England and Northern Ireland.

Homecare Association

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CARE FORUM WALES

Based on feedback from Homecare Association members we understand that, as of January, few public sector commissioner had begun engaging with providers about fee rates for 2022-23.

We therefore urge you, if you have not already done so, to move as soon as possible to discussing and agreeing fee rates for 2022-2023 with providers, as uncertainty risks increasing market instability.

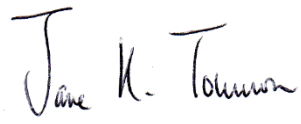
In reviewing fee rates for homecare, it is critical that you consider inflationary costs, most notably wage levels, but also non-wage costs, including increases in fuel and insurance costs. As already stated, our calculations indicate inflationary pressures of at least 8% and possibly as much as 25%.

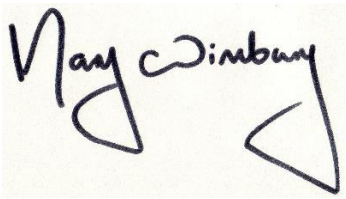
Failure to increase fee rates for homecare by enough risks further loss of workforce capacity. In turn, this could lead to further increases in unmet need; providers handing work or entire contracts back; or provider insolvency.

We call on you to act now, engage with providers and commit to increase fee rates for homecare to fund the Real Living Wage, or preferably to enable a pay rate of £11.14 per hour, equivalent to NHS Band 3, in line with ADASS recommendations.

Many thanks for your ongoing support for the homecare sector.

Yours sincerely,





Dr Jane Townson
Chief Executive
Homecare Association

Mary Wimbury
Chief Executive / Prif Weithredwr
Care Forum Wales / Fforwm Gofal Cymru

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th July 2022 Agenda Item: 4.1

Aneurin Bevan University Health Board

Winter Planning 2021/22
Reflections on the impact of the Gwent Regional Partnership Board Integrated Winter Plan and the Health Board's Winter Plans for 2021/22

Executive Summary

Health systems are used to preparing for winter and the need to adapt, expand and enhance services to meet population needs and these are expressed through the Health Board's Winter Plan.

The Health Board developed an overarching winter plan underpinned by the Gwent Regional Partnership Board Integrated Winter Plan. It set out the priority areas and actions to protect our population from Covid-19 and other seasonal viruses and improve the resilience of the health and care system.

The report sets out an overview of the planning assumptions made, the challenges that were material over the period and the impact of the actions that were taken this winter. Winter relates to the period 1 December 2021 to 31 March 2022).

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

Executive Sponsor: Nicola Prygodzicz, Executive Director of Planning, Digital and ICT
Dr Chris O Conner, Interim Executive Director of Primary Care, Community and Mental Health

Report Author: Roxanne Green, Assistant Director Partnership & Integration
Eithne Hunter, Head of Strategic and Operational Planning

Report Received consideration and supported by:

Executive Team		**Committee of the Board [Committee Name]**	**Board**

Date of the Report: July 2022

Supplementary Papers Attached:
Aneurin Bevan University Health Board Winter Plan 2021/22 (Appendix 1)
Gwent Regional Partnership Board Integrated Winter Plan 2021/22 (Appendix 2)
Gwent Regional Partnership Board Integrated Winter Plan Assurance Report (Appendix 3)

Purpose of the Report

The purpose of this report is to provide an overview of the impact of the actions that were taken this winter, the degree to which they enabled the health and care system to respond to and maintain services to meet patient needs over this period, and the lessons that have been learned together with recommendations on the approach that should be adopted for planning for winter 2022/23.

Background and Context

Winter is always a challenging time for organisations working to deliver health and social care services. This year winter was expected to be particularly difficult because of the pandemic, multiple respiratory and other viruses, staffing constraints as well as the potential for extreme weather.

Modelling for Covid-19 had suggested that community cases of Delta variant had peaked and would see a slow reduction in Covid bed occupancy with a prolonged decline in cases. However, the Health Board plan recognised the need to remain vigilant for new variants.

Collectively the RPB and Health Board winter plans focused on:

- Protecting staff and communities from Covid and other viruses
- Keeping people well
- Maintaining safe health and care services (increased capacity to meet anticipated increased winter demand)
- Supporting the workforce
- Keeping staff and communities informed

Assessment and Conclusion

The report provides an assessment of the Winter Plans in the context of performance of the system over the winter period. Headlines include:

- The impact of the highly transmissible Omicron variant on workforce availability and system capacity
- The rising acuity of patient needs and its impact on system flow (notably length of stay and discharge)
- The promising outcomes from Step Closer to Home approaches and the need to move away from temporary increases in this type of capacity to more sustainable solutions

Recommendation

The Board is asked to discuss and note the contents of this report.

Supporting Assessment and Additional Information

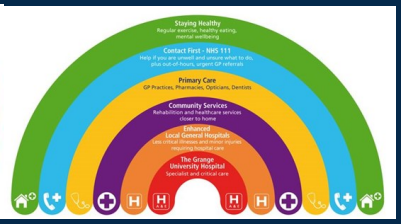
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework together with the re-instatement of the Regional Strategic Co-ordination Group (under civil contingency measures) for

	the winter period and the Regional Partnership Board assurance machinery.
Financial Assessment, including Value for Money	This report has not financial consequences although the mitigation of risks and future winter planning rounds may do.
Quality, Safety and Patient Experience Assessment	The report has not QPS consequences
Equality and Diversity Impact Assessment (including child impact assessment)	The report has no Equality and Diversity Impacts
Health and Care Standards	The report contributes to the good governance elements of health care standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The winter plan objectives and approaches reflect and are incorporated within the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The Gwent RPB Integrated Winter Plan has been developed and implements collaboratively it embodies the WBFGA
Glossary of New Terms	
Public Interest	Report for public domain

Aneurin Bevan University Health Board - Winter 2021/22

Winter Plan Report

December 2021 - March 2022



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

CONTENTS

INTRODUCTION…… .P.3

CONTEXT…..……..P.4

WINTER 21/22 (Activity and Performance ……..P.5

WE SAID/ WE DID ……..P.7

Protecting Us from Covid-19 and Influenza ……..P7

Primary Care Services ……..P8

Community Services (including Frailty) ……..P9

Front Door/Flow ……..P10

Workforce ……..P11

Communication & Engagement ……..P12

LESSONS FOR THE FUTURE …..……..P14

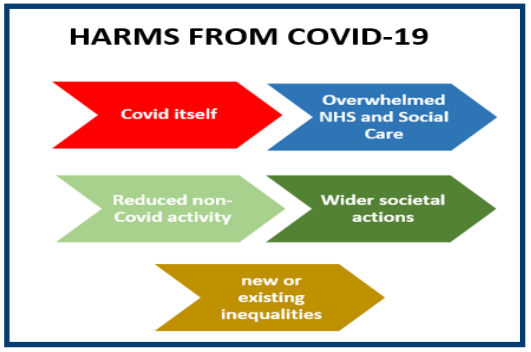
INTRODUCTION

Winter is always a challenging time for organisations working to deliver health and social care services to meet the needs of patients, service users and their carers. The Health Board is used to preparing for winter, each year the Winter Plan sets out how services will adapt, expand and enhance services to meet population need.

This year winter was expected to be a particularly difficult one as a consequence of the pandemic, multiple respiratory and other viruses, staffing constraints across health and care due to illness, isolation requirements and staff wellbeing, as well as the potential for extreme weather. The winter plan set out to balance planned care and managing elevated urgent and emergency care demand at a time when fluctuations in COVID-19 cases make planning services more complex and unpredictable.

The core principle of 'Partnership First' is an intrinsic component of winter planning and has been integral to the joint management of the system during the winter period. The Health Board developed a winter plan that focused on the actions required (Appendix 1) and through the Regional Partnership arrangements an integrated system wide winter plan was developed (Appendix 2) and is accompanied by an assurance report (Appendix 3).

Planning for winter has been guided by the National Health and Social Care Winter Plan for 2021/22, which highlighted the importance of local plans balancing the harms from Covid-19.



With this in mind winter plans sought to ensure that inequalities in the health and wellbeing of citizens were not further exacerbated by the approach adopted to meeting the needs of the population over this winter season. The plan focused on:

* Protecting the public and staff through delivery of covid boosters, flu vaccinations and Test, Trace, Protect
* Keeping people informed
* Treating the sickest and most urgent patients first
* Maintaining infection prevention control measures to keep people safe
* Ensuring urgent care and emergency care services are there for those who need them
* Protecting children's service throughout winter
* Protecting cancer services (lifesaving diagnosis and treatment)
* Using hospital care only for those who need it
* Ensuring social care has the resources to support care delivery
* Delivering planned care, where it is safe to do so

It is first and foremost frontline staff who have risen to the challenge of meeting the needs of citizens this winter. For the past two years staff across health and social care have shown resilience, bravery, dynamism, resourcefulness and great skills they continued to respond to the overwhelming challenges presented by the pandemic.

This short report provides an overview and evaluation of the actions taken to maintain services in response to winter pressures, as an organisation and in partnership with others against the plan.

CONTEXT

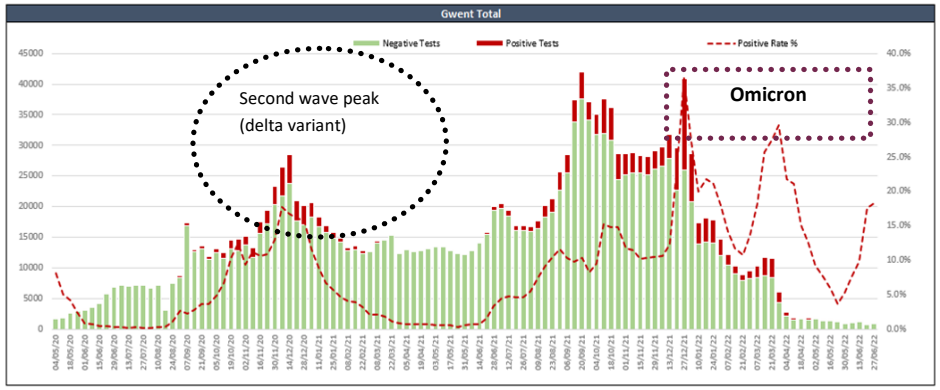
Throughout successive pandemic waves demand and performance across the health and care system has been volatile. The system entered the winter period under significant pressure as a consequence of the harms caused both directly and indirect from Covid-19. In preparing winter plans the following assumptions were made about the additional challenges associated with winter.

* Influenza season could be 50-100% higher than a typical season with case rate of 499.2/100,000, peaking at 10-12 admissions/day
* Respiratory Syncytial Virus (**RSV)** a common respiratory virus that can be serious for infants could see a 40% increase
* Community cases of delta variant have peaked, modelling suggests a prolonged decline in cases
* Stand ready for new variants of concern
* Flex bed capacity up to 1,758 beds (200 above core capacity) to meet anticipated respiratory demand, increased acuity and protect elective capacity

In the lead up to winter protecting people from Covid-19 saw the roll out of the booster vaccination programme to anyone who is either a care home resident; 50 or over; frontline health or social care worker; anyone aged 16-64 years classified as extremely clinically vulnerable or having specific underlying health conditions.

The anticipated higher levels of influenza did not materialise, weekly GP consultations for Influenza Like Illness in Wales remained below the baseline threshold of 10.97/100,000 for the duration of the winter season. RSV activity was relatively low and below usual seasonally expected levels during winter after out-of-season increases in summer 2021.

The emergence of the Omicron variant has been a significant challenge for the health and care system. Omicron's main threat is its extreme contagiousness. It was infecting so many people that even if a smaller proportion need hospital care, the absolute numbers were still enough to saturate the system. Although less of a threat to individual people, this variant had a considerable impact on the health-care system that those individuals will ultimately needed.



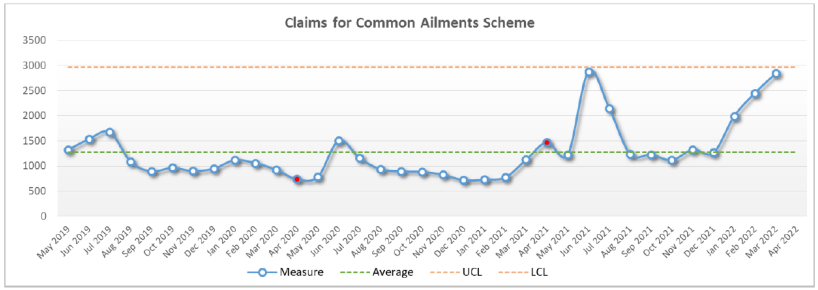
Over winter this highly transmissible variant has resulted in high levels of staff absence across services and sectors, outbreaks on wards and in care homes impacted how patients moved through the system from admission to discharge leading to increased lengths of stay in hospital settings, and the need to maintain infection prevention and control measures continued to constrain capacity.

Nationally, the staffing crisis this winter was recognised as the worst that it has been throughout the pandemic. Many staff were exhausted and workforce so diminished that the system was disproportionately challenged by a fraction of the patient volumes seen in earlier waves.

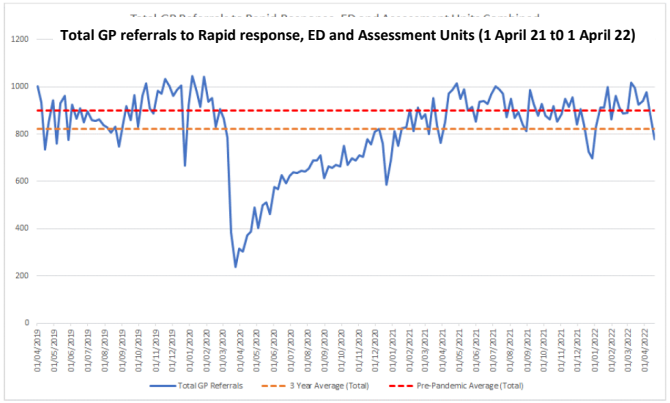
WINTER 21/22 (Activity and Performance)

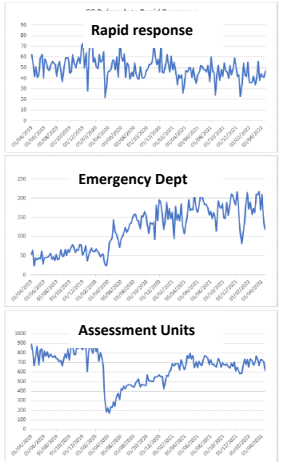
Demand across the urgent and emergency care system was within normal planning parameters (based on a four year rolling cycle) throughout the winter season with the exception of the two week Christmas and New Year where activity was substantially below anticipated/forecasted activity. This winter:-

- 22,413 Urgent Primary Care attendances as the day time service was implemented at NHH and RGH (80% of attendances were in-hours)
- Significant increase in use of the common ailments scheme



- GP referrals for urgent assessment via Rapid Response, ED and Assessment Units returned to pre-pandemic levels, with a higher proportion of patients being referred to ED (changes in local pathways).

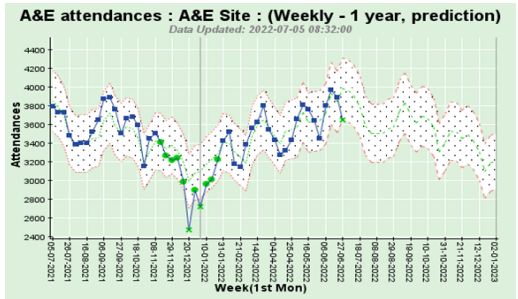




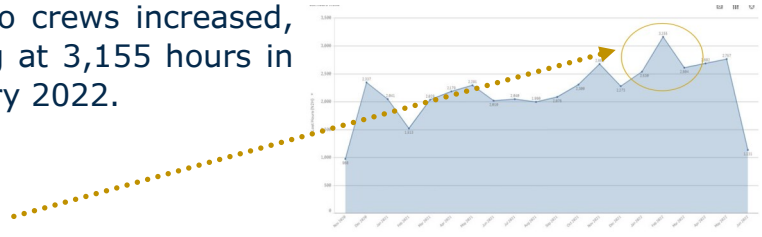
HEADLINES

- Urgent Primary Care Centres at NHH and RGH, Think 111 and use of Common Ailments scheme in community pharmacists increased this winter
- The number of people who attended ED was within the upper end of planning parameters, on average 20 additional attendance/day compared to pre-Covid winters
- Timely assess to triage and to be seen by an ED clinician was maintained
- Moving patients through ED into the hospital system has been a significant challenge with average waits of 13 hours
- Ambulance handover times and lost hours to crews have improved

This winter an average of 459 people attended the urgent care hospital system each day. This was within the upper limits of planning parameters.



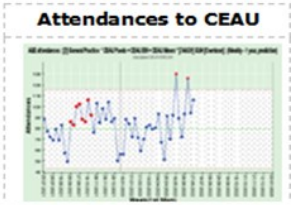
- Everyone was triaged within 40 minutes
- The time from request to allocation of a specialty bed averaged 13 hours. This ranged from 5.5 hours (19th December 2021) to 21.6 hours (7th February 2022)
- Ambulance Handover Times deteriorated and lost hours to crews increased, peaking at 3,155 hours in February 2022.

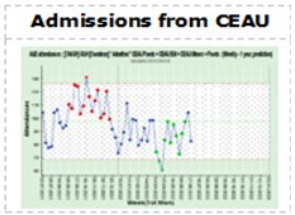


WINTER 21/22 (Activity and Performance)

Children

- The pattern of attendances for children was within normal parameters for winter.
- More children are being assessed and treated within the unit and admissions to inpatients have reduced over the period.



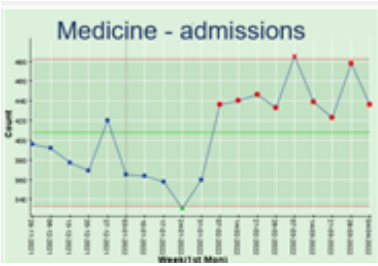


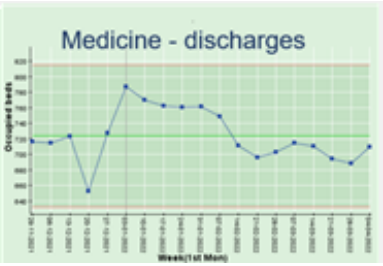
Adults

- Admissions stayed around the average (four year trend) with the exception of Christmas Week where activity was substantially below forecasted activity.
- The winter bed plan predicted the system would need 200 additional beds to meet this demand. The table below shows that the predicted capacity requirement was realised this winter.

	Plan	Dec-21	Jan-22	Feb-22	Mch22	Ave
Medicine	758	703	769	727	703	726

- Medicine, most notably Care of the Elderly experienced sustained increased admissions over winter.
- Admissions and discharges were balanced for all specialties (i.e. numbers of patients admitted ≤ number of patients discharged) with the exception of Care of the Elderly.
- The graphs below illustrates sustained and growing number of medical admissions, mirrored by a deterioration in discharges, driven predominantly by COTE.

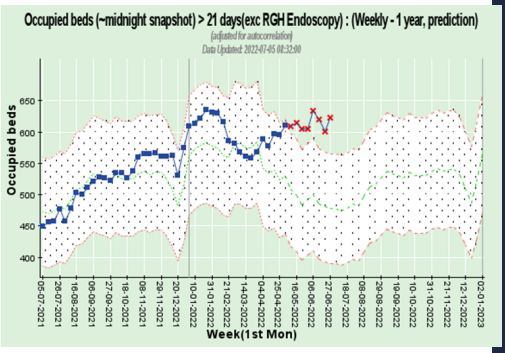




HEADLINES

- Children's services were protected throughout winter, improvements to the service model resulted in fewer admissions
- Numbers of admissions were stable, however, Care of the Elderly experienced sustained and growing number of admissions.
- Length of stay for CoTE deteriorated over winter
- Patient acuity was higher for many patients
- High levels of sickness and absence together with Covid outbreaks in care settings and a fragile domiciliary care market constrained the systems ability to deliver plans for care closer to home
- Bed Plan for medicine 200 additional beds was accurate with medical (mostly CoTE) patients occupying between 700 and 769 beds this winter

- Length of stay had been rising since early November 21, with a sharp rise immediately after Christmas that peaked at the end of January, by mid March length of stay has begun to rise again



- Contributing factors that could explain the observed increase in length of stay include:
- Increasing levels of patient acuity (exacerbations of pre -existing conditions, decondition, social isolation) as evidenced through levels of enhanced care this winter
- Fragile and unstable domiciliary care market with more people within community than those in hospital awaiting packages of care
- High levels of sickness and absence across health and

PROTECTING US FROM COVID-19 & seasonal viruses (we said, we did)

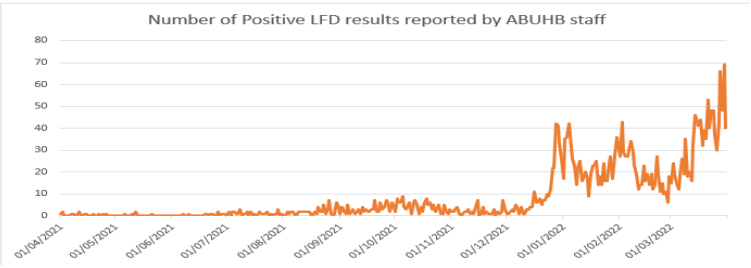
Both the Gwent RPB Integrated Winter Plan and the Health Board's winter plans set out how, collectively, vaccinations including boosters would be delivered at scale and pace, together with a robust Test, Trace and Protect Service in line with the Welsh Government's Coronavirus Control Plan and strengthen communications across the system to keep people well and minimise the risks of seasonal viruses.

Gwent Test, Trace, Protect service

- traced over 175,000 positive cases and provided support to 125,000 people.
- through local Digital innovation 37,500 electronic tracing forms during the Omicron wave.
- testing remained an integral component of the Coronavirus Control Plan for Gwent. Over 1 million tests were performed on local residents last year.

Lateral Flow Testing for Staff

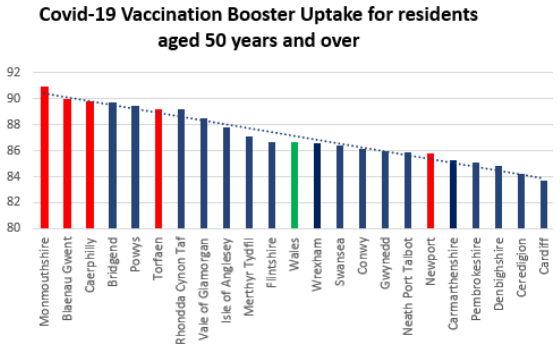
Routine asymptomatic testing for staff using Lateral Flow Devices (LFD) has played a crucial part in the last year to reduce the risk of transmission. The total number of LFDs reported by staff from 1st April 2021 – 31st March 2022 is 381,402 with 3,063 positive results recorded. Positivity rose sharply this winter, a combination of Omicron variant and the change in national guidance where restrictions were lifted and prevalence of Covid remained high.



Mass Vaccination and Booster Programmes

1,312,353 vaccines were delivered between 8th December 2020 and the end of March 2022, with 100,285 of these being delivered in 14 days during the accelerated booster programme last December that set out to protect those in higher risk and vulnerable groups, and the health and social care frontline workforce.

The programme has a strong leaving nobody behind strategy to narrow inequalities in uptake and continues to achieve high coverage rates with four of the five local authority areas in the Health Board's catchment area having the six highest uptake rates for booster doses for those aged 50 years and over.



Influenza Vaccination

Seasonal flu plans were implemented in primary care (including care homes), schools and for Health Board Staff.

The flu vaccine uptake for those 65 years and older and in clinical risk groups aged 6 months to 64 years was the highest in Wales at 80% and 53.4% respectively. Over half of 2 to 3 year old children also had the vaccine.

Within the Health board 9,190 members of staff (66.4%) received the flu vaccine. Each year the proportion of staff coming forward for seasonal flu vaccines is increasing.

PRIMARY CARE (we said, we did)

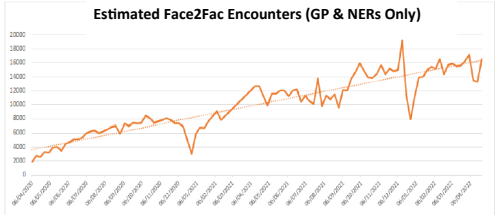
Urgent Primary Care (UPC) 24/7 service this winter this service became more resilient with two UPC units one RGH and NHH sites fully operational. Consequently 7,944 patients were re-directed from ED and 1,736 to the **Think 111 First** pathway.

At times of escalation Primary Care could use the Urgent Primary Care Pathway directing their patients for urgent assessments as alternative to attending GP practice.

General Practice activity levels increased over the winter period, having reduced during autumn, and have largely stabilised.

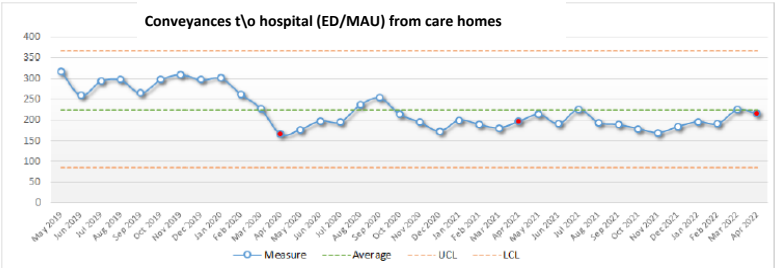
- 45 practices were commissioned to collectively provide 100 additional sessions each week
- 25 practices increased reception hours to provide 917 additional hours each week
- 9 practices were commissioned to provide GP clinical triage, telephone and video consultation, face to face patient consultation, outside of contracted hours. They provided an additional 113 sessions over Bank Holidays and weekends

There has been a clear increase in face-to-face activity as a proportion of total encounters this winter.



- 3 practices were commissioned to provide care home ward rounds, with 46 ward rounds provided over winter. With enhanced support from wider community teams.

Conveyances to hospital from care homes and subsequent admissions were maintained at 60/70% of the pre-pandemic levels.



Community Dentistry prior to Covid-19 the Health Board commissioned 157 urgent dental appointments per week, this had increased to 300 for the winter period.

- Additional Out of Hours sessions provided care to 287 patients
- Additional Bank Holiday sessions provided care to 152 patients

Community Pharmacy have continued to play a significant role in supporting people this winter.

- Influenza vaccine delivery increased by 77% with over 29,000 vaccines delivered during 2021/22 Flu season.
- The Common Ailments Service has seen a 22% increase in activity on average 2,152 people using this service each month over winter.
- Emergency Hormonal Contraception activity has increased by 11% with 3612 consultations (reporting period April 2021—Jan 2022)

Optometry practices continued to provide urgent and essential appointments and also provided routine sight tests to patients.

COMMUNITY SERVICES (including frailty) we said we did

Building resilient community support

Flow Centre Frailty Pathway was introduced this winter in Caerphilly Borough, **32** older people used this pathway avoiding the need to travel hospital. The local Rapid Response Team was enhanced to support this service and as a result of learning from this, the Health Board is training Advanced Nurse Practitioners to facilitate the roll out of this model across Newport, Monmouthshire and Blaenau Gwent.

Direct Admission Pathway that enabled appropriate patients to be admitted directly to a community hospital was also introduced this winter. **88** older people have used this pathway and their length of stay in hospital averages 8.1 days less than similar patients admitted through the acute hospital network.

Step Closer to Home Approaches was a key priority within the Gwent RPB Integrated Winter Plan where people who no longer require the support of a hospital transfer to a community care home bed. Due to capacity constraints faced by social care it was not possible to realise the planned additional capacity and a decommissioned ward within St Woolos Hospital was repurposed as a Step Closer to Home Unit, supporting patients to manage their health conditions, restore functionality and improve wellbeing. **70** patients have used this service, average length of stay in the unit is 9.87 days. 32% of patients were discharge from the unit fully independent, and overall there has been a reduction of 1.38 house calls per person per day (Packages of Care).

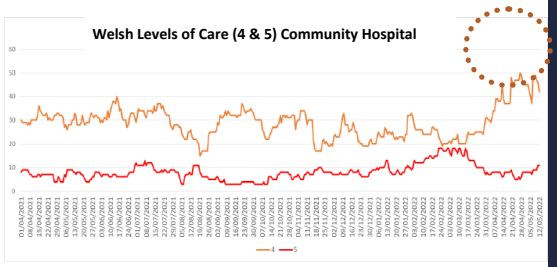
16 out of every 100 new emergency admissions for patients over 65 years of age were admitted to a community hospital this winter. This is higher than pre-pandemic levels.

Supporting High Risk Older Adults working with data partners cohorts of high risk older adults were identified. These were patients who could benefit from focused, proactive interventions from community services in order to anticipate and manage health crises and avoid a hospital admission. This winter this approach was launched in Blaenau Gwent (December 2021). 198 individuals were identified, 51 of these were assessed and supported in their communities, only 1 needed a hospital admission this winter for a matter unrelated to frailty.

Reablement Service capacity was increased by 800 hours/ week, assessing peoples' independence in their own homes after a period of recovery in order to determine their long term needs.

Throughout winter community hospitals have operated with maximum surge capacity open. There is evidence that average length of stay is increasing and overall discharges decreasing. Two of the factors driving this are:

- increasing levels of patient acuity with 125% increase in patients assessed as level 4 (Welsh Level of Care).



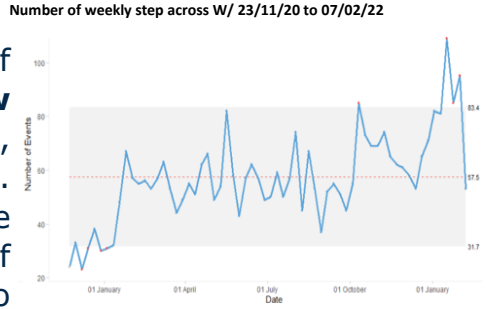
- an unstable and fragile domiciliary care market where there are more people in the community awaiting packages of care than those in hospital settings.

Maintaining Social Care Services the RPB Integrated Winter Plan placed significance emphasis on the resilience needed within the domiciliary care sector. Although challenging in terms of capacity existing packages of care were under constant review to release capacity where possible.

FRONT DOOR (we said we did)

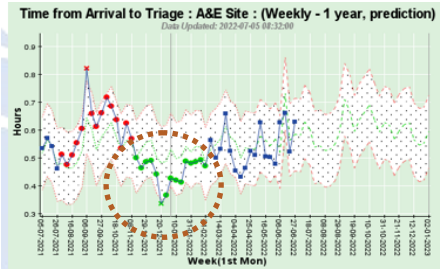
Urgent Care Transformation improving urgent care requires a system wide approach encompassing 24/7 Urgent Primary Care, Improved Emergency Care performance and effective community services that reduce the need for admissions and/or reduce the time a patient needs to stay in hospital settings (refer to Primary Care and Community sections).

This winter the Health Board introduced a series of pathways to the **Flow Centre,** notably chest pain, head injury and minor injury. This facilitated a large increase in the number of patients stepping across to more appropriate care pathways.

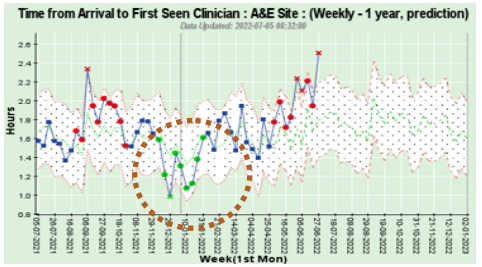


Resilient ED Workforce additional 8 doctors were recruited as part of the safer medical staffing review this winter. The Health Board also invested in additional Registered Nurses and support staff for the Emergency Department at the Grange University Hospital and also minimised unfilled shifts with bank and agency throughout winter.

Time to Triage

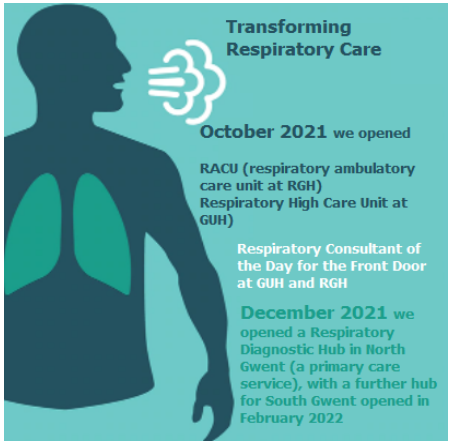


Time from arrival to first seen clinician



Respiratory Care

In August 2021, action was taken to stablise the service, both to manage the ongoing pressure of Covid-19 hospitalisations and the extended demands of winter on respiratory illness.



RACU provides same-day emergency respiratory care. 383 patients have received a more responsive service that provided an alternative to hospital admission. 80% of patients who used this service said their experience was excellent.

Respiratory Diagnostic Hub monitors and manages complex patients in their community, with a comprehensive range of diagnostic tools and treatment management plans. To date 493 referrals have been received with 162 patients actively managed and plans in place for the remaining 296 people. In the next year each Locality will have its own hub.

Mental Health

Sanctuary in ED was launched in December 2021. Peer support workers have helped 92 patients in emotional distress through their emergency experience. The service operated over extended weekends Thursday—Sundays).

Ty Cynnal (Crisis Support Home) opened it's doors in December 2021, providing safe alternative to inpatient admissions for guests experiencing mental health crises. 13 people have been hosted during January and February 2022.

WORKFORCE (we said, we did)

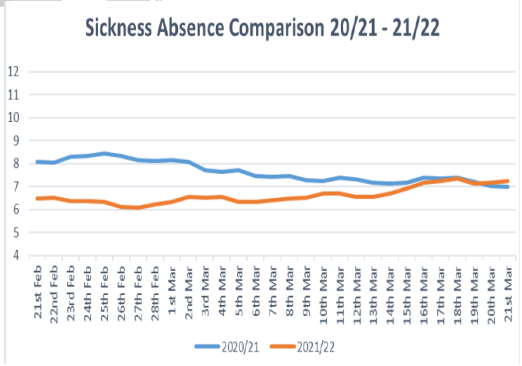
Winter Workforce Capacity

The Health Board's plans to respond to winter 2021/22 recognised that a range of staffing solutions to increase capacity implemented during the previous winter were not available this year as professional training programmes and clinical services had resumed. Large scale overseas recruitment had been concluded and the next cohort of registered nurses would complete their training in September 2022.

Staff faced this winter having working tirelessly throughout successive pandemic waves which continued to have an impact on high levels of staff absence. To respond to winter pressure the system needed to be able to increase workforce capacity flexibly to meet fluctuating demands and to protect the wellbeing of health and social care staff.

Recruitment activities delivered 8 additional doctors, over recruited healthcare support workers and nursing for the Emergency Department. In December efforts focused on securing additional reablement staff. Fast track recruitment for return to work and enhanced overtime rates for core staff were maintained.

Deployment focused largely on supporting the mass vaccination and booster programmes. A comparison of staff sickness/absence levels over the past two winters indicated that the booster programme provided additional protection to staff and helped to retain them in the workplace with lower levels of sickness for most of the winter period.

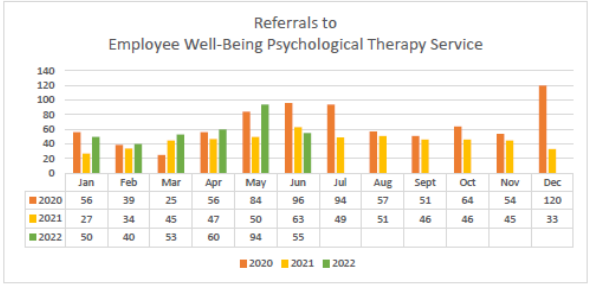


Bank and Agency Supply since December the number of additional staff available through bank, agency or overtime was increased from 570 to 658 WTE, this minimised the number of unfilled shifts. This winter the equivalent of 293 WTE registered nurse/week through agency nursing were deployed, this compares with 146 WTE in September 21.

Staff Wellbeing

This winter occupational health capacity was increased and supported staff, some of whom, after the past 2 years were chronically fatigued, burnout and/or struggling with their mental health and wellbeing. The Health Board continued to deliver the therapy trauma pathway and strengthen staff networks. Uptake of this service continued to grow, 179 employees were waiting for support over the period, with a waiting time of 18-20 weeks for face2face and 8 weeks for telephone/TEAMS sessions.

The service also delivered 4 psychological debrief sessions, 12 webinars, and supported 13 service areas. Online resources had 1,137 (SharePoint site) and 1,114 (website) hits.



The Melo Website was established and provided useful self-help resources and together with the Connect5 training programme supported emotional wellbeing of those in receipt of training, and has aided the identification of others who may need emotional wellbeing support. This remains part of the RBB Enhanced Foundation Tier Programme.

COMMUNICATION & ENGAGEMENT (we said we did)

Throughout winter, communications activities with staff, the public and partners have been strengthened. The Health Board continued to lead the way on the use of Digital Communications, as well as more traditional methods of sharing important messages to:

- Help local residents understand what to do and where to go when they are unwell or injured.
- Provide a 'trusted voice' to convey timely and accurate information.
- Increase face-to-face and digital engagement with local people.
- Reach more people with important winter messaging.
- Improve communication and engagement with diverse and hard-to-reach communities.
- Respond to comments and concerns, helping and reassuring people throughout the winter period; and
- Ensure staff are well informed and supported in their roles

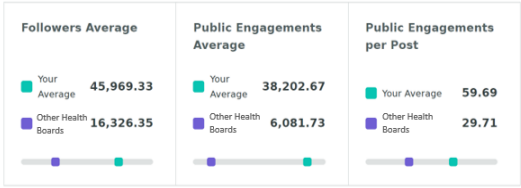
The high-profile Winter Campaign focused on accessing the right healthcare services, the COVID-19 Pandemic response and vaccination programme, recruitment, and celebrating staff.

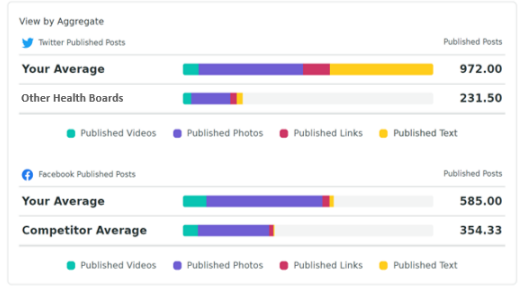
The Clinical Futures campaign continued this winter and was further developed to inform and engage people on the changes to NHS health services in the Health Board area. In March 2022, an updated information booklet was sent to every home across Gwent. The booklet is also available to view in a variety of formats and languages on the Health Board's website.

Social media

Considerable time was invested in co-ordinating and responding to patient and public approaches on a day-to-day basis. The numbers of followers on the Health Board's Facebook, Twitter, Instagram and Youtube followers continued to grow, with more people communicating through these social media channels.

Over the winter period the Health Board's social media channels reached over 20 million people and saw 826,062 engagements. Some of the most popular posts were Facebook Live service updates with clinicians across the Health Board.





Traditional comms

Use of graphics, video clips, patient and staff stories, and live Question and Answer sessions were expanded to support more traditional forms of Communication and Engagement with the public and stakeholders.

A new animated video was produced to explain how best to access services. As well as being shared online and on waiting room screens, the video was used as a trailer in cinemas in the Health Board area.

COMMUNICATION & ENGAGEMENT (we said we did)

Advertising banners, posters and television screen content were produced for GP surgeries and hospital waiting areas. Posters were also displayed in local pharmacies and on buses. A successful poster campaign targeting people through pubs, taxis and takeaways was run over the Christmas period which helped to direct ill or injured people to appropriate health services. Health Board delivery vans were used as 'moving billboards' by producing eye-catching ads to display on them as they drove around the local communities on a daily basis.

Partnerships were formed with local organisations such as Dragons Rugby, who shared messages on pitch advertising during live broadcast matches, & Newport Live leisure Centres.

In October 2021, the Health Board launched a 'Work with Us' Engagement & Recruitment Roadshow to ensure equitable geographical engagement with communities to improve understanding of access to health care services throughout the winter period. A key focus on the use of the Emergency Department at The Grange University Hospital and Minor Injuries Units was taken.

The roadshow also provided an opportunity to promote a range of job roles within the Health Board and accepted expressions of interest for a variety of vacancies.

Over the winter period, **88** locations were visited by a specially commissioned double decker bus or pop-up gazebo, over **2,000** face-to-face conversations with visitors took place and **360** expressions of interest received for job roles within the Health Board.

Geographical spread of events was well balanced that capitalised on routine, established events (market days), attendance at natural high footfall venues (supermarkets and town centre locations) and a presence at high profile events including Pontypool Cavalcade and the Newport Half Marathon.

A **Diverse Communities Health Forum** was developed in early 2021 to strengthen relationships with partner organisations who support and already work with diverse communities and to develop initiatives to engage with all communities, meetings took place at regular intervals throughout the winter period to ensure that key Health Board messages were delivered. Face to face engagement with two 'Kidcare4u' Somali and Arabic Ladies groups took place in December 2021. The informal sessions allowed the Health Board to engage with 43 women on a 1-1 and group basis, with representation from Gwent Police and local MPs also in attendance.

LESSONS FOR FUTURE

What worked well

Booster and Vaccination Programmes delivered at scale and to time to optimise protection for vulnerable people, and health and social care staff.

The Bed plan modelled the bed capacity requirements for the winter period. The system was not able to deliver the full bed plan with surgical inpatient capacity operating at 50%, due in part to covid measures and workforce.

The system made significant strides to improve workforce capacity and resilience. Temporary staffing solutions enabled the system to manage sickness and absence together with the increase in enhanced care for a sicker patient cohort. It did not provide additional capacity.

The Winter Communication and Engagement providing public facing information and advice throughout the period and helped to reduce attendances when the system was overwhelmed.

What showed promise

- Ambulatory Service Models providing alternatives to ED attendances and admissions (Paediatrics, Respiratory).
- Admission Avoidance - flow pathways to community (rapid response, direct admissions, High Risk Adults)
- Step Closer to Home pathways
- Urgent Primary Care Service and Think First

Many of these are new service models that need robust evaluation to build in terms of scale to deliver significant change to the system.

What didn't work so well

Last winter saw a sustained increase in emergency medical admissions (particularly for older people), with growing acuity, increasing lengths of stay and reduced discharges.

The wider system response, care homes and domiciliary care services were fragile and subject to unpredictable changes, for example a Covid outbreak.

The flow through the system remains the biggest challenge with an inability to balance the numbers of patients being admitted with discharges resulting in increasing lengths of stay.

Preparing for winter 2022/23

- Working in partnership has been at the centre of efforts to respond to the challenges within the health and social care system and this approach must be strengthened and stretched
- Same rigour and resource for vaccination programme
- Using data and intelligence to model system requirements for winter
- Development of ambulatory pathways including SDEC
- System solutions that show promise must be developed, operational and sustainable before winter 2022/23 (Care Closer to Home Pathways, CRTs). Introducing additional community capacity on a temporary basis has been a useful test of change, however putting this solution on a sustainable footing means that a longer terms/permanent solutions are needed to support system resilience all year round.
- Work on right-sizing the workforce together with robust plans for temporary workforce solutions to support fluctuations in demand

This report has been produced by Aneurin Bevan University Health Board

Digital Strategy: Programme Update

Executive Summary

This past year has seen a refreshed focus to the principles and objectives of the Digital Strategy and further progress has been made in taking the strategy forward. The 4 key themes at the core of the strategy are as important now as they were when they were approved in 2019. These are:

Digital community –
Enable people to manage their health and care needs independently wherever possible

Digital organisation –
Enable staff to be equipped to deliver truly holistic care and high quality services

Digital data, information and intelligence –
Getting the maximum we can from our data and information

Digital foundations –
Provide fast, highly reliable and secure devices, storage and networks

Digital community: the requirements to meet patient and clinical need during COVID pandemic meant that the Health Board developed its services to the public very quickly. An online booking service for vaccinations has been deployed so that patients can cancel, reschedule or opt out of appointments with an expectation of over 1.75 million bookings to be completed by the end of the year. The introduction of the prostate self-management platform will help achieve co-production with patients and improve accessibility, quality, responsiveness and cost effectiveness of the Urology Service and during the last year over 80,000 virtual consultations have taken place, although this past year has seen a gradual reduction in its use as the number of face to face appointments increase.

Digital organisation: COVID has impacted on staffing across all partners and has affected the implementation of a number of systems including, the implementation of the Welsh Community Care Information System (WCCIS), Welsh Intensive Care Information System (WICIS) and the cancer management system (CANISC). However, it is planned to deploy WCCIS across Mental Health & Learning Disabilities Services by the Autumn this year, WICIS by January 2023 and CANISC later this year. The replacement laboratory information system (LINC) has been procured on a national basis and THE Health Board continues to plan for its deployment for Summer 2024.

The transfer of paper health records to digital is expected to go over 1.1 million this year and alongside the new national digital nursing documentation system will form a significant set of patient data.

CWS is now 25 years old and continues to be highly valued by all users. However, the digital platform upon which it works is now out of date and needs replacing to ensure continued functionality; a roadmap for replacement is under development. This will include improvements in the way in which we capture patient data such as, using dynamic electronic forms and voice recognition.

The adoption of CareFlow Vitals across the Health Board alongside the patient flow management system VitalFlo deployed for the opening of GUH and the EHR will improve the availability of critical patient information at the bedside and throughout the Health Board.

The use of Robotic Process automation (RPA) has delivered over £625,000 on non-cash releasing value and is expected to improve further.

Digital data, information & intelligence: In order to improve the use of the information collected the Health Board will be improving its digital platform including major components such as the operational data store and the data warehouse.

The Health Board is moving towards a whole system approach to planning and has used the "Signals from Noise" (Lightfoot) application to create scenarios using referred demand, un-referred demand and capacity across various levels of the organisation as part of developing the IMTP for the year. This type of predictive approach is being used to refresh the plans.

Digital foundations: Strong foundations provides the basis by which all other services can function. To be able to benefit from improvements in technology and to support the services the Health Board has started the transformation of business processes, deploying Mcirosoft 365 and modernising its estate such as moving and improving its data centre and computer rooms and replacing older telephony withbetter and more cost effective Voice over IP (VOIP).

Adjustments to governance arrangements provides improvements in the way digital services are managed including involving all parts of the organisation and ensuring Executive oversight and reporting. This is especially important to manage the cyber security threats.

However, there are significant challenges to ensure achievement of the strategy. COVID continues to affect staff across all services and the inability to recruit and retain professional staff of the required calibre has and will impact on the Health Boards ability to move forward. The commercial and private sectors offer higher salaries than the NHS and in today's financially difficult environment this is perhaps more important to prospective employees than other perceived benefits offered by the NHS.

Overall, it is believed that although progress has been impacted due to the challenges faced over the last 2 years, the Health Board is in a position to refocus to build a digital service that will meet its strategic aims, although significant risks remain around the ability to recruit and retain senior and professional staff.

The Board is asked to:			
Approve the Report			
Discuss and Provide Views			✓
Receive the Report for Assurance/Compliance			✓
Note the Report for Information Only			
Executive Sponsor: Nicola Prygodzicz, Director Planning, Performance, Digital & ICT			
Report Authors: Mike Ogonovsky Chief Digital Officer, Cynthia Henderson, Interim ADI Governance & Assurance Janice Jenkins, Interim ADI Digital Programmes John Frankish, Interim ADI Strategy, Planning & Design Stephen Crandon, Head of Informatics, Service Management Richard Howells, Informatics			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board**	
Date of the Report: 15th July 2022			
Supplementary Papers Attached: n/a			

Purpose of the Report

This report is intended to provide a high-level update and assurance on progress of the Health Board Digital Strategy objectives over the past 2 years.

Background and Context

The Health Board approved the Digital Strategy – Transformation through Digital 2019-2024 in July 2019 and it is seen as a key enabler to deliver A Healthier Wales and the Health Board's Clinical Futures Strategy as well as underpinning the five ministerial priorities of prevention, reducing health inequalities, supporting primary care and mental health and providing timely access to care.

The past 2 years have seen unprecedented challenges to the Health Board and the delivery of the Digital Strategy was not exempt from these and digital services resources were re-prioritised to assist with dealing with these challenges. However, the 4 core themes of the Digital Strategy remains the focus and the past year has been on re-committing to these and moving the delivery of the strategy forward. The 4 key themes at the core of the strategy are:

The following provides an update within each of the core themes.

Assessment and Update

Delivering the digital community element of the strategy is intended to assist to fulfil the Health Boards Clinical Futures aims where patients, carers and service users can manage their own (and others) health and care requirements as close to their home as possible. The work identified here are the major building blocks to achieving this.

1. Citizen Platform

(a) DSPP

The Health Board is engaged with the Digital Services for Public and Patients Programme (DSPP) which is the new national NHS Wales "Citizen Platform" (NHS Wales app). One of

the early adopter projects for this national programme is the PSA portal, led by the Health Board (see section 2).

(b) Covid Mass Vaccination Programme

From August 2020-22, the Health Records service actively planned for and implemented the COVID mass vaccination booking programme for the Health Board. An Online booking solution was deployed on 12th February 2022 so that patients can now cancel, reschedule and opt out of appointments and their Welsh Immunisation System (WIS) records are updated. Close to 1.5 million vaccinations have been delivered with a further 250,000 bookings expected through autumn. It is believed that the demand for this service will continue and a business case has been developed to create a permanent workforce across the mass vaccination booking programme.

2. Technology Enabled Care

(a) Prostate Self Management Programme

The National Planned Care Programme has challenged Health Boards to reduce the number of follow up and unnecessary appointments and to adopt more innovative methods of patient care whilst improving patient experience alongside providing an enhanced quality of care to patients and their families and prevent unnecessary visits to secondary care.

The Health Board's Urology service does not have a digital solution to enable virtual follow up and self-care of patients living with prostate cancer and enlarged prostate glands. The Health Board has undertaken a technical appraisal of a prostate self-management platform used and developed by the University Hospital Southampton (UHS) and believes that the solution is appropriate to both act as a discovery evaluation project of the DSPP and the most appropriate and cost-effective candidate for meeting the needs of the Urology service. The platform, supported by a recommended self-management pathway, is heavily informed by evidence and has had the benefit of early learning and pilot work funded by Macmillan at Southampton as part of the National Cancer Survivorship Initiative. The Health Board's Technical project focuses on establishing an integrated platform that will provide patients living with Prostate Cancer, access to a supported self-management platform. It will provide a technical toolkit and the technical capability for the application to be used by all Health Boards and Trusts in Wales, with integrated patient demographics and PSA blood results. The development of a fully integrated platform for patients living with Prostate Cancer will help achieve co-production with patients and a digitally enabled workforce, improving accessibility, quality, responsiveness and cost effectiveness of the Urology Service.

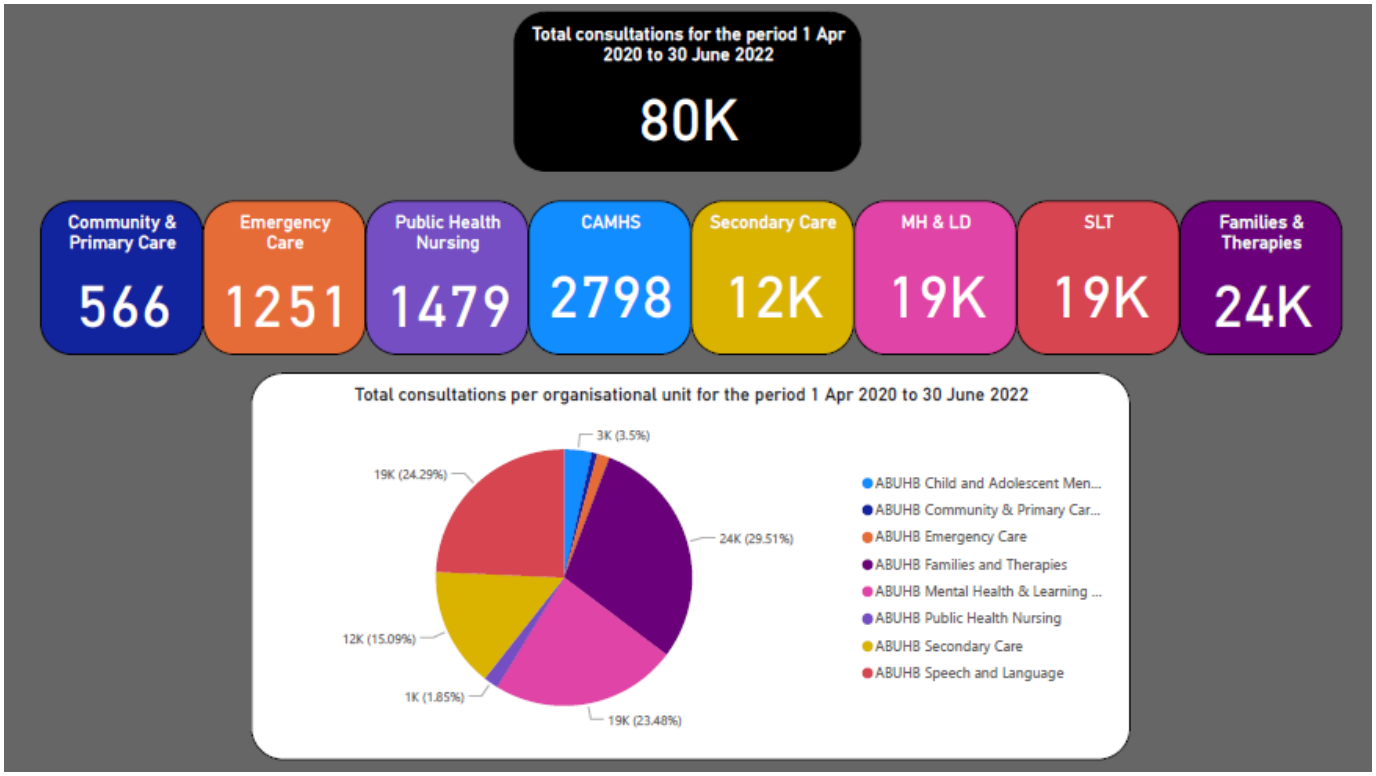
The project is supported across Wales under the sponsorship and funding of the Planned Care Programme with a mandate to deliver capability in 2022/23. The project is hosted by the Health Board's Informatics team in collaboration with all other NHS Wales providers, Digital Services for Patients and Public Programme (DSPP), Digital Health Care Wales (DHCW) and Welsh Government.

(b) TEC Cymru & Video Consultation

Technology Enabled Care Cymru hosted by the Health Board has now been made the Centre for Technology Enabled Care (TEC) for both NHS Wales and local authorities. A

review is currently being conducted in terms of health and care priorities and hosting arrangements for the Centre. A formal launch is anticipated for quarter 3.

During 2021, the ABUHB project team focused on engagement with services and the Outpatient Transformation Group to improve the use of Video Consultations by providing additional support, training and equipment. During the period 1st April 2020 to 30th June 2022, ABUHB conducted over 80k virtual consultations - broken down as follows:



The national Centre for TEC is embarking on a scale and spread project during 2022/23 and Health Board is awaiting funding and the announcement of Welsh Government targets to support this. Other Health Boards have continued to increase usage through adaptations to the estate to facilitate Virtual Consultations and developing roles such as, "Virtual Receptionists". The initiative forms part of the Welsh Governments programme to drive up the number of "Virtual Consultations".

However, within the Health Board, there has been a decline in usage of the Attend Anywhere platform for virtual consultations from March 2021 to June 2022. It's reported that the main causes to this change are the demand by medical staff returning to provide face-to-face consultations and a change in the demand of the type of out-patients seen, such as, an increase in Urgent Suspected Cancer (USC) requiring a face-to-face appointment. We recognise that there are improvements that can be made and working alongside the Centre for TEC we will be reviewing how to improve education about benefit, facilitate adaptations and increase its use in the next year.

Digital organisation –
Enable staff to be equipped to deliver truly holistic care and high quality

The digital organisation element of the strategy intends to ensure that our staff have the most appropriate and available digital equipment and applications in order to undertake their role, ranging from the simplest communication tools, through service specific applications to the complex patient records.

1. Electronic Health Record

The Electronic Health Record (EHR) is the functionality that allows our clinicians to record and review aspects of a patient's care including a patient's medical history, diagnoses, medications, treatment plans, immunisation dates, allergies, radiology images, and laboratory and test results. It also provides access to evidence-based tools that providers can use to make decisions about a patient's care and to clinical workflow management tools.

The main focus for the Health Board's EHR is Clinical Workstation (CWS) supplemented by local and national clinical applications. CWS is highly valued, having been developed over the last 25 years with full clinical involvement in its design and has been tailored to meet the service needs. However, the technology upon which it is based is now aged and is challenging to develop further to meet our future requirements. A new digital platform (see below Digital Foundations) provides a roadmap for the technical development work to ensure that CWS remains functionally applicable and the information usable. The implementation and development of the roadmap will include dialogue with clinicians and other service users to understand their priorities for the platforms development in enabling new EHR functionality and benefits. The Clinical Informatics Council will be the forum at which discussions will be held to proactively guide and schedule our priorities.

The functional development to improve the capture of data will have a direct benefit for clinicians and patients. The programme is using dynamic e-forms technology to replace the existing simple single use set of forms i.e. blank forms where all information has to be entered multiple times, to forms that have re-usable data components such as, a patient's demographic details. There is a commitment to develop this to support the delivery of a digital pre-assessment clinic (PAC) on the scheduled care pathway as the first of its form type using reusable components; learning from this will assist with increasing digital form development and remove dependency on scanning paper records. However, demand for services and capacity constraints for the existing software team means the digital forms will not be ready for another year – quarter 1 2023/24.

A project to digitise the current and relevant paper records has resulted in over 850,000 paper records being digitised with over 250,000 further records expected to be digitised in the mental health, community and therapies services in the coming year. The adoption of the NHS Wales solution to support the digitisation of nursing documentation will be rolled out across ABUHB following the delivery of the national integration project in Quarter 2 of 2022.

These pieces of work are essential to facilitate the use of the EHR alongside the adoption of CareFlow Vitals which would enable the sharing of the critical information at the bedside. The Health Board is sharing its experiences with NHS Wales organisation to help with their efforts to digitise their records.

2. Welsh Community Care Information System (WCCIS)

There have been several challenges to the previous scheduled implementation dates including delays to national programme and supplier delivery, risks of the ePEX legacy system (support expires Sept 2022) and the reduction of staffing resources because of COVID (Omicron), which affected the ability to perform the necessary technical tasks such as, re-platforming (moving) WCCIS from an unsupported version to one which is supported.

These issues prompted a review and update of all system configuration and improvements to the operational guides was required to reflect new ways of working or processes.

It is planned to implement WCCIS across the Mental Health & Learning Disabilities (MH&LD) service in August 2022, following completion of final testing of the national product. Unfortunately, many of the integration items and the mobile app enabling community working will not be available for this go LIVE date. Significant focus has been on continuing to test the system and any new releases to ensure the quality, integrity and security of the approved functionality is ready for use at go LIVE.

Planning continues with the national programme team, Digital Health & Care Wales (DHCW) and the supplier to ensure roll out of integration, including e-referrals and WPAS notifications and the mobile app will be available and rolled out after go LIVE in August. The local programme team is also working with Community Nursing services to schedule its go LIVE later in the year.

The Health Board continues to work with the South East Wales Local Authority partners to standardise terminology and share information using WCCIS. The Health Board hosts the Regional Programme Team which is supporting the local implementation to ensure service wide benefits are realised across the region.

3. Electronic patient flow

The roll out and adoption of CareFlow Vitals over the last 12 months delivers a shared digital record of critical documentation at the bedside and is used extensively across the Health Board hospital sites.

VitalFlo, which is the patient flow management system, was introduced during the opening of the GUH but a re-embedding exercise is underway ahead of 2022 winter pressures. Key to enabling benefits is operational use of the system by staff concerned with flow management and system wide pressures in real time. Work is ongoing to standardise admission, discharge and step up/step down policies which will enable further benefit from the solution.

4. Diagnostics modernisation

Laboratory Information Network Cymru (LINC)

LINC is the replacement Pathology solution which needs to be implemented by March 2025. A new national system has been procured and a local programme team established to work with the national programme on the delivery and migration to the new product. Planning is underway with deployment scheduled for Summer 2024. The national programme is being led by the NHS Wales Collaborative and both the national and local programmes face a number of challenges including ambitious timescales, All Wales standardisation requirements and migration from multiple legacy solutions.

Masterlab (used for blood transfusion) is reaching end of contract. At its meeting of 14th July the Executive Team considered the options available to mitigate this risk which will required approval by the Board.

5. Medicines modernisation

Electronic prescribing is a key commitment of the Welsh Governments healthcare programme. An NHS Wales programme has been established, with the ambition to

deliver e-prescribing across primary, community and hospital care over the next 3 – 5 years.

The first priority element is to deliver hospital e-prescribing and a procurement exercise is underway to establish a national framework from which Health Boards will procure a system that is fully aligned to NHS Wales national standards. The Health Board has submitted its funding bid for this element of the work. The funding will allow us to establish a multi-disciplinary pre-project implementation team to develop our local business case, identify and agree the funding strategy and, with appropriate authority to proceed, commission the full project team to manage procurement and implementation. The business case will be ready in the second half of 2023/24. It is expected that the local implementation team will engage across the medical, nursing and pharmacy disciplines and work in partnership across NHS to ensure consistency of development, adoption and implementation.

6. Specialty specific systems priorities

(a) Welsh Intensive Care Information System (WICIS)

Across NHS Wales there is limited deployment of electronic solutions to support and enable critical care staff to capture and use patient status data to assist them with timely and safe clinical care. The system is due to go in LIVE in January 2023 and ABUHB will be the first Health Board in Wales to implement the national solution. As part of the readiness plan the Health Board has installed the TEST system in GUH and is currently developing the test scripts and is developing the local training plans. As part of the national delivery learning ABUHB will be working with other Health Boards to demonstrate functionality.

(b) CANISC Replacement Programme

CANISC is a national software application used to manage cancer, palliative care and some screening services but the system has become increasingly difficult to maintain and no longer meets the needs of the service. A business case was approved by Welsh Government in November 2019 to fund a three-year programme to replace CANISC and develop the functionality in the Welsh Patient Administration System (WPAS) & Welsh Clinical Portal (WCP).

The pandemic impacted delivery of the programme, but the Health Board has an implementation team in place which is currently testing the national development work in WPAS and WCP in order to replace CANISC later this year.

(c) Maternity System Replacement Programme

The Maternity Service in the Health Board has been using the same digital patient recording system since 1999 and whilst provided value for money it no longer meets the Royal College of Obstetricians and Gynaecologists (RCOG) standards to record in real time and to provide remote access for staff and patients. As such it retained several clinical risks from the use of shared paper handheld records and digital systems. The Health Board has procured a new system and a project team is currently working with the clinical service to implement the solution in March 2023. The new application will provide:

~ A single open comprehensive record, available 24/7, to support the maternity pathway

- Real time data capture, without duplication that can be accessed at any time
- Early detection of complications by identification of clinical risks, and will use an alert system and prompts to improve practice
- An auditable system with mandated record completion
- A medicolegal record for litigation purposes
- Real-time alerts and notifications associated with potential and actual safeguarding issues to be acted on by all clinicians involved in the women's and baby's care
- Mobile devices for community midwives

7. Agile and mobile workforce

The Health Board has several clinical communication tools in place including Vocera, Bleeps, Long Range Pagers as well as a core telephony system. Following the roll out of Vocera into the GUH, significant work has been undertaken to optimise the hospital network to enhance the user experience of Vocera. Work is continuing with Switchboard services to roll out additional bleeps to support doctors and on-call roles at GUH.

A Clinical Communications project has been launched to support the identification of a long-term clinically led communications solution across the Health Board. The project has held workshops to explore existing communication processes and will collect the clinical requirements of users to assist a Clinical Steering Group with formulating an agreed criteria to assess the marketplace options available.

Informatics is a key partner to the Accommodation and Agile Working Group and as such is piloting agile working on the Mamhilad site. Informatics is also supporting the Agile Working Group in identifying requirements and potential solutions for software to help manage and make best use of offices and rooms across the estate.

8. Robotic Process Automation (RPA)

RPA is a technology that uses robots (bots) to mimic human operators but at an increased speed and over a longer duration i.e. the robot can work 24 hours per day 7 days a week. It is secure as it is essentially a digital procedure and does not hold any data.

Since its inception during COVID in 2020 RPA has delivered 28 automations across Finance, Human Resources, Health Records and Workforce and Organisational Development and has so far provided over £625,000 of non-cash releasing value. It has been used successfully to populate CWS with COVID vaccination details of patients and to provide a translation service to help with Ukrainian refugees (changing a 6-week turnaround time to 24 hours). The approach to translation services has been tested on Welsh translation and it is likely to be adopted as a rapid turnaround tool meaning that documents would then only require proof reading by the Welsh Language Unit team to provide an improved and effective QA service. It is intended to use the same approach to translate the top 10 other languages within the region so that we can provide an improved service to our diverse population.

We are pleased that the RPA Team was recognised as the ABUHB Team of the Year 2022. The Team is now other NHS organisations in Wales with their implementation and RPA is seen as a major tool to improve the provision of routine services across the NHS Wales.

A programme of work will formally be established to ensure we optimise the use of the existing robots and identify the potential for further use.

Digital data, information and intelligence – Getting the maximum we can from our data and information

This aim intends to ensure that the Health Board obtains the best value using the data we collect to inform clinical and corporate decision making and direction.

1. Clinical decision support

The Information Department is currently developing a Business Intelligence and Insight Strategy which will enable the re-use of digitally captured patient data to inform clinical practice, performance, risk and planning decision making.

The adoption of CareFlow across the Health Board enables consistency based on clinical evidence clinical care and management of sepsis risk.

The Health Board also has a Value Based Healthcare Programme focussed on the development of patient outcome data collection for patient care optimisation and clinical service improvement. The work is undertaken within the provisions and standards of the NHS Wales Value in Health Programme.

The Health Board uses a Patient Reported Outcome Measures (PROMs) application to deliver this information in the form of Dr Doctor. The Health Board Dr Doctor application is due for re-procurement, however, a national procurement for PROMS application is underway and the Health Board will await the outcome of that procurement exercise to determine the best path for the Health Board's PROMS platform delivery.

2. Data warehouse

As the informational needs of the Health Board grows the Health Board's Data Warehouse infrastructure also needs to change to accommodate this growth and demand. To reduce risk in the short-term additional infrastructure hardware to provide additional capacity has been procured and will be installed in Quarter 3. A review of requirements to provide a long-term solution has been completed and a business case is currently being developed by the Assistant Director of Performance & Information that will be presented in Quarter 3.

There is also local development of performance management dashboards to improve the business intelligence across the organisation.

3. Population health & predictive analytics

The Health Board is moving away from traditional approaches to how we plan and deliver services to a new 'Always On' data rich system that allows us to understand how our system is behaving; to determine the potential impacts of changing circumstances on our demand/capacity profiles and enables us to plan how to respond to those challenges within the context of our system of care.

This is a core enabler to building a culture of support around teams and will facilitate whole system planning through seeing systems together. We are utilising the Signals from Noise Platform (Lightfoot) to do this work.

To plan for our IMTP, the organisation utilised the platform to scenario plan a realistic and balanced approach to understanding our true demand and system capacity. Unlike other NHS organisation the Health Board was also able to use the system to calculate our un-referred demand (patients who had not been referred during the pandemic but may come into the system), this information coupled with using our previous system behaviour as an indicator the organisation was able to develop scenarios that provided a realistic assessment to inform the Health Boards plans. The ability to produce scenarios at specialty, divisional and organisational levels in a connected way enabled support from front line teams in agreed activity profiles. This predictive approach is now being used to refresh our plans at quarter one.

Digital foundations –
Provide fast, highly reliable and secure devices, storage and networks

Achievement of the objectives within the Digital Foundations domain is intended to ensure that the Health Board has firm pillars by which it can deliver its overall strategic objectives. As the domain suggests strong foundations provide a strong base by which the Health Board rely to achieve its aims.

1. Next generation software

Providing applications to our clinical workforce is no longer enough; taking a platform approach whereby integration is central to its purpose to reduce multiple logins and access to multiple systems to look after one patient. The platform proposal will set out a clinically driven scalable and sustainable approach to supporting our clinicians and patients.

The solution overview for the Platform has been developed and was endorsed by the Digital Delivery Oversight Board in April 2022. A quick delivery of the new Platform is constrained by the size of the software development team. A business case to aid the acceleration of the building of the digital platform including additional software team development resource required to meet needs is being finalised.

2. Next generation operating system

The Health Board has started the transformation of current business processes to take full benefit of improvements in the underlying technology.

Microsoft 365 has been deployed as the standard office application suite across the Health Board. This supports full collaboration regardless of the users location and/or the device used. The Intranet has now been updated to a much more up to date and intuitive application based on SharePoint. This is accessible to all staff from any device.

These types of changes will help the Health Board move towards a different way of working having a positive impact for staff enabling a better agile and mixed working environment (including working from home).

3. Modernised network

The programme of work intends to mitigate the risks identified and to ensure that the Health Board is able to use technology now and for the foreseeable future.

a) Computer Rooms:

The current poor physical state of a significant number of our computer rooms are inherent to the rapid change of ICT technology and the need to quickly change the building infrastructure to support past ICT requirements across the Health Board.

Additionally, some computer rooms are now at full capacity, and creates a clinical risk as additional services within some clinical areas which rely on digital services to deliver improvements within the clinical area, cannot be delivered or supported without bringing the rooms to the full standard.

The Edge Computer Rooms (ECR) and Core Computer Rooms (CCR) Compliance capital submission supports an ongoing programme of works that focuses on refreshing the hardware and environment within our Edge and Core computer rooms across the Health Board to an agreed set of standards and compliance.

Due to the challenges of available capital funding, at the moment the upgrade of the remaining computer rooms at NHH (Nevill Hall Hospital) and LGH (Llanfrechfa Grange Hospital) are prioritised. If further funding is available, the Core and Edge room refresh programme at RGH (Royal Gwent Hospital) will be started.

b) Telephony:

A programme to improve telephony standards and reduce cost has seen a successful replacement of the old digital telephone handsets at Ysbyty Ystrad Fawr and County Hospital with new VOIP (Voice over IP) handsets. The LGH (Llanfrechfa Grange Hospital) telephony refresh programme is projected to complete later this financial year. This change means an improvement in their management and deployment as the system runs over the ICT network and does not require separate cabling, reducing cost.

c) Data Centre:

The Health Board has operated its own data centres for many years. One data centre is located in lease premises and occupies a large amount of space which does not meet current Data Centre management standards. A project to relocate the Data Centre from Mamhilad to our own purpose build premises at GUH and YAB is scheduled for completion this year.

4. Cyber security & Resilience

The Health Board has engaged with Templar Consultancy to review its Digital and Cyber security arrangements. It has created the Health Board Office of the Senior Information Risk Owner (SIRO) (HBOTS) to ensure that there are a suite of policies and procedures that govern information security and that there is direct access to the SIRO for any issues or risk escalation. A roadmap is available of the requirements to achieve the milestones over the period July to December 2022 and these were presented to the Health Board in June 2022.

The Cyber Security Team continue to lead on the management of technical risk and a programme of activity alongside the Templar resilience programme is progressing well. A monthly report is now shared with the SIRO and will be refined and matured as the reach of the cyber team continues to develop. The report shows progress in terms of Critical Security patches, migration from end of life platforms. From the last strategic update last year we have seen compliance with patch compliance on desktops for example increase from 45.9% to 85.4% and for our own servers we have almost

achieved the 95% standard although commercial and third party systems are proving more challenging. Further enhancements in flight include simulated Phishing software to help assess risk and raise awareness and the team were successful in securing £19k for Cyber courses and development from South Wales Police Palisade fund.

The importance of the role of the SIRO and their training and knowledge was seen key to the successful implementation of the new governance and assurance regime. The revised regime also saw the establishment of new Governance & Assurance Groups (GAG's) within each of the Divisions and at which there is Cyber representation. These groups will include the nominated Senior Information Asset Owners for each Division and these will identify the individual Information Asset Owners within each Division. Letters of delegation will be issued by the SIRO to ensure compliance. The nominated staff will receive bespoke training for them to spread and disseminate training within their respective divisions and have clear governance structure. This will ensure that Cyber Information risk is immediately escalated to the SIRO but also formally at the DDOB.

5. GUH live

The GUH is now operational with up to date infrastructure and networks. System pressures requires continued support from Informatics e.g. Same Day Emergency Care (SDEC). However, the remediation and improvement on network resilience and mobile phone connectivity for patients and visitors have been completed.

A clinically led review of clinical communications business continuity is being undertaken which will support the review of the use of Vocera, pagers and bleeps.

6. Target Operating Framework

Following the adoption of the Digital Strategy in July 2019 the Health Board commissioned a review of the capability of the operating framework in order to be able to deliver the ambitions set out in the strategy (Chanel 3 October 2021). The report set out a number of priorities in terms of governance assurance capacity and the operating model of the Informatics Directorate. A number of objectives in the last reporting period have been achieved including:

Governance: The Health Board is adjusting its reporting and operating structure to align with the recognised service model and includes an elevated level of governance and assurance throughout the flow of projects from instigation to completion and handover. The Health Board is the first in Wales to adopt this type of model to improve digital services throughout the organisation. The Digital Delivery Oversight Board (DDOB) has been initiated and has met providing Executive Team oversight and ownership. In addition, Directorates service delivery and programmes now have formal board meetings.

Quality: The Programme Management Office (PMO), clinical risk assurance processes, programme management standards and risk management standards are embedded into programmes being rolled into service delivery.

Service Desk: The Service Desk has achieved professional accreditation and the Directorate is now a corporate Member of the British Computer Society (BCS) enjoying improved learning and training opportunities. It now has a modest budget for learning and education for the year. Adopted Information Technology Infrastructure Library, adopted MSP.

Achievement of the Target Operating Framework has been challenging with financial constraints, changes to resource, the loss of senior level management affecting the ability to progress speedily and recruitment challenges in a competitive market. However, priority service changes for this year have been identified as have some restructuring in order to drive forward the changes. A business case will be provided to ensure these changes reflect the ambition of the TOF and that the financial model is controlled and will be within existing resources this year.

Conclusions & Recommendations

Overall, it is recognised that delivery of the strategy has had to adapt due to COVID affecting staff availability and changing the emphasis on priorities across all services. There remains the difficulty of recruiting and retaining staff in a comprehensive private sector market. However, it's believed that the Health Board can build on its current progress to create a digital service that will meet its strategic aims, albeit timescales may need to be aligned. Therefore, the Board is asked to:

- Note the contents of this report and the progress to deliver the Digital Strategy
- Provide views on the approach and progress

Supporting Assessment and Additional Information	
Risk Assessment **(Including links to Risk Register**)	The delivery of the Digital Strategy will assist to mitigate a number of organisational risks
Financial Assessment, including Value for Money	All requirements will have gone through a vigorous benefits, value for money and financial assessment prior to acceptance and regular budget reviews are undertaken with the Finance Directorate.
Patient Quality, Safety and Experience Assessment	The Office of the CCIO & CNIO provide a formal approach to clinical safety of the delivery of digital services and solutions. The approach encompasses the management and investigation of clinical incidents. A National Welsh Clinical Information Council provides multi-disciplinary oversight of standards.
Equality and Diversity Impact Assessment **(including child impact assessment)**	The Digital Strategy was subject to an equality and diversity impact assessment covering all patient and staff groups.
Health and Care Standards	This report contributes to the good governance elements of the H & CS where the strategy delivers improvements, especially: 3.4 – Information Governance and Communication Technology 3.5 – Record Keeping
Link to Integrated Medium Term Plan / Corporate Objectives	The objectives will be referenced in the IMTP's across the organisation
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	The WBFGA requirements are considered as part of the strategic aims and reflected in delivery of the objectives. **Long Term:** Patients will be enabled to coproduce their health care using technology to support well-being management, long-term health management and short-term episodes of illness or injury. A digitised framework will be provided within which Practitioners are able to interact with and empower their patients using a wider range of consulting, coaching and informatics skills. Practitioners will have access in real time to the information they need to treat and care for their patients releasing time to care from non-value adding work. **Integration:** Computing infrastructure will be ubiquitous, and information collected joined up and available at each level of

	the organisation through to population health Patients will enjoy the benefits of integrated information and communication systems operating across primary, secondary and tertiary health care in Wales and across Health and Social Care public sector bodies, third sector and other health care settings. **Involvement:** ABUHB has engaged leaders who are deeply knowledgeable about the clinical and technological systems in place with Chief Information and Information Officers ensuring a digitally mature approach to service transformation. **Collaboration:** Informatics Directorate has established long term relationships with academia, technology vendors and suppliers including consortia and small and medium enterprises, social care, third sector and other health organisations, patient representatives and other stakeholders delivering and demonstrating the benefits of innovative uses of informatics to enhance health care. **Prevention:** Informatics Directorate Service Management will provide a sustainable service that prevents and minimises the risk of service disruption and outages to clinical and operational environments through a service and appropriately qualified staff operating within best practice assurance frameworks.
Glossary of New Terms	Core Computer Rooms (CCR) - This is the main room where ICT technical equipment services enter and leave the building. The rooms also house the servers, networking and telephony services for that building. Edge Computer Rooms (ECR) - These are spread throughout a site and are connected to the CCR. ECR's deliver ICT services to the end users, i.e. its where the PC's, telephones, printers and other end user equipment are connected - commonly referred to as a Hub room
Public Interest	Report can be published

Aneurin Bevan University Health Board

Finance Board Report – June (Month 3) 2022/23

Executive Summary

This report sets out the financial performance of Aneurin Bevan University Health Board, for the month of June 2022 (month 3) and the year-to-date performance position for 2022/23.

The 2022/23 financial performance is measured by comparing the expenditure with the budgets as delegated in the Budget Delegation papers agreed at the March 2022 Board meeting and updated during the year. 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-22
Performance against key financial targets 2022/23
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	3,481	8,364	↑	**0**
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £49,107	1,362 2.8%	4,702 9.6%	↔	**0**
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	91.7%	93.6%	↓	**>95%**

Performance against requirements 21/22		**19/20**	**20/21**	**21/22**	**3 Year Aggregate (19/20 to 21/22)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	✓	**(32)**	**(245)**	**(249)**	**(526)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	**(28)**	**(13)**	**(50)**	**(91)**
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓				

Underlying Financial Position (Brought Forward ULP)	**19/20**	**20/21**	**21/22**
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	**£11.405m Deficit**	**£16.261m Deficit**	**£20.914m Deficit**

Note: The Health Board has submitted an IMTP for 2022/23 – 2024/25, which has been approved by WG on the basis of achieving financial balance.

Key points to note for month 3 include:

- A reported year to date position of **£8.4m deficit**, (the IMTP plan forecast at month 3 expected position was £5.3m deficit),
- Income - includes anticipated Covid-19 and exceptional cost pressure funding,
- Pay Spend – has decreased (by c.£1.5m), due to decreased enhancement costs as well as medical variable pay costs. Both medical and nursing variable pay remain extremely high due to elective recovery activity, emergency & urgent care pressures, continued use of additional surge capacity linked to Covid-19 and on-going operational pressures such as enhanced care despite low levels of Covid-19 positive patients.
- Non–Pay Spend (excluding capital adjustments) - has remained at a similar level to May. Decreased costs in specific funded areas are off-set by increased facilities and energy costs compared to May.
- Savings – overall achievement is in line with plan for month 3 however there are now significant risks with delivery of a number of savings opportunities where achievement is assumed after quarter 1. These savings plans remain amber for month 3 reporting to enable the Health Board the opportunity to drive these plans into an achievable position. These will be reviewed for month 4 reporting.

At Month 3, the year to date reported revenue position is an £8.4m deficit and the reported capital position is break-even. The forecast position for both is break-even, however, the revenue position has extremely significant risks to be mitigated to achieve this* forecast. *The Finance and Performance Committee were provided with a full financial update including risks to break-even on the 6th July. To support mitigation the Executive team have been engaged in focussed discussions and have implemented an internal financial recovery 'turnaround' approach. Mitigating actions will need to be fully developed and options presented for Board consideration.

The underlying financial deficit coming into 2022/23 (£20.9m) will need to be addressed to support financial sustainability and recurrent balance in future years. The IMTP assumes recurrent savings opportunities will be achieved to reduce the underlying financial deficit for 2023/24 (to £8m). This assumption will need to be adjusted if the savings and mitigating actions are not achieved during the year.

The Board has approved the 2022/23 – 2024/25 IMTP and the initial Budget delegation plan for 2022/23. Welsh Government (WG) have now approved the IMTP.

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

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

Report Author: Suzanne Jones – Interim Assistant Director of Finance

Report Received consideration and supported by:

Executive Team		**Committee of the Board**	√

Date of the Report: 15th July 2022

Supplementary Papers Attached:

1. Glossary
2. Appendices

Purpose of the Report

This report sets out the following:

- The financial performance at the end of June 2022 and forecast position – against the statutory revenue and capital resource limits,
- The savings position for 2022/23,
- The 2022/23 forecast,
- The significant level of risk to the current financial position,
- The revenue reserve position on the 30th of June 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy.

Assessment & Conclusion

- **Revenue Performance**

  The month 3 position is reported as a **£8.364m deficit,** with a forecast **year-end out-turn reported position as break-even, however, there is significant risk to this forecast**. A summary of the financial performance is provided in the following table.

Summary Reported position - June 2022 (M03)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	258,411	3,030	2,114	916
Prescribing	99,190	1,537	961	576
Community CHC & FNC	63,411	1,150	1,461	(311)
Mental Health	101,461	1,961	826	1,135
Director of Primary Community and Mental Health	311	17	11	6
Total Primary Care, Community and Mental Health	**522,785**	**7,694**	**5,373**	**2,321**
Scheduled Care	219,870	7,040	4,988	2,052
Medicine	98,729	8,052	5,595	2,457
Urgent Care	33,452	4,053	2,793	1,260
Family & Therapies	117,745	241	157	84
Estates and Facilities	78,205	3,886	2,481	1,406
Director of Operations	5,440	463	309	155
Total Director of Operations	**553,442**	**23,736**	**16,322**	**7,414**
Total Operational Divisions	**1,076,227**	**31,430**	**21,695**	**9,735**
Corporate Divisions	112,963	(1,471)	(892)	(579)
Specialist Services	171,680	76	51	25
External Contracts	82,925	117	(167)	284
Capital Charges	32,042	(25)	(0)	(25)
Total Delegated Position	**1,475,836**	**30,126**	**20,687**	**9,439**
Total Reserves	84,792	(21,762)	(15,803)	(5,959)
Total Income	(1,560,628)	(0)	(0)	(0)
Total Reported Position	**(0)**	**8,364**	**4,884**	**3,481**

The year to date overspend is £4.4m higher than forecast in the submitted IMTP. The position has been underpinned by appropriately releasing part of the annual leave accrual, maximising available non-recurrent opportunities and assuming an on-going level of funding for Covid-19 to match appropriate increased costs. Current service pressures being experienced are incredibly challenging, presenting an increasingly significant risk to the Health Board's ability to meet its statutory requirement to break-even. The Health Board reaching a break-even position in 2022/23 is predicated on:

- Achieving savings of at least £26m,
- Managing and mitigating the £19m risks included in the IMTP through cost avoidance,
- Managing any new in year cost pressures,
- WG funding for Covid-19, exceptional cost pressures and wage award.

The Health Board Executive Team have implemented an internal financial recovery turnaround approach to recover the financial position. If this is not achieved there is a significant risk to achieving break-even for 2022/23. On-going weekly meetings as part of the Executive Team agenda have identified an initial list of proposed actions which require further development to assess the full financial, service, workforce and patient implications of proposals.

To ensure delivery of the IMTP service, workforce and financial plans, progress must be made to deliver transformational change to support value driven efficiency improvement and financial sustainability. While transformation is the preferred sustainable solution for long term efficiency and value gain, short term actions need to be invigorated to support 2022/23 balance in parallel with accelerating efficiency delivery through the IMTP priority transformation programmes.

Financial impact of service and workforce pressures

- During June 2022, pay expenditure decreased compared to May mainly due to reduced enhancements paid. Variable pay costs decreased compared to May due to a planned review of medical shifts accrued that are over 6 months old. On-going surge capacity, service recovery plans and operational pressures remain especially for nurse staffing. Significant operational pressures remain due to vacancies, enhanced care hours and sickness. Non-pay expenditure has remained a similar level to May due to the decreased costs in specific funded areas such as RIF (£1m) offset by in-month energy and facilities costs compared to May. The expected energy price increases have resulted in an additional cost of £1.7m for the year to date.

- The number of Covid-19 positive patients in hospital has decreased in June, however, the total number of patients (positive, suspected and recovering) is 165 (30th June 2022) at a similar level to middle of September 2021 (164 as at 19th September 2021). There remains a considerable number of patients recovering from Covid-19 across several wards in the Health Board. The temporary staffing cost to operate these areas remains significant. This rising incidence is impacting on efficient bed utilisation.

- Demand for emergency and urgent care across all services, including primary care, mental health, acute and community hospitals, remains in many cases above the levels seen pre-pandemic. In June the levels of patients deemed ready for discharge but remained in hospital increased notably. There are in excess of 300 patients who could be discharged as at the end of June. The surge capacity required for this as well as the increased Covid measures in place continues to result in overspends across the Health Board. There also remain challenges in terms of demand and flow across the Health Board. The challenge is now to reduce the requirement for this capacity to achieve a safe and sustainable service, workforce and financial plan across the Health Board.

- The operational factors above coupled with enhanced care as well as increasing elective activity, result in significant financial pressures. If the service response to Covid-19 implications could be de-escalated it should result in cost reductions to some of the operational factors currently in place where funding is assumed.

Additional local Covid-19 transitional costs are being incurred due to the following:

- Additional services implemented to deal with exceptional emergency pressures across all sites,
- 'green' patient pathways to minimise infection,
- GUH ward A1 urgent care temporary ward,
- additional bed capacity across hospital sites,
- the number of patients requiring enhanced care,
- delayed discharges for patients waiting for social care support and packages of care, and
- service models being flexed to respond to service pressures faced.

To mitigate, key areas of focus for the Health Board are:

- System level working - updating bed capacity forecasts & additional capacity requirements
- Urgent care and elective care re-design,
- Demand and flow management, - reviewing the social care community actions,
- Workforce efficiency, reducing variable pay where possible, and
- Other actions to underpin the operational management and leadership to support clinical teams e.g. Medicines Management, non-pay and training/support.

These areas for mitigation aligned with turnaround actions need to be invigorated and implemented as a priority, whilst maintaining patient safety, to support achievement of financial balance.

Workforce

The Health Board spent £60m on workforce in month 3 22/23 (21/22 monthly average of £58.3m).

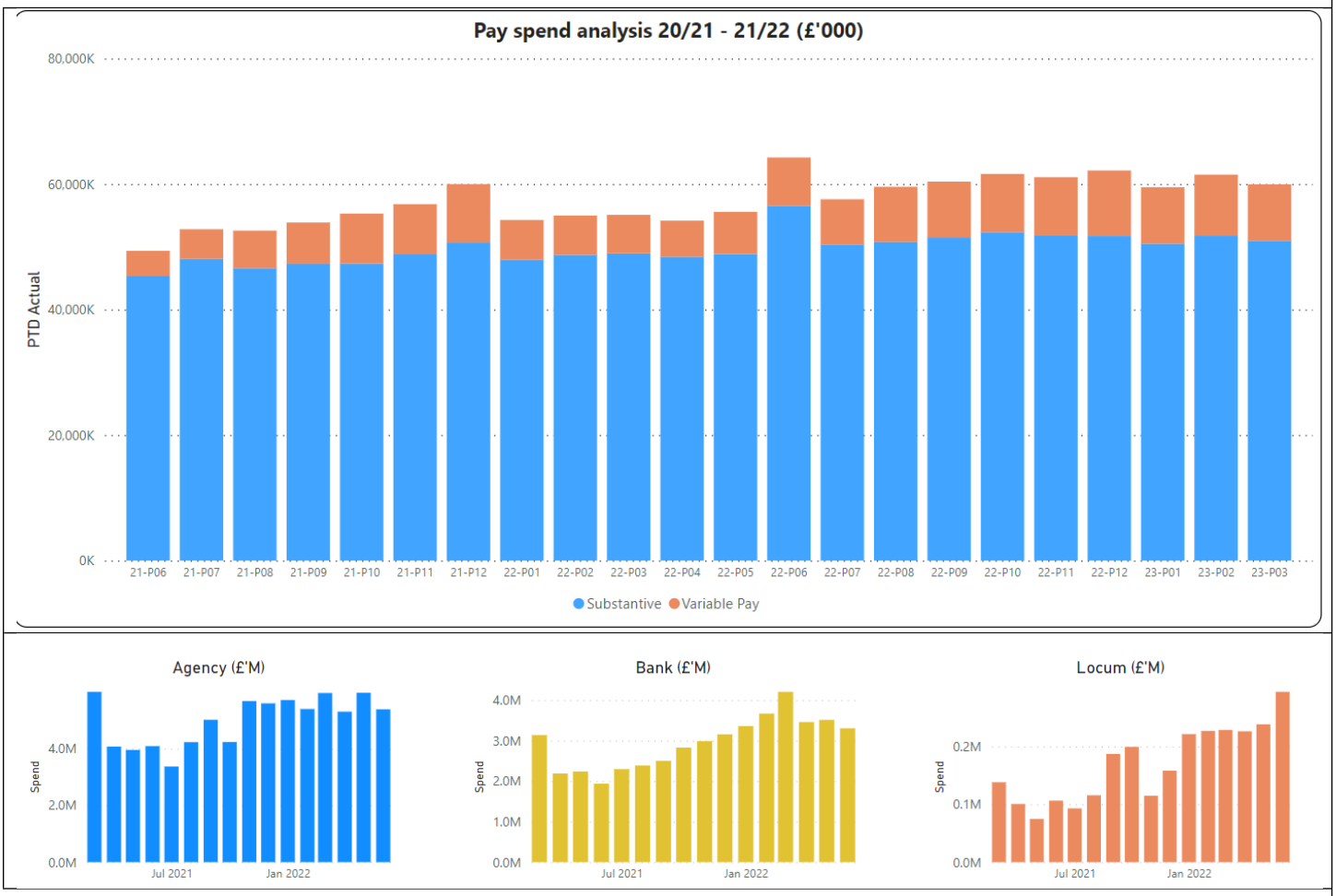
Substantive staffing costs (excluding the increased annual leave provision and notional 6.3% pension costs in March) have decreased by £0.8m (-1.6%) compared to May. Monthly enhancement payments have decreased by £0.5m plus reduced overtime payments linked to a review of medical shifts over 6 months old.

Compared to month 2, bank costs have decreased by £0.2m (-5.9%) and agency costs have significantly decreased by £0.58m (-9.8%). The decrease is linked to a review of medical shifts coupled with a recruitment conversion from bank HCSW to substantive posts. A significant risk exists whereby the appointed staff have selected wards which are at a lower risk of unfilled shifts than areas within for example COTE which are at the greatest risk in terms of workforce. As a result there has been increased HCSW agency costs to cover these and other operational pressures. There also remain on-going high levels of enhanced care provision across the HEALTH BOARD.

There is still a continued and significant reliance on the use of agency and bank staff.

Workforce expenditure is shown below differentiating between substantive and variable pay[1]:

[1] *To enable useful comparisons and trends all references to 21/22 pay expenditure exclude the month 12 expenditure for: Covid-19 annual leave provision (£2m), and Additional employer pension contributions (6.3%/£27m).*



Substantive staff
Substantive pay was £51m in June (exc. annual leave related adjustments) – a decrease of £0.8m compared with May. Substantive pay has decreased by £0.3m for registered nursing, £0.2m for estates and ancillary staff, and £0.2m for additional clinical services. The majority of these changes relate to additional weekly and bank holiday enhancements paid in May and now reducing in June.

Variable pay
Variable pay (agency, bank and locum) was £9.0m in June – a decrease of £0.7m compared to May.

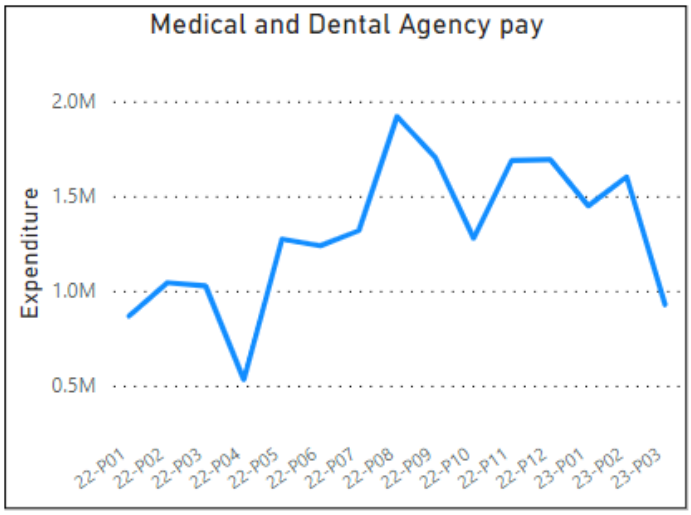
The Executive Team have agreed a variable pay programme which is aimed at reducing high cost variable pay and developing alternative solutions. This includes a number of areas including recruitment of substantive staff, review of specialist rates, reduction in HCSW agency as well as detailed review of nurse staffing across ward areas. Current service demand for agency is challenging the level of achievment.

It should be noted that the number of unfilled nursing shifts remains at a high level throughout the HB. If all these shifts were filled through variable pay the cost impact would be significant.

Bank staff
Total bank spend in June was £3.3m – a similar level to May. There remains continued high usage of enhanced care shifts. Areas where bank usage continues to be significant are the medical wards for YYF and NHH which are linked to recovering Covid-19 patients and those with on-going Covid-19 additional support requirements. There was a reduction in costs compared to May in older adult mental health as well as across community hospitals.

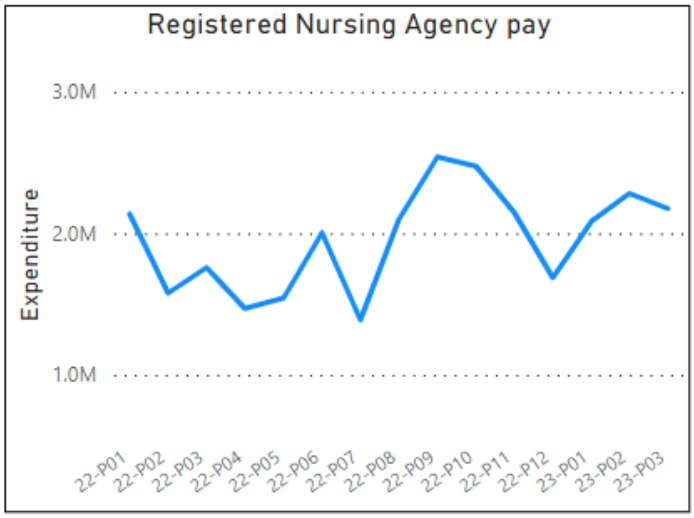
Agency

Total agency spend in June was £5.4m – a decrease of £0.6m compared with May. Medical agency accrued shifts over 6 months old have been reviewed resulting in a reduction of c.£0.8m. This reduction was off-set by increased elective recovery costs of £0.2m mainly within Scheduled Care areas. It should be noted that medical agency costs increased if the accrued shifts reduction were excluded. This is due to recovery costs coupled with the on-going operational pressures for covering vacancies, sickness and staff who cannot undertake patient facing duties. Estates and facilities costs due to Covid, enhanced cleaning and cover of vacancies remains a consistent pressure. On-going costs in medicine wards across the HEALTH BOARD due to Covid recovery, emergency and urgent care, surge capacity and enhanced care continue to provide an extreme pressure both in June but also as a significant risk to the forecast position.



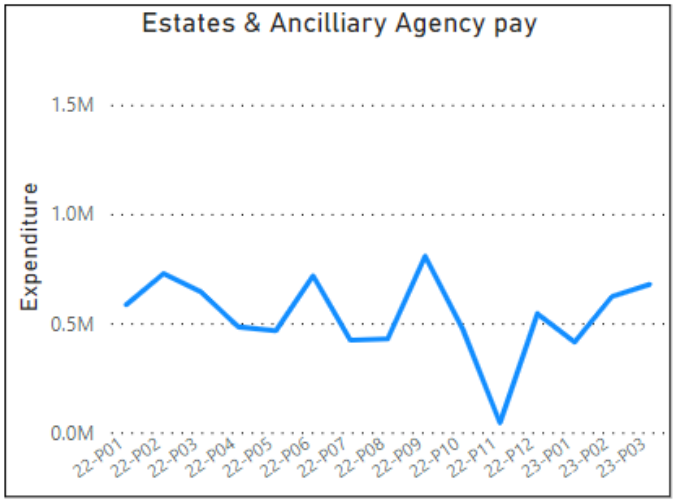
- In-month spend of £0.9m, a £0.7m decrease compared to May.
  - Continued pressures in GUH ED and RGH Medical wards as well as COTE and YYF medical staff backfilling a number of staff who are still non-patient facing and numerous vacancies.
  - Increase in frailty costs linked to cover of vacancies.
  - On-going costs for managed practices (£0.12m in June) with a likely further increase due to notice of closure in 22/23.
  - Review of shifts over 6 months old resulting in a reduction of £0.8m.

- Medical agency spend averaged c.£1.3m per month in 2021/22.



- In-month spend of £2.2m a decrease of £0.1m compared to May.
- Reasons for use of registered nurse agency include:
  - Additional service demand including opening additional hospital beds, support for recovering Covid-19 patients, increase of £0.1m in critical care compared to May costs.
  - Enhanced care and increased acuity of patients across all sites,
  - On-going sickness and international recruitment costs,
  - vacancies, and
  - enhanced pay rates.

- Registered Nursing agency spend averaged c.£1.9m per month in 2021/22.

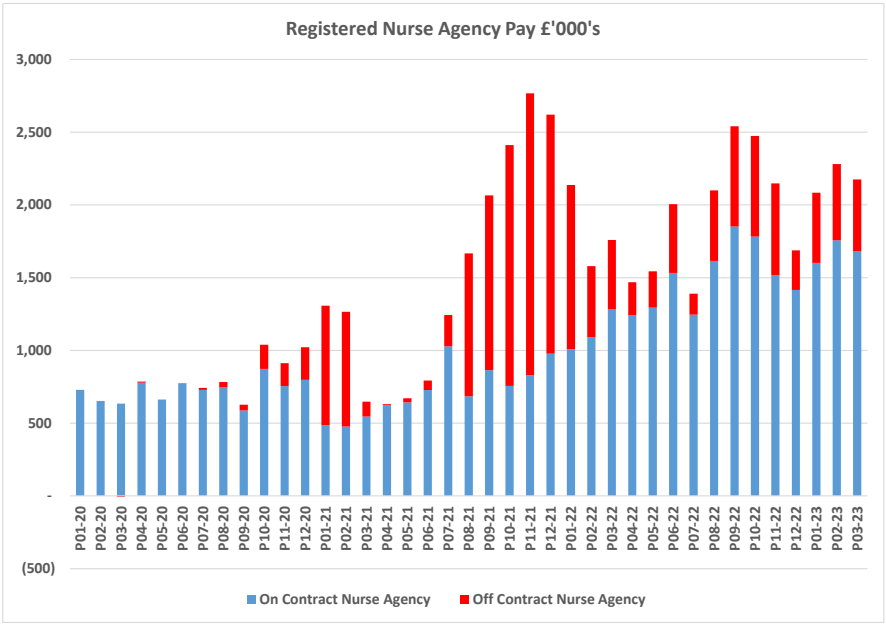


- In month spend of £0.7m on Estates & Ancillary (£0.1m increase from May), which is primarily within GUH and related to Covid.
- Reasons for use of agency include:
  - Meeting enhanced cleaning standards,
  - Covid-19 and surge capacity
  - Enhanced care and increased acuity of patients,
  - Sickness,
  - Vacancies and
  - Supporting the Mass Vaccination Programme.
- Estates and Ancillary agency spend averaged c.£0.5m per month 2021/22.

Registered Nurse Agency

Registered nurse agency spend totalled £22.8m in 2021/22, £18.1m in 2020/21 and £10.2m in 2019/20.

Health Board spend for the year to date is £6.5m on nurse agency, if this level of use continues throughout the financial year it would cost £26m in 2022/23. The use of "off-contract" agency – not via a supplier on an approved procurement framework – usually incurs higher rates of pay and remains significant in month.



The Health Board spent £0.5m on 'off' contract RN agency in June which is at a similar level to May and reflects the increased vacancy hours used and the on-going usage of agency to cover enhanced care hours. The main reasons for its usage are:

- Enhanced care,
- Additional capacity,
- Nursing vacancies,
- Patient safety,
- Covid-19 responses (especially for recovering patients), and
- Increased sickness and cover for staff in isolation.

As part of the new Variable Pay savings programme for 2022/23, the Nurse Agency Reduction Plan will form a key part of delivering efficiencies.

Medical locum staff

Total locum spend in June was £0.29m which is at a similar level to May. Radiology, Dermatology, GUH ED and oral surgery are the areas of highest expenditure relating to on-going operational pressures, elective recovery and substantive vacancies.

Enhanced Care
Enhanced Care, also known as 'specialling', can include a spectrum of reasons ranging from the provision of assistance to help a patient mobilise, through to one-to-one patient monitoring. Enhanced care is designed to ensure a patient centred safe approach for patients with additional care needs.

A review of the financial impact of 'enhanced care' – including the use of bank and agency staff – has identified the following use of nursing staff:

	2020/21	2021/22	2022/23	2022/23 increase
Average number of hours used per month	15,305	35,446	42,121	19%
Average monthly notional expenditure (£m)	0.24	0.70	0.94	
Increase in average notional cost per month compared to prior year				£0.2m
Estimated increase in the calculated annual cost based on average hours				£2.9m

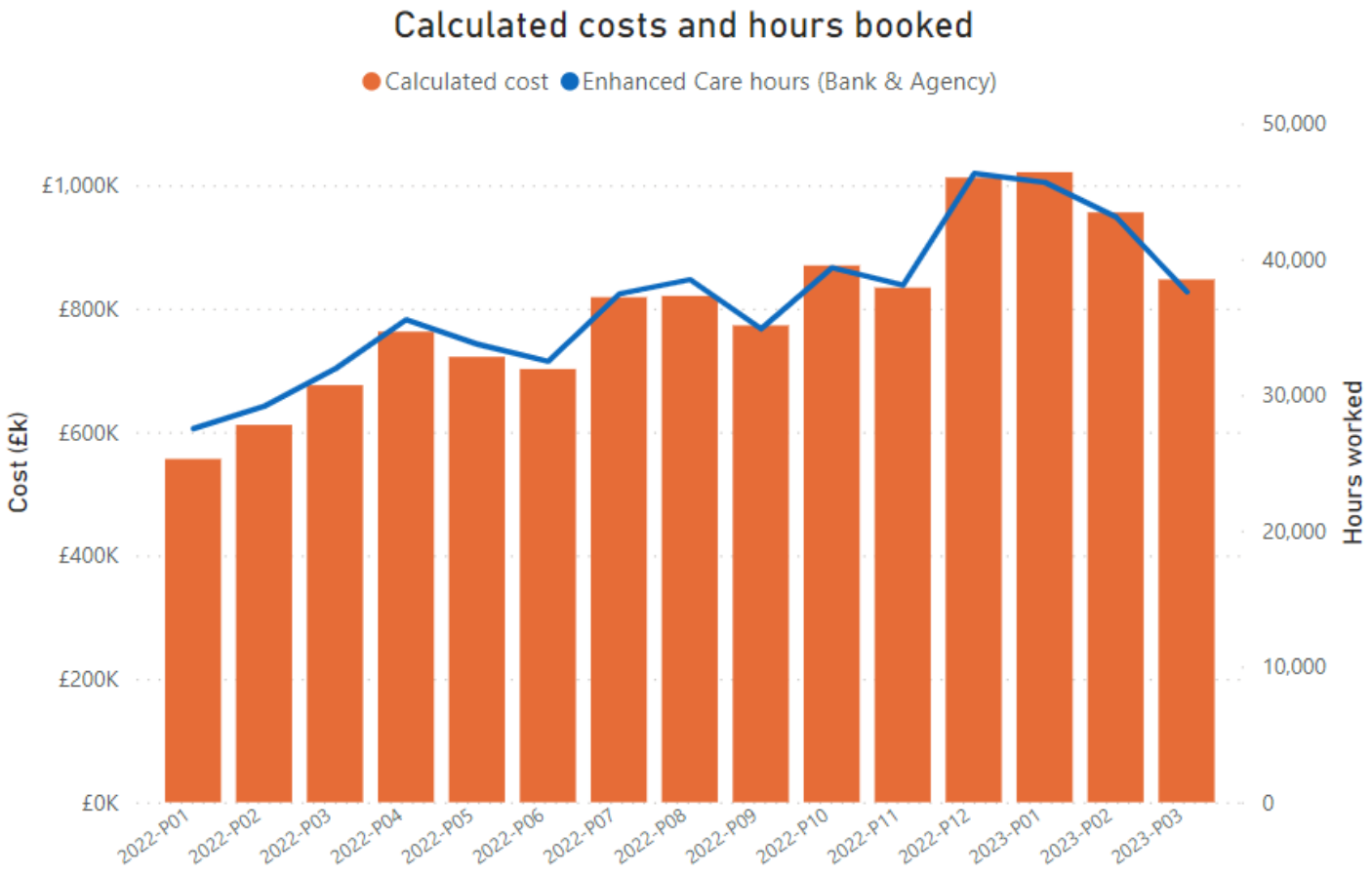
In June (P03-2023), enhanced care hours and associated costs remained high within the Medicine and Primary Care & Community Divisions. It should be noted that the hours quoted are the number of bank and agency hours worked using 'enhanced care' as the reason for booking, notional costs are calculated using average registered/unregistered hourly rates incurred. These have been updated for 2022/23 where possible using shift time, type and specialist rates where defined. Further updates will be completed to reflect the off-contract nature of many shifts which will inevitably increase the costs described.

There is a distinct increase in enhanced care hours (and associated costs) from February 2022 compared to the last four months (March – June 2022). The monthly average from April 2021 to February 2022 is approx. 34,400 hours and £0.6m cost. The June cost of £0.85m is an increase of £0.25m above that average, even though June is a decrease compared to May. This continues to indicate a step change which reflects the change in acuity of patients across the Health Board.

The level of the provision of enhanced care on beds within Medicine for June 22 is shown below:

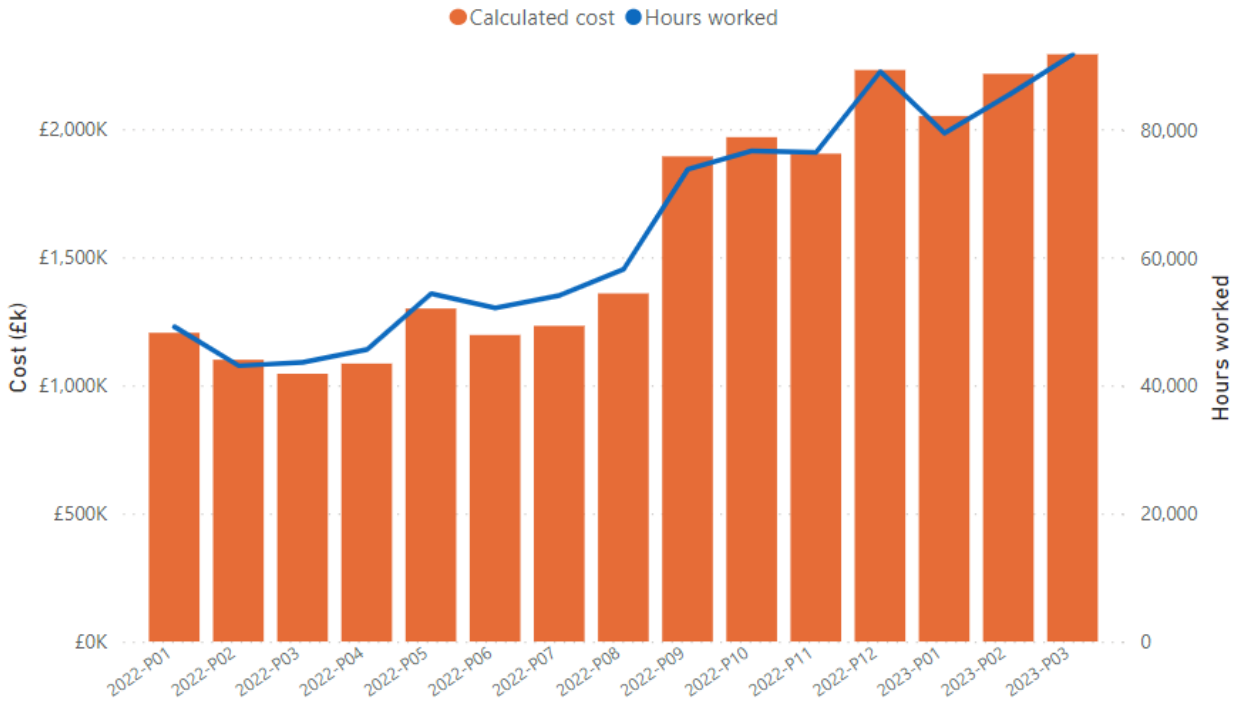
Enhanced Care by Hospital Site as a percentage of total bed capacity	
RGH	
Total no of Medicine beds	192
June's monthly average enh care patients	43
%age of beds in receipt of enh care	**22%**
NHH	
Total no of Medicine beds	164
June's monthly average enh care patients	59
%age of beds in receipt of enh care	**36%**
GUH	
Total no of Medicine beds	91
June's monthly average enh care patients	24
%age of beds in receipt of enh care	**26%**
YYF	
Total no of Medicine beds	148
June's monthly average enh care patients	63
%age of beds in receipt of enh care	**43%**

The following graph highlights the increase in hours attributed to enhanced care for the period April 2020 (P01-2021) to June 2022 (P03-2023) using bank and agency registered nurses and health care support workers.



The graph below describes the hours and costs relating to those booked to cover vacancies. The graph highlights that in June whilst enhanced care hours decreased this was off-set by increased costs for vacancies. Further analysis needs to be undertaken regarding any correlation and whether this is Division specific.

Vacancy calculated costs and hours booked



Non-Pay

Spend (excluding capital) was £79m in June which is at a similar rate to May, specific funded areas such as RIF decreased in June by £1m which was offset by increased in-month energy and facility costs compared with May. The in-month energy costs reflect the volatility in energy prices, which is regarded by Welsh Government as an exceptional cost pressure. Additional funding has been anticipated for this volatile cost pressure estimated as £16.1m and will continue to be adjusted in future months based on the latest data from NWSSP.

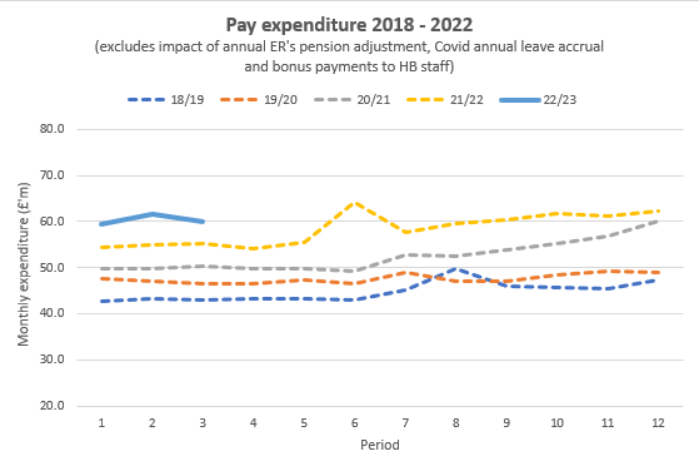
Other areas to note are:

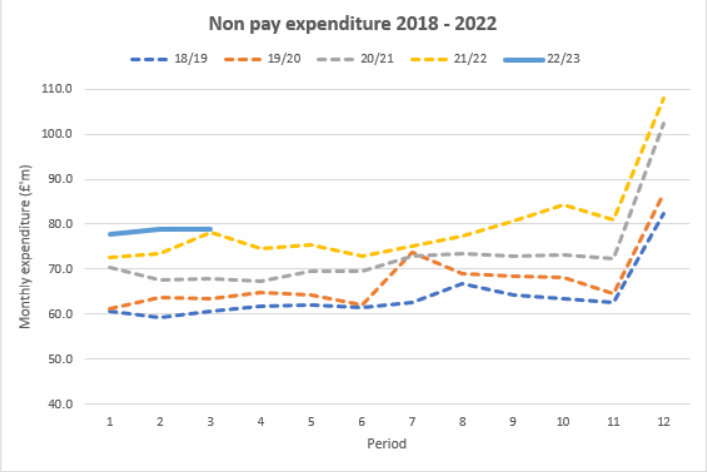
- CHC Mental Health – the current patient numbers at the end of June were 409 which is a net increase of 2 MH patients in month within high cost packages.
- CHC Adult / Complex Care - 678 active CHC and D2A placements (increase of 4 from May). There was an increase of 5 D2A patients, with a decrease of 2 placements on the 'Step Closer to Home' pathway (45 total) in June at a forecast cost of £0.9m for the financial year. The table below provides analysis of this:

Activity	May 2022	June 2022	Movement
D2A	65	70	+5
Step Closer to Home	47	45	-2
All Other CHC	562	563	+1
Total	674	678	+4

- FNC - currently 868 active placements, which is an increase of 15 from May.
- Primary Care medicines – the expenditure year to date is £26.3m. The June 2022 forecast is based on growth in items of 0.8% (using underlying growth estimate) with an average cost per item of £6.75, category M drugs prices continue to fluctuate but presents an in-month pressure for June/July prices. The pre Covid-19 baseline expenditure for prescribing assumed an average cost of closer to £6.50 per item presenting a financial pressure which requires mitigating actions and savings.

Pay and Non-Pay expenditure run-rates for the last four financial years are shown below to demonstrate the on-going step change in expenditure. If the service response to Covid-19 implications could be de-escalated it should result in cost reductions to some of the operational factors currently in place where funding is assumed.





Current operational forecasts based on March bed and activity plans, are assuming a similar level of spending to the end of the year. These assumptions will now be subject to detailed review as part of financial recovery 'turnaround' work to re-assess the 22/23 operational service, workforce and financial plans. These plans will inform a revised, service, workforce and financial forecast for ABHEALTH BOARD.

Service Pressures & Activity Performance

Bed Capacity

Additional medical beds have been opened as part of responding to the system pressures described previously. Additional capacity beds in Medicine were 73 in June as described in the table below:

No. of Additional Beds							
Site	**Ward**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**	**Description**
RGH	B3 Winter Ward	27	26	0	0	0	26 Additional Capacity
	C6E Med Additional Capacity from Oct			0	30	28	Old Resp Ward converted to Add Cap
	Other wards				6	0	
NHH	3rd Floor	11	9	7	8	11	32 (flexed up from 28)
	4th Floor	3	2	6	7	9	28 (flexed up from 30)
	4/1 winter	27	28	0	0	0	Winter ward from 27th Dec (flexed up from 28)
GUH	C4	2	2	0	0	0	2 Covid beds in March
	B4			8	8	8	
	A4	2	2	1	1	1	Using Ringfenced beds
	Fox Pod			8	8	8	
RGH AMU	D1W	12	0	18	0	8	Empty from 14/06/22
Sub-total Medicine		**155**	**119.5**	**48**	**68**	**73**	
STW	Ruperra	24	24	24	24	24	
	Holly	10	10	10	10	10	
YAB	Tyleri	15	11	11	15	15	
Sub-total Community		49	45	45	49	49	
Total		**204**	**164.5**	**93**	**117**	**122**	

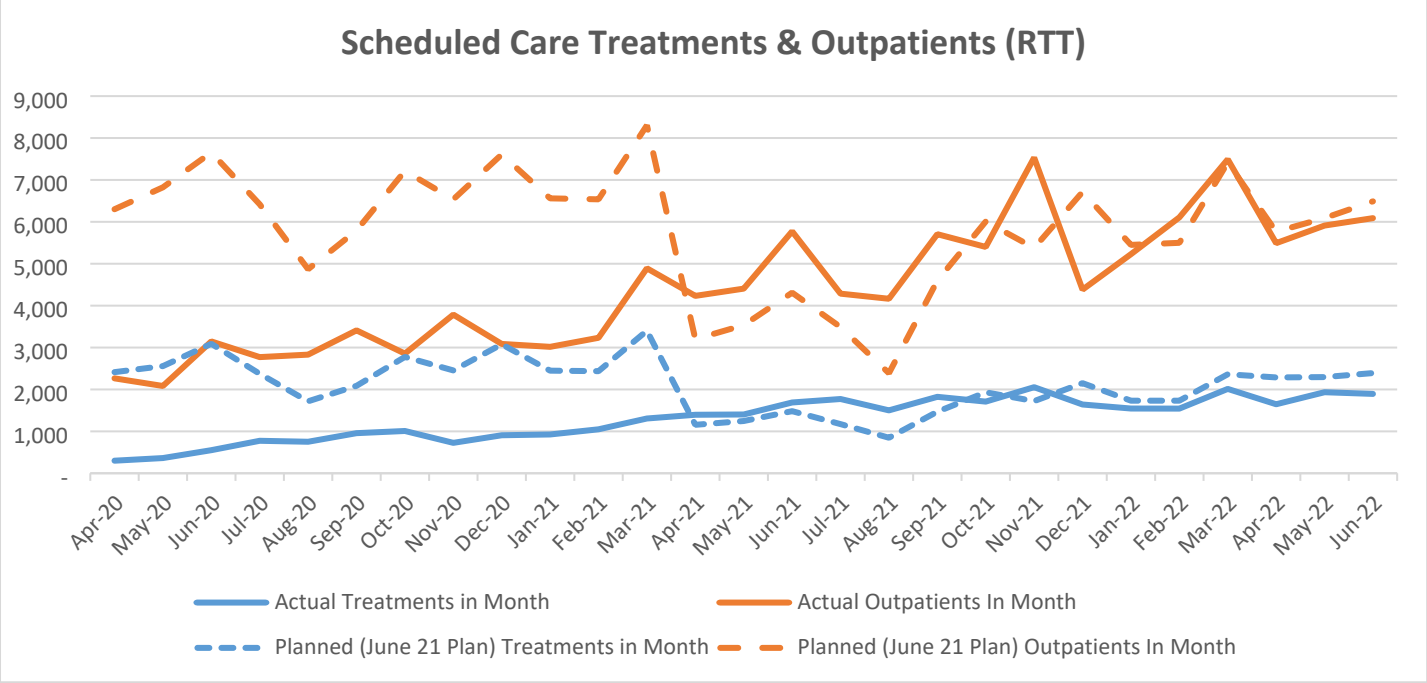
It should be noted that Holly ward is the "Step Closer to Home" ward and many of these beds are expected to transfer to a nursing home in the summer. Cost implications are expected to be managed through RPB arrangements.

The number of medically fit and delayed transfers of care remain at significant levels and total in excess of 300 patients as at the end of June. Approximately 30% of these patients relate to social care delays. These patients are across multiple sites and are generally within the Medicine specialities. These delays affect flow and the level of additional capacity across the HEALTH BOARD resulting in significant additional costs. The level of which were not factored into the IMTP for 2022/23. Further discharge support solutions have been implemented to mitigate the flow pressures and continue to increase the financial pressure for the Health Board.

Scheduled Care treatments and outpatients

Elective activity has increased in June compared to April & May but remains below planned levels (year to date 497 treatments under plan), activity remains below plan due to a range of operational reasons including specific vacancies, reduced theatre utilisation and a low uptake to provide additional sessions. Outpatient activity is also below plan (year to date 401 appointments under plan), virtual clinics are being used as well as review clinic templates to increase activity. Whilst most routine elective services have resumed, elective activity remains lower than pre-Covid-19 levels.

Activity plans are finalised linked to demand and capacity plans triangulated with service, workforce and financial affordability, however, these are being reviewed.



- Elective Treatments for June '22 was 1,894 (May '22 was 1,934).
- Outpatient appointments for June '22 was 6,088 (May '22 was 5,911).

Medicine Outpatient Activity

Medicine Outpatient activity for June '22 was 1,372 attendances (2021/22 activity 15,581 a monthly average of 1,298) this is presented by specialty below:

Jun-22

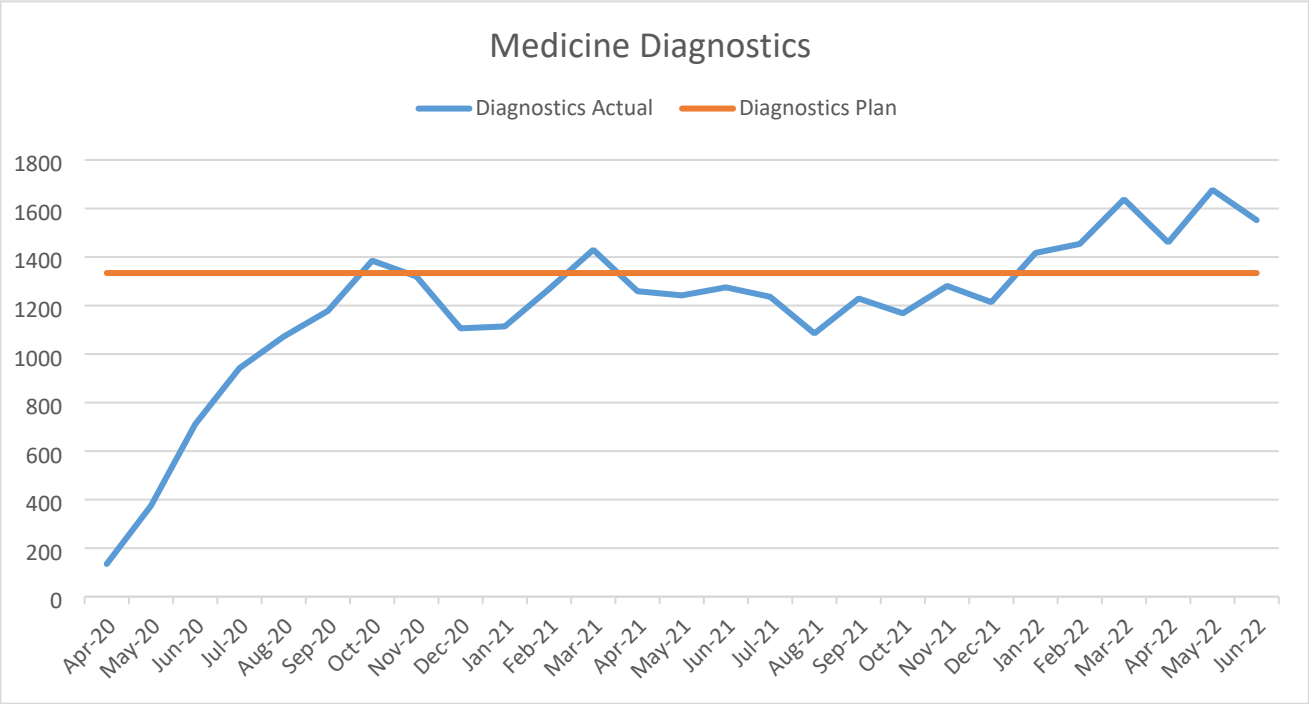
YTD June-22	Assumed monthly activity	Actual activity	Variance	Variance
Gastroenterology	1530	627	-903	59%
Cardiology	1659	836	-823	50%
Respiratory (inc Sleep)	1818	906	-912	50%
Neurology	777	630	-147	19%
Endocrinology	726	425	-301	41%
Geriatric Medicine	693	507	-186	27%
Total	**7203**	**3931**	**-3272**	**45%**

A year-to-date underperformance of 45% is presented.

Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for June '22 was 1,552 procedures which is 218 cases more than plan.

The activity undertaken since April '20 is shown below;



Covid-19 – Revenue Financial Assessment

Total Covid-19 costs are shown as c.£76m and at this stage the Health Board is including matched funding, these are full year forecasts unless otherwise stated:

- Testing - £6.5m. It should be noted that the WG policy lead has indicated that only £4m will be available for testing in 22/23, the current forecast is £6.5m, the Director of Therapies is in discussions with WG regarding the level of funding and forecast. This includes Testing Team and Pathology department costs.
- Tracing - £6m
- Mass Vaccination - £9m
- PPE - £3.7m
- Cleaning standards - £2.5m
- Long Covid - £0.9m
- Nosocomial investigation - £0.8m, and
- Other additional Covid-19 costs (now including dental income target reduction) - £45.6m.

The Health Board is reporting costs for additional capacity and maintaining Covid-19 safe and compliant operational service delivery across all sites, as part of the other additional Covid-19 costs section.

The cost impact of responding to Covid-19 and emergency system pressures along with increased patient acuity will be closely monitored and the implications for Q2 to Q4 will continue to be reviewed and appropriately reflected in future months reports.

Though a higher cost, the assumptions are in line with those used for the submitted IMTP, correspondence from WG and the IMTP financial assumptions letter sent in March 2022. In addition, forecast costs have decreased for discharge support, facilities and enhanced cleaning, this is linked to revised workforce plans for later in the financial year. On-going review of the local schemes will be required to ensure forecasts and classifications remain in line with the assumptions described.

The Health Board is not including costs for Velindre Trust Covid-19 (recovery or outsourcing) within these figures, in line with the All Wales LTA agreement.

Type	Covid-19 Specific allocations - June 2022	£'000
HCHS	Testing (inc Community Testing)	6,508
HCHS	Tracing	6,000
HCHS	Mass COVID-19 Vaccination	9,000
HCHS	PPE	3,654
HCHS	Cleaning standards	2,491
HCHS	Extended flu	1,517
HCHS	Long Covid	887
HCHS	A2. Increased bed capacity specifically related to C-19	9,971
HCHS	A3. Other capacity & facilities costs	7,174
HCHS	B1. Prescribing charges directly related to COVID symptoms	280
HCHS	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	15,043
HCHS	D1. Discharge Support	8,685
HCHS	D4. Support for National Programmes through Shared Service	0
HCHS	D5. Other Services that support the ongoing COVID response	2,131
Dental	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS income	2,308
HCHS	Nosocomial investigation and learning	753
	Total Covid-19 Allocations (anticipated)	**76,402**

Exceptional Cost Pressures

The exceptional cost pressures recognised by Welsh Government for 22/23 includes energy prices, employers NI and the Real living wage costs for social care contracts. It has been agreed that these be managed with WG on a collective basis with funding assumed to cover costs, albeit the funding is not confirmed. The Health Board still has a duty to mitigate these costs within its financial plan to reduce the collective risk. Real living wage costs only relate to CHC, the agenda for change element will receive an allocation in line with wage award funding once confirmed. It should be noted that increased energy costs are based on forecasts provided by NWSSP adjusted for any local information.

Type	Exceptional items allocations - June 2022	£'000
HCHS	Energy prices increase	16,100
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,154
	Total Exceptional items allocations (anticipated)	**22,860**

Budget Setting / Delegation
In line with Health Board SFI's budget delegation letters have been sent to Executive Directors, these clearly set out the expectations regarding managing within the delegated budget levels.

Executive Directors are expected to issue delegation letters to Deputies and Divisional Directors, stating the level of budget and the expectations associated with managing that budget. This should be cascaded to all budget holders.

A budget delegation paper for quarter 2 budgets including adjustments for Covid-19 and exceptional items will be presented to July's Board for consideration, with a quarterly review thereafter.

- **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 per the Board Budget Setting paper have been actioned, however, some funding allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific purpose.

The following reserves, relating to WG Funding, were approved for delegation by the CEO in Month 3.

£1,517k Extended Flu – anticipate additional funding and delegate to Primary Care / F&T	£101k Outpatient Treatment Centre (Q1&2) – anticipate additional funding and delegate to Scheduled Care
£132k IT costs – recover budget from Corporate Divisions to reserves	£69k - VERS delegation to Workforce & OD
£10k TEC Cymru Dementia – delegation to Informatics	£130k Primary Care Improvement grants – delegation to Primary Care (GMS)
£445k – Dementia Action Plan funding - delegation to Gwent RPB (Chief Exec)	£511k Junior Doctors - delegation to relevant Divisions in line with posts

Long Term Agreements (LTA's)

LTA agreements have now been signed with all Welsh providers/commissioners in accordance with the DOF LTA Financial Framework for 2022-23. However, forecasting with any certainty is difficult at this stage with only limited 2022-23 data available.

Initial performance data shows variation from baseline levels (both under and over performance) depending on the provider / commissioner. Further work is ongoing to understand this variation and to understand the financial risk opportunities that may crystallise in future.

Underlying Financial Position (ULP)

The Underlying (U/L) forecast position is a brought forward value of £21m.

Financial sustainability is an on-going priority and focus for the Health Board.

The IMTP forecasts an improved closing 2022/23 underlying deficit of £8.1m. This is now at risk given the challenges of 22/23.

This is based on the current assessment of available recurrent funding, savings and the recurrent financial impact of existing service and workforce commitments. It continues to exclude any potential recurrent impact of Covid-19 decisions or 2022/23 operational pressures outside of the IMTP.

The Health Board's 2022-25 IMTP identifies several key priorities where the application of Value-Based Health Care principles – improving patient outcomes along with better use of resources – should result in delivering greater service, workforce and financial sustainability whilst improving the health of the population. The actions being taken to improve financial sustainability are integral to this approach.

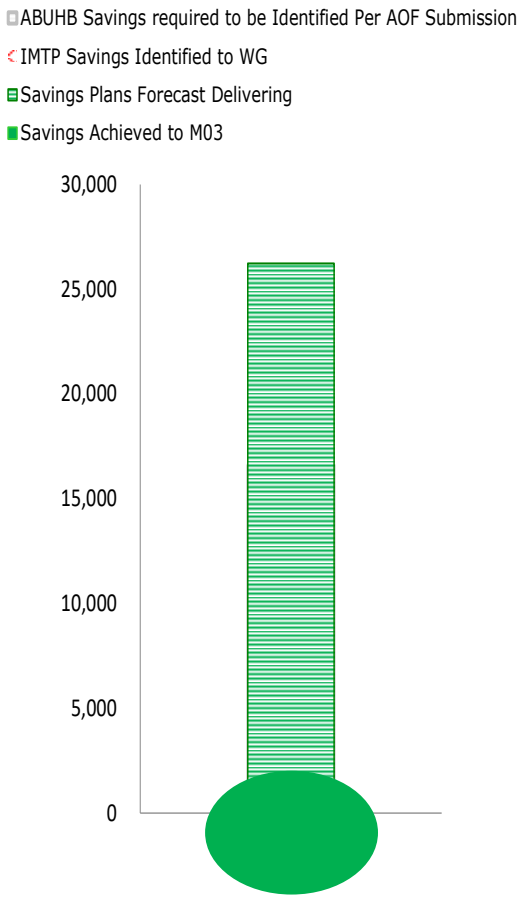
The Board approved approach to the refreshed 22/23 IMTP financial plan is to focus on making previous investment decisions sustainable before new investments are committed to. The WG allocation funding 22/23 provided the Health Board with the opportunity to help address its historic underlying financial position and prioritise current challenges and commitments as part of the 2022/23 IMTP.

Health Board savings schemes for 2022/23 need to be implemented in full and on a recurrent basis both to manage future cost pressures and reduce the underlying deficit. This position is assumed at present but will require constant management and implementation of new schemes to mitigate new cost pressures and manage risks as they arise.

Savings delivery

As part of the IMTP submitted by the Board to Welsh Government (March 2022), the financial plan for 2022/23 identifies a core savings requirement of £26.2m and cost mitigation of £19m. As at Month 3 forecast savings achievement in 22/23 is £26.2m however this includes an **extreme level of on-going risk to ensure full delivery** of savings and cost avoidance from opportunities identified.

Actual savings delivered to June amounted to £1.32m, compared with month 3 planned delivery of £1.0m. The profile of savings expected to be achieved is significantly increased in later months.



Month 3 Forecast Savings Plans

	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
Medicines Management (Primary and Secondary Care)	3,214	0	3,214	3,332
Pay	10,000	388	9,612	9,797
Non Pay	13,024	7,956	5,068	4,973
Total	**26,238**	**8,344**	**17,894**	**18,102**

Month 2 Forecast Savings Plans

	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
Medicines Management (Primary and Secondary Care)	3,233	0	3,233	3,332
Pay	9,916	213	9,703	9,715
Non Pay	13,089	8,021	5,068	5,055
Total	**26,238**	**8,234**	**18,004**	**18,102**

Further scheme detail is provided in the appendices

Forecast savings by Division and RAG rating are shown below:-

		Forecast Savings												
Category	IMTP & Green/Amber (as at Month 3)	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Complex Care	IMTP													0
	Green													0
	Amber	-	-	-	-	-	-	-	-	-	83	83	84	250
Medicine	IMTP	42	42	42	251	251	251	251	251	251	251	251	251	2,388
	Green	8	12	18	9	9	9	9	9	9	9	8	8	112
	Amber	-	-	-	6	10	12	12	12	12	212	213	213	702
Urgent Care	IMTP	-	-	-	102	102	102	102	102	102	102	102	102	915
	Green	6	8	10	8	8	8	8	8	8	8	8	8	95
	Amber	-	-	-	102	102	102	102	102	102	102	102	102	915
Scheduled Care	IMTP	48	175	175	1,305	1,305	1,305	1,305	1,305	1,305	1,305	1,305	1,305	12,144
	Green	166	192	122	122	122	122	123	123	123	123	123	123	1,585
	Amber	-	-	-	371	371	371	371	371	371	2,986	2,986	2,984	11,178
Primary Care and Community	IMTP	54	54	54	54	54	54	54	54	54	54	54	54	646
	Green	219	150	192	202	228	236	242	249	252	251	263	271	2,755
	Amber													0
Mental Health and Learning Disabilities	IMTP	32	32	32	32	32	32	32	32	32	32	32	32	378
	Green	-	-				54	54	54	54	54	54	54	378
	Amber													0
Family & Therapies	IMTP	25	25	25	125	125	125	125	125	125	125	125	125	1,202
	Green	25	25	25	25	25	25	25	25	25	25	25	25	300
	Amber	-	-	-	28	28	28	28	28	28	245	245	246	902
Estates and Facilities	IMTP	29	29	29	84	84	84	101	101	101	101	101	101	947
	Green	29	29	29	29	29	29	29	29	29	29	29	29	347
	Amber	-	-	-	26	26	26	42	42	42	131	131	132	600
Corporate	IMTP	18	18	18	245	245	245	888	888	888	888	888	888	6,118
	Green	18	18	18	18	18	18	18	18	18	18	18	18	214
	Amber	-	-	-	-	-	-	-	-	-	1,968	1,968	1,968	5,904
Commissioning	IMTP				167	167	167	167	167	167	167	167	167	1,500
	Green													0
	Amber													0
Total	IMTP	247	374	374	2,365	2,365	2,365	3,025	3,025	3,025	3,025	3,025	3,025	26,238
	Green	471	434	414	413	438	501	507	515	517	516	527	535	5,787
	Amber	-	-	-	532	536	538	554	554	554	5,727	5,728	5,729	20,451

Green schemes are assumed to be fully deliverable. Amber schemes require either progression or equivalent alternative plans as soon as possible to mitigate this risk. The schemes remain amber, despite the WG requirement to classify schemes as green (deliverable) or red (not achievable) by the end of quarter 1 (M3). The Health Board Executive has agreed with WG the definitive savings position and forecast will be established for month 4 reporting, allowing for consideration of options by the Board.

Savings by WG monitoring return (MMR) and general category are shown as per the table below:-

Category	Category	Forecast Green	Amber	Total
Medicines Management	Prescribing	2,200		2,200
	Scheduled Care rationalisation	70		70
	Scheduled Care Lenaliomide	944		944
Pay	Variable pay - sickness / overseas & medical agency	2,573	-	2,573
	CHC - agency mitigation	-	250	250
	MSK	-	250	250
	All others	-	6,927	6,927
Non-pay	Corporate / CHC review		3,657	3,657
	NR opps		2,047	2,047
	Facilities related		600	600
	Theatres		4,368	4,368
	Other non-pay / schemes		2,352	2,352
Total		**5,787**	**20,451**	**26,238**

Savings classified as amber must be re-classified as green or red at month 3 reporting, the impact of not finalising plans to achieve these savings will mean a deficit is forecast. To achieve a balanced core financial plan, the Health Board needs to ensure that savings plans are achieved in line with IMTP. In addition, further cost avoidance plans are required to ensure that any other financial pressures are mitigated. The IMTP narrative notes potential risks that require mitigation either through additional savings plans or other solutions. These risks are emerging and are causing difficulties in transforming the opportunities to green savings plans.

Savings schemes straddle transformational, transactional, and operational plans. Aligned to progressing the savings and mitigating actions a value focussed pathway approach is being employed. The Health Board has agreed ten priority areas for focussed support using a programme management approach with MDT support through an Executive lead, value, performance, workforce, service, planning and finance representation. These now need to be accelerated.

In addition, further programmes have been added given the difficulty in obtaining 'traction' to progress these opportunities. Variable Pay, CHC, Procurement/Non-pay and Medicines Management programmes will need to drive savings delivery during 2022/23.

These programmes of work will identify potential options and actions for reducing costs and assess patient performance, and financial impact. An organisational re-assessment of priorities and forecast service demand will be undertaken and considered by the Executive and the Board before finalising the re-profiled plan which will include these savings plans.

The Value Based Health Care team as part of the "AB Connect" forum are working across programmes and divisions to support service improvement and outcomes capture. National schemes are being developed and the Health Board will be participating fully with these programmes.

Furthermore, the Health Board will continue to identify and implement transactional and operational savings including the reduction in agency spend, to leverage the benefits of digital investment and will fully utilise the ABHEALTH BOARD opportunities compendium and other sources where appropriate.

The Health Board will continue to pursue all available operational and transactional savings however this alone will no longer achieve the savings target.

To deliver greater levels of savings and to achieve better use of resources, which improves health outcomes – and doesn't adversely impact on safety and quality – a greater focus is required on savings and efficiency improvement related to:

- Eliminating unwarranted clinical variation
- Transformational service change
- Reducing waste

It is important to note at present that a number of Divisions are pursuing savings plans internally to mitigate local cost and underlying pressures.

The Executive have implemented an internal financial recovery 'turnaround' approach to accelerate financial cost reduction for 2022/23, this is a standing item at Executive Team meetings and reports will be provided through the FPC and to the Board.

Forecast

The Health Board is required to submit a forecast position to the WG on the fifth working day of each month, for month 2 and now at 3 this forecast was withheld until the monitoring returns are submitted on working day 9. This was to allow further discussions with senior leaders and executives in the organisation to deliberate the potential to manage the growing in-year deficit and to consider what actions are required to deliver financial balance.

The Health Board preferred approach to financial balance is to improve efficiency and sustainability through the agreed IMTP priority programmes. Current operational and service pressures are continuing to drive additional expenditure above IMTP planned levels and are affecting the level of savings achievement required. In response a financial recovery 'turnaround' approach has been implemented and options to significantly improve the emerging risk to financial balance will be discussed with the Board. Welsh Government will expect a definitive forecast to be established and agreed by the Board as part of month 4 reporting.

Without changes being agreed and actioned, at pace, the Health Board may not be able to sustain and justify continuing to report a break-even position.

2022/23 IMTP revenue plan profile

The in month expected variance profile as submitted as part of the IMTP for 2022/23 is presented below:

£m Deficit (Surplus)	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total Year End Position
Forecast Monthly Position	1.67	1.27	1.01	- 0.39	- 0.39	- 0.39	- 0.45	- 0.45	- 0.45	- 0.45	- 0.45	- 0.52	0.00

This profile has now been updated for month three to reflect slippage in savings and cost reduction delivery profiles and is now shown as follows in the table below:-

£m deficit (surplus)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position
Revised forecast position	1.673	3.211	3.481	2.900	2.789	2.639	0.150	(0.087)	(0.172)	(5.406)	(5.510)	(5.668)	**(0)**

Risks & Opportunities (2022/23)

There are serious, immediate and significant risks to managing the 2022/23 financial position, which include:

- Ensuring full delivery of the savings plans identified in the IMTP
- Identifying savings to mitigate any further financial risks identified outside of the IMTP,
- Quarter 2-4 additional Covid cost pressures (c.£8m),
- Workforce absence / self-isolation / vacancies, availability of staff for priority areas,
- Responding to any specific Covid-19 impacts e.g., new variants, outbreaks,
- Continued or increased delayed discharges of care / medically fit patients in hospital beds including delays in social services and packages of care,
- Unconfirmed levels of funding for exceptional cost pressures and the local covid responses, that the Health Board is currently assuming (c.£99m),
- Additional discharge support costs and pressure (c.£2m),
- Implications of social care and delayed discharges (c.£8m),
- Additional operational pressures including increased managed practice, prescribing and nurse vacancy cover,
- Funding for any wage award or change in terms and conditions,
- Responding to the ongoing impact of Covid-19 and associated preventative and Public Health services,
- Addressing backlogs in waiting times for services, due to the Covid-19 pandemic,
- Specific economic factors/Ukraine conflict issues such as energy costs, supply chain issues and non-pay inflation including travel expense costs, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.
- IFRS16 - implementation of IFRS16 (lease accounting) in NHS Wales will go live in April 2022. The Board assumes that any revenue or capital resource implications of implementation will be managed by Welsh Government, with no financial impact to Health Boards or Trusts across Wales.

The table below presents the risks reported to Welsh Government for month 3:

Risk narrative	Likelihood	£'000
Under delivery of Amber Schemes included in Outturn via Tracker	High	20,451
Operational pressures requiring mitigation actions	High	19,000
Additional Covid costs q2 -q4 not assumed in covid response	High	8,000
Funding for exceptional cost pressures	High	22,860
Funding for local Covid response	High	48,083
Funding for National Covid response	Low	28,319
Employment Appeal Tribunal arrears (Q1 only)	High	233
Total		**146,946**

To note that the employment appeal tribunal arrears are estimated for quarter one only, clarification is being sought as to whether there are any additional WG allocations for this payment linked to holiday pay on overtime.

Managing the financial risk is dependent on developing service and workforce plans that are sustainable during 2022/23 and in the future. Current forecasts reflect current

service intelligence and intended delivery plans. These operational assumptions will be reviewed to inform revised forecasts for 2022/23.

Capital

The approved Capital Resource Limit (CRL) as at Month 3 totals £49.107m. The current forecast outturn is breakeven.

The works to the Same Day Emergency Care Unit, Resus, CEAU and Grange House are progressing from the remaining Grange University Hospital funding. All Laing O'Rourke works are due to complete by the middle of September. The tender for the Well-being works to Grange House is due back in July. The additional works costs are being offset by the final VAT recovery claim (£3.5m) due in the last quarter of 2022/23 resulting in a credit budget allocation of £394k. The Health Board's VAT advisors are currently working with HMRC and the external cost advisors to expedite the VAT recovery claim and mitigate the risk that an agreement is not reached in the current financial year.

The YYF Breast Centralisation Unit scheme is currently delayed due to contractual issues with the main contractor (inflationary pressures). The issues are being worked through with the external cost advisors and NWSSP-Estates to allow the scheme to progress.

The works at Tredegar H&WBC are continuing. The handover of the building is now expected to be delayed to April 2023 as the original brick order for the façade has been cancelled by the supplier due to supply issues. A revised cashflow has been requested from the contractor as expenditure is £1.1m behind the original 22/23 profile.

The Newport East Health and Well-being Centre site set up works have commenced and works to replace the Multi Use Games Area are starting w/c 4th July.

Final approval and funding have been received for the Endoscopy Unit at RGH. The contractor has been appointed and works are due to commence on site 18th July.

The FBC for the NHH Satellite Radiotherapy Centre has concluded and has been submitted to WG for approval. The Outline Business Case for the Mental Health SISU is on-going and expected to be submitted to Board for approval in Quarter 2.

The second year of the National Imaging Programme funding totals £4.7m for ABHEALTH BOARD. The spend in the current year includes the replacement of two CT Scanners (NHH / RGH) and the installation of three general rooms.
The Health Board Discretionary Capital Programme (DCP) allocation for 2022/23 is £8.227m (a reduction of 24% compared to 2021/22). Final All Wales Capital Programme scheme brokerage for 2021/22 slippage was £1.859m, leaving a balance of £6.638m to address spend in the current financial year.

During June, the RGH Endoscopy AWCP scheme was approved, enabling a reimbursement of £207k to the Discretionary budget for fees that had been incurred prior to approval. New schemes totalling £903k were also released in relation to essential works schemes and the replacement of critical IT and equipment. The unallocated contingency budget as at the end of June is £576k.

Cash

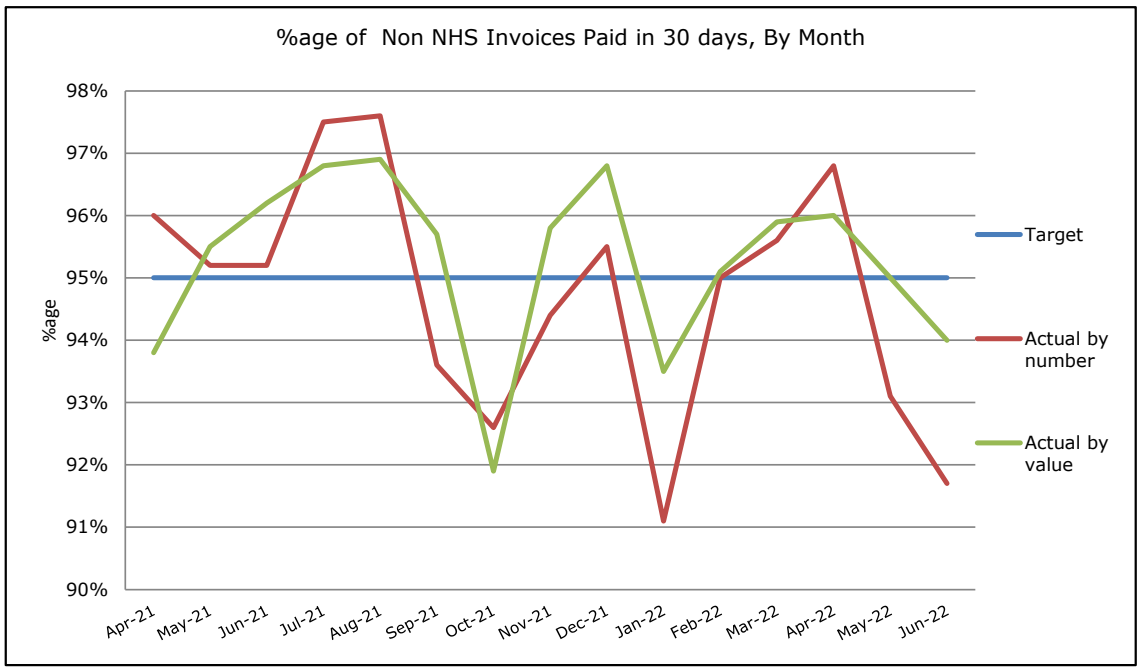
The cash balance on the 30th of June is £3.641m, which is within the advisory figure set by Welsh Government of £6m.

PSPP

The HB has not achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in May or cumulatively. A large number of the invoices paid outside of the target relate to Pharmacy and Agency staffing.

The Corporate Finance senior team are working with the Resource Bank management to manage the volume of invoices that they are processing on a daily basis, and to help improve payment processing times. A new process has been agreed, alongside Internal Audit, to clear the significant back-log of invoices that the resource bank team have, which have caused issues in recent months. Processing these invoices however will have a short-term impact on the PSPP figures, due to their age and the volume of invoices to process.

There are also a significant volume of current invoices to process, with two new members of staff expected to help improve processing times. The Resource Bank team are working with the Nursing Director and the Divisions on Agency reduction, with the aim to reduce the reliance on Agency staff and in turn reduce the volume of invoices currently being received.



Recommendation

The Board is asked to note:

- The financial performance at the end of June 2022 and forecast position – against the statutory revenue and capital resource limits,
- The savings position for 2022/23,
- The 2022/23 forecast,
- The significant level of risk to the financial position,
- The revenue reserve position on the 30th of June 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy, and

Appendices
 ABUHB%20Finance %20board%20report

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks of achieving the Health Board's statutory financial duties and other financial targets are detailed within this paper.
Financial Assessment, including Value for Money	This paper provides details of the year to date and forecast financial position of the Health Board for the 2022/23 financial year.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its AOF/IMTP priorities and opportunities to improve efficiency and effectiveness.
Equality and Diversity Impact Assessment (including child impact assessment)	The Assessment forms part of the AOF service plan.
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the financial position that supports the Health Board's 3 year plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Long-term financial linked to IMTP completion **Integration –** Regional partnership and integration with other NHS Wales organisations **Involvement –** use of environmental fund and specific investment as well as on-going links with services for engagement **Collaboration** – collaboration with external partners **Prevention** – long-term strategy to provide investment and savings through preventative measures across the HEALTH BOARD. The Health Board Financial Plan has been developed based on the approved AOF/IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	See Below
Public Interest	Circulated to board members and available as a public document.

Glossary

A		
A&C – Administration & Clerical	A&E – Accident & Emergency	A4C - Agenda for Change
AME – (WG) Annually Managed Expenditure	AQF – Annual Quality Framework	AWCP – All Wales Capital Programme
AP – Accounts Payable	AOF – Annual Operating Framework	ATMP – Advanced Therapeutic Medicinal Products
B		
B/F – Brought Forward	BH – Bank Holiday	
C		
C&V – Cardiff and Vale	CAMHS – Child & Adolescent Mental Health Services	CCG – Clinical Commissioning Group
C/F – Carried Forward	CHC – Continuing Health Care	Commissioned Services – Services purchased external to ABHEALTH BOARD 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	
D		
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
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	eLGH – Enhanced Local general Hospital
ENT – Ear, Nose and Throat specialty	EoY – End of Year	ETTF – Enabling Through Technology Fund
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		

GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital	GIRFT – Getting it Right First Time	
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus
HSDU – Hospital Sterilisation and Disinfection Unit	H&WBC – Health and Well-Being Centre	
I	IMTP – Integrated Medium Term Plan	INNU – Interventions not normally undertaken
IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure	ICF – Integrated Care Fund
L		
LoS – Length of Stay	LTA – Long Term Agreement	LD – Learning Disabilities
M		
MH **–** Mental Health	MSK - Musculoskeletal	Med – Medicine (Division)
MCA – Mental Capacity Act	MDT – Multi-disciplinary Team	
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre	OD – Organisation Development	
P		
PAR – Prescribing Audit Report	PCN – Primary Care Networks (Primary Care Division)	PER – Prescribing Incentive Scheme
PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis	PSNC –Pharmaceutical Services Negotiating Committee
PSPP – Public Sector Payment Policy	PCR – Patient Charges Revenue	PPE – Personal Protective Equipment
PFI – Private Finance Initiative		
R		

RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit
RTT – Referral to Treatment	RPB – Regional Partnership Board	RIF – Regional Integration Fund
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	TAG – Technical Accounting Group
U		
HEALTH BOARD / HB – University Health Board / Health Board	USC – Unscheduled Care (Division)	UC – Urgent Care (Division)
ULP – Underlying Financial Position		
V		
VCCC – Velindre Cancer Care Centre	VERS – Voluntary Early Release Scheme	
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	YYF – Ysbyty Ystrad Fawr

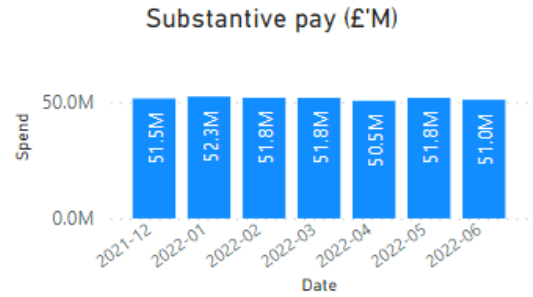
Aneurin Bevan University Health Board

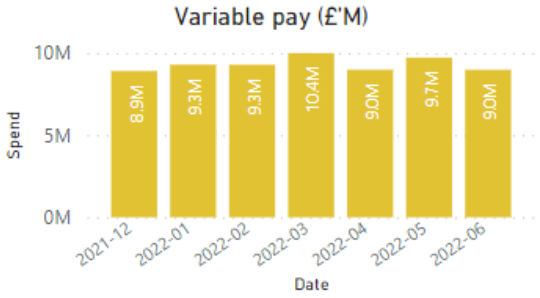
Finance Report – June (Month 3) 2022/23

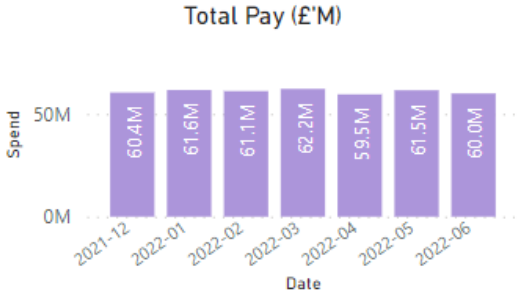
Appendices

Section	Page Number(s)
Pay Summary 1	2
Pay Summary 2 Substantive Pay	3
Pay Summary 3 Variable Pay	4
Non Pay Summary	5
RTT & Waiting List Initiatives	6-8
Covid-19 Funding Assumptions & Delegation	9
Savings	10
Reserves	11
Cash / Public Sector Payment Policy	12
External Contracts – LTA's	13
External Contracts – Specialised Services	14
Balance Sheet	15
Health Board Income	16
Capital Planning & Performance	17-18

Pay Summary (1) (subject to change excluding annual leave and Pension employer costs):







Substantive (£'000)

Pay category	22-P09	22-P10	22-P11	22-P12	23-P01	23-P02	23-P03	Change	%	Avg 21/22
ADD PROF SCIENTIFIC AND TECHNICAL	2,253	2,258	2,497	2,267	1,916	1,939	1,909	-30	-1.6%	2,219
ADDITIONAL CLINICAL SERVICES	6,616	6,922	6,595	6,486	6,352	6,693	6,504	-189	-2.8%	6,550
ADMINISTRATIVE & CLERICAL	8,342	8,948	8,747	8,597	8,593	8,655	8,710	55	0.6%	8,262
ALLIED HEALTH PROFESSIONALS	3,287	3,284	3,350	3,311	3,558	3,630	3,542	-87	-2.4%	3,249
ESTATES AND ANCILLIARY	2,600	2,805	2,631	2,758	2,529	2,704	2,520	-184	-6.8%	2,611
HEALTHCARE SCIENTISTS	972	975	961	1,011	977	1,000	996	-4	-0.4%	996
MEDICAL AND DENTAL	11,866	11,801	11,879	12,910	12,059	12,146	12,087	-59	-0.5%	11,744
NURSING AND MIDWIFERY REGISTERED	15,538	15,329	15,143	14,426	14,523	15,008	14,695	-313	-2.1%	15,021
STUDENTS	2	2	3	6	6	6	9	3	48.8%	3
Total	**51,478**	**52,324**	**51,805**	**51,771**	**50,512**	**51,781**	**50,972**	**-809**	**-1.6%**	**50,655**

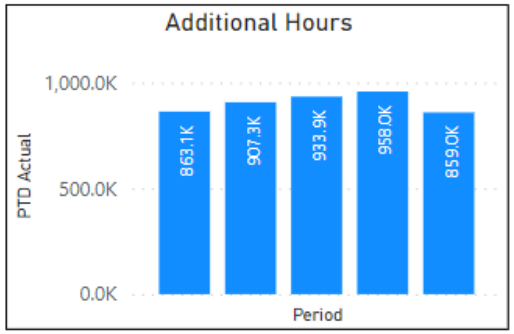
Variable pay (£'000)

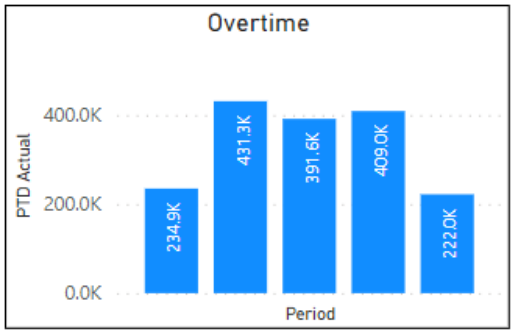
Pay category	22-P09	22-P10	22-P11	22-P12	23-P01	23-P02	23-P03	Change	%	Avg 21/22
Agency	5,594	5,711	5,395	5,958	5,301	5,968	5,384	-583	-9.8%	4,774
Bank	3,155	3,359	3,667	4,203	3,458	3,512	3,304	-209	-5.9%	2,812
Locum	158	221	227	229	226	238	294	56	23.6%	152
Total	**8,907**	**9,292**	**9,289**	**10,389**	**8,986**	**9,718**	**8,982**	**-736**	**-7.6%**	**7,738**

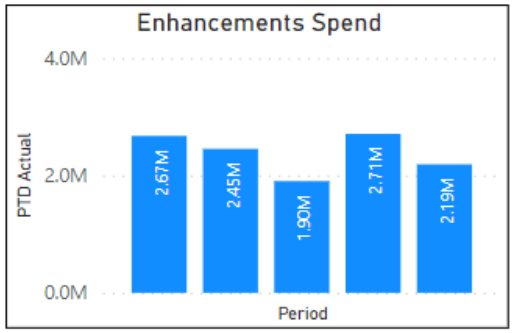
Total pay (£'000)

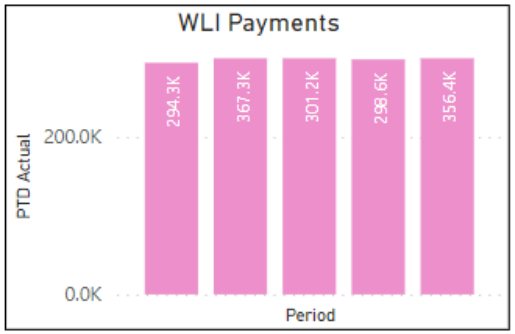
Pay category	22-P09	22-P10	22-P11	22-P12	23-P01	23-P02	23-P03	Change	%	Avg 21/22
Pay	60,385	61,616	61,093	62,160	59,498	61,499	59,955	-1,545	-2.5%	58,392

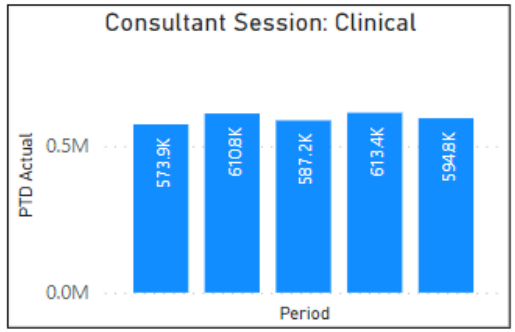
Pay Summary (2): Substantive Pay

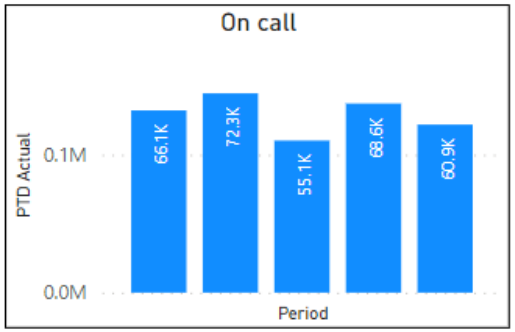










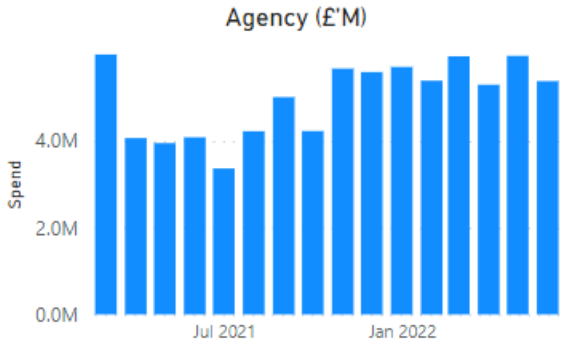


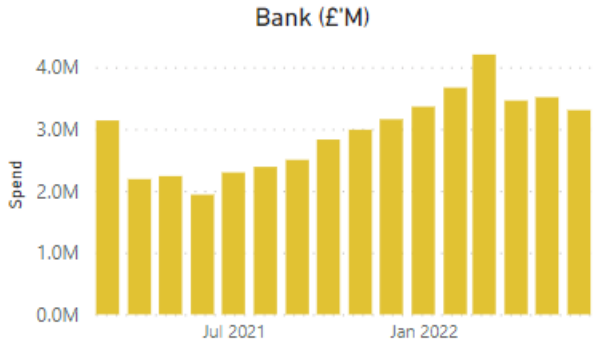
Analysis type by Division

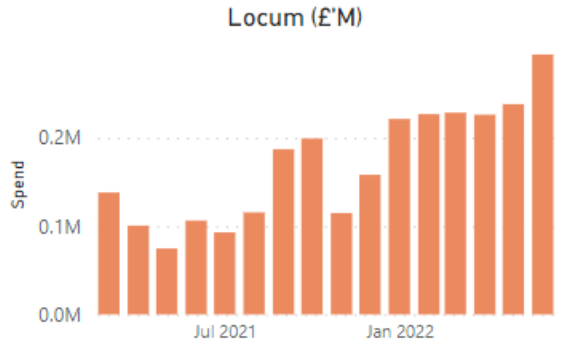
Analysis type	22-P11	22-P12	23-P01	23-P02	23-P03	Total
Enhancements						
Scheduled Care	511	491	373	525	425	**2,325**
Medicine	425	386	294	415	339	**1,859**
Estates and Facilities	381	358	284	396	303	**1,722**
Primary Care & Community	369	303	244	360	302	**1,578**
Family & Therapies	321	319	247	338	278	**1,503**
Mental Health	226	203	156	242	195	**1,023**
Urgent Care	225	190	152	213	171	**951**
CHC/FNC	116	111	82	117	94	**520**
Corporate	100	92	72	103	82	**450**
Total	**2,674**	**2,454**	**1,903**	**2,709**	**2,189**	**11,930**
ADDITIONAL HOURS						
Scheduled Care	273	376	306	351	422	**1,727**
Medicine	237	223	294	273	180	**1,207**
Urgent Care	196	150	216	256	195	**1,013**
Family & Therapies	138	133	121	51	38	**481**
Primary Care & Community	7	16	3	15	14	**55**
Mental Health	6	2	8	11	7	**33**
Corporate	6	7	-14	2	3	**5**
Total	**863**	**907**	**934**	**958**	**859**	**4,521**
CONSULTANTS SESSION: CLINICAL	**574**	**611**	**587**	**613**	**595**	**2,980**
Overtime	**235**	**431**	**392**	**409**	**222**	**1,689**
WAITING LIST PAYMENTS: CONSULTANTS	**294**	**367**	**301**	**299**	**356**	**1,618**
ON CALL	**66**	**72**	**55**	**69**	**61**	**323**
Total	**4,706**	**4,843**	**4,172**	**5,056**	**4,283**	**23,061**

Pay Summary (3): Variable Pay

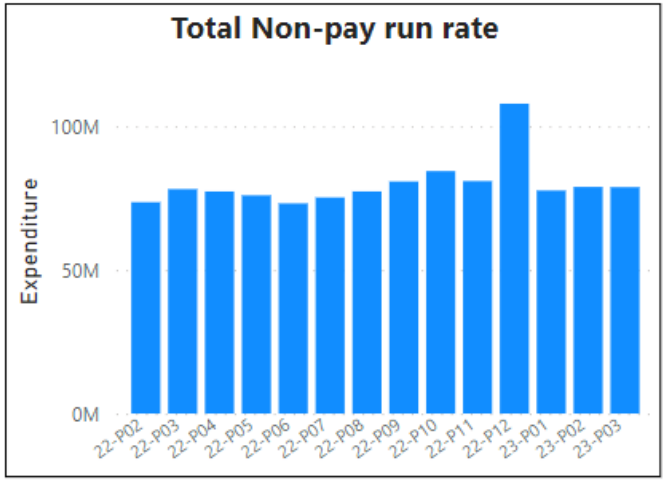
Pay category	21-P12	22-P01	22-P02	22-P03	22-P04	22-P05	22-P06	22-P07	22-P08	22-P09	22-P10	22-P11	22-P12	23-P01	23-P02	23-P03	Change	%
Agency																		
Admin & Clerical Agency	386	183	227	222	128	208	82	182	115	191	243	237	412	148	179	164	-15	-8.2%
Allied Health Prof Agency	186	45	3	-31	76	91	124	88	104	172	144	155	213	108	136	169	33	24.4%
Estates & Ancilliary Agency	1,417	585	726	643	483	465	717	422	428	807	474	44	544	413	622	677	55	8.8%
Medical Agency	1,085	866	1,043	1,027	531	1,272	1,238	1,318	1,920	1,704	1,278	1,688	1,693	1,448	1,602	927	-675	-42.1%
Nurse HCA/HCSW Agency	162	166	261	358	611	590	756	729	880	67	917	951	1,020	1,101	1,086	1,185	99	9.1%
Other Agency	142	89	114	110	71	59	92	103	128	114	180	170	390	-1	61	87	26	42.2%
Registered Nurse Agency	2,620	2,138	1,579	1,759	1,469	1,544	2,006	1,390	2,100	2,540	2,475	2,148	1,687	2,084	2,282	2,175	-107	-4.7%
Total	**5,998**	**4,070**	**3,953**	**4,088**	**3,369**	**4,228**	**5,015**	**4,232**	**5,674**	**5,594**	**5,711**	**5,395**	**5,958**	**5,301**	**5,968**	**5,384**	**-583**	**-9.8%**
Bank																		
Admin & Clerical Bank	166	98	97	132	129	120	111	134	111	108	131	102	117	104	111	102	-9	-7.8%
Estates & Ancilliary Bank	138	86	80	89	119	142	145	154	146	148	153	142	173	159	168	172	4	2.5%
Nurse HCA/HCSW Bank	1,250	972	1,013	812	1,005	1,079	1,102	1,185	1,114	1,193	1,217	1,397	1,427	1,276	1,313	1,140	-173	-13.2%
Other Bank	2	1	1	0	-2	2	-1	0	0	0	0	0	0	0	0	0	0	-189.7%
Registered Nurse Bank	1,581	1,031	1,046	903	1,044	1,043	1,144	1,355	1,616	1,706	1,858	2,026	2,486	1,919	1,920	1,889	-31	-1.6%
Total	**3,137**	**2,188**	**2,238**	**1,936**	**2,295**	**2,386**	**2,500**	**2,828**	**2,987**	**3,155**	**3,359**	**3,667**	**4,203**	**3,458**	**3,512**	**3,304**	**-209**	**-5.9%**
Locum																		
Medical Locum	138	101	75	106	93	116	187	199	115	158	221	227	229	226	238	294	56	23.6%
Total	**138**	**101**	**75**	**106**	**93**	**116**	**187**	**199**	**115**	**158**	**221**	**227**	**229**	**226**	**238**	**294**	**56**	**23.6%**
Total	**9,273**	**6,359**	**6,265**	**6,130**	**5,757**	**6,729**	**7,702**	**7,259**	**8,775**	**8,907**	**9,292**	**9,289**	**10,389**	**8,986**	**9,718**	**8,982**	**-736**	**-7.6%**

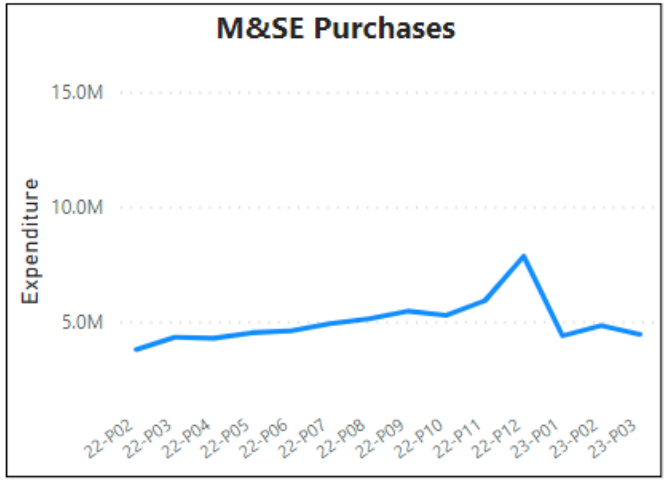


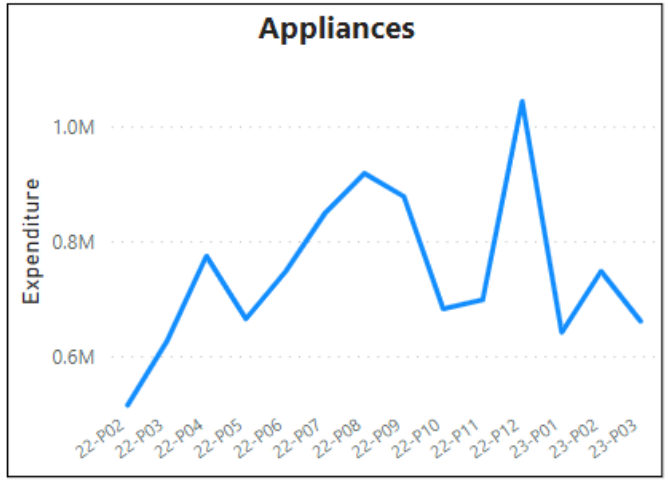


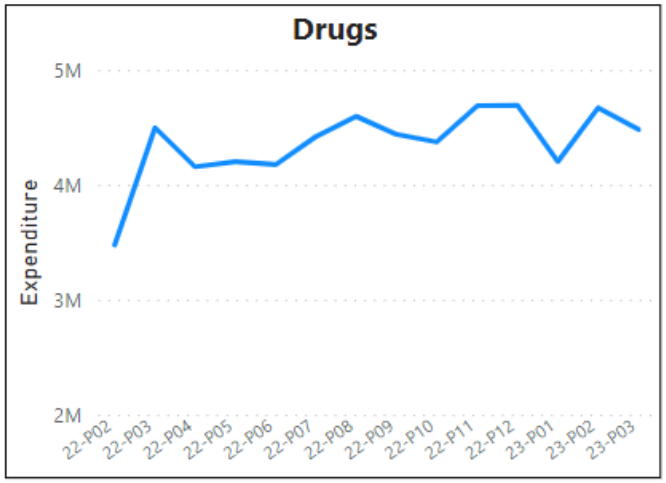


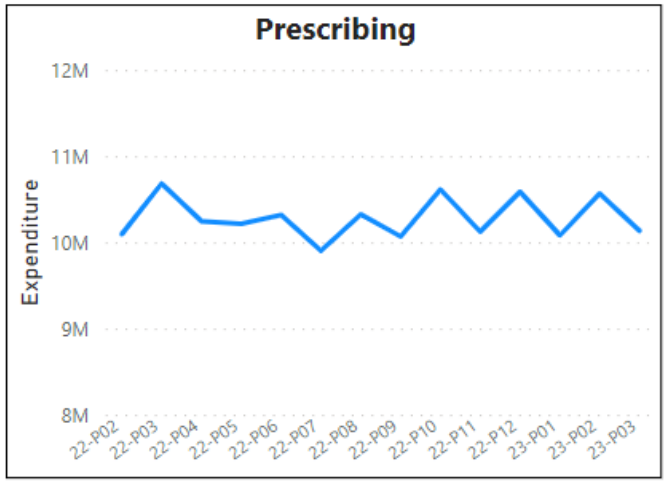
Non-Pay Summary:

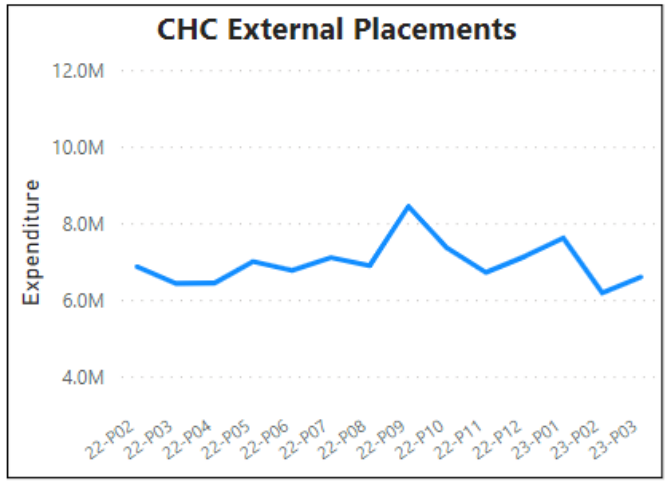












Referral to Treatment (RTT):

Elective activity has significantly reduced as part of the Health Board's Covid-19 planned response. Whilst some routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

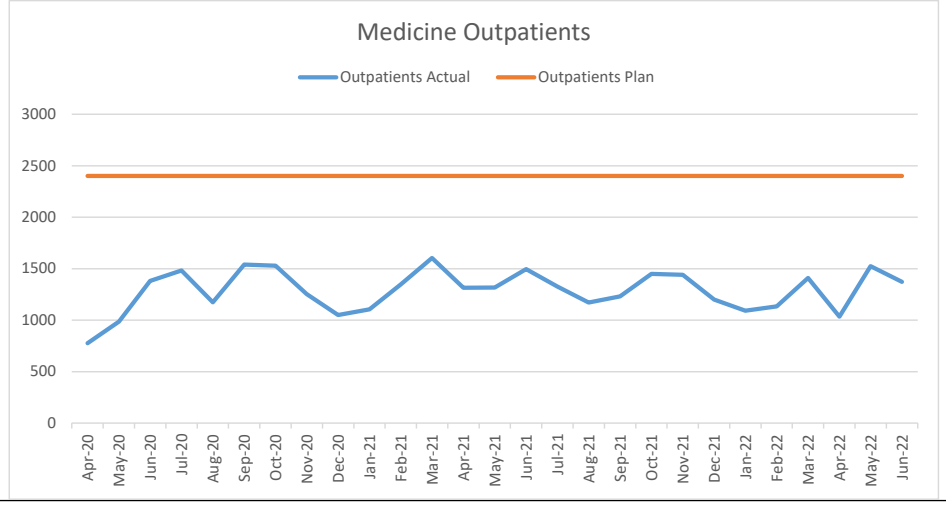
- Elective Treatments for June '22 was 1,894.

Directorates	Plan	Actual	Variance in Activity (Cases)				
			Core	Backfill	WLI	Other	Total
Derm	196	158	(32)	3	(9)	0	**(38)**
ENT	181	101	(45)	0	(35)	0	**(80)**
GS	395	339	(58)	2	0	0	**(56)**
Max Fax	204	191	23	(12)	(24)	0	**(13)**
Ophth	378	212	(151)	(9)	(6)	0	**(166)**
Rheum	0	0	0	0	0	0	**0**
T&O	518	498	47	11	(78)	0	**(20)**
Urology	519	395	(146)	9	13	0	**(124)**
Total	**2,391**	**1,894**	**(362)**	**4**	**(139)**	**0**	**(497)**

- Outpatient activity for June '22 was 6,088.

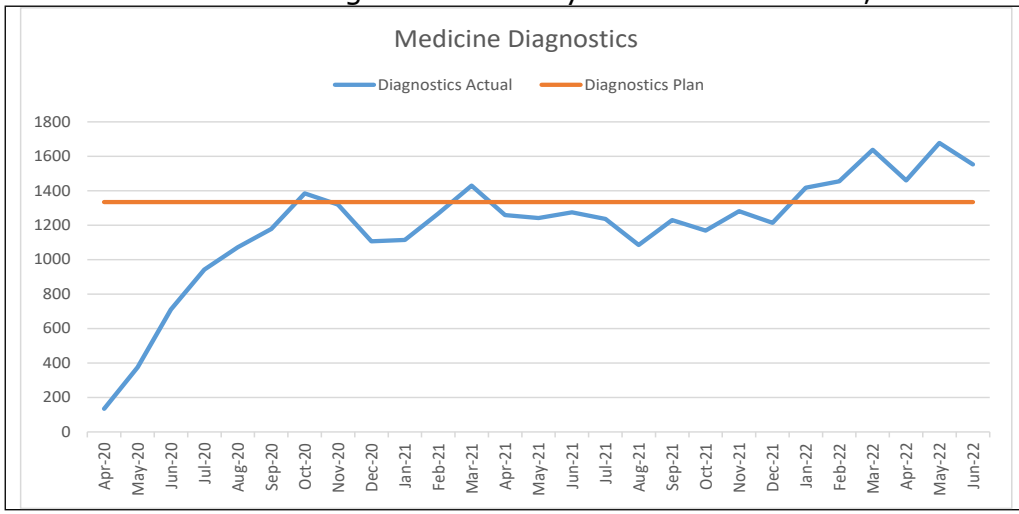
Plan	Actual	Variance in Activity (Cases)				
		Core	Backfill	WLI	Other	Total
1,280	1,131	(113)	0	(36)	0	**(149)**
547	432	(15)	(100)	0	0	**(115)**
1,353	1,935	612	(44)	14	0	**582**
262	349	97	0	(10)	0	**87**
1,149	612	(336)	(81)	(120)	0	**(537)**
183	176	(7)	0	0	0	**(7)**
1,262	1,098	(197)	(118)	151	0	**(164)**
453	355	(82)	0	(16)	0	**(98)**
6,489	**6,088**	**(41)**	**(343)**	**(17)**	**0**	**(401)**

- Medicine Outpatients activity for June '22 was 1,372:



	Assumed monthly activity	Actual activity	Variance
Gastroenterology	510	194	-316
Cardiology	553	311	-242
Respiratory (inc Sleep)	606	319	-287
Neurology	259	244	-15
Endocrinology	242	133	-109
Geriatric Medicine	231	171	-60
Total	**2401**	**1372**	**-1029**

- Medicine Diagnostics activity for June '22 was 1,552:



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YTD June 22	Assumed monthly activity	Actual activity	Variance	Variance
Endoscopy	4002	4689	687	-17%
Total	**4002**	**4689**	**687**	**-17%**

Waiting List Initiatives:

Medicine have spent £90k in June 22:

- Gastroenterology (£62k): the number of endoscopy lists undertaken was 87 (79 in May). Patients seen in June 2022 was 510 (430 in May)
- Cardiology (£19k): for 20 clinic sessions including virtual, telephone, Tilt, and Echo (27 in May) seeing 246 patients (318 in May), plus 5 Cath lab sessions treating 15 patients (7 sessions and 21 patients in May).
- Diabetes (£9k): for 11 clinic sessions including telephone, face to face, virtual and audit (0 in May) seeing 88 patients.

Scheduled Care Division have spent £256k in June:

- Radiology (£95k)
- Pathology (£25k)
- ENT/PAC (£1k)
- Trauma & Orthopaedics (£79k)
- General Surgery (£17k)
- Urology (£10k)
- Dermatology (£4k)
- Oral Surgery (£1k)

Family & Therapies Division have spent £3k all relating to CAMHS, Mental Health have spent £7k all relating to Older Adult Mental Health.

Covid-19 and Exceptional items Funding Assumptions

The Health Board has anticipated WG funding for Covid-19 as listed below;

Type	Covid-19 Specific allocations - June 2022	£'000
HCHS	Testing (inc Community Testing)	6,508
HCHS	Tracing	6,000
HCHS	Mass COVID-19 Vaccination	9,000
HCHS	PPE	3,654
HCHS	Cleaning standards	2,491
HCHS	Extended flu	1,517
HCHS	Long Covid	887
HCHS	A2. Increased bed capacity specifically related to C-19	9,971
HCHS	A3. Other capacity & facilities costs	7,174
HCHS	B1. Prescribing charges directly related to COVID symptoms	280
HCHS	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	15,043
HCHS	D1. Discharge Support	8,685
HCHS	D4. Support for National Programmes through Shared Service	0
HCHS	D5. Other Services that support the ongoing COVID response	2,131
Dental	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS income	2,308
HCHS	Nosocomial investigation and learning	753
	Total Covid-19 Allocations (anticipated)	**76,402**

Type	Exceptional items allocations - June 2022	£'000
HCHS	Energy prices increase	16,100
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,154
	Total Exceptional items allocations (anticipated)	**22,860**

Covid-19 Funding & Delegation

The HB has anticipated Covid funding totalling £76m. The UHB has anticipated funding of £23m for exceptional items listed in the WG letter dated 14th March.

Only funding for specific National Programmes has been delegated at this stage.

It should be noted that a review of local Covid schemes continues to be undertaken to ensure assumptions are in line with WG guidance.

Savings – list of schemes tracker

Division	Savings Scheme Number	Scheme / Opportunity	Recurrent / Non Recurrent	Current Year Annual Plan £'000	Current Year Forecast	Scheme RAG rating
Commissioning	COMM01	GUH OOA cost reduction	R	1,500	0	Amber
Complex Care	CHC01	Reduction of RN Agency (RJ)	R	250	250	Amber
Corporate	CORP01	Workforce and OD	NR	3,657	3,657	Amber
Corporate	CORP02	Workforce variable pay	R	214	214	Green
Corporate	CORP03	R&D savings	R	200	200	Amber
Corporate	CORP04	Non-recurrent opportunities	NR	2,047	2,047	Amber
Estates and Facilities	EF01	Minor works	NR	138	138	Amber
Estates and Facilities	EF02	Agency (non-contract)	NR	268	268	Amber
Estates and Facilities	EF03	Park Square car park	NR	94	94	Amber
Estates and Facilities	EF04	Agile working related opportunities	NR	100	100	Amber
Estates and Facilities	EF05	Workforce variable pay	R	347	347	Green
Family & Therapies	FT01	Family & Therapies non-pay	NR	652	652	Amber
Family & Therapies	FT02	MSK	R	250	250	Amber
Family & Therapies	FT03	Workforce variable pay	R	300	300	Green
Medicine	MED01	Medicine non-pay	NR	500	500	Amber
Medicine	MED02	Medical staffing roster	R	140	102	Amber
Medicine	MED03	LoS bed reduction - GUH plan	R	1,242	0	Amber
Medicine	MED04	Workforce variable pay	R	506	0	Amber
Medicine	MED05	Endoscopy Backfill Cost Reduction	R	100	100	Amber
Medicine	MED06	Retinue Savings	NR	8	113	Green
Mental Health and Learning Disabilities	MH01	Workforce variable pay	R	378	378	Green
Primary Care and Community	PCC01	Workforce variable pay	R	646	555	Green
Primary Care and Community	PCC02	Prescribing support dieticians (Prescribing)	R	100	100	Green
Primary Care and Community	PCC03	Waste reduction scheme (Prescribing)	R	168	168	Green
Primary Care and Community	PCC04	Pharmacy led savings (Prescribing)	R	50	40	Green
Primary Care and Community	PCC05	Scriptswitch (acute) (Prescribing)	R	180	180	Green
Primary Care and Community	PCC06	Scriptswitch (repeat) (Prescribing)	R	390	390	Green
Primary Care and Community	PCC07	Darifenacin to Solifenacin switch	R	80	75	Green
Primary Care and Community	PCC08	Respiratory Inhaler Switches	R	349	248	Green
Primary Care and Community	PCC09	Rebate - total (Prescribing)	R	1,000	1,000	Green
Scheduled Care	SCH01	Anaesthetics-POCU temporary staffing	NR	180	180	Amber
Scheduled Care	SCH02	Scheduled Care non-pay	NR	500	500	Amber
Scheduled Care	SCH03	Vascular mitigation opportunity	R	1,150	1,150	Amber
Scheduled Care	SCH04	Theatres overall opportunity	R	3,949	3,949	Amber
Scheduled Care	SCH05	GUH Theatre establishment	R	419	419	Amber
Scheduled Care	SCH06	Eye Care / Cataracts	R	500	500	Amber
Scheduled Care	SCH07	Medical staffing roster	R	140	140	Amber
Scheduled Care	SCH08	Enhanced Care	R	1,400	1,005	Amber
Scheduled Care	SCH09	SACU / POCU	R	77	77	Amber
Scheduled Care	SCH10	LoS bed reduction - Scheduled Care / Family	R	864	864	Amber
Scheduled Care	SCH11	Outpatient transformation (DNA & Follow-up)	R	2,394	2,394	Amber
Scheduled Care	SCH12	Workforce variable pay	R	571	571	Green
Scheduled Care	MM SCD1	Antibiotic savings	R	3	0	Amber
Scheduled Care	MM SCD2	Lenalidomide Price Reduction	R	944	944	Green
Scheduled Care	MM SCD3	Bortezomib rationalisation	R	70	70	Green
Urgent Care	URG01	Medical staffing roster	R	141	141	Amber
Urgent Care	URG02	SDEC / Ambulatory Care	R	774	774	Amber
Urgent Care	URG03	Retinue	NR	6	95	Green

Reserves

Confirmed or Anticipated	R / NR	Description	22/23
Anticipated	NR	Mental Health Service Improvement funding 22-23	1,363,823
Anticipated	NR	Real Living Wage Bands 1&2	658,000
Anticipated	NR	Urgent Primary Care	1,400,000
Anticipated	NR	Primary Care 111 service	623,000
Anticipated	NR	End of Life Care Board	112,000
Anticipated	NR	C19 Response-Cleaning Standards	2,490,900
Anticipated	NR	C19 Response-Increased bed capacity	9,970,600
Anticipated	NR	C19 Response-Other Capacity & facilities costs	7,174,200
Anticipated	NR	C19 Response-Prescribing charges - Covid symptoms	279,800
Anticipated	NR	C19 Response-Increased workforce costs	15,043,100
Anticipated	NR	C19 Response-Discharge Support	8,685,100
Anticipated	NR	C19 Response-Other Services that support the ongoing COVID response	2,131,300
Anticipated	NR	Exceptional-Incremental National Insurance	4,606,000
Anticipated	NR	Exceptional-Incremenntal Real Living Wage	2,154,000
Anticipated	NR	Exceptional-Increase in Energy Costs (net of baseline costs)	16,100,000
Anticipated	NR	C19 National-Covid PPE	3,654,000
Anticipated	NR	C19 National-Covid Testing	6,508,000
		Confirmed Allocations to be apportioned	**82,953,823**

7788-COMMITMENTS TO BE DELEGATED

Description	22/23
Value Based Recovery balance	1,083,000
Recovery of pay budget relating to VERS	56,421
Other (inc.B1&2 enhancement alloc)	698,443
Total Commitments	**1,837,864**

Reserves Delegation:

As at month 3, anticipated allocations are being held to be delegated namely for Covid-19, exceptional items, mental health and other primary care elements. Other commitment reserves are held which are due to be delegated once values and plans are finalised.

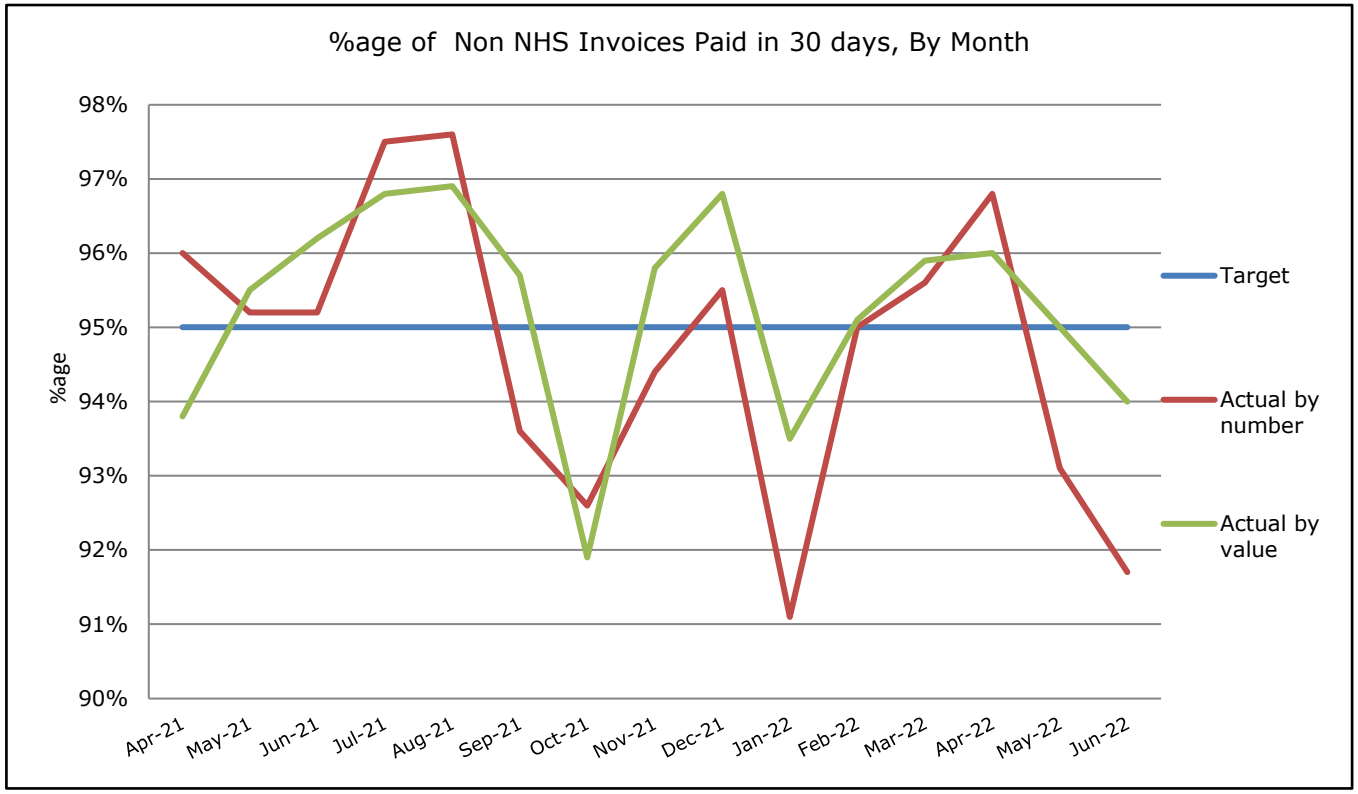
A budget delegation paper will be presented to the Board in July for further funding delegation, this is primarily the funding that is anticipated at risk, but will be monitored quarterly.

Cash Position

- The year end cash balance at the 30th June is £3.641m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

- The HB has not achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in May or cumulatively. A large number of the invoices paid outside of the target relate to Pharmacy, Agency & Catering. We are continuing to work with those departments where invoices are being processed outside of the 30 day payment terms.

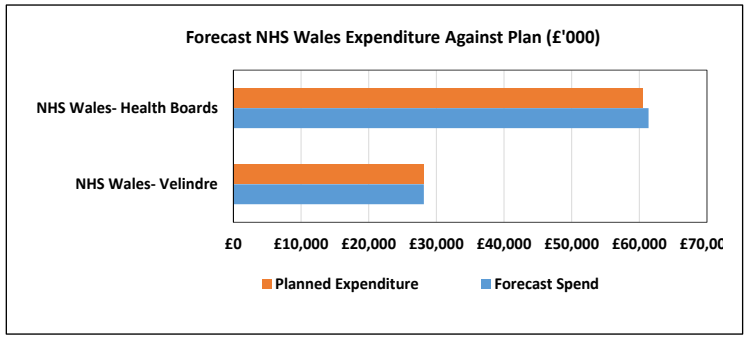


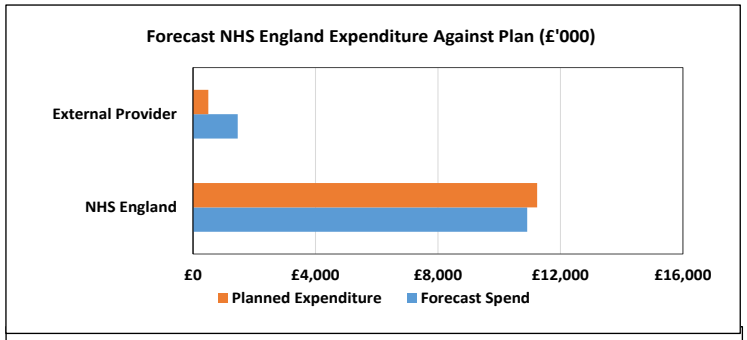
Contracting & Commissioning – LTA Spend & Income

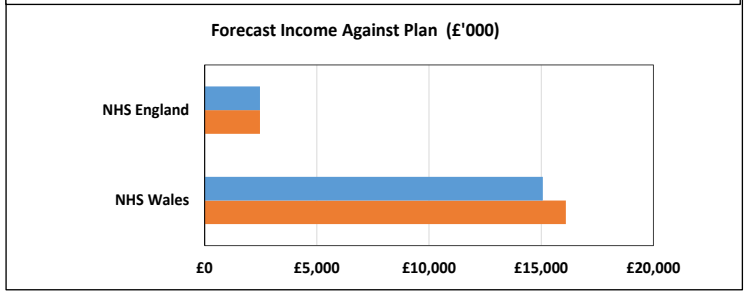
Month/Financial Year:- Month 3 (June) 2022-23

At Month 3 the financial performance for Contracting and Commissioning is a YTD adverse variance of £117k.

The key elements contributing to this position at Month 3 are as follows:







NHS Wales Expenditure

Contract Expenditure with NHS Wales has moved away from block agreements in 2022-23. Forecasting with any certainty is difficult with only limited 2022-23 data available. However early indications are that there is potential for significant over and under performance by providers. This is being closely monitored.

NHS England Expenditure

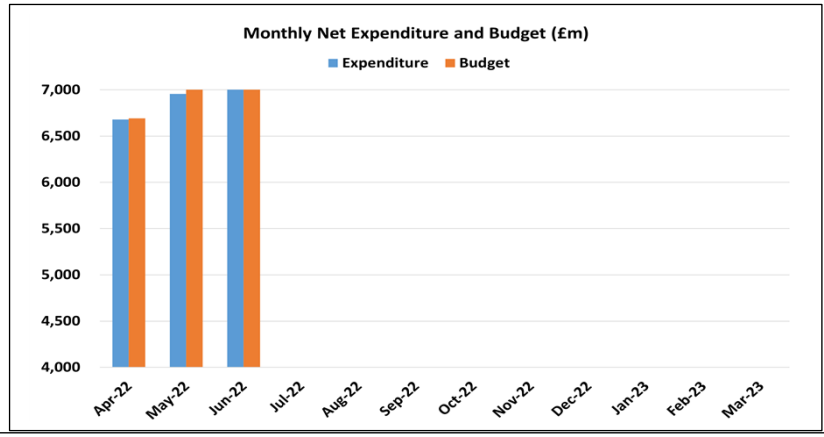
Contract Expenditure with NHS England organisations is expected to move away from Block agreements in 2022-23

There is a risk of increased expenditure if English providers deliver additional activity.

Provider Income

There is a c£2m cost pressure expected from the reduced activity being delivered for Powys LHB following the opening of the GUH hospital

This has been partly funded by £972k budget delegated in Month 2.



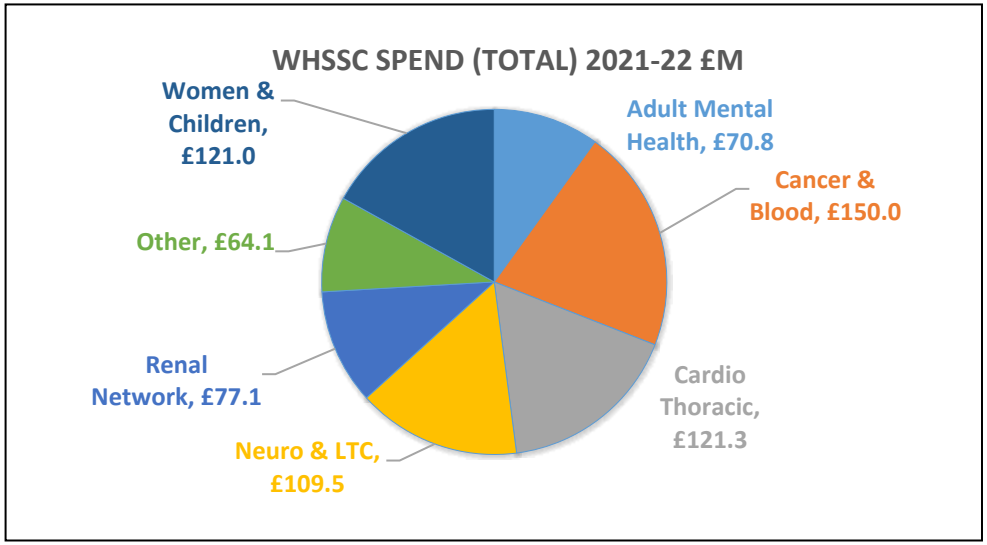
Key Issues 2022-23

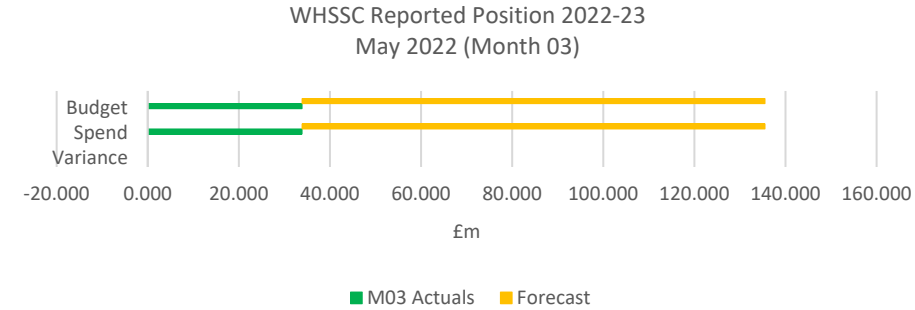
- All LTAs are required to be signed by the Welsh Government deadline of 30th June 2022. ABUHB have sent documents and updated schedules to all other Health Boards which have been agreed and signed. The nationally agreed inflationary uplift of 2.8% and the impact of the 21-22 NHS Pay Award has been funded and is reflected in the above position.
- Directors of Finance have agreed a contract mechanism within Wales to 'block' non admitted patient care charges based on 2019/20 and to apply a 10% 'tolerance' to admitted patient care to reduce volatility in the contracting position. Enhanced rates will be available for recovery/increased activity.
- NICE costs continue to operate on a pass through basis and there is a c£700k recurrent pressure vs budget for NICE and High Cost Drug charges from Cardiff and Cwm Taf.
- There is a c£2m cost pressure expected from the reduced activity being delivered for Powys LHB following the opening of the GUH hospital partly funded by £972k budget delegated in Month 2. There is a c£1m cost pressure expected from outsourcing activity to St Joseph's hospital to support endoscopy and MRI.

WHSSC & EASC Financial Position 2022-23

Period: Month 03 2022-23

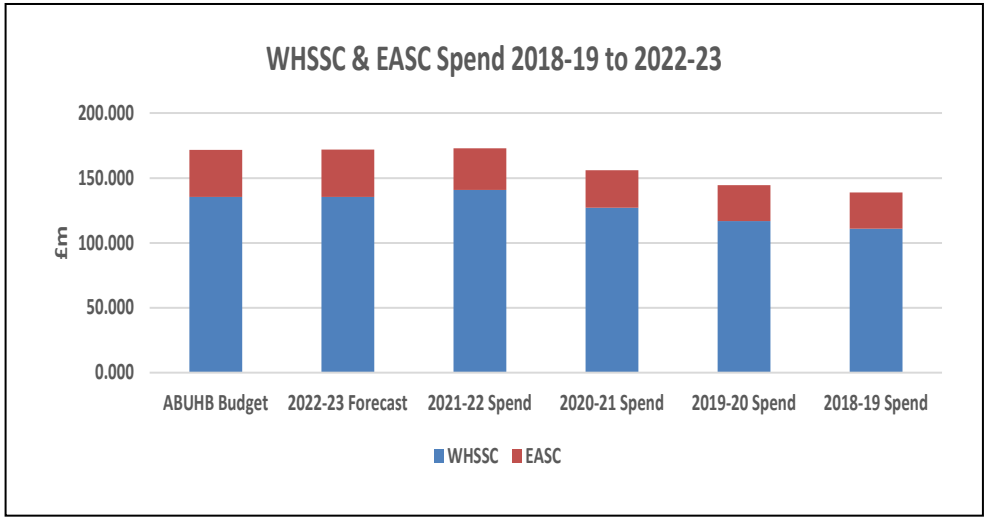
The Month 03 financial performance for WHSSC & EASC is a YTD overspend of £76k. The Month 03 position reflects the agreed IMTP & LTA agreements with providers.

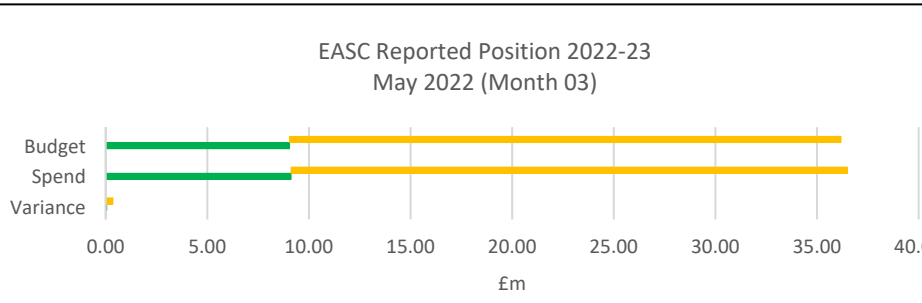




Key Variances

- The WHSSC outturn position reflects the 2022-23 WHSSC IMTP agreed by Chief Executives at the WHSSC Joint Committee
- Current pressures around English recovery and individual MH placements currently offset by slippage and underperformance on Welsh agreements resulting in a breakeven forecast.





Key Variances

- The EASC outturn position reflects the 2022-23 EASC IMTP agreed by Chief Executives at the EASC Joint Committee.
- The variance reflects the HB's contribution share of £1.8m non recurring support to Welsh Ambulance Services Trust in 2022-23 to support ongoing recruitment and service pressures.
-

Balance Sheet

Balance sheet as at 30th June 2022	2022/23 Opening balance £000s	30th June 2022 £000s	Movement £000s
Fixed Assets	810,479	804,386	-6,093
Other Non current assets	131,429	130,517	-912
Current Assets			
Inventories	8,726	8,726	0
Trade and other receivables	133,807	117,601	-16,206
Cash	1,720	3,641	1,921
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	144,253	129,968	-14,285
Liabilities			
Trade and other payables	226,999	220,234	-6,765
Provisions	195,707	192,160	-3,547
	422,706	412,394	-10,312
	663,455	**652,477**	**-10,978**
Financed by:-			
General Fund	530,429	519,458	-10,971
Revaluation Reserve	133,026	133,019	-7
	663,455	**652,477**	**-10,978**

Other Non-Current Assets:

- This relates to a decrease in Welsh Risk Pool claims due in more than one year £0.8m since the end of 2021/22.

Current Assets, Trade & Other Receivables:
The main movements since the end of 2021/22 relate to:

- A decrease in the value of debts outstanding on the Accounts Receivable system since 2021/22 to the end of June £3.0m. A decrease in the value of both NHS & Non-NHS accruals of £15.1m, of which £4.8m relates to a decrease of Welsh Risk Pool claims due in less than one year, £9.6m relates to a decrease in NHS & Non NHS accruals and £0.7m relates to a decrease in VAT & other debtors since the end of 2021/22.
- An increase in the value of prepayments held of £1.9m.

Cash:

- The cash balance held in month 3 is £3.641m.

Liabilities, Provisions:

- The movement since the end of 2021/22 relates to a number of issues the most significant of which are:- a decrease in Capital accruals (£7.9m), an increase in NHS Creditor accruals (£7.6m), a decrease in the level of invoices held for payment from the year end (£9.5m), an increase in non NHS accruals (£7.3m), an increase in Tax & Superannuation (£8.1m), a decrease in other creditors (£11.5m), an increase in payments on account (£0.9m).
- Due to the increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £3.5m.

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: £1.55bn

Confirmed Allocations as at June 2022 (M3 2021/22)

	£'000
HCHS	1,257,081
GMS	104,906
Pharmacy	32,831
Dental	33,249
Total Confirmed Allocations - June 2022	**1,428,067**
Plus Anticipated Allocation - June 2022	**120,753**
Total Allocations - June 2022	**1,548,820**

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 £105m. (£109m for 21/22). 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.

Funding (allocations & income) for the UHB totalled £1.65bn for 22/23.

WG Anticipated allocations: £120.75m

	STATUS OF ISSUED RESOURCE LIMIT ITEMS				Total Revenue Resource Limit
	HCHS £'000	Pharmacy £'000	Dental £'000	GMS £'000	£'000
DEL Non Cash Depreciation - Baseline Surplus / Shortfall	298				**298**
DEL Non Cash Depreciation - Strategic	21,122				**21,122**
DEL Non Cash Depreciation - Accelerated	483				**483**
DEL Non Cash Depreciation - Impairment	0				**0**
AME Non Cash Depreciation - Donated Assets	342				**342**
AME Non Cash Depreciation - Impairment	(13,929)				**(13,929)**
Total COVID-19 (see below analysis)	71,824	0	0	0	**71,824**
Energy (Price Increase)	16,100				**16,100**
Employers NI Increase (1.25%)	4,606				**4,606**
Real Living Wage	2,154				**2,154**
(Provider) Substance Misuse & increase	3,184				**3,184**
(Provider) SPR's	112				**112**
(Provider) Clinical Excellence Awards (CDA's)	298				**298**
Technology Enabled Care National Programme (ETTF)	1,805				**1,805**
Informatics - Virtual Consultations	2,813				**2,813**
I2S DHR Phase 2 (£143k) & Omnicell (£425k)	(568)				**(568)**
Carers Funding	191				**191**
National Nursing Lead Community & Primary Care	53				**53**
National Clinical Lead for Falls & Frailty (£26k) & Primary & Comty Care (£113k)	139				**139**
National Allied Health Professional (AHP) Lead for Primary and Community Care	85				**85**
Accelerated cluster development programme	200				**200**
AHW:Prevention & Early Years allocation 20/21	1,171				**1,171**
Healthy Weight-Obesity Pathway funding 21-22	550				**550**
Community Infrastructure Programme	180				**180**
C19 Support for Post Anaesthetic Critical Care Units (PACU)	904				**904**
WHSSC - National Specialist CAMHS improvements	139				**139**
Same Day Emergency Care (SDEC)	1,500				**1,500**
PSA Self-management Programme (Phase 1 & 2)	114				**114**
OP Transformation-Dermatology Specialist Advice and study day	26				**26**
Digital Priority investment fund (DPIF)	500				**500**
Strategic Primary Care - additional posts	113				**113**
Learning Disabilities-Improving Lives	64				**64**
Nurse Operation lead pump-prime funding 22-23 (18mths)	68				**68**
WHSSC All Wales Traumatic Stress Quality Imprmt (ANEHFS 13 21/22)	159				**159**
Children & Young People MH & Emotional Wellbeing (ANEHFS 16 21/22)	200				**200**
Support all age Mental Health - Tier 0/1 provision (ANEHFS 22 21/22)	200				**200**
Memory Assessment Services - Gwent RPB (ANEHFS 37 21/22)	565				**565**
EASC/WAST Improvements in MH Emergency Calls (ANEHFS 54 21/22)	51				**51**
WHSSC - Impl of National Specialist CAMHS Improv. (ANEHFS 90 21/22)	131				**131**
NHS Pay enhancement Band 1 to 2 - 3% uplift 21-22 (ANEHFS 21/22)	152				**152**
Mental Health - additional resources 22-23	1,364				**1,364**
GMS Refresh				1,603	**1,603**
Welsh Risk Pool	(4,118)				**(4,118)**
Urgent Primary Care	1,400				**1,400**
Primary Care 111 service	623				**623**
End of life Care Board	112				**112**
PSA self-management Programme Platform development	465				**465**
Outpatient Treatment Centre project costs	101				**101**
Real Living Wage	658				**658**
Dementia Action Plan-Age Cymru National advocacy project	445				**445**
Total Anticipated Funding	**119,149**	**0**	**0**	**1,603**	**120,753**

Capital Planning & Performance

Summary Capital Plan Month 3 2022/23	2022/23			
	Original Plan £000	Revised Plan £000	Spend to Date £000	Forecast Outturn £000
Source:				
Discretionary Capital:-				
Approved Discretionary Capital Funding Allocation	8,227	8,227		8,227
Less AWCP Brokerage	-1,534	-1,859		-1,859
NBV of Assets Disposed	0	0		0
Total Approved Discretionary Funding	6,693	6,368		6,368
All Wales Capital Programme Funding: -				
AWCP Approved Funding	24,615	42,739		42,739
Total Approved AWCP Funding	24,615	42,739		42,739
Total Capital Funding / Capital Resource Limit (CRL)	**31,308**	**49,107**		**49,107**
Applications:				
Discretionary Capital:-				
Commitments B/f From 2021/22	1,317	1,498	-9	1,408
Statutory Allocations	576	576	58	576
Divisional Priorities	587	1,102	299	1,099
Corporate Priorities	2,182	758	120	758
Informatics National Priority & Sustainability	1,800	2,142	287	2,142
Remaining DCP Contingency	231	500	0	576
Total Discretionary Capital	**6,693**	**6,575**	**754**	**6,559**
All Wales Capital Programme:-				
Grange University Hospital Remaining works	-1,408	-394	293	-394
Tredegar Health & Wellbeing Centre Development	10,023	9,934	1,121	9,934
Fees for NHH Satellite Radiotherapy Centre Development	198	257	106	257
YYF Breast Centralisation Unit	8,989	8,978	236	8,978
Newport East Health & Wellbeing Centre Development	0	9,287	495	9,287
Fees for MH SISU	258	263	90	263
Covid Recovery Funding	1,400	1,620	1,272	1,636
National Programme - Imaging	4,700	4,686	-5	4,686
Digital Eyecare	0	66	7	66
National Programme - Infrastructure	12	12	4	12
NHH SRU Enabling Works	400	403	296	403
SDEC Equipment	0	79	30	79
ICF Discretionary Fund Schemes	43	153	3	153
RGH Endoscopy Unit	0	7,395	0	7,188
Total AWCP Capital	**24,615**	**42,739**	**3,949**	**42,548**
Total Programme Allocation and Expenditure	**31,308**	**49,314**	**4,702**	**49,107**
Forecast Overspend / (Underspend) against Overall Capital Resource Limit				**0**

The approved Capital Resource Limit (CRL) as at Month 3 totals £49.107m. The current forecast outturn is breakeven.

The works to the Same Day Emergency Care Unit, Resus, CEAU and Grange House are progressing from the remaining Grange University Hospital funding. All Laing O'Rourke works are due to complete by the middle of September. The tender for the Well-being works to Grange House is due back in July. The additional works costs are being offset by the final VAT recovery claim (£3.5m) due in the last quarter of 2022/23 resulting in a credit budget allocation of £394k. The Health Board's VAT advisors are currently working with HMRC and the external cost advisors to expedite the VAT recovery claim and mitigate the risk that an agreement is not reached in the current financial year.

The YYF Breast Centralisation Unit scheme is currently delayed due to contractual issues with the main contractor (inflationary pressures). The issues are being worked through with the external cost advisors and NWSSP-Estates to allow the scheme to progress.

The works at Tredegar H&WBC are continuing. The handover of the building is now expected to be delayed to April 2023 as the original brick order for the façade has been cancelled by the supplier due to supply issues. A revised cashflow has been requested from the contractor as expenditure is £1.1m behind the original 22/23 profile.

The Newport East Health and Well-being Centre site set up works have commenced and works to replace the Multi Use Games Area are starting w/c 4th July. Final approval and funding have been received for the Endoscopy Unit at RGH. The contractor has been appointed and works are due to commence on site 18th July.

The FBC for the NHH Satellite Radiotherapy Centre has concluded and has been submitted to WG for approval. The Outline Business Case for the Mental Health SISU is on-going and expected to be submitted to Board for approval in Quarter 2.

The second year of the National Imaging Programme funding totals £4.7m for ABUHB. The spend in the current year includes the replacement of two CT Scanners (NHH / RGH) and the installation of three general rooms.

The Health Board Discretionary Capital Programme (DCP) allocation for 2022/23 is £8.227m (a reduction of 24% compared to 2021/22). Final All Wales Capital Programme scheme brokerage for 2021/22 slippage was £1.859m, leaving a balance of £6.638m to address spend in the current financial year.

During June, the RGH Endoscopy AWCP scheme was approved, enabling a reimbursement of £207k to the Discretionary budget for fees that had been incurred prior to approval. New schemes totalling £903k were also released in relation to essential works schemes and the replacement of critical IT and equipment. The unallocated contingency budget as at the end of June is £576k.

Aneurin Bevan University Health Board

STRATEGIC RISK REPORT

Executive Summary

This report provides an overview of all **21** strategic risks described on the Corporate Risk Register and makes recommendations to **reframe one risk (CRR007)** and endorse an **additional 5 risks** which have been identified through monitoring of Divisional risk registers, discussions at Committee meetings and highlighted from a strategic, Executive level. The detail and risk assessment of the additional risks are attached to this report at ***Appendix 1***.

Response to the COVID-19 pandemic, through front line service delivery, restart and recovery plans, Primary and Secondary Care demand increase and associated risks continue to have the greatest impact on service delivery. This sustained response continues to represent the most significant risk to the Health Board's delivery of its non-COVID-19 services and the achievement of the objectives outlined within the IMTP 2022/23.

The Board is asked to note the **21** risks which currently encompass the corporate risk register and endorse the **addition of 5 further risks,** taking the total number of risks on the Corporate Risk Register to **26**.

The Board is requested to note that it's Committees (Audit, Risk and Assurance, Patient, Quality, Safety and Outcomes, People and Culture, Partnerships, Population Health and Planning Committee and Finance and Performance Committee) have received and considered the risk profiles for which they are responsible for monitoring and reviewing. Further opportunity for escalation and de-escalation has been offered to Executive risk owners and any change in position is reflected within the body of the report and the dashboard at ***Appendix 2***. Any concerns regarding these risk profiles will have been escalated to the Board via the Committee Assurance Report.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Rani Mallison, Director of Corporate Governance	
Report Author: Danielle O'Leary, Head of Corporate Services, Risk and Assurance	

Report Received consideration and supported by :			
Executive Team	**X**	**Committee of the Board [Audit, Risk and Assurance Committee Patient, Quality, Safety and Outcomes Committee People and Culture Committee Finance and Performance Committee Partnership Population Health and Planning Committee]**	
Date of the Report: 18th July 2022			
Supplementary Papers Attached: **Appendix 1 – Additional risk profiles – for approval and endorsement** **Appendix 2 - Dashboard of Corporate Risk Register**			

Purpose of the Report

This report provides an overview of the **26** strategic risks (5 subject to Board endorsement) which currently comprise the Health Board's Corporate Risk Register. The report outlines the changes since the last reporting period including an escalation of **CRR016 – Achievement of financial balance**.

A de-escalation of:

CRR013 – Infection, prevention, and control (IPAC) – Is now being managed within an agreed risk tolerance level.

CRR020 – Implementation of the WCCIS system – Is not currently managed within an agreed risk tolerance level.

The Board is requested to note that 3 risks on the Corporate Risk Register continue to be actively managed within an approved and agreed risks appetite/tolerance level, these are:

CRR023 – Avoidable harm to the population

CRR004 – WboFG Act and Socio-Economic Duty

CRR008 – Health Board estate being fit for purpose

A minor amendment to the risk descriptor wording of CRR002 to reflect that mass re-deployment is no longer required:

CRR002 - Failure to recruit and retain staff across all disciplines and specialities to critical areas, leading to adverse impacts on delivery of care for patients across acute and non-acute settings and non-compliance with safe staffing principles and standards.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the Risk Management Approach, the Health Board can review and assess its strategic risks against achievement of objectives as set out in the IMTP 2022/23.

The Health Board uses a Risk Matrix to assess the potential consequence and likelihood of occurrence of all predicted risks to form an overall risk score. In the risk identification and assessment process, a risk appetite level is agreed alongside a target score. Risks may then be **treated** or mitigated to a lower more manageable level or can be ***tolerated, transferred, or terminated*** dependent upon the level of organisational benefit in undertaking a specific mitigation or course of action.

Internal controls and action plans are then developed to mitigate the risk and reduce either the likelihood, consequence, or both. Committees are then responsible for the active monitoring and review of all risks which receive oversight from each respective committee.

Executive Engagement and Divisional Review

A review of all Divisional risks captured through the DATIX electronic risk management system has been undertaken and several 'themes' were identified. The risk categories with highest numbers of high/significant risks, categorised by risk subtype are highlighted as follows:

- **Agile working**
- **Environment and estates**
- **Health and Safety**
- **Patient Safety**
- **Quality**
- **Service and Business Disruption**
- **Staff Shortages**

Most of the above themes were already captured through the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) however, where potential gaps have been identified, additional risk profiles have been drafted and shared with Executive Team risk owners for approval and endorsement. Executive risk owners have approved the additional 5 new risks and 1 reframed risk. The outline of these [1]risks are outlined below:

Risk of Health needs/complexities of the population not being met	***Due to*** the Clinical Futures model of care not taking into consideration the evolving population needs
Risk of unsustainable provision of Primary Care Services	***Due to*** a range of factors including changes in professional working practices, impact of COVID and new demand e.g. impact of the Ukrainian refugee crisis.
Risk of an inability to deliver components of the Health Board's overarching strategy and key priorities	***Due to*** an essential reliance and involvement of Key Partners
Risk of clinically unsafe and inappropriate inter-site patient transfers and into communities	***Due to*** lack of availability of safe and appropriate transfer vehicles, staff and skill mix to facilitate the transfers.

[1] **Detailed risk assessments are included at Appendix 1**

Risk of an inability to staff acute sites appropriately and provide acceptable levels of care in line with best practice and guidelines.	***Due to*** Increased levels of patient acuity presenting
Risk of delays in discharging medically fit patients	***Due to*** partly due to delays in accessing packages of care from Partners -covered in part by CRR019 (unmet demand and ambulance delays) on CRR

Assessment and Conclusion

Risk Management ensures that the Health Board focuses on the risks and concerns that may impact on the organisations ability to deliver its objectives. Whilst active risk management is performed daily at an operational level, the Health Board's risk management strategy and process ensures that the Board is informed, engaged, and assured about the approach that Health Board uses to identify and respond to perceived risks.

Whilst the key risks and issues need to be regularly considered at each of the Board's Committees and at the Executive Team, the way in which the Health Board responds to the COVID-19 pandemic, restart and recovery plans, systems pressures/increased demand and the risks associated with these areas of activity have taken priority.

The approach adopted by the Health Board to strengthen the alignment between Board and Committee business and the Board Assurance Framework continues to embed and provide a foundation for Board and Committee business to be risk based and focussed on assurance needs. This approach will also help to ensure the correct business is directed to the most appropriate committee.

Current Organisational Risk Profile:

There are currently **26** Organisational Risk Profiles, of which **17** form Principal Risks due to the scoring being 15 or greater and are included within the Board Assurance Framework. The following table provides a breakdown of the risks and level of severity:

High	**17**
Moderate	**8**
Low	**1**

A high-level breakdown dashboard of all strategic risks including, current score, target score, risk appetite level, risk treatment and trend since last reporting period is included at ***Appendix 1***. The Board can be assured that the risks which comprise the corporate risk register continue to be reviewed and monitored via the Executive Team with complimentary Health Board escalation arrangements in place.

Changes in Risk Status Since Last Reporting Period

Since the last reporting period there has been an escalation of risk:

CRR016 – Achievement of financial balance

In addition to this, and following Executive risk owner review, the following risks have reported a de-escalation:

CRR013 – Infection, prevention, and control (IPAC) – Is now being managed within an agreed risk tolerance level.

CRR020 – Implementation of the WCCIS system – Is not currently managed within an agreed risk tolerance level.

The Board is requested to note that 3 risks on the Corporate Risk Register continue to be actively managed within an approved and agreed risks appetite/tolerance level, these are:

CRR023 – Avoidable harm to the population

CRR004 – WboFG Act and Socio-Economic Duty

CRR008 – Health Board estate being fit for purpose

Wider Organisational Progress – Risk Management Strategy

The revised Risk Management approach continues to embed across the organisation however, some targeted support and interventions have been completed with some Divisions and Departments including Workforce, Scheduled Care, Urgent Care and Mental Health and Learning Disabilities. These interventions include the underpinning of the Risk Management principles of using the Divisional risks to inform Divisional Management Team (DMT) and Senior Management Team (SMT) meetings. This will ensure that due focus and energy is channelled into the areas of business that most require it. Clear escalation routes for risk management remains in development although, as this work progresses across the Health Board, clarity in relation to **when** risks need to be escalated and **areas where risk management training** is required, is being noted. This information will help support and inform the approach as embedding continues.

Divisions that have not yet received support from the Head of Corporate Services, Risk and Assurance will be contacted in the coming weeks and months to ensure consistency of approach.

Recommendation

The Board is requested to:

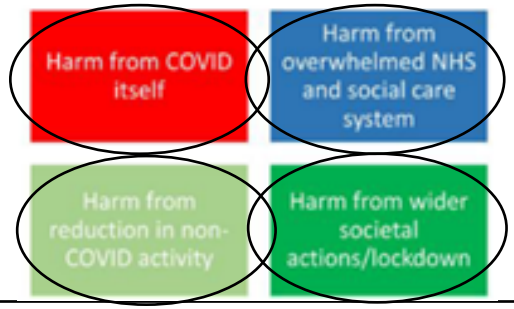
- Note that delegated committees and Executive risk owners have reviewed their respective risks.

- Note the update on engagement work with Divisional colleagues to further embed the risk management approach.
- Acknowledge the Divisional DATIX review and strategic Executive led review of emerging and existing corporate risks.
- Endorse the de-escalation, escalation, wording amendments and additional risks to the Corporate Risk Register.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of New Terms	Not required.
Public Interest	Report to be published.

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="3">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2" rowspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="3">CRR007 – (March-2017, reframed July 2022)
Risk of Health needs/complexities of the population not being met
Due to the Clinical Futures model of care not taking into consideration the evolving population needs
TREAT</td></tr>
<tr><td colspan="3">Impact
Reputational damage to the Board, non-compliance with best practice, poorer patient and staff experience and outcomes.</td></tr>
<tr><td>High Level Themes</td><td>Population health
Partnership
Patient Outcomes and Experience
Quality and Safety
Reputational
Public confidence</td><td colspan="2">Risk Appetite</td><td>Moderate (cautious risk taking)
Risk Appetite
Level 3</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Partnerships, Population Health and Planning Committee</td><td>Section 33 Pooled budgets for Care Homes to support sustainability in place.
Continued training, equipment and staff support is provided to care homes.</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• Implementation of agreed joint contract. • Health Boards continue to work on an All-Wales basis to comply with requirements of the Supreme Court Judgement. • Risk assessment updated monthly and reported to Complex Care and Health Board Quality and Patient Safety meetings.							
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			4	4	4	4	3	4
Sustainability Funding Plan to be developed.		Mar-20	**16**		**16**		**12**	
Trend	**NEW RISK**		**Executive Owner: Director of Planning, Performance and Digital**					
Mapping Against 4 Harms of COVID			**Update**					


Harm from COVID itself
Harm from overwhelmed NHS and social care system
Harm from reduction in non-COVID activity
Harm from wider societal actions/lockdown

NEW RISK

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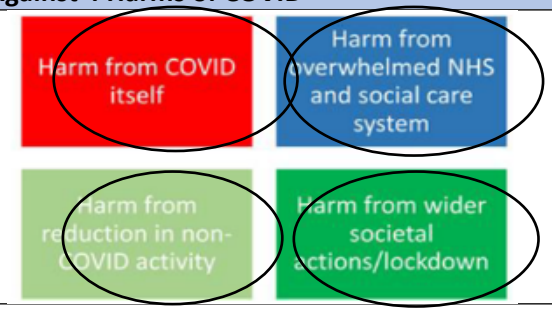
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="3">Risk of unsustainable provision of Primary Care Services
due to a range of factors including changes in professional working practices, impact of COVID and new demand e.g. impact of the Ukrainian refugee crisis.

TREAT</td></tr>
<tr><td colspan="3">Impact- Inability to staff services provided through GMS causing patient harm, reputational harm and poorer patient experiences and outcomes.

This position is also being adversely impacted by the Health Board Ukrainian refugee response (CRR034) as many Divisional colleagues have ceased core Primary Care work to address the refugee need. Latest messages from WG indicate this may move to a civil contingency risk (CRR033)</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Quality and Patient Safety
Patient Outcomes and Experience
Public Confidence
Reputational
Financial</td><td>Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Partnership, Population Health and Planning Committee</td><td>GMS Contracts
Establishment of some ‘Managed Practices’
Divisional SMT meetings</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• Regular performance management of Primary Care contracts • PPV reporting						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	4	3	4	2	4
Establishment of a Primary Care sustainability Board with its inaugural meeting scheduled for August 2022. Consider and explore if additional resource is required to respond to the refugee crisis. Local impact assessment to be undertaken with Primary Care colleagues as wider disruption is anticipated due to re-purposing of some teams in Primary and Community Services. Targeted recruitment in relation to GPs Community outreach programmes alongside public health initiatives to keep population well in the communities. Workshops to be undertaken with NCNs to explore challenges and identify potential mitigations.	Aug 2022 July 2022 Ongoing Ongoing Ongoing Aug 2022	**16**		**12**		**8**	
Trend	**NEW RISK**	**Executive Owner: Director of Primary, Community and Mental Health Services**					

Mapping Against 4 Harms of COVID	Update
	**NEW RISK**

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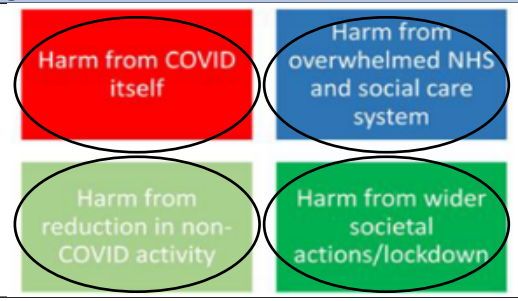
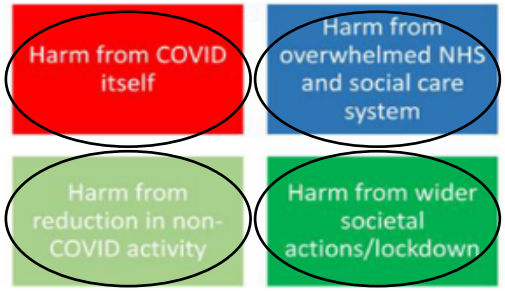
due to an essential reliance and involvement of Key Partners

TREAT TOLERATE</td></tr>
<tr><td colspan="3">Impact Reputational damage to the Board, non-compliance with best practice, poorer patient and staff experience and outcomes and contribution to congested health and social care systems.</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Quality and Patient Safety
Patient Outcomes and Experience
Public Confidence
Reputational
Financial</td><td colspan="2">Risk Appetite</td><td>Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Partnership, Population Health and Planning Committee</td><td>Key priorities of IMTP monitored through separate workstreams
Clear escalation routes to Executive Team if risks of non-delivery identified</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• RPB arrangements • Regional/local contractual arrangements with partners						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		3	4	2	4	1	4
		12		**8**		**4**	
Trend	**NEW RISK**	**Executive Owner: Director of Planning, Performance, Digital and ICT.**					
Mapping Against 4 Harms of COVID		**Update**					
		**NEW RISK**					

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Provide high quality care and support for older adults** • **Care closer to home** • **Less serious illness which require hospital care**		***Risk of*** clinically unsafe and inappropriate inter-site patient transfers and into communities ***Due to*** lack of availability of safe and appropriate transfer vehicles, staff and skill mix to facilitate the transfers. **TREAT**					
		Impact Compounds the Health Board's inability to discharge into communities and negatively impacts the DToCs position. Poor patient/families and staff experience and outcomes. Potential financial implications and reputational/public confidence damage.					
High Level Themes	• Quality and Patient Safety • Patient Outcomes and Experience • Public Confidence • Reputational • Financial	**Risk Appetite**		**Low (averse to risk)** **Risk Appetite** **Level 2**			
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient Quality, Safety and Outcomes Committee	• Existing Health Board contractual arrangements with WAST •	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	3	5	1	5

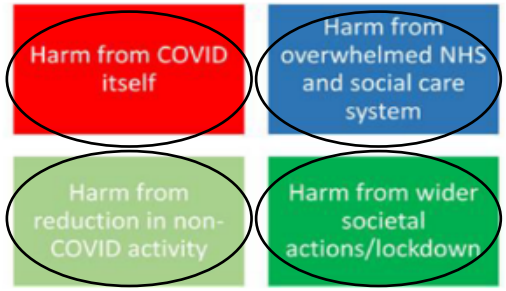
score or maintain it.							
		20		15		5	

Trend	**NEW RISK**	**Executive Owner: Director of Operations**
Mapping Against 4 Harms of COVID		**Update**
		**NEW RISK**

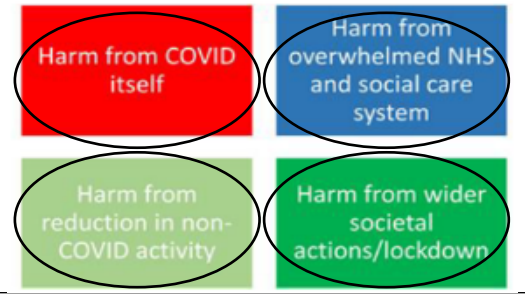
Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22	**Risk Description, Appetite and Decision**

<table>
<tr><td colspan="2">Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="4">Risk of an inability to staff acute sites appropriately and provide acceptable levels of care in line with best practice and guidelines.
Due to Increased levels of patient acuity presenting

TREAT TOLERATE</td></tr>
<tr><td colspan="2"></td><td colspan="4">Impact Negative impact on staff morale, patient experience and outcomes. Non-compliance with legislative and statutory requirements, creating exposure to reputational damage.</td></tr>
<tr><td>High Level Themes</td><td>Staff well-being
Patient experience and outcomes
Reputational
Public Confidence
Quality</td><td colspan="2">Risk Appetite</td><td colspan="2">Low (averse to risk)
Risk Appetite
Level 2</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>Health Board Recruitment drives
Safer staffing legislation
Pay incentives for Health Board bank staff
Proactive engagement with agencies</td><td colspan="2">Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td colspan="2">Current Risk level after initial controls/mitigations have been implemented.</td><td colspan="2">Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
<tr><td colspan="2">Action Plan SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.</td><td>Due Date</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td></tr>
<tr><td colspan="2"></td><td></td><td>4</td><td>5</td><td>3</td><td>5</td><td>1</td><td>5</td></tr>
</table>

		20	15	
Trend	**NEW RISK**	**Executive Owner: Director of Nursing and Director of Operations**		
Mapping Against 4 Harms of COVID		**Update**		
		**NEW RISK**		

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2" rowspan="2">• Provide high quality care and support for older adults
• Care closer to home
• Less serious illness which require hospital care</td><td colspan="3">Risk of delays in discharging medically fit patients
Due to partly due to delays in accessing packages of care from Partners - covered in part by CRR019 (unmet demand and ambulance delays) on CRR
TREAT TOLERATE</td></tr>
<tr><td colspan="3">Impact
Deteriorating position in relation to social care crisis significantly impacts on Health Board’s ability to do its business and manage increased demand. Full understanding of partner risk profiles is required to develop new ways of whole system working.</td></tr>
<tr><td>High Level Themes</td><td>• Partnership
• Patient experience and outcomes
• Quality
• Financial
• Reputational
• Public Confidence</td><td>Risk Appetite</td><td colspan="2">Moderate (cautious risk taking)
Risk Appetite
Level 3</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>• Multiple internal SOPs to support the timely discharge of medically fit patients
• Existing relationships and professional</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	• arrangements with social care • Legislation requirements e.g. S117 etc.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	4	5	2	5
• RPB review of step closer to home pathway. • Explore options to increase community beds/virtual bed capacity in conjunction with Partners.	Autumn 2022	**20**		**20**		**10**	
Trend	**NEW RISK**	**Executive Owner: Director of Operations and Director of Primary, Community and Mental Health Services**					
Mapping Against 4 Harms of COVID		**Update**					
		**NEW RISK**					

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(June 2022 PQSO)** 	**PQSO**	**Director of Operations**
CRR002 Failure to recruit and retain staff across all disciplines and specialities leading to adverse impacts on delivery of care to patients across acute and non-acute settings and non-compliance with safe staffing principles and standards **(re-**	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles.	**No**	**Treat** the impact of the risk by using internal controls.	**(May 2022 Board)** 	**P&C**	**Director of Workforce and OD**

framed Jan 2022)								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	10	10	**Zero or low** due to patient safety and quality of service.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Nursing**
CRR020 Failure to implement WCCIS leading to inaccessibility of essential patient information.	16	10	**High** level of appetite for risk in this area to innovate in the area of digital technologies. **Low** level risk appetite for the realisation of this risk and to maintain patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(June 2022 PQSO)** 	**PQSO**	**Director of Operations**
CRR007 Inability to reflect demands of an increasingly aging population. ***re-framed July 2022*** Clinical Futures model of care does not take into consideration the evolving needs of	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.	**(June 2022 PPHPC)** 	**PPHPC**	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships**

the population at this time								
CRR010 Inpatients may fall and cause injury to themselves.	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(June 2022 PQSO)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population,	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(June 2022 PQSO)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

for Mental Health support, in light of the COVID 19 pandemic.			reconfigure services and implement new arrangements.					
CRR026 Risk to the general population and patients already within our services, due to less than adequate surge capacity to address any further exponential increase in pandemic response. ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PQSO)** 	**PQSO**	**Director of Operations**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**(May 2022 Board)** 	**ARAC**	**Director of Public Health and Strategic Partnerships and Board Secretary**
CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**

CRR016 Achievement of Financial Balance	16	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However, responding to COVID 19 implications and maintaining safe services take precedence.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 FPC)** 	**FPC**	**Director of Finance and Procurement**
CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 PPHPC)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate. **Moderate** risk appetite with regard to innovation and developments across the Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence***	**(May 2022 Board)** 	**FPC**	**Director of Operations**

					should the risk be realised, is significant.			
CRR032 Failure to achieve underlying recurrent financial balance	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(June 2022 FPC)** 	**FPC**	**Director of Finance and Procurement**
CRR033 (Dec 2021) Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**FPC**	**Director of Planning, Performance and ICT**
CRR021 Welsh Language Act Compliance	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**P&C**	**Director of Workforce and OD**
CRR025 Well Being of Staff and normalisation of risk	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**P&C**	**Director of Workforce and OD**
CRR034 (April 2022) Disruption to Health Board services due to the Ukraine crisis.	10	5	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when reviewing regional responses to the crisis and how the Health Board and its Partners can work collectively to address and mitigate the risks.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(May 2022 Board)** 	**ARAC**	**Director of Planning, Performance and ICT**
CRR035 Sustainability of Primary Care Services due to	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PPHPC**	**Director of Primary, Community and**

increased demand, revised working patterns and continued response to Ukrainian refugee crisis.			innovative ways of providing Primary Care Services.		**Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.			**Mental Health Services**
CRR036 Inability to deliver components of the Health Board's strategy and key priorities where the involvement of key Partners is essential	12	8	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PPHPC**	**Director of Planning, Performance and ICT.**
CRR037 Clinically unsafe and inappropriate inter-site patient transfers and into communities	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PQSO**	**Director of Operations**
CRR038 Increased levels of patient acuity presenting resulting in an inability to staff appropriately and provide acceptable levels of care in line with best practice and guidelines.	15	5	**Low** risk appetite in this area in respect of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**NEW RISK**	**PQSO**	**Director of Nursing/Director of Operations**

CRR039 Delays in discharging medically fit patients partly due to delays in accessing packages of care from Partners - *__covered in part by CRR019 on CRR (unmet demand and ambulance delays)*__	20	10	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when exploring new and innovative ways of working alongside key Partners and acknowledge that some controls and mitigations are outside of the Health Board control.		**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some contributing factors are outside of the Health Board's control.	**NEW RISK**	**PQSO**	**Director of Operations and Director of Primary, Community and Mental Health Services.**

Aneurin Bevan University Health Board

Executive Team Report – July 2022

Executive Summary
This report provides the Board with an overview of a range of activities regarding the Executive Team, including local, regional, and national issues. This report covers the period since the last Board meeting of 25th May 2022.

The Board is asked to:	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	☐
Executive Sponsor: Glyn Jones, Interim Chief Executive Officer	
Report Author: Rani Mallison, Director of Corporate Governance	
Date of the Report: July 2022	
Supplementary Papers Attached: Attachment One – ABUHB Response to HSC Committee Inquiry on Hospital Discharge Attachment Two – National VC Programme – Scale and Spread Project	

Purpose of the Report

This report provides the Board with an overview of a range of activities regarding the Executive Team, including local, regional, and national issues. The report also provides the opportunity to update the Board on organisational achievements, issues and actions being taken which might not otherwise be brought to the attention of Board, as key discussion papers.

Highlights

Executive Team Business

The Chief Executive Officer meets with the Executive Team on a weekly basis, in a formal capacity (Executive Team Business Meetings), with a view to ensuring the effective operational co-ordination of all functions of the organisation, and thus supporting the Chief Executive Officer to discharge the responsibilities delegated to them, including those as Accountable Officer.

During June and July 2022, the Executive Team considered several updates, proposals and service developments, much of which has informed substantive agenda items for Board and Committees. In addition, the following items were also considered:

- Water Safety Management
  The Executive Team supported investment to fund a dedicated internal water safety team to manage and develop water safety compliance within the Health Board. This

investment reflects best practice as seen in other organisations and will enable the water safety team to monitor, manage and implement remedial actions as required but also work proactively to prevent an outbreak and a catastrophic patient safety incident.

- Midwifery Staffing - An Update following the Temporary Service Change
  In response to staffing deficits within maternity services, highlighted in a local options appraisal paper considered by the Executive Team on the 5th May 2022, it was agreed to introduce a temporary service change to maintain safe services. On 30th June 2022, the Executive Team received an update on the impact of the change in the service provision, which commenced from the 9th May 2022, together with the current staffing status. The Executive Team was pleased to note the temporary changes to the model at YYF, RGH and NHH had not seen any untoward patient outcomes. Women have continued to opt to give birth in YYF, home and YAB, both safely and positively. There had also been no concerns raised regarding the temporary changes by women and families. The Executive Team will continue to monitor the temporary change in service provision.
- Mass Vaccination Programme: COVID-19 Autumn Booster Delivery Plan
  The Executive Team approved the combined mass vaccination programme and primary care delivery model for the COVID-19 autumn booster vaccination programme. The aim of the COVID-19 Mass Vaccination Programme (MVP) for the remainder of 2022/23 continues to be the prevention of serious disease, hospitalisation, and mortality.
- Flu Immunisation Programme 2022-23
  The Executive Team approved the Flu Immunisation Programme for 2022-23, which will maximise opportunities for a single programme for COVID-19/ flu vaccination during the 2022-23 season. Planning and awareness raising will be on the basis of a single, coordinated and coherent programme for both vaccines, and wherever possible, delivery models will be aligned to allow for co-administration, to help maximise efficiencies and vaccine uptake.
- Whole System Pressures
  The Executive Team has maintained its focus and attention on the pressures facing the organisation in terms of Urgent and Emergency Care Demand and system flow, working with the organisation to implement actions to support improved performance and improved staff and patient experience. The Executive Team extends its continued thanks to all our staff working tirelessly to care for our communities under sustained levels of pressure.

Consultations and Submissions of Evidence

Hospital discharge and its impact on patient flow through hospitals
The Health Board submitted written evidence to the Health and Social Services Committee in support of the inquiry during January 2022. (Attachment One)

The Health & Social Services Committee published their findings in June 2022, link below.

Hospital Discharge and its impact on patient flow through hospitals

Updates from Operational Services

Vascular Services

On Monday 18th July, the way in which vascular services are delivered in South-East Wales will change to ensure the provision of high-quality, safe and effective care is maintained for the future.

The change will affect Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board areas.

The introduction of a 'hub and spoke' model means all vascular surgery will be undertaken at the University Hospital of Wales in Cardiff, but the majority of care will take place closer to people's homes in spoke hospitals. Spoke hospitals will be maintained at Grange University Hospital, Royal Gwent Hospital, Royal Glamorgan Hospital and Lakeside Wing at University Hospital of Wales.

Improving Quality in Liver Services (IQILS)

The Improving Quality in Liver Services (IQILS) initiative was launched by the Royal College of Physicians in 2017 to accredit liver units across the UK against established standards across a number of domains. Areas for best practice and areas for change are highlighted by the assessment team who conduct a site visit ensuring that the liver service continually develops with improving patient care at the centre of the assessment.

The Gwent Liver Unit achieved level 1 accreditation 2020 and have been working towards full accreditation since that time despite the difficulties with the pandemic and the reconfiguration of ABUHB services. The full assessment took place at the Grange University Hospital in May 2022. The assessment team included Consultant Hepatologists, a Hepatology nurse Consultant from other units in the UK and a patient assessor who interviewed 5 patients known to the Gwent Liver Unit. The day began with a presentation about ABUHB liver services delivered by the Hepatology clinical leads; the assessment team had a tour of the hepatology ward and then interviewed a few members of the liver and management team.

The Unit received positive feedback from the assessment team who reported that patient feedback was excellent and a number service developments received recognition, including the Gastroenterology Ambulatory Care Unit and the Hepatology Nurse specialist home visits, the latter which has received national and international recognition over the last 2 years.

The assessment team has recommended the Gwent Liver Unit for full accreditation; being the 1st in Wales and the 7th in the UK. The Royal College of Physicians will write to the Health Board in due course about this recommendation.

Ysbyty Ystrad Fawr (YYF) - Same Day Emergency Care (SDEC)

Plans for a SDEC Unit at YYF are progressing. Linking with the SDEC project board and the development of SDEC at the Grange University Hospital, the YYF project will provide an opportunity to test SDEC at the eLGH level. Teams are building relationships with GPs via the Neighbourhood Care Network to target supporting those practices that are high volume users of the Medical Assessment Unit and working closely with the Value Based Care team to develop a matrix of qualitative and quantitive data. A business case will be developed for consideration, and submitted by the end of 2022/23.

Ysbyty Ystrad Fawr (YYF) – Medical Assessment Unit

The Medical Assessment Unit at YYF has completed a capital project to increase the assessment spaces from 9 to 14 and add a triage room to improve the flow of patients through the department. Changes in practice and systems have helped to make best use of these additional spaces. The additional spaces have also improved the post pandemic pathways for respiratory and non-respiratory patients attending the assessment unit.

Ysbyty Ystrad Fawr (YYF) - Re-wilding / Green Issues

For 4 years a team of staff based at YYF have been working with Cardiff University Pharma Bees to develop the site into a wildflower / rewilding area to support a beehive on the site. The pharma bees project investigates the development of antimicrobial products from honey. The beehive is being installed in July and 10 members of staff will be trained to be beekeepers. As a well-being project, Cardiff University will be supporting data collection from the members of staff involved with the rewilding and beekeeping to monitor the impact of these activities.

Mental Health and Learning Disability (MHLD) Week 2022

Aneurin Bevan University Health Board celebrated Learning Disability Week 2022 sharing a blog from Melanie Vale, Professional Head of Occupational Therapy for Learning Disability Services). The blog was developed in partnership with Digital Communities Wales to support digital inclusion for people with a learning disability accessing services.
The blog was published by DCW (Digital Communities Wales). It reflects some of the hard work that has gone on during Covid and which continues now. The development of the bid was also supported with the help of Jess Moss (Older Adult MH Head of OT) and Lucy Goodwin (Adult MH Head of OT). The Blog is accessible at the following link: **MV- Log**

Veterans Therapy Space – Maindiff Court Hospital

The formal opening event for Aneurin Bevan University Health Board's Veteran Service Remembrance Garden and therapeutic space at Maindiff Court Hospital will be held on Monday 18th July, 10am -12pm.
Brigadier Aitken, appointed by Her Majesty the Queen as Lord-Lieutenant of Gwent, will be opening the Garden, and will be attended by a wide range of stakeholders, including Veterans.

Wellbeing - PsychPPE

The Mental Health and Learning Disability Division has rolled out an initiative to support employee mental health and wellbeing by helping individuals develop self-care plans to protect their mental and emotional wellbeing. Training has been rolled out using train the trainer principles. There is ongoing evaluation of the initiative with progress of workshops and outcomes being reported to the Mental Health & Learning Disabilities Divisional Assurance meetings. Early reports suggest the approach is valued by participants.

Maternity Services Volunteering Project

Maternity Services, alongside service user group (BABI), have been delighted to secure £12,500.00 funding for a volunteer project from Safer Beginnings (incorporating The White Ribbon Alliance and Best Beginnings). This is essentially to reach more women in our diverse community and encourage feedback and involvement at our BABI group from families who are currently underrepresented (where English is not the first language in the household, families who are homeless, refugees, etc.). The Service has seen increased health inequalities and disparity in care which are usually related to people who do not speak English, not knowing where to find the information and resources available, or able to access these in their first language.

Staff Celebrations, Achievements and Events

Dr Ami Jones collects George Cross on behalf of NHS Wales

Ami Jones, Intensive Care Consultant for Aneurin Bevan University Health Board, joined NHS Wales Chief Executive Judith Paget to collect the George Cross from the Queen at a ceremony in Windsor Castle on 12th July2022.

Ami and Judith, our former CEO, received the award on behalf of the entire team of NHS Wales workers in recognition of their courage, compassion and skill throughout the Covid-19 pandemic.

The Queen was accompanied by the Prince of Wales for the presentation.
Ami, who is also a Lieutenant Colonel in the Army Reserves, said: "As someone who serves in the Military, I appreciate that only the very best receive this medal and our amazing NHS staff are certainly worthy recipients. Our staff would have never imagined that such a daunting pandemic would take place in their lifetimes, but they put their own fears aside to provide excellent care to their patients and find solutions to the unprecedented problems that they faced on a daily basis."

Medicine Practice Education

The Medicine Practice Education team have been awarded a 'highly commended' runner up certificate for the development and implementation for the Band 4 Assistant practitioner programme across the acute care setting.

Therapy Services

- Following our success in winning a Tech Cymru award for our virtual work during the Covid pandemic and since, SLT and Physiotherapy have been invited to a Scale and Spread awards dinner in August. The attached document shows the scale of our deployment of video conferencing virtual clinical work (highest Health Board area in Wales for these two services) and also all of the good practice videos are from within Therapies in ABUHB (Physio, SLT and Podiatry). (Attachment Two)

Clinical Research Practitioner

Sean Cutler began working in Research as a trials co-ordinator. His interest in working alongside the research nurse specialists to delivery clinical trials was rewarded when he was appointed to the position of Clinical Research Practitioner (CRP). Sean has supported the delivery of many clinical trials and most recently has become the first CRP in Wales to receive formal accreditation.

CRPs are now identified as an occupational group in health and care in the UK by the UK Professional Standards Authority (PSA). The PSA is the body that sets the standards for accredited registers of people who work in health and social care. In April 2020, accredited registration for CRPs was approved by the PSA as part of the Academy for Healthcare Science (AHCS) Accredited Register.

Child Health Volunteer

The Community Paediatrics Team would like to celebrate the long service of Zoe Wise who has volunteered within the Child Health department for 21 years. Zoe has supported the work of the paediatric team, and her contribution has helped staff in their efforts to

improve services for children and young people. We wish to thank Zoe for all her hard work and to recognise her as a valued member of our team.
Recommendation
The Board is asked to note this report for information.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	COVID-19 and system pressures remain key risks on the Board's Corporate Risk Register.
Financial Assessment, including Value for Money	There are no direct implications arising from this report.
Quality, Safety and Patient Experience Assessment	There are no direct implications arising from this report.
Equality and Diversity Impact Assessment (including child impact assessment)	An EQIA has not been undertaken on the contents of this report.
Health and Care Standards	The range of activities outlined in the report will contribute to the Health Board's approach to Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The range of activities outlined in the report will contribute to the Health Board's strategic objectives.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The range of activities outlined in the report will contribute to the Health Board's approach to the Well Being of Future Generations Act.
Glossary of New Terms	No new terms have been identified.
Public Interest	This report is written for the public domain.

Aneurin Bevan University Health Board (ABUHB) response to support the Health & Social Care Committee Inquiry on Hospital discharge and its impact on patient flow through hospitals

- **The scale of the current situation with delayed transfers of care from hospital.**

  Prior to the Covid pandemic, Welsh Government (WG) received robust, validated reporting from all Health Boards and Local Authorities across Wales concerning the number of patients delaying in all hospital beds. WG had removed any local agreements being applied in order to apply a consistent approach across all Wales. This validation was a snapshot in time on a monthly basis however it did allow Health Boards and Local authorities the ability to apply a thematic approach towards their delay reasons and apply changes in practices to improve areas of concern and reduce or prevent particular delays from reoccurring.

  Delayed Transfers of Care (DToC) reporting was suspended at the commencement of the Covid Pandemic and as such the joint approach to validation is not in place, with figures collected locally and owned by Health Boards.

  The scale of the current situation is quite significant with patients occupying hospital beds who have completed their in-patient episode of care but are 'stranded' in hospital. Our DToC numbers vary from circa 200 – 250 at any given time, with the present staffing issues within domiciliary care and social care having a very real impact, together with the challenges of transferring patients back to care homes (due to Covid incidents). This is translating into other key metrics such as increased Lengths of Stay (LoS), increasing numbers of patients with a hospital episode of greater than 21 days and high numbers of patients who are categorised as Level 4/5 (based on the Welsh Levels of Care) illustrating dependency.

- **The impact of delays in hospital discharge, both on the individual and the patient flow through hospitals and service pressures.**

  The impact of remaining in hospital when you are ready for discharge is well known and evidenced within the literature. For the patient these include exposure to hospital-related risks such as hospital-acquired infection, the creation of physical and emotional dependency and consequent patient deconditioning in hospital. The National Audit for Intermediate Care cited a delay of seven days can result in a 10% decline in muscle strength due to long periods of immobility (emphasised through the national End PJ Paralysis campaign). From a system perspective DToC means a lack of available beds for other patients (scheduled and unscheduled) and therefore impact on patient flow and increasing costs.

It would perhaps be prudent to focus on the impact of poorly planned discharge or premature discharge to illustrate the broader challenge for health and social care and indeed the patient and their family. Much of the literature & evidence refers to sub-optimal care as a direct result of poorly coordinated and premature discharge arrangements, with avoidable adverse events and in some instances post-discharge deaths. Whilst risks can be variable and complex, ineffective collaborative working and poor communication are often cited as key contributors to unsafe patient discharge. This clearly impacts on the patient and the system.

- **The variations in hospital discharge practices throughout Wales and cross-border, and how they are meeting the care and support needs of individuals.**

  There have been significant efforts to secure a consistent approach to hospital discharge from a national perspective, some of which have been driven by the Delivery Unit.

  We have policies and multiple initiatives aimed at enhancing safe, timely and effective hospital discharge but it could be seen that the policies are initiatives focus on process as opposed to the complex system within which health and care operate and the vulnerable connections between stakeholder organisations.

  From an ABUHB perspective, our geographical area is made of five Local Authorities; Blaenau-Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. The Health Board also liaises with Powys Teaching Health Board for residents in South Powys as well as Hereford and Gloucester for cross-border care.

  In reality, there is system complexity with each Local Authority operating differently with different models of care and bespoke ways of working which makes hospital discharge for Health Board staff confusing, exacerbated by vulnerable connections.

- **The main pressure points and barriers to discharging hospital patients with care and support needs, including social care services capacity.**

  Safe, timely, effective hospital discharge is ever-more challenged at the present time as a direct result of the pandemic. The reasons are multi-faceted and some of which have been outlined above.

  The main challenges are bullet pointed, albeit simplistically, below and include:

  - Workforce gaps across health and social care (most notably, but not exclusively, domiciliary care);
  - The fragility of the independent sector (Care Homes);
  - Interagency communication;
  - Demand and capacity mis-match, increasing LoS and patient dependency couple with pressure to discharge which can equate to premature discharge;
  - Knowledge, skill and competency in the discharge process; and
  - Differing accountabilities between health and social care.

- **The support, help and advice that is in place for family and unpaid carers during the process.**

  Gwent has a number of established citizen panels which are made up of informal carers, unpaid carers and service users. The panels have been instrumental in the development of targeted documents which are easy to understand and relevant to patients, carers and family at the time of discharges.

  We have well-established discharge coordinators who support more complex discharge and operate at an inter-organisational level. They have a deeper understanding of the discharge process and help navigate the system, aligning divergent ways of working and supporting families/unpaid carers. That said, multiple national audits and independent reviews (Carers UK for example) show there is an increase in care burden which is having a detrimental impact on the health and well-being of unpaid carers.

  We believe there is an increasing reliance on families and unpaid carers, especially with the workforce gaps evident currently and this may cause unintended consequences upstream.

- **What has worked in Wales, and other parts of the UK, in supporting hospital discharge and improved patient flow, and identifying the common features.**

  - Hospital Discharge seen as one of multiple transitions in a patient's journey and a risk episode (not a simple transaction);
  - Discharge Coordinators;
  - The SAFER initiative;
  - D2RA;
  - A pathway approach: on admission, during admission and 48 hours pre-discharge, day of discharge safety checks and post-discharge follow-up;
  - Transitional and intermediate care models;
  - MFFD and TEPS;
  - The Trusted Assessor mode; and
  - Choice Policy.

- **What is needed to enable people to return home at the right time, with the right care and support in place, including access to Reablement services and consideration of housing needs**

  A cultural shift across the way health and social care operate and interact. Within ABUHB we have very good working relationships with our Local Authority colleagues, however working together to get patients in the right place at the right time needs to be improved, with greater system thinking and joined up service provision, with more of a risk-based approach.

  Patients are admitted for a specific health care reason however health services have generally had a culture of "fixing" every part of a person's life and addressing the entirety of their social care needs; when quite often these needs were long standing or already being addressed at home prior to their healthcare 'blip'. The delay in the patients discharge through this perceived misconception that discharge home is no longer safe to continue without formal

services as opposed to 'wrap-around' services being in place has the detrimental impact of deconditioning individuals resulting in an increased dependency.

The Delivery Unit model of Discharge to Recover to Assess and what good looks like clearly evidences how reablement services should be operating on pathway 2 (and indeed on pathway 0, 1 and 4) we have listed below as a focus on the need to not lose site of excellent work already identified however the issue still remains on how will this consistently be achieved when there are inconsistencies across models within an area of five (6) Local Authorities.

DISCHARGE TO RECOVER THEN ASSESS IN A PERSON'S OWN HOME

What good looks like……

1. Any existing plans, including Anticipatory and Advance Care Plans, will be conveyed to hospital with the patient or electronically. These plans will be actively used in the discharge planning process.

2. An early 'What Matters to Me' conversation will take place as soon as possible during admission, ideally at the 'front door' of the hospital (Emergency Department/Assessment Unit). What matters to the individual will be clearly communicated and will form the basis of all multi-disciplinary discussions regarding discharge.

3. During the hospital admission, the ward team will use the information provided to minimise risks of deconditioning.

4. The principles of good discharge planning through 'Passing the Baton' guidance will be adhered to, including ongoing dialogue with the individual and their families (answering the 4 key questions to help patients return home) and the implementation of the SAFER patient flow bundle.

5. D2RA Pathway 2 will be the default pathway for any individual deemed likely to need new or additional support at home during their recovery period, and/or on a longer-term basis. Evidence to date indicates that we can expect around a quarter of older people admitted to hospital to be discharged on this pathway.

6. In addition, around 20% of older people discharged from hospital may need short-term practical support to get back on their feet. This can include for example, putting the heating on, settling back in, shopping, washing etc. and is often commissioned from third sector organisations. Individuals in this group do not need to be placed on D2RA Pathway 2, but the individual or the provider organisation should be able, as part of the contingency plan, to access it from the community if required.

7. A trusted assessor will attend MDT Board Rounds and, using the Clinical Criteria for Discharge (CCD) and Estimated Date of Discharge (EDD), will assess the minimum requirements needed to take the individual home on Discharge to recover then Assess Pathway 2.

That assessment will:

- Centre on what matters to the individual;
- Be strengths-based; and
- Encompass positive risk-taking.

8. This assessment will be used to co-produce the individual's Discharge & Recovery Plan, alongside the community team that will be providing the wrap-around support.

9. The wrap-around support will be:

   - Timely (i.e. available within 48 hours of the individual no longer requiring in-patient treatment);
   - Proportionate and focussed on recovery (there is evidence that care and support is currently often over-prescribed);
   - Time-limited; and
   - Funded via intermediate care.

10. The type of support provided can include a range of services, such as those listed below, and therefore the plan will need to be co-ordinated by the trusted assessor or other named individual, who will need up-to-date knowledge of what is available locally:

    - Community Resource Teams including Reablement teams;
    - Virtual Wards;
    - District Nurses;
    - Community-based therapies;
    - Community Pharmacy;
    - Equipment services (statutory and third sector);
    - Assistive technologies;
    - Community Mental Health teams; and
    - In-house support provided by social housing.

11. The nature of the support, including the enablement approach, should be clearly communicated to the individual and their family/unpaid carers (where appropriate).

12. Set timescales for the intervention should be avoided e.g. there is growing evidence to suggest that many people recover and require no further support after 2 or 3 weeks intervention. However, it is difficult to withdraw a service that is no longer required if, for example, an individual/their family has been provided with the expectation of 6 weeks support. It is recommended that all individuals on D2RA Pathway 2 should be reviewed by the MDT after 2 weeks, so that the input can be modified in response to changing need/recovery. This can then release scarce resource to provide timely support for more people ready to join the Pathway.

13. At the end of the period of supported recovery and assessment, the next steps for the individual will be agreed with them, their families and the relevant support services.

In regards to housing issues, Care and Repair services embrace the principles of co-production and prudent healthcare by working with patients and clinicians to develop housing solutions together and through our Healthcare standards we maintain the following principles however the issues of inconsistencies across ABUHB is evident.

Staying Healthy – their Healthy Homes Check and falls risk assessment are delivered as part of the Hospital to a Healthier Home (H2HH) service to ensure that appropriate, prudent action is taken to allow patients to return from hospital to a home that has already been adapted to meet their needs for safe independent living. Their H2HH caseworkers offer a full casework service, including signposting, referral and advice about local support and opportunities available. Their H2HH caseworkers also completes an income check to ensure patients are in receipt of the benefits, income, and financial support they may be entitled to, which can be used to maintain a safe and warm home.

Safe Care – They work with clinicians to understand a patient's clinical needs, as well as completing the Healthy Homes Check and falls risk assessment. This ensures sustainable outcomes for independent living over the long term.

Effective Care – all actions undertaken are to meet the needs of the individual. They take a whole person, whole house holistic approach. Their work is integral to wider policy goals and aims such as Discharge to Recovery to Assess, and care closer to home.

Dignified Care – Care & Repair want a Wales where all older people can live independently in warm, safe and accessible homes. Their mission and values centre on dignity and respect for the individual; an inclusive, person-centred approach; and a quality service that respects the different cultures and life experiences of their clients. Their staff are aware of responsibilities to make services accessible across all Equalities strands and they have an operational Equalities Guide, developed through a partnership with Tai Pawb.

Individual Care – aids, adaptations and home improvements are delivered on a case-by-case basis subject to individual need as determined through conversations with the patient, clinicians and Healthy Home Check. They take a whole person, whole house approach and their What Matters conversations ensure that individual desires as well as needs are taken into consideration before agreed services are acted upon.

Staff and resources – Their services assist NHS staff to make the best use of their time and resources. They are the eyes and ears of a patient's home, meaning clinicians can spend more time on wards rather than visiting homes.

There is also added-value from this additional level of perception, where community-facing NHS staff like Occupational Therapists and Physiotherapists can receive more information about the living environment post-discharge. Through bed days saved and avoided readmissions, they provide ABUHB with cost savings.

In relation to re-housing there is evidently a need to review and invest in a variety of step down and temporary accessible housing facilities; commission a housing focused hospital discharge service (align and address gaps in existing housing and social care discharge and admission prevention services) and develop clear hospital discharge pathways including increased focus on early referrals to and communication with housing support schemes.

Nicola Prygodzicz
Dirprwy Brif Weithredwr Dros Dro / Interim Deputy Chief Executive
10th January 2022

Aneurin Bevan University Health Board

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) Update Report – July 2022

Purpose of Report	
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 Welsh Health Specialised Services Committee (WHSSC) as a Joint Committee of the Board.	
The Board is asked to: *(please tick as appropriate)*	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	
Executive Sponsor: Interim Chief Executive Officer	
Report Author: Director of Corporate Governance	
Report Received consideration and supported by: N/A	
Date of the Report: 15th July 2022	
Supplementary Papers Attached: 1) Chair's Summary of the Joint Committee Meeting held 10th May and 12th July 2022 2) Chair's Summary of WHSSC's Quality and Patient Safety Committee meeting held 7th June 2022	

Background and Context

WHSSC was established in 2010 by the seven Health Boards in Wales to ensure that the population of Wales has fair and equitable access to the full range of specialised services. WHSSC is therefore responsible for the joint planning of Specialised and Tertiary Services on behalf of Health Boards in Wales.

In establishing WHSSC to work on their behalf, the seven Health Boards recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

The Joint Committee is led by an Independent Chair, appointed by the Minister for Health and Social Services, and membership is made up of three Independent Members, one of whom is the Vice Chair, the Chief Executive Officers of the seven Health Boards, Associate Members and a number of Officers. The Standing Orders of each of the seven Health

Boards include the Governance Framework for WHSSC, including a Scheme of Delegation as published on the WHSSC website Schedule 4 (nhs.wales).

Whilst the Joint Committee acts on behalf of the seven Health Boards in undertaking its functions, the responsibility of individual Health Boards for their residents remains and they are therefore accountable to citizens and other stakeholders for the provision of specialised and tertiary services.

Specifically, the role of the WHSSC Joint Committee (as set out in Standing Order 1.1.4 Schedule 4 (nhs.wales)https://easc.nhs.wales/the-committee/governance/easc-standing-orders-july-2021-and-sfis-march-2022/) is to:

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;
- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;
- Agree annually those services that should be planned on a national basis and those that should be planned locally;
- Produce an Integrated Commissioning Plan, for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the in-year risks associated with the agreed service portfolio and new pressures that may arise;
- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and
- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

Each of the seven Health Boards have agreed a Memorandum of Agreement (https://whssc.nhs.wales/publications/governance/whssc-memorandum-of-agreement-2021/)
in respect of the Joint Committee and in doing so have agreed that each Health Board recognises the following principles, aligned to the agreed Standing Orders:

- the Management Team will be held to account by the Joint Committee for the delivery of a strategy for the provision of specialised and tertiary services for Wales as well as providing assurance that the systems of control in place are robust and reliable.
- 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.
- that each individual LHB is responsible for the people who are resident in their area. This means that the Joint Committee of which each Chief Executive is a member is acting on behalf of the 7 LHBs in undertaking its role.
- 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.

- that each Chief Executive as a member of the Joint Committee will require the Management Team of the Joint Committee to ensure that, in the timetabling of the annual work programme, sufficient time will normally be allowed to enable each Chief Executive to consult with their own LHB and appropriate local partners and stakeholders.
- that when an individual Chief Executive is unable to attend a meeting of the Joint Committee, he/she will appoint in advance and identify to the Committee Secretary a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

Assessment and Conclusion

This report provides an update regarding business undertaken during the last reporting period.

The Joint Committee held its most recent meeting on 12th July 2022. The papers for the meeting are available at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/20222023-meeting-papers/jc-public-agenda-july-2022/
The Committee was attended by Nicola Prygodzicz, Director of Planning, Performance, Digital and IT and the Interim Deputy Chief Executive Officer.

A summary of the business held is outlined as follows:

Presentation

1. Recovery Trajectories across Wales

Items for Consideration and/or Decision:

1. Chair's report
   Chair of the Individual Patient Funding Request (IPFR) Panel - It was noted that the WHSSC Chair had written to NHS Wales Chairs for support in appointing an interim Health Board Chair for a 6-month period from amongst their Independent Members (IM's) to ensure business continuity. In the meantime, the Vice Chair of the IPFR panel was undertaking the Chair's role on an unremunerated interim basis until July 2022 as agreed by the Joint Committee.
2. Neonatal Transport – The Joint Committee received an update from the Neonatal Transport Delivery Assurance Group (DAG) meeting held on 21 June 2022.
3. Draft Specialised Paediatric Services 5-year Commissioning Strategy – The Joint Committee considered the contents of the draft Specialised Paediatric Services 5-year Commissioning Strategy which will be issued for a 6 week engagement process to obtain stakeholder feedback, prior to the final version being presented to the Joint for Committee for approval in September 2022.
4. South Wales Cochlear Implant and BAHA Hearing Implant Device Service – The Joint Committee received the outcome of a recent review of tertiary auditory services and the considered the planned next steps for the South Wales Cochlear Implant and BAHA Hearing Implant Device Service.
5. Hepato-Pancreato-Biliary (HPB) Services for Wales – The Joint Committee received a summary on the Hepato-Pancreato-Biliary (HPB) surgery project for South and West Wales, and considered the proposed arrangements to provide assurance to the WHSSC Joint Committee as the future commissioners for the service.

6. Policy for Policies and EQIA Policy – The Joint Committee received feedback from the stakeholder consultation on the revised WHSSC 'Policy for Policies' Policy and the new Equality Impact Assessment (EQIA) policy, and approved both for publication.
7. Policy position for the commissioning of drugs and treatments for patients aged between 16 and 18 years of age – The Joint Committee considered and supported the preferred policy position for the commissioning of drugs and treatments for patients aged between 16 and 18 years of age.
8. Supporting Ukrainian Refugees with Complex Health Needs – The Joint Committee considered and supported a proposal for managing the complex health needs of Ukrainian refugees arriving in Wales.
9. Proposal for Welsh Renal Clinical Network (WRCN) Name Change – The Joint Committee received the outcome of an engagement process to consider a change of the name of the Welsh Renal Clinical Network (WRCN) and supported the decision of the WRCN Board to change the name to the Welsh Kidney Network.
10. Results of the Annual Committee Effectiveness Self-Assessment 2021 -2022 & Joint Committee Development Plan – The Joint Committee received an update on the actions from the annual Committee Effectiveness Self-Assessment undertaken in 2020-2021 and to noted the results of the annual committee effectiveness self-assessment 2021-2022.
11. Corporate Risk Assurance Framework (CRAF) – the Joint Committee received an updated Corporate Risk Assurance Framework (CRAF) which outlined the risks scoring 15 or above on the commissioning teams and directorate risk registers.
12. All Wales IPFR Panel Sub-Committee Annual Report 2021-2022 – The Joint Committee received the All-Wales IPFR Panel Annual Report 2021-2022.

Items Noted for Information:

1. Activity Report, Month 1 of 2022-2023,
2. Financial Performance Report, Month 2 of 2022-2023
3. Corporate Governance Matters Report
4. Reports from the Joint sub-committees.

This report also provides, as supplementary papers, a Chair's Summary of the Joint Committee Meeting held on 10th May 2022 (attachment 1) and a Summary of WHSSC's Quality and Patient Safety Committee meeting held 7th June 2022 (attachment 2).

Recommendation

The Board is asked to receive this report for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report.
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report.

Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report as it is for assurance purposes only.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to the Plan associated with this report, however the work of the Joint Committee contributes to the overall implementation and monitoring of health board IMTPs.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the Joint Committee's considerations, where appropriate.
Glossary of New Terms	IPFR – Individual Patient Funding Requests WHSSC – Welsh Health Specialised Services Committee
Public Interest	This report is written for the public domain.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 10 MAY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 10 May 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings

The minutes of the meeting held on the 15 March 2022 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. Genomics Presentation

Members received an informative presentation on the All Wales Genomics Laboratory and how the Wales Infants and Children's Genome Service (WINGS) had pushed the boundaries of genomic testing in Wales to an unprecedented scale using whole genome sequencing which had the capacity to sequence the entire DNA structure of the human body in a matter of hours.

Members noted the Watson family's patient story (publically available on the BBC website) which shared their first hand experience of using the WINGS, when their baby suffered from breathing difficulties and complications to her nose and airways.

Members **noted** the presentation.

4. Chair's Report

Members received the Chair's Report and **noted**:

- An update on the proposal for an interim Chair of the Individual Patient Funding Request (IPFR) Panel,
- Attendance at the Integrated Governance Committee (IGC) meetings on the 30 March 2022 & 19 April 2022; and
- Attendance at key meetings.

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- That WHSSC had been successful in publishing an article in the Applied Health Economics and Health Policy Journal on a "A Case Study on Reviewing Specialist Services Commissioning in Wales: TAVI for Severe Aortic Stenosis",
- The first two NRP (Normothermic Regional Perfusion) organ retrievals undertaken by the the Cardiff Transplant Retrieval Service,
- The stakeholder engagement being undertaken on the Genomics Delivery Plan for Wales,
- The positive feedback received following the Extension of the FastTrack Process for Military Personnel; and
- The findings of a review into Molecular Radiotherapy (MRT) to guide development of an all Wales MRT service.

Members **noted** the report.

6. Interim Appointment of Chair for the All Wales IPFR Panel

Members received a report proposing that an Interim Chair is appointed to the Individual Patient Funding Request Panel (IPFR) for a 3 month period to support business continuity and to allow sufficient time to prepare for, and undertake, a recruitment process to appoint a substantive Chair.

Members (1) **Noted** the report; and (2) **Approved** the proposal to appoint an interim Chair to the Individual Patient Funding Request Panel (IPFR) for a 3 month period to support business continuity and to allow sufficient time to recruit a substantive Chair.

7. Neonatal Transport Operational Delivery Network

Members received a report providing an update from the Neonatal Transport Delivery Assurance Group (DAG) established to provide commissioner assurance on the neonatal transport service.

Members (1) **Noted** the information presented within the report; and (2) **Received assurance** that there were robust processes in place to ensure delivery of the neonatal transport services.

8. Draft Mental Health Specialised Services Strategy for Wales 2022-2028

Members received a report presenting the draft Mental Health Specialised Services Strategy for Wales 2022-2028, and seeking endorsement for its circulation through key stakeholder groups for comment.

Members (1) **Noted** the draft Mental Health Specialised Services Strategy for Wales 2022-2028, and provided comments on the document,

(2) **Noted** that the draft Mental Health Specialised Services Strategy for Wales 2022- 2028 would be circulated through a comprehensive stakeholder list in a bilingual format for comment and that the suggested date of between 10 May and 6 June 2022, would be reviewed and extended; and (3) **Noted** that it was anticipated that the final strategy would be published during Winter 2022, and will be brought back to the Joint Committee for approval.

9. Preparedness for the COVID-19 Inquiry
Members received a report providing an update on WHSSC's preparedness for the COVID-19 Public Inquiry.

Members **noted** the report.

10. Disestablishment of the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group
Members received a report providing a brief overview of the work that had been undertaken by the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group and which was seeking support to disestablish the advisory group, as there was no longer a requirement for it to be established as a sub group of the Joint Committee.

Members (1) **Noted** the work undertaken by the Joint Committee's sub group the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group, (2) **Approved** the proposal to disestablish the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group; and (3) **Noted** that the work of the group had been incorporated into the Inclusion and Corporate Business Division within Social Services in Welsh Government (WG), and that further consideration was required on the system of oversight of health board commissioned LD placements.

11. Annual Governance Statement 2021-2022
Members received the Annual Governance Statement (AGS) 2021-22 for retrospective approval.

Members (1) **Noted** the report, (2) **Noted** that the Draft Annual Governance Statement (AGS) was endorsed at the Integrated Governance Committee (IGC) on 19 April 2022 and the draft was submitted to CTMUHB in readiness for the 29 April 2022 deadline set, (3) **Approved** the WHSSC Annual Governance Statement (AGS) 2021-2022, (4) **Noted** that the WHSSC Annual Governance Statement (AGS) 2021-2022 will be included in the CTMUHB Annual report being submitted to Welsh Government and Audit Wales by 15 June 2022, recognising that it had been reviewed and agreed by the relevant sub committees of the Joint Committee; and (5) **Noted** that the final WHSSC Annual Governance Statement (AGS) will be included in the Annual Report presented at the CTMUHB Annual General Meeting (AGM) on 28 July 2022.

12. Sub-Committee Annual Reports 2021-2022

Members received the Sub- Committee Annual Reports for the reporting period 1 April 2021 to 31 March 2022 which set out the activities of each sub-committee during the year and detailing the results of reviews into performance.

Members **noted** the Sub-Committee Annual Reports for 2021-2022.

13. Sub-Committee Terms of Reference

Members received the updated Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) and the Management Group (MG) for approval.

Members noted that ToR for the sub-committees of the Joint Committee were reviewed on an annual basis in line with Standing Orders and to ensure effective governance.

Members noted that ToR for the Welsh Renal Clinical Network (WRCN) were approved by the Joint Committee on 18 January 2022, and discussions were ongoing with Welsh Government concerning updating the ToR for the All Wales IPFR panel.

Members (1) **Noted** that the Terms of Reference were discussed and approved at sub-committee meetings on 30 March 2022 and 28 April 2022; and (2) **Approved** the revised Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) and the Management Group (MG).

14. COVID-19 Period Activity Report for Month 11 2021-2022

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members (1) **Noted** the report; and (2) **Agreed** to hold an extended session on activity reporting at the next meeting of the Joint Committee in July to scrutinise provider recovery reports.

15. Financial Performance Report – Month 12 2021-2022

Members received the financial performance report setting out the financial position for WHSSC for month 12 2021-2022. The financial position was reported against the 2021-2022 baselines following approval of the 2021-2022 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in January 2021.

The financial position reported at Month 12 for WHSSC was a year-end outturn under spend of £13,112k.

Members **noted** the report.

16. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

17. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee (ARC)
- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR)Panel; and
- Welsh Renal Clinical Network (WRCN).

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 12 JULY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 12 July 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings

The minutes of the meeting held on the 10 May 2022 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. Recovery Trajectories across NHS Wales

Members received informative presentations on the recovery trajectories across Wales from the NHS Wales Delivery Unit, Betsi Cadwaladr UHB (BCUHB), Swansea Bay UHB (SBUHB) and Cardiff & Vale (CVUHB).

Members **noted** the presentations and requested that an update on the trajectories for paediatric recovery be brought to the next meeting.

4. Chair's Report

Members received the Chair's Report and **noted**:

- No Chair's actions had been taken since the last meeting,
- An update on the letter issued to NHS Chairs requesting support in appointing an interim HB chair for the All Wales Individual Patient Funding Request (IPFR) Panel for a 6 month period from amongst their Independent Members (IMs) to ensure business continuity,
- An update on plans for the recruitment process to fill the WHSSC IM vacancy,
- Attendance at the Integrated Governance Committee (IGC) meeting on the 7 June 2022; and
- Attendance at key meetings.

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates on:

- Discussions with Welsh Government (WG) concerning the All Wales IPFR Panel and the authority of the Joint Committee to update and approve the panel's Terms Of Reference (ToR), the governance process for updating the All Wales IPFR policy, the briefings given to the Board Secretaries on the 10 June 2022, and to the All Wales Medical Directors Group (AWMDG) on the 1 July 2022 and that a letter confirming next steps was awaited from WG,
- The revised timeline for the draft Mental Health Specialised Services Strategy 2022-2028 engagement process,
- The funding for Cell Path Labs to meet the growing demand for commissioned WHSCC cancer genomic testing; and
- The designation of SBUHB as a provider of Stereotactic Ablative Radiotherapy (SABR).

Members **noted** the report.

6. Neonatal Transport – Update from the Delivery Assurance Group (DAG)

Members received a report providing an update from the Neonatal Transport Delivery Assurance Group (DAG) meeting held on 21 June 2022.

Members (1) **Noted** the report, (2) **Received** assurance that Neonatal Transport was being scrutinised by the Delivery Assurance Group (DAG), (3) **Noted** that further work was being undertaken by the transport service on the reporting to strengthen the assurance; and
(4) **Noted** the update on the implementation of the Neonatal Transport Operational Delivery Network (ODN).

7. Draft Specialised Paediatric Services 5 year Commissioning Strategy

Members received a report presenting the Draft Specialised Paediatric Services 5 year Commissioning Strategy for information and which sought support to share the strategy through a 6 week engagement process to obtain stakeholder feedback.

Members (1) **Noted** the contents of the draft Specialised Paediatric Services 5 year Commissioning Strategy; and (2) **Supported** that the Strategy be issued for a 6 week engagement process to obtain stakeholder feedback, prior to the final version being presented to the Joint for Committee for approval in September 2022.

8. South Wales Cochlear Implant and BAHA Hearing Implant Device Service

Members received a report presenting the process and outcome of a

recent review of tertiary auditory services and the planned next steps for the South Wales Cochlear Implant and BAHA Hearing Implant Device Service.

Members discussed the preferred commissioning option and agreed that the report be updated with more detail on the process undertaken to agree the preferred option for engagement, and that the report be presented the next Management Group meeting for review prior to being brought back to the Joint Committee either virtually or at an extraordinary committee meeting.

Members (1) **Noted** the report, (2) **Noted** and **received assurance** on the assessment process inclusive of a) clinical options appraisal, b) external review against standards and c) financial option appraisal, (3) **Noted** the outcome of the clinical options appraisal for the south Wales centres, the external hearing implant centre and the financial appraisal, (4) **Noted** the preferred commissioning option as the basis of engagement/consultation; and **agreed** a review of the process at the Management Group meeting on the 28 July 2022 and for reconsideration of the proposals either virtually or at a future extra-ordinary meeting of the JC; and (5) **Agreed** to receive the required engagement/consultation documentation and process at the September meeting of the Joint Committee.

9. Hepato-Pancreato-Biliary (HPB) Services for Wales
Members received a report providing a summary on the Hepato-Pancreato-Biliary (HPB) surgery project for South and West Wales, and which sought support for the proposed arrangements to provide assurance to the WHSSC Joint Committee as the future commissioners for the service.

Members (1) **Noted** the report, (2) **Supported** the Hepato-Pancreato-Biliary (HPB) surgery Project Initiation Document (PID) and Action Plan Tracker; and (3) **Supported** the proposals to receive assurance that the outputs of the Hepato- Pancreato-Biliary (HPB) project align with the WHSSC strategic objectives and commissioning intentions.

10. Policy for Policies & EQIA Policy
Members received a report presenting feedback from the stakeholder consultation on the revised WHSSC 'Policy for Policies' Policy and the new Equality Impact Assessment (EQIA) policy, and which sought approval for publishing both documents.

Members (1) **Noted** the report, (2) **Supported** the rationale and process that had been applied when updating the WHSSC 'Policy for Policies' Policy and developing the new EQIA policy; and (3) **Approved** the request to publish the WHSSC 'Policy for Policies' Policy and EQIA Policy following stakeholder consultation.

11. Policy Position for the Commissioning of Drugs and Treatments for Patients aged between 16 and 18 years of age
Members received a report seeking support from the Joint Committee on the preferred policy position for the commissioning of drugs and treatments for patients aged between 16 and 18 years of age.

Members (1) **Noted** the report; and (2) **Supported** the preferred option identified within the report.

12. Supporting Ukrainian Refugees with Complex Health Needs
Members received a report setting out a proposal for managing the complex health needs of Ukrainian refugees arriving in Wales and seeking approval to manage the excess costs (>£20k per annum) within the current funding baselines in year, offsetting against non-recurrent slippage and reserves.

Members (1) **Noted** the report; and (2) **Approved** the proposal to manage the excess costs within the current funding baselines in year, offsetting against non-recurrent slippage and reserves.

13. Name Change Welsh Renal Clinical Network (WRCN
Members received a report informing the Joint Committee of the outcome of the engagement process to consider a change of the name of the Welsh Renal Clinical Network (WRCN) and to ratify the decision of the WRCN Board to change the name to the Welsh Kidney Network.

Members (1) **Noted** the outcome of the engagement process to seek views to change the name of the Welsh Renal Clinical Network (WRCN); and (2) **Ratified** the decision of the WRCN Board to change the name of the WRCN to the "Welsh Kidney Network".

14. Results of the Annual Committee Effectiveness Self-Assessment 2021 -2022 & Joint Committee Development Plan
Members received a report presenting an update on the actions from the annual Committee Effectiveness Self-Assessment undertaken in 2020-2021 and to present the results of the annual committee effectiveness self-assessment 2021-2022.

Members (1) **Noted** the completed actions made against the Annual Committee Effectiveness Survey 2020-2021 action plan, (2) **Noted** the results from the Annual Committee Effectiveness Survey for 2021-2022, (3) **Noted** that the findings were considered by the Integrated Governance Committee (IGC) on the 7 June 2022, (4) **Noted** that the feedback will contribute to the development of a Joint Committee Development plan to map out a forward plan of development activities for the Joint Committee and its sub committees for 2022-2023; and (5) **Noted** the additional sources of assurance considered to obtain a broad view of the Committee's effectiveness.

15. Corporate Risk Assurance Framework (CRAF)

Members received a report presenting the updated Corporate Risk Assurance Framework (CRAF) and outlining the risks scoring 15 or above on the commissioning teams and directorate risk registers.

Members (1) **Noted** the updated Corporate Risk Assurance Framework (CRAF) as at 31 May 2022, (2) **Approved** the Corporate Risk Assurance Framework (CRAF); and (3) **Noted** that a follow up risk management workshop was planned for the 20 September 2022 to review how the Risk management process is working, and to consider risk appetite and tolerance levels across the organisation.

16. All Wales IPFR Panel Sub-Committee Annual Report 2021-2022

Members received a report presenting the All Wales IPFR Panel Annual Report 2021-2022.

Members **noted** the All Wales IPFR Panel Annual Report 2021-2022.

17. COVID-19 Period Activity Report for Month 1 2022-2023 COVID-19 Period

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members **noted** the report.

18. Financial Performance Report – Month 2 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 2 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 202-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 2 for WHSSC was a year-end outturn forecast under spend of £515k.

Members **noted** the report.

19. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

20. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee (ARC),

- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR) Panel; and
- Welsh Renal Clinical Network (WRCN).

21. AOB

- **WHSSC Specialised Services Strategy** – Members noted that work had commenced to plan the engagement process for developing the WHSSC Specialised Services Strategy and that a workshop would be held at the Joint Committee on the 6 September 2022.

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**June 7th 2022**

Summary of key matters considered by the Committee and any related decisions made

Commissioning Team and Network Updates

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

1.0 Welsh Renal Clinical Network (WRCN)

The Committee received the report from the network. There were no issues to report.

2.0 Cancer & Blood

The Welsh Centre for Burns and Plastic Surgery, Morriston Hospital, Swansea Bay University Health Board (SBUHB) remained at escalation level 3. Work continued with Swansea around the long-term model, which was dependent on the redevelopment of Morriston's ICU unit, including receipt of capital for a long-term plan. WHSSC continued to monitor the two phase action plan with input and advice from the South West & Wales Burns Network (SW&WBN).

The Positron Emission Tomography Imaging Centre (PETIC) remained in Escalation and monitoring meetings were in place. Another concern around the of the age of the current scanner was also highlighted. There is a procurement process underway to replace this scanner which will mitigate this risk. The service was maintaining turnaround times within the agreed target of 10 working days.

The committee noted that there were long waiting times for plastic surgery within Swansea Bay. A recovery plan had been requested but this had not been received to date.

3.0 Cardiac

Members received an update regarding the two cardiac surgical services in South Wales that remained in escalation. An update was received on the action plan in place in response to the GIRFT report undertaken at SBUHB and the Committee

received assurance that SBUHB was making good progress on its delivery and the level of escalation would be reconsidered shortly.

Cardiff and Vale University Health Board (C&VHB) had recently been re-escalated from Level 2 to Level 3 due to the lack of assurance to engage with WHSSC regarding their GIRFT improvement plan. WHSSC have since received a more detailed action plan with involvement from the Surgical Clinical Board and good engagement at the last escalation meeting. WHSSC have facilitated the engagement of the two Health Boards to share learning and will continue to monitor the service against key indicators.

Despite the services being in escalation the committee noted that the risk for patients waiting for cardiac surgery had been reduced. Cardiac Surgery waiting lists were currently at their lowest for four years. However, there were growing concerns around diagnostics and cardiology clinical pathways within Health Boards as people are not making their way onto cardiac surgery lists.

4.0 Mental Health & Vulnerable Groups

Members received a separate update report regarding Ty Llidiard, which was currently in Escalation Level 4. Members requested that their concerns regarding the length of time that the services had been in escalation and the slow progress be escalated to Joint Committee for further discussion and assurance.

The committee were informed that a stakeholder engagement with NHS England, with the aim of securing a new Perinatal Mother & Baby Unit service for mid Wales and North Wales patients, was ongoing but this was dependent on the securing of capital funding by NHSE.

Following receipt of notice for the termination of the WHSSC contract with Oxford Health NHS Foundation Trust, colleagues in NCCU were scoping alternative providers to ensure ongoing and uninterrupted service provision.

Prior to the Welsh Gender Service (WGS) being set up in 2019, patients were referred to the London GIC in Charing Cross hosted by Tavistock & Portman NHS Foundation Trust (T&PNFT). In 2019, the WGS repatriated a number of patients based on the level of complexity they could manage at that time. The WGS has now completed the repatriation of the remaining validated waiting list of 130 patients. It was also noted that additional funding had been secured in order to set up a satellite clinic for North Wales and Powys patients to reduce the distance to access treatment.

The Committee was informed that work was ongoing with NHS England to consider a clinical model for the Gender Identity Development Service (GIDS) and explore a regional solution given the recommendation from the Cass Review to move away from a single provider.

5.0 Neurosciences

Members noted one significant area of concern about the use of an imaging platform that health boards have been using to transfer images between NHS Wales and thrombectomy providers in North Bristol and the Walton. The issue had been escalated to the Delivery Unit and Welsh Government and work was currently being undertaken to improve stroke pathways.

6.0 Women & Children

Concerns remained with paediatric intensive care beds, as a result of staffing issues, which could potentially result in paediatric patients requiring intensive care being transferred out of Wales. The Committee was assured that work was ongoing and a set of controls was in place to mitigate the risk.

Members were informed that Paediatric Surgery remained a concern. There was a risk that paediatric patients waiting for surgery in the Children's Hospital of Wales were waiting in excess of 36 weeks, due to the COVID-19 pandemic and that, as a consequence, the condition of the patient could worsen. The WHSS team had asked for a recovery trajectory and plan and there is continuous monitoring with the Clinical Board at CVUHB and through SLA meetings.

7.0 Intestinal Failure (IF)– Home Parenteral Nutrition

The Committee was provided with a detailed update on the creation of a temporary IF commissioning team and the on-going review of IF arrangements. The report highlighted some concerns with the current supply issues with Calea and progress with the HPN contract renewal. It was confirmed that WHSSC had formally instructed procurement to act on behalf of WHSSC in raising concerns around the contract performance. The ultimate aim is to move to an NHS provided service in order to mitigate the risk further.

Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. One service had increased its level of escalation and all others remain unchanged; progress and further work was detailed in the commissioning team reports.

- **CRAF Risk Assurance Framework**

Members received a report presenting the updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers. There were currently 18 risks on the CRAF of which 16 were commissioning risks and two were organisational risks. Four risks were de-escalated during the period between February - May 2022 and work continues with the commissioning teams to address the remaining risks. It was noted that IPFR remained one of the highest risks. The Committee was informed that following a meeting with WG it had been confirmed that WHSSC were able to commence a wider engagement exercise to

consider the ToR and will be referenced in the Joint Committee's Managing Director's Report in July 2022 and a final report will be presented in September 2022.

- **CQC/HIW Summary Update**

- **Quality Newsletter**

Members received a draft copy of the First Quality Newsletter for comment and feedback. This was well received and is an appendix to the report for wider circulation as appropriate.

- **Service Innovation & Improvement Report**

The report which provided an update on the Service Improvement and Innovation Workshops and similar externally organised events that have taken place since the Covid-19 pandemic was received.

- **Policy Group Report**

Items for information

Members received a number of documents for information only, which members needed to be aware of:

- Chair's Report and Escalation Summary to Joint Committee 12 May 2022;
- Datix – Cymru Incident Investigation – User Guide
- QPS Forward Work Plan;
- QPS Distribution List

QPSC Committee Effectiveness Self- Assessment Results and Forward Work Plan

The findings of the self-assessment results were shared and it was confirmed that they had also been presented to IGC and to the JC in July. Overall the comments were positive. It was difficult for some members to comment as there had been a change in membership at the same time as the survey was circulated

Key risks and issues/matters of concern and any mitigating actions

The items highlighted above.

Summary of services in Escalation (Appendix 1 attached)

Quality Newsletter (Appendix 2 attached)

Matters requiring Committee level consideration and/or approval

Members agreed the following would be highlighted in the Chair's Report to Joint Committee.

- Ty Llidard updates and to include paper as Appendix to JC,
- Increased escalation of PICU,
- Intestinal Failure position; and
- CRAF - Concerns around IPFR more specifically the changes to the Terms of Reference and governance review.

Matters referred to other Committees Ensure chairs report are part of health board's agenda items	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	9th August 2022 at 13.00hrs

1.0 SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of-Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Participation in weekly bed management panel meeting. • Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician.	

					• Level of escalation will be considered following QAIS annual review in June	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, however March 22 meeting stood down for the report on a visit from NCCU into the unit to be published to inform ongoing discussions. • Service spec discussions progressed with work ongoing to consider the requirements of the unit. • Awaiting publication and implementation of Medical Emergency Response SOP by CTM. • Coroner's inquest concluded. Implementation of outcomes of inquest to be incorporated into escalation plan alongside the outcomes of HIW and NCCU visits	

					• Executive meeting held on May 3rd 2022. • Managing Director wrote to CEO CTUHB on 6th May with agreed actions following meeting. • Response received from Health Board 12th May outlining work and jointly agreed improvement plan going forward.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	The 12 CQV meetings have now been held. The service remains at level 3. Good progress is being made against the key actions key actions remaining: • Substantive Consultant Psychiatrist job description is with the Royal College of Psychiatrists for approval. • Clinical Lead to be advertised once CAMHS Consultant posts have been appointed. • The service has been asked to submit a revised staffing plan to increase the resilience of the team using underspend. • The FACTS service specification (for CAMHS) is planned to go to policy group on	

					13th July for approval to consult. • FACTS have ongoing issues in Parc Prison linked to offsite system access and personal safety that have been escalated via the appropriate channels.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Continued six weekly meetings in place to receive and monitor against the improvement plan. • Although the service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime, the pathway will remain unchanged. • Escalation level will	

					be reviewed on provision of six months of data following delivery of GIRFT recommendations.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
July 2021 April 2022 (from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of continued failure to provide the GIRFT improvement plan and HEIW report the service has been re-escalated • First level 3 meeting scheduled for 1 June, with subsequent meetings at 6 weekly intervals; these supersede bi-monthly meetings previously agreed for monitoring purposes.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 31.05.2022	Movement from last month
November 2021	Burns	SBUHB	3	• The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU.	• The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan). • Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required. • The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea. • The service re-	

					opened on Monday 14 February with an interim service model delivered with the support of general anaesthetics and general ICU consultants. • The escalation meetings will be led by WHSSC with support and advice from the Burns Network to ensure standards are maintained through the transition process. • An outline scoping case for the capital development of ITU at Morriston Hospital was shared with WHSSC in May. The first escalation monitoring meeting with SBUHB is currently being arranged.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position	Movement from last month
February 2022	PETIC	Cardiff University	3	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures. • Failure to produce a	• The quality control issue has been addressed and isotope production restarted on 25 February after a three week suspension. • Analysis of the impact of the delays on patients indicates that while it caused patient anxiety and stress, it is unlikely there will be harm to patients' clinical outcomes. • Current waiting times are within the target turnaround time of 10 days. • The first escalation meeting took place on Friday 25 March. • An action plan has	

				business case of sufficient quality in a timely manner for replacement of the scanner.	been agreed with focus on the management and governance arrangements for the service. The next escalation meeting is on Tuesday 7th June 2022.	

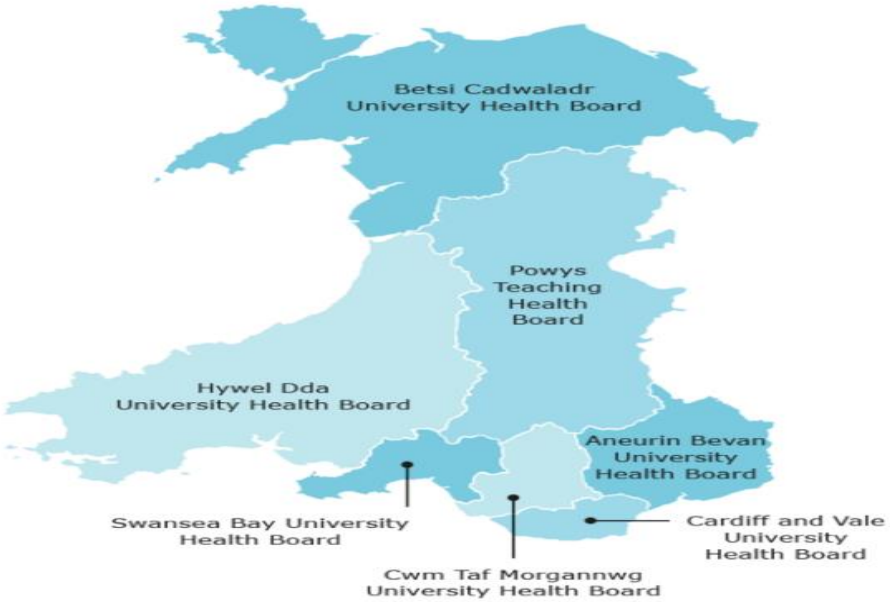
Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SERVICES SPECIALISED COMMISSIONING QUALITY UPDATE



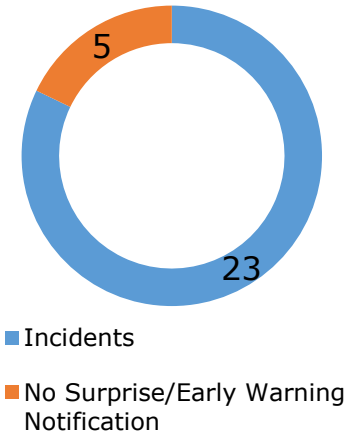
This is the 1st edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be developed on a quarterly basis to supplement some of the reports and data which already feedback through different forums into the Welsh Health Boards.

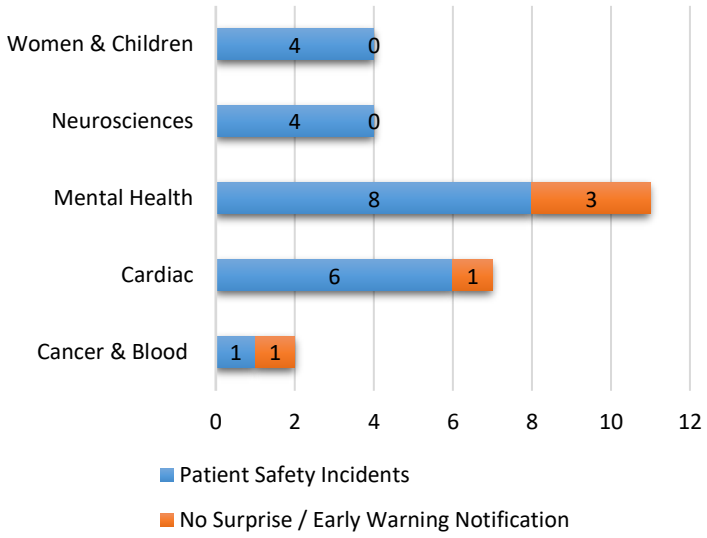
These are some of the highlights and an overview of some of the work we are involved with from a commissioning perspective. The services commissioned from WHSSC are both in Wales and with NHS England this will only provide a very brief snapshot of some of these.

Reporting for the last Quarter

WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and any action plans themes or trends arising from concerns are completed and support learning. WHSSC facilitate the continued monitoring of commissioned services and work with providers when any issues arise.

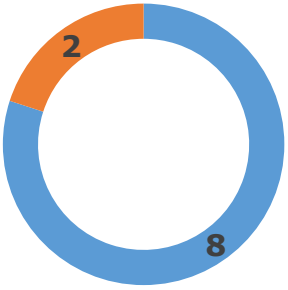
As at March 2022 there are **23** Patient Safety Incidents and **5** No Surprise/Early





Complaints

As at March 2022 a total of **8** Patient Safety Incidents and **2** No Surprise/Early



Service Innovation and Improvement Days
Formerly known as Audit and Outcome Days

During the Covid period these were put on hold but are now back and underway. To date, two days have been held this year one with the Intestinal Failure team and another with the Cancer Network and the Sarcoma specialist teams. A further date is planned for July 2022 with the Cystic Fibrosis team. The days have been really beneficial and the following is an illustration of some of the themes which have emerged:-

These have provided a forum for patient experience to be shared and an opportunity to hear about innovation and different ways of working which

have been adopted to support and deliver services through Covid. They have also provided an opportunity for services to discuss horizon scanning and the development of new services / pathways to support emerging new treatment and therapies. They have facilitated networking opportunities and provided a platform for benchmarking.

The following are some comments received from attendees of the day:-

Whatever the future holds, I am confident that I have received the very best treatment currently available to science to minimise the risk of a re-occurrence. It is reassuring that I am regularly being rechecked and have been made aware of the self-surveillance I need to be undertaking.
Know that I still have the support at the end of the telephone, helps me and my family get answers to questions when they arise, although I try to keep these to a minimum.

Overall having a team that I could have confidence in had a really positive impact on both my mental and physical health.

Thanks for the skills of the medical team and the care I have received. My quality of life is much the same is was pre-sarcoma. I have come through this with as much of a positive mental attitude for the future as I enjoyed in the past.

The fact that to achieve this quality care incurred travelling a greater distance than to my local general hospital has been more than worthwhile. Throughout my treatment, I felt I was more part of the team than just a patient. This was achieved by keeping me well informed and giving me guidance on the options available.

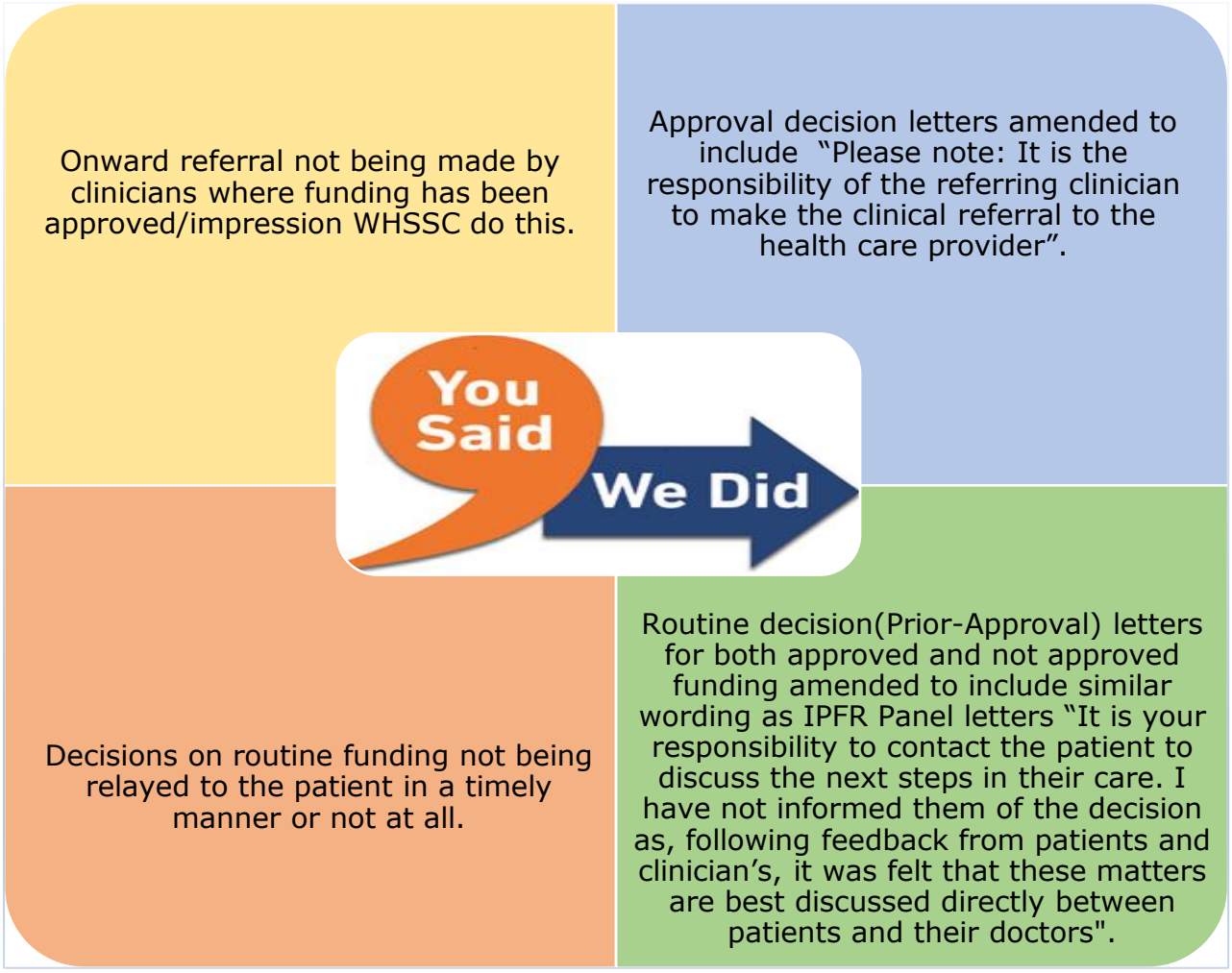
Update from the Patient Care Team
IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed 2021 – 2022 (Quarter 1 – 4):

Qtr 1	
April – June	551
Qtr 2	
July – September	449
Qtr 3	
October – December	434
Qtr 4	
Jan – March	603

Total Number of IPFRs 2038
Feedback received to the IPFR team
You Said, We Did – listening to feedback and implementing change:-



Engagement with Patient Experience

Listening and learning from Patient stories and experience provides the team with great insight into the services commissioned by WHSSC. One story shared with the team last year was from the prosthetic team in Cardiff and involved a patient who had received a microprocessor prosthetic knee. The patient was able to demonstrate over Teams the difference this had made to his mobility and the impact and improvement this had on his quality of life. The prosthetic team were also able to demonstrate how important their work is and how individual this had to be to patients requiring their services.

Many teams have had to work in different ways over the last year and have had to be very innovative in their approach. Some of the teams have shared how they have had to adapt to working with SMART phones and apps with their patients to monitor their wellbeing over virtual appointments and how much they have learnt through doing them to this. Some of this has promoted independence in some of their client groups and been enabling for them.

Some data shared with the team form the Clinical Nurses in Adult Congenital heart disease included an evaluation from patients on virtual clinics.

The Survey was undertaken through survey monkey and sent to **64** patients, a total of **35** responses were received resulting in the following summary,

- A blended approach mix of virtual and face to face appointments thought to work well by patients

- Virtual clinics to be offered as video rather than telephone call to improve the patient experience
- Prior to virtual appointment, patients who require tests such as ECG and Echocardiograms beforehand are undertaken prior to the appointment.
- Promotion and support of patient self-management such as Blood pressure self-monitoring, weight management and symptoms, use of fit watches, pulse measurement apps for heart rhythm recognition felt to be helpful and supportive.

It was evident the Team had learnt to respond and manage patients during the pandemic in new and innovative ways. The experience has seen the team and the patients become more confident with the new ways of working and the ongoing approach to be more of a blended approach.

Other surveys and stories which WHSSC have supported have been the impact delays have had on patients in treatment within certain specialties, such congenital cleft lip and palate, , the following are just a few comments from patients into the survey:-

Quick Round up of Commissioning Teams

Mental Health

5 year strategy being developed and well underway with excellent engagement and support from the Welsh Clinical Teams.

Women and Chidren's

Paediatric Strategy is gaining momentum and moving forward with improved engagement

Neurosciences and long term condition

Plan to develop All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation

Cancer and Blood

Recent successful Sarcoma Service Improvement and Innovation Day held.

Cardiac

Richard Palmer has joined the commissiong team as a planner . Andrea will be returning to supporting Patient care team after a brief retirement

Intestinal Failure

Ongoing work being undertaken with the recently formed IF commissioning team and as a result of the IF review and Service Improvement and Innovation Day

Recognition of significant events and useful links

Well done to the team Professor Iolo Doull/ Sian Lewis and Andrew Champion on their recent publication:-

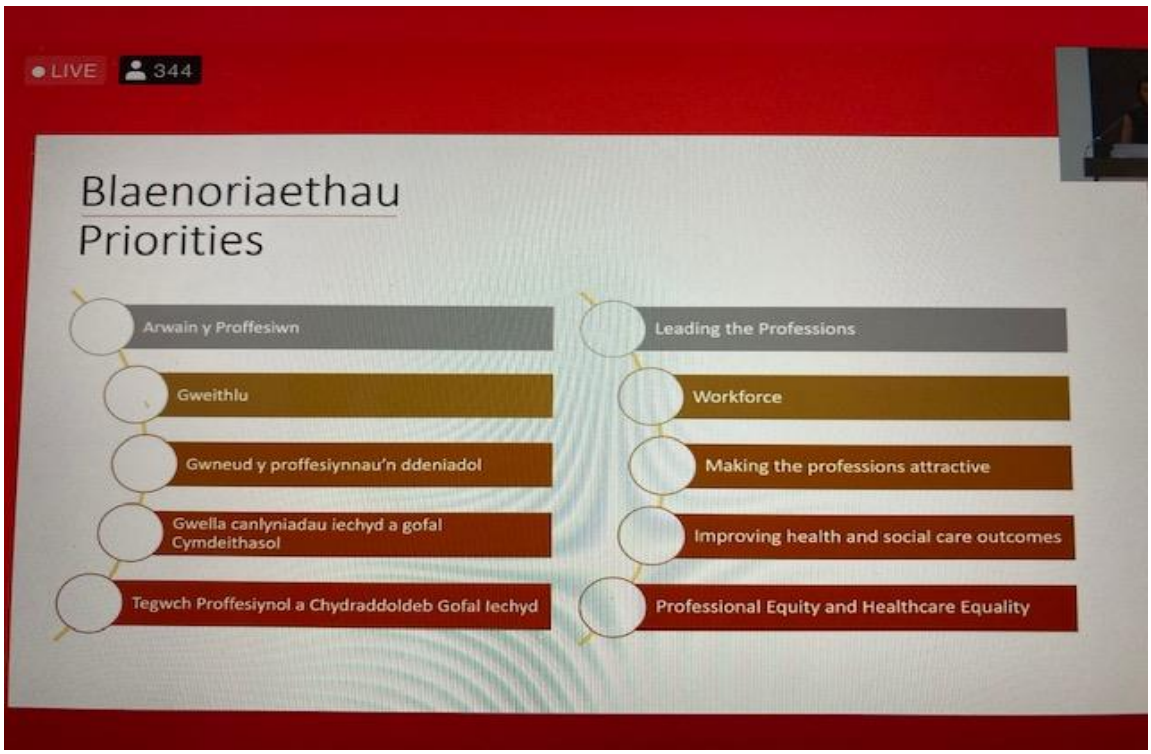
A Case Study on Reviewing Specialist Services Commissioning in Wales:
TAVI for Severe Aortic Stenosis
Applied Health Economics and Health Policy Journal

A Case Study on Reviewing Specialist Services Commissioning in Wales: TAVI for Severe Aortic Stenosis | SpringerLink

Chief Nursing Officer Conference Wales

Sue Tranka, Chief Nursing Officer for Wales

The recent Chief Nursing Officer Conference held in April 2022 saw the launch of the CNO priorities included below. WHSSC team will be supporting and continuing to incorporate these into their practice. The theme of the conference was very much around professional leadership and delivering this with kindness and Compassion.



Developed in collaboration with stakeholders, the five priorities are:

- Leading the profession - invest in and develop nurse and midwife leaders at all levels in health and social care through dedicated leadership programmes;
- Workforce - close the vacancy gap and attract, recruit and retain a motivated, skilled workforce;
- Making the professions attractive - inspire people to enter the nursing and midwifery professions as the most attractive healthcare career choice in Wales;
- Improving health and social care outcomes - deliver equitable, good-quality, person-centred care; and
- Professional equity and healthcare equality - create a nursing and midwifery workforce that reflects the population it serves and addresses inequalities.

220405 Patient Safety
Update 5 April 2022 i:

OTHER USEFUL LINKS WHSSC WEBSITE ….

Welsh Health Specialised Services Committee

Aneurin Bevan University Health Board

EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC) Update Report – July 2022

Purpose of Report	
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 Emergency Ambulance Service Committee as a Joint Committee of the Board.	
The Board is asked to: *(please tick as appropriate)*	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	
Executive Sponsor: Interim Chief Executive Officer	
Report Author: Director of Corporate Governance	
Report Received consideration and supported by:	
Date of the Report: 18th July 2022	
Supplementary Papers Attached: 1) Chair's Summary of the Joint Committee Meeting held 10th May 2022 and 12th July 2) Confirmed Minutes of the Joint Committee Meeting held 15th March 2022 and 10th May	

Background and Context

The Emergency Ambulance Services Committee is a Joint Committee of all Health Boards in NHS Wales. The Minister for Health and Social Services appointed an Independent Chair through the public appointment process to lead the meetings and each Health Board is represented by their Chief Executive Officer; the Chief Ambulance Services Commissioner is also a member.

The Joint Committee has been established in accordance with the Directions and Regulations to enable the seven LHBs in NHS Wales to make joint decisions on the review, planning, procurement and performance monitoring of Emergency Ambulance Services (Related Services), the Emergency Medical Retrieval and Transfer Service (EMRTS) and the Non-Emergency Patient Transport Service and in accordance with their defined Delegated Functions. The Standing Orders of each of the seven Health Boards include the Governance Framework for EASC, including a Scheme of Delegation as published on the EASC website Schedule 4 (nhs.wales).

Although the Joint Committee acts on behalf of the seven Health Boards in discharging its functions, individual Health Boards remain responsible for their residents and are therefore accountable to citizens and other stakeholders for the provision of Emergency Ambulance Services (EAS); Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) and Non-Emergency Patient Transport Services (NEPTS).

Specifically, the role of the EASC Joint Committee (as set out in Standing Order 1.1.3 Schedule 4 (nhs.wales)) is to:

- Determine a long-term strategic plan for the development of emergency ambulance services and non-emergency patient transport services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance and non-emergency patient transport services;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual Health Boards Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of emergency ambulance and non-emergency patient transport services at a national level, and determining the contribution from each Health Board for those services (which will include the running costs of the Joint Committee and the EASC Team) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the commissioning risks; and
- Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance and non-emergency patient transport services and take appropriate action.

Each of the seven Health Boards have agreed a Memorandum of Agreement (MEMORANDUM OF AGREEMENT (nhs.wales)) in respect of the Joint Committee and in doing so have agreed that each Health Board recognises the following principles, aligned to the agreed Standing Orders:

- The Emergency Ambulance Services Committee Team (EASCT) will be held to account by the EAS Joint Committee for the delivery of a strategy for the provision of emergency and non-emergency ambulance services for Wales as well as providing assurance that the systems of control in place are robust and reliable.
- That any decision taken and approved by the Joint Committees 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.
- That each individual LHB is responsible for the people who are resident in their area. This means that the Joint Committee of which each Chief Executive is a member is acting on behalf of the 7 LHBs in undertaking its role.
- 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.
- That each Chief Executive as a member of the Joint Committee will require EASC Team of the EAS Joint Committee to ensure that, in the timetabling of the annual work programme, sufficient time will normally be allowed to enable each Chief

Executive to consult with their own LHB and appropriate local partners and stakeholders.

- That when an individual Chief Executive is unable to attend a meeting of the Joint Committee, he/she will appoint in advance and identify to the Committee Secretary a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

Assessment and Conclusion

This report provides an update regarding business undertaken during the last reporting period.

The Joint Committee held its most recent meeting on 12 July 2022. The papers for the meeting are available at: July 2022 - Emergency Ambulance Services Committee (nhs.wales)
The Committee was attended by Nicola Prygodzicz, Director of Planning, Performance, Digital and IT and the Interim Deputy Chief Executive Officer.

A summary of the business held is outlined as follows:

1. Performance Report – The Joint Committee received an update on current emergency ambulance performance and an overview of the range of actions and processes that have or are being implemented to support performance improvement.

2. Quality and Safety Report – The Joint Committee received an update on quality and safety matters for commissioned services currently being supported by the EASC Team, which included a focus on Healthcare Inspectorate Wales (Welsh Ambulance Services NHS Trust) Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover.

3. Welsh Ambulance Services NHS Trust Provider Update – The Joint Committee received a report providing an update on key issues affecting quality and performance for Emergency Medical Services (EMS) and Non-Emergency Patient Transport Services (NEPTS) and noted an update on commissioning and planning for EMS and Ambulance Care (including NEPTS).

4. Immediate Release Protocol and Regional Escalation Protocol - The Joint committee discussed the All-Wales Immediate Release Protocol and the All-Wales Regional Escalation Protocol, considering any further actions needed.

5. Chief Ambulance Services Commissioner's Report – The Joint Committee received receive an update on key matters related to the work of the Chief Ambulance Services Commissioner (CASC).

6. Emergency Ambulance Services Commissioning Framework
   The Joint Committee received an update on the ongoing work to develop the Emergency Ambulance Services Commissioning Framework. In response to the approach being taken by health boards as commissioners of ambulance services, the Framework will provide clarity on the commissioning of core service provision alongside services that are considered transformational but are ultimately optional within the commissioning arrangements.

7. EASC Commissioning Update – The Joint Committee received an update of the progress being made against the key elements of the collaborative commissioning approach including: EASC Commissioning Cycle; EASC Commissioning Frameworks; EASC Integrated Medium Term Plan (IMTP); and EASC Commissioning Intentions.

8. Finance Report Month 2 – The Joint Committee received a report setting out the estimated financial position for EASC for the 2nd month of 2022/23 together with any corrective action required.

9. EASC Governance – The Joint Committee considered the: EASC Risk Register; Changes to complete the Standing Orders; EMRTS DAG Annual Report 2021-2022; EASC Communications and Engagement Plan; EASC Assurance Framework; EASC Audit Recommendations Tracker; and EASC Key Organisational Contacts.

This report also provides as supplementary papers a Chair's Summary of the Joint Committee Meeting held on 10th May 2022 (attachment 1) and the Confirmed Minutes of the Joint Committee Meeting held 15th March 2022 (attachment 2).

Recommendation

The Board is asked to receive this report for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report.
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report as it is for assurance purposes only.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to the Plan associated with this report, however the work of the Joint Committee contributes to the overall implementation and monitoring of health board IMTPs.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the Joint Committee's considerations, where appropriate.
Glossary of New Terms	EASC – Emergency Ambulance Services Committee

	EMRTS – Emergency Medical Retrieval and Transfer Service WAST – Welsh Ambulance Service Trust
Public Interest	This report is written for the public domain.

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	10 May 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link:https://easc.nhs.wales/the-committee/meetings-and-papers/may-2022/.

The minutes of the EASC meeting held on 15 March 2022 were approved.

CHAIR'S REPORT

- Members noted the recent meetings attended by the Chair and that the end of year assessment with the Minister would take place on 30 May 2022.
- Following recent conversations with the All Wales Chairs' Group relating to the EASC agreed 'red lines' for ambulance handover delays (November 2021) it was agreed that the Chair's Summary would now also be sent directly to the Chairs, in addition to EASC Committee Members.

AMBULANCE HANDOVER DELAYS

- Noted the continuing unsustainable levels of ambulance handover delay and the inability to deliver safe and effective ambulance responses.
- Handover improvement plans were being developed by health boards that concentrated on the pre-front door and front door. Actions already being undertaken were noted, including:
  - Fortnightly tripartite meetings (Health boards, the Welsh Ambulance Services NHS Trust (WAST) & Chief Ambulance Services Commissioner (CASC))
  - Evolving handover improvement plans
  - NHS Leadership Board 'System Wide Review'
  - WAST Integrated Medium Term Plan (IMTP) commitments
  - All-Wales Escalation Framework
  - Welsh Government Integrated Quality Performance and Delivery (IQPD) meetings
  - Developing a new Commissioning Framework.
- Carol Shillabeer reported on the progress made at the NHS Wales Leadership Board in response to the sustained pressure across the health and social care system and increasing risk of harm to patients and staff.
- The Board recognised the need for a different approach, involving defined deliverables, a key one being to increase the community care capacity across the system by an equivalent of 1,000 beds by October 2022.

- Recognition that while there was a significant energy in relation to this work it would not in itself solve all of the current issues.
- Jeremy Griffith highlighted the significant risk implications for patients in relation to ambulance handover delays and their continued pattern of deterioration; the Welsh Government Integrated Quality Planning and Delivery (IQPD) meetings would now test the progress made against handover improvement plans.
- Members discussed the increase in red call demand (approximately 70% in the last two years); recently undertaken analysis to be shared and considered in more detail at the EASC Management Group.
- Noted the need to re-consider and agree a system-wide position for 'red-release requests' from the ambulance service, with release refusal to be considered a 'never event' and also noted the collective discussions among HM Coroners regarding their concerns in relation to ambulance delays and the potential Regulation 28 Prevent Future Deaths Reports.
- In addition to the existing actions, also a need to develop a 'Plan B' via the EASC Management Group in order to address the current position and patient safety issues.
- Noted the ongoing work in relation to Handover Improvement Plans and the need to analyse the impact on the patient experience and the requirement that actions must lead to improved outcomes for patients.

Members **RESOLVED** to: **NOTE** the report and the ongoing work on handover improvement plans.

PERFORMANCE REPORT

Received the Ambulance Quality Indicators for January to March 2022 and noted the:

- reduction in the volume of 999 calls relating to breathing difficulties
- number of re-contacts into the system within the following 24 hours
- impact of Community First Responders (CFR), particularly in rural areas and the ongoing discussions regarding the role of CFRs as part of the emergency ambulance services provision.
- Noted a reduction in both conveyance volume and percentage within the Performance Report, though it was noted that the impact needed to be considered in light of the decisions relating to the impact of the Clinical Safety Plan.
- that optimising appropriate conveyance was a key aim of the Six Goals for Urgent and Emergency Care programme within Goal 4.

Following discussion, Members **RESOLVED** to: **NOTE** the report and the published Ambulance Quality Indicators.

PROVIDER ISSUES

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:

- key challenges in relation to handover delays and current position in terms of red and amber performance.
- the number of patients waiting more than 12 hours in the community, noting over 800 patients in March 2022 with some patients not receiving a same day service (these numbers will be higher in April 2022).
- Electronic Patient Clinical Record (ePCR) is live nationally, phase 2 would include connecting to the Welsh Clinical Portal and access to patient records for WAST clinicians in the community to support decision-making in terms of non-conveyance, see and treat and see, treat and refer in the community

- the implementation of the Emergency Communication Nurse System (ECNS - software to support and enhance 999 clinical triage) for 'consult and close' on track for planned implementation.
- the offers made by WAST in relation to the Six Goals for Urgent and Emergency Care Programme, particularly for Goals 2, 3 and 4.
- Noted that no specific resource had been made available to WAST to establish a dedicated team to progress this work. Members were asked to confirm their health board leads for this work in order that the WAST team could make contact.
- Noted that no resource allocation had been made to WAST from the £25m earmarked for urgent and emergency care and that WAST were bidding for resources following allocations made to health boards.

RESOLVED to: **NOTE** the report.

CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT

Stephen Harrhy presented the report and highlighted the following:

- The £1.8m temporary funding agreed at the last meeting was being utilised to continue services such as cohorting in order to support patient safety within the system.
- 'System-wide Escalation Framework' agreed by the NHS Wales Leadership Board; the proposed next steps were noted.
- Proposal to create a new Commissioning Framework be considered at the EASC Management Group and received at the next EASC meeting for approval.
- A bid for funding had been made to the Six Goals for Urgent and Emergency Care Programme relating to the Emergency Communication Nurse System (ECNS), this would ensure the ability to clinically assess, advise and re-direct patients within the system; providing a key element of patient safety during the current and ongoing pressures
- NHS Wales Delivery Unit (DU) Review of Serious Adverse Incidents (SAI) in relation to Appendix B (transferred from WAST to health boards). The DU had undertaken a review and there appeared to be a mismatch between the incidents referred for further investigation in health boards and the subsequent assessment and reporting of those incidents formally to Welsh Government as SAIs.
- EASC Management Group have established a Task and Finish Group to consider the NHS Wales Delivery Unit's Review of Appendix B Serious Adverse Incidents and also a group to coordinate responses to the Healthcare Inspectorate Wales Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover.

RESOLVED to: **NOTE** the report.

CHAIR'S SUMMARY EASC MANAGEMENT GROUP – 21 APRIL 2022

- The Chair reminded Members that there was often a time delay in receiving confirmed minutes. Therefore, it was proposed that a Chair's Summary was produced after each sub-group meeting to mirror the arrangements of the EAS Joint Committee.
- For illustrative purposes, the Chair's Summary for the EASC Management Group meeting held on 21 April 2022 was presented.
- **APPROVED** the preparation of a Chair's Summary following each sub-group meeting.

EASC COMMISSIONING UPDATE

- Noted that there were a number of operational and commissioning documents that had been prepared and updated for the Committee. The Commissioning Update had been prepared to provide Members with an overview of the progress being made against the key elements of the collaborative commissioning approach including:
  - Commissioning Frameworks
  - EASC Integrated Medium Term Plan (IMTP)
  - Commissioning Intentions
  - EASC Action Plan.

Noted that the EMS Commissioning Framework was currently being refined. The EASC Team would continue to progress the work and would engage further with the WAST team ahead of presentation at the next EASC Management Group. The EASC IMTP had been included for information and that a quarterly update with regard progress made against the IMTP would be provided going forward.

Members **RESOLVED** to:

- **NOTE** the collaborative commissioning approach
- **RECEIVE** the EASC IMTP, Commissioning Intentions Update (2021-22), the EASC Commissioning Intentions for 2022-23 and the EASC Action Plan
- **NOTE** the proposal to develop the EASC Commissioning Update to provide an overview of the progress being made against the key elements of the collaborative commissioning approach.

FOCUS ON SESSION: NON-EMERGENCY PATIENT TRANSPORT SERVICES (NEPTS)

Rachel Marsh gave the presentation on the NEPTS service including the scope and scale of the service, managing demand and also the development of transfer and discharge services. Areas highlighted included:

- The differences with the Emergency Medical Services (EMS) including higher daily patient volumes and differing mobility requirements.
- In addition to WAST, the different transport providers of NEPTS as part of the plurality model
- It was a predominantly daytime weekday service with a small volume of activity at weekends
- Patient journey types, mainly for outpatient or enhanced care appointments.
- The impact of the pandemic on core outpatient demand and the effects of social distancing regulations (relaxed in recent weeks)–with additional resources provided in 2021-22 to engage private sector capacity to meet service demand.
- The requirement to understand health board plans for reset and recovery.
- Performance metrics centred around timeliness; noted a need for improvement particularly in relation to oncology patient journeys arriving within 30 minutes of appointment time and lost hours on transfers and discharges.
- Eligibility criteria and suggested that an indicative 30% of NEPTS transport provided to patients that were not eligible and WASTs intention to work with commissioners and health boards towards a position where non-eligible patients were steered towards alternative providers.
- NEPTS Demand and Capacity Review; identification of a range of efficiencies to be worked towards and the predicted impact on performance.
- The agreed commissioning intentions for NEPTS

- Map of key strategic changes being undertaken across health boards and the modelling undertaken to understand the impact on patient transport.
- Ambitions for the NEPTS service within the WAST IMTP.

Detailed discussion included:

- the current weekday nature of the service but that there could be flexibility to provide for services being delivered at weekends subject to the required activity profiles, workforce discussions and changes to roster patterns.
- that patient demand was at approximately 90% of the pre-pandemic levels including the sharp increase experienced in March and that work would be undertaken to understand this in light of the reduction in outpatient activities and increased use of digital technology.
- in terms of eligibility criteria, the likely political and public interest in relation to any proposal for changes to patient transport provision and the need to collectively undertake a robust equality impact assessment to progress this work.
- the need to agree the scope of the work to deliver a National Transfer and Discharge Service and sign off the sequencing of the implementation at a future meeting.
- the need for WAST to provide assurance regarding the efficiencies and additional investment intended for renal and oncology services, included in the original case for transforming NEPTS services.
- the need to consider the challenges and complexities regarding the cross-border activity and nature of Powys THB and the associated procurement routes.
- the fragmented NEPTS services that exist in England, with many small providers under differing contractual arrangements were noted in comparison.
- the specific need for performance improvement for oncology patients

Members **RESOLVED** to: **NOTE** the key discussion points and agreed actions.

FINANCE REPORT

The EASC Finance Report was received including the Month 12 outturn showing an underspend of £347k.

EASC SUB GROUPS

The confirmed minutes from the following EASC sub-groups were **APPROVED**:

- EASC Management Group – 24 February 2022
- NEPTS Delivery Assurance Group – 3 February 2022
- EMRTS Delivery Assurance Group – 28 September 2021 (meeting cancelled in December 2021 due to operational system pressures).

EASC GOVERNANCE INCLUDING THE RISK REGISTER

The report on EASC Governance was received. Governance documentation is available at https://easc.nhs.wales/the-committee/governance/

Members **RESOLVED** to:

- **APPROVE** the risk register and **NOTE** the updates relating to red performance
- **APPROVE** the EASC Annual Governance Statement 2021-2022
- **APPROVE** the EASC Response to the Annual Audit Enquiries Letter 2021-2022.
- **APPROVE** the EASC Annual Report 2021-2022
- **APPROVE** the EASC Audit Recommendations Tracker
- **APPROVE** the EASC Sub-Groups Annual Reports 2021-2022
- **NOTE** the EMRTS DAG Annual Report for 2021-2022 will be presented at the next Committee meeting.

Key risks and issues/matters of concern and any mitigating actions				
• Red and amber performance • Handover delays and the development of handover improvement plans in HBs • Community care capacity				
Matters requiring Board level consideration and/or approval				
• To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to agree and implement a local handover improvement plan for every emergency department • System-wide position for 'red-release requests' from the ambulance service with health board release refusal to be considered a 'never event' • From the WAST report, the number of patients waiting more than 12 hours in the community, noting over 800 patients in March 2022 with some patients not receiving a same day service and the impact on patient safety and patient experience				
Forward Work Programme				
Considered and agreed by the Committee.				
Committee minutes submitted	Yes	✓	No	
Date of next meeting	**12 July 2022**			

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	12 July 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/meetings-and-papers/july-2022/. The minutes of the EASC meeting held on 10 May 2022 were approved.

CHAIR'S REPORT

Members noted:

- the recent meetings attended by the Chair including the Appraisal with the Minister for Health and Social Services on 30 May 2022. The Chair confirmed that it would require a collaborative effort working with the Committee, Welsh Ambulance Services NHS Trust (WAST) and health boards (HBs) to deliver the objectives relating to reductions in handover delays.
- the meeting with the Chief Ambulance Services Commissioner (CASC), WAST Chair and Chief Executive and WAST Sub-Committee Chairs on 1 July 2022. Both the Chair and Jason Killens reported that all present at the meeting felt this was a useful session with all able to share their concerns in relation to quality, safety and patient experience.
- the meeting with Judith Paget, Chairs and Chief Executives on 8 June 2022. Members were aware that the Chairs and Chief Executives had made a commitment to improve immediate release requests.

'FOCUS ON' PERFORMANCE REPORT

The significant challenge in the provision of timely ambulance services at present was noted and the actions being taken and opportunities to drive improvement were discussed in the Focus on session which included:

Recent high-level outputs from the Performance Report

- Red performance remained extremely challenging (at approximately 50%) with some variation noted
- Increasing median response times (approximately 7minutes 50seconds) and the implications in terms of the response for patients and outcomes
- Median response times for Amber 1 patients (over 2 hours)
- Increasing lost hours (baseline last October of approximately 74 minutes with current average handovers of approximately 2 hours)
- 4 hour waits for patients continue to be significant with in excess of 100 x10 hour plus waiting times.

EASC Action Plan

It was noted that the EASC Team has been asked via the Welsh Government (WG) Integrated Quality, Planning and Delivery (IQPD) meeting to enhance the existing EASC Action Plan to provide one overall comprehensive plan with the focus on the improvement priorities and actions for the remainder of 2022-23.

The work undertaken, led by the CASC working with WAST and health board teams as part of the fortnightly handover improvement plan meetings, was noted including:

- the agreement of trajectories against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- the undertaking of an annual review at the end of September 2022 against the trajectories
- the number of core actions being undertaken across each health board
- an element of variation in some of the other actions being undertaken by health boards
- the impact that these actions would have on the trajectories and in ensuring the required progress was made.

The EASC Action Plan would continue to be developed to reflect the discussions with Chief Operating Officers (COOs) and WAST and reported via the existing EASC governance arrangements, via the NHS Wales Leadership Board and also through the WG IQPD process.

Members commented that:

- the weekly WAST Performance Dashboard (of management information) circulated by the EASC Team was very helpful and provided up to date live information that health board teams could relate to the previous week, month and 3 monthly trend
- information relating to immediate release was not as transparent and it was requested that it could be added to the dashboard as a weekly metric. It was agreed that the EASC Team would work with WAST to provide this information as soon as practicable. A live PowerBI dashboard for Immediate Release Directions (previously red release requests) would be available to all NHS Wales colleagues from week commencing 25 July 2022 as a screen in the current WAST health board view of the Operational Delivery Unit PowerBI data set
- the focus should be on the actions with the highest impact
- there was a need as individual Chief Executives to take responsibility for communicating decisions and agreements made to their respective Boards thus ensuring the required openness and transparency. This would ensure that Boards had oversight of the actions individual HBs were committed to and would ensure that Executives and Independent Members were clear on the actions being taken locally and nationally to improve system safety and the patient experience.
- The EASC Action Plan would be shared at the NHS Wales Leadership Board.

Handover Delays

- An update was provided on the local fortnightly meetings being held between the CASC, COOs and WAST. This included the development of handover improvement plans for each health board, agreed trajectories for each organisation against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours, core actions being taken across the system and an element of variation in some of the other actions being undertaken.

Members noted a number of core actions to avoid conveyance including:

- the advanced paramedic practitioner and its navigator role (SBUHB)
- the need to explore the impact on the number of conveyances into emergency departments (EDs) and continuing to link in with flow centres, community hubs and primary care clusters to maximise the opportunities
- the potential for WAST access to urgent primary care centres
- the increased use of 111
- the likely impact of same day emergency care services (SDEC) following the immediate success of the Hywel Dda UHB pilot, although the likely staffing challenges were noted
- 111 press 2 for Mental Health (MH)and its likely impact due to the number of MH calls to WAST.

It was agreed that the next version of the EASC Action Plan would focus on the increasing number of long wait handovers.

The principle of the importance of immediate red release was agreed, there was a concern about its viability at the present time. A proposal for maximising the impact of this was therefore made relating to compliance (of immediate release) when approaching the 4-hour deadline and the significant impact that this could have in terms of freeing up ambulance resources. Members noted that this would require the right conversation at the time between the hospital and ambulance control to ensure risks are balanced in the moment.

Members noted issues relating to the lack of social care input (and ambulance services) and a proposal was made to consider the inclusion of a social care practitioner in the WAST control room to ensure that the social care requirements were identified to avoid ambulance conveyance to EDs; this could also be extended to provide an advice line for care homes. Other opportunities, such as having a national maternity line, would be explored further with the WAST Team, COOs and the EASC Management Group as appropriate.

Red Demand and Variation

- Variation in terms of red performance was noted and an acceptance that this variation needed to be reduced.
- It was agreed that further work would be undertaken with Optima with a view to facilitating a presentation at a future meeting of the Committee to broaden colleagues understanding of the drivers of variation in red performance.

Performance Reporting

- Members noted exciting work relating to the linking of system wide data with Digital Health Care Wales which described and tracked the patient's journey through the system and how this could present opportunities for improving the design of services.
- Members noted that the most important aspect currently being looked at was the application of the WAST Clinical Safety Plan, in particular understanding the impact of higher levels of CSP on patients waiting in the community. The risk and harm that patients could be exposed to, and also quantifying the impact of the non-attendance of an ambulance, would be areas to be focused on next.

- Members queried whether there was any evidence to suggest that escalation of the WAST CSP impacted on the numbers of patients attending ED by their own means; and also, the impact that this had on those waiting outside in an ambulance. Members noted that progress was slow as this was a complex and extensive data set and work to retrospectively track patients following 'can't send' and other touch points with health services were expected to provide clarity in relation to levels of harm and the impact of prioritisation.

Members were asked to note that the two commitments (25% reduction on the minutes lost per arrival and no handover delays over 4 hours) had been referred to by the Minister for Health and Social Services as part of the update on the Six Goals for Urgent and Emergency Care Programme on the 19 May 2022 and were the subject of recommendations by the Health and Social Care Committee in their recent report on Hospital discharge and its impact on patient flow through hospitals.

Members noted the information contained within the latest version of the Ambulance Service Quality Indicators (April & May 2022) and are available at this link https://easc.nhs.wales/asi/ .

Following discussion, Members **RESOLVED** to:
- **NOTE** the content of the report.
- **NOTE** the Ambulance Services Quality Indicators
- **ENDORSE** the EASC Action Plan
- **ENDORSE** the handover improvement trajectories
- **NOTE** the performance reporting information submissions.

QUALITY AND SAFETY REPORT
The Quality and Safety Report provided Members with an update on quality and safety matters for commissioned services. The following areas were highlighted:
- the work of the Healthcare Improvement Wales (HIW) Task & Finish Group established to coordinate and lead the work in response to the recommendations made as part of the HIW Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover
- progress of the NHS Wales Delivery Unit on Appendix B Task & Finish Group which will be established to review the process related to serious incident joint investigation framework; working between WAST and health board and make recommendations for improvement
- the general growth in the demand and focus on quality and safety issues closely linked to the deteriorating performance position.

Members **RESOLVED** to:
- **NOTE** the content of the report
- **NOTE** the impact of deteriorating performance and the resulting challenges in commissioning the provision of safe, effective and timely emergency ambulance services
- **NOTE** the provision of Quality and Safety Reports relating to commissioned services at all future meetings.

PROVIDER ISSUES

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:

- the seasonal forecasting and modelling undertaken by WAST as a matter of routine and the concerning modelled results
- WAST had updated its tactical Performance Improvement Plan with specific action for the summer months
- WAST was currently at escalation level 3 (maximum 4)
- in the last 3 months, 33 patient safety incidents had been shared with health boards as part of the joint investigation framework (known as Appendix B).
- lost hours in relation to handover delays for May totalled 22,080 hours (18% of WAST's total capacity or 25% of total conveying capacity)
- WAST has recently introduced a new Managing Attendance Plan with seven work-streams and improvement trajectories. The Plan was being reported to the Executive Management Team every two weeks
- Post-production Lost Hours (PPLHs) amounting to 5,835 hours were lost in May-22 for a range of reasons e.g. vehicle defect, trauma stand down, police interview, etc. Members noted these could not be viewed as areas for potential efficiencies.
- detailed the significant programme of work relating to the Non-Emergency Patient Transport Service (NEPTS) including to further assess the benefits of the all Wales business case and the transfers of work from HBs. Members noted that a roster review to maximise efficiency would be undertaken with implementation expected in 2023-24.

Members noted that the 4-stage process to develop rosters had been completed, with the new rosters implemented from September 2022 starting with Hywel Dda University Health Board. It was confirmed that the roster review roll-out would continue as follows:

- Cardiff and Vale UHB in late September
- Swansea Bay UHB in early October
- Aneurin Bevan UHB during mid-October
- Cwm Taf Morgannwg UHB in late October
- Betsi Cadwaladr UHB in early November and
- Powys mid-November 2022.

Members noted that each health board would benefit from growth in terms of total numbers of staff and a commitment was made to ensure that there would be no reduction in emergency ambulance cover in West Wales. However, there would be changes in the mix of the fleet including less single staffed cars and an increase in double staffed resources. It was agreed that more information would be provided by WAST on a health board by health board basis.

Stephen Harrhy updated Members in relation to the ongoing work WAST to ensure the required progress was made against key elements of work within the report including:

- the roster review programme equated to approximately 70 additional WTEs
- supporting the constructive discussions with the staff side representatives regarding working practices – it was noted that indicative timescales would be helpful and would be provided in the next report
- the improvement trajectories for sickness as part of the new Managing Attendance Plan

- the role that first responders could take to supplement ambulance services, although not at the expense of the core ambulance service.

Immediate red release
The Immediate Release Protocol developed by WAST was considered and discussed with a view to agreeing the next steps. It was noted that the protocol had been considered by Chief Operating Officers and set out the national process relating to Red and Amber 1 immediate release requirements.

A conversation was held on the implications of classifying each episode where an immediate release direction was declined as a 'never event' (this was specific terminology used within the Welsh Health Circular WHC / 2018 / 12 https://gov.wales/sites/default/files/publications/2019-07/never-events-list-2018-and-assurance-review-process.pdf which did not include immediate release of ambulances). It was agreed that the protocol needed to emphasise the requirement to improve and enhance the escalation process; all were keen not to over complicate the process and there was agreement that WAST would amend the language used and circulate a further version. Once received, Members recognised that each organisation would be responsible for taking the revised protocol through their local governance processes.

Members **RESOLVED** to:
- **NOTE** the WAST Provider Report
- **NOTE** the actions required for the immediate red release protocol.

CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT
Stephen Harrhy presented the report and highlighted the following:
- Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) and the Wales Air Ambulance Charity had undertaken a strategic review of the service and confirmed that the existing model of four aircraft would be retained for the population of Wales. Members noted that a strategic review of air bases was also being considered in order to maximise coverage. It was noted that this could impact on the location of the existing bases in North Wales. Jason Killens suggested that there could be opportunities to explore efficiencies in co-locating services for EMRTS and WAST and agreed to make contact to discuss potential options
- Temporary funding (£3m non–recurrent funding) for additional ambulance capacity had been secured from Welsh Government to fund additional front-line staff (approximately 100 additional staff members) to support WAST services during these unprecedented system wide pressures. The progress of recruitment, utilisation and impact would be reported via the EASC Management Group and an update on progress provided at the next Committee meeting.

Members **RESOLVED** to: **NOTE** the report.

EMERGENCY AMBULANCE SERVICES COMMISSIONING FRAMEWORK
Members noted that the approach taken in the development of the Framework had been adapted to provide clarity on the commissioning of core services alongside services considered to be 'transformational,' but optional, within the commissioning arrangements.

Members received a draft of the Framework as an appendix to the report and it included the high-level expectations of the ambulance service and proposed the opportunity to develop local Integrated Commissioning Action Plans (ICAPs). The process would involve more joint working with WAST and health boards to develop plans at a local level. Members noted the process would also provide the foundation for development of the Commissioning Intentions for emergency ambulance services.

In addition to recognising opportunities for national transformation, the local ICAPs would capture the local transformation programmes and their implications for ambulance services, identifying opportunities and developing and tracking resource requirements for delivery. The key principles and content of the draft Framework were endorsed, it was confirmed that the existing Framework would remain extant until the final version was presented and approved.

Following discussion Members **RESOLVED** to:

- **NOTE** the progress made in developing the new Emergency Ambulance Services Commissioning Framework
- **ENDORSE** the content of the Framework and the ongoing plans for development.

EASC COMMISSIONING UPDATE

Members noted that formal confirmation was awaited from Welsh Government regarding the status of the EASC Integrated Medium Term Plan and that a quarterly update with regard progress made against the IMTP would be provided at the next meeting. An update against the Commissioning Intentions (Emergency Ambulance Services, Non-Emergency Patient Transport Services and Emergency Medical Retrieval and Transfer Services) would be provided to EASC Management Group at the August meeting.

FINANCE REPORT

The EASC Finance Report was received and the purpose of the report was to set out the estimated financial position for EASC for the 2nd month of 2022/23 together with any corrective action required. No corrective action was required.

EASC SUB GROUPS

The confirmed minutes from the following EASC sub-groups were **APPROVED**:

- Chair's Summary EASC Management Group – 16 June 2022
- EASC Management Group – 21 April 2022
- NEPTS Delivery Assurance Group – 3 May 2022
- EMRTS Delivery Assurance Group – 29 March 2022.

EASC GOVERNANCE INCLUDING THE RISK REGISTER

The report on EASC Governance was received. Governance documentation is available at https://easc.nhs.wales/the-committee/governance/

Members **RESOLVED** to:

- **ENDORSE** the risk register
- **NOTE** the progress with the actions to complete the requirements of the EASC Standing Orders
- **APPROVE** the EMRTS DAG Annual Report 2021-2022
- **APPROVE** the EASC Communications and Engagement Plan
- **APPROVE** the EASC Assurance Framework

- **APPROVE** the completion of the Internal Audit on EASC Governance
- **NOTE** the information within the EASC Key Organisational Contacts.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays (and the development of handover improvement plans in HBs with trajectories)
- Community care capacity

Matters requiring Board level consideration

- Consider and oversee the implications of the commitment made at the meeting with Judith Paget by Chairs and Chief Executives improve immediate release requests on 8 June 2022.
- To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plan and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- Note that a live PowerBI dashboard for Immediate Release Directions (previously red release requests) would be available to all NHS Wales colleagues from week commencing 25 July 2022 as a screen in the current WAST health board view of the Operational Delivery Unit PowerBI data set
- Note the roll out of roster reviews for each area before the end of November 2022
- From the Performance Report
    - Red performance remains extremely challenging (at approximately 50%)
    - Increasing median response times (approximately 7minutes 50seconds) and the implications in terms of the response for patients and outcomes
    - Median response times for Amber 1 patients (over 2 hours)
    - Increasing lost hours (baseline last October of approximately 74 minutes with current average handovers of approximately 2 hours)
    - 4 hour waits for patients continue to be significant with in excess of 100 x10 hour plus waiting times.

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**6 September 2022**			

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 15 MARCH 2022 AT 09:30HOURS VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Glyn Jones	Interim Chief Executive, Aneurin Bevan ABUHB
Suzanne Rankin	Chief Executive, Cardiff and Vale CVUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
Steve Moore	Chief Executive, Hywel Dda HDdUHB
Hayley Thomas	Deputy Chief Executive, Powys Teaching Health Board
Sian Harrop-Griffiths	Director of Strategy, Swansea Bay SBUHB
Associate Members:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
In Attendance:	
Nick Wood	Deputy Chief Executive NHS Wales, Health and Social Services Group, Welsh Government
Aled Brown	Policy Lead Official, Welsh Government
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Nick Lyons	Executive Medical Director, Betsi Cadwaladr BCUHB
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Deputy Chief Ambulance Services Commissioner, EASC Team, National Collaborative Commissioning Unit (NCCU)
Matthew Edwards	Head of Commissioning and Performance, EASC Team, National Collaborative Commissioning Unit (NCCU)
Gwenan Roberts	Committee Secretary

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 22/13	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee and gave an overview of the arrangements for the meeting.	Chair

	Suzanne Rankin, the new Chief Executive of the Cardiff & Vale UHB and Hayley Thomas, Deputy Chief Executive of Powys Teaching HB were welcomed to their first EASC meeting. The Chair also took opportunity to reaffirm the role of the EAS Committee in terms of its role within the EASC Directions to plan and secure sufficient ambulance services in Wales in line with Welsh Government and NHS Planning Frameworks. In terms of context for many of the discussions to take place at the meeting, the Chair reminded Members of the agreed deliverables. In particular, the previous agreed commitment to reducing handover delays – no handover delays over 4 hours and reduce the average time of lost hours by 25% from October 2021 level. It was noted that the current position needed to be significantly improved. In addition, Members noted the phasing out of the military support to WAST at the end of March and the likely impact on performance. The Chair noted that due to these and other system issues, the ability of the EAS Joint Committee to plan and secure sufficient ambulance resources was at risk and therefore the need to reduce this risk, as soon as practicable, was critical. Members noted that the Chair had agreed to a request from Jason Killens to leave the meeting early, therefore the agenda had been rearranged to assist this.	
EASC 22/14	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Jo Whitehead, Mark Hackett, Carol Shillabeer, Tracey Cooper and Ricky Thomas.	Chair
EASC 22/15	**DECLARATIONS OF INTERESTS** There were none. It was noted that the EASC Team would soon be asking for the annual declarations of interest and that this will need to be done specifically for EASC, in addition to those submitted to individual organisations.	Chair
EASC 22/16	**MINUTES OF THE MEETING HELD ON 18 JANUARY 2022** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 18 January 2022. Members **RESOLVED** to: • **APPROVE** the minutes of the meeting held 18 January 2022.	Chair

EASC 22/17	**ACTION LOG** Members **RECEIVED** the action log and **NOTED**: **EASC 22/10 Key Reports and Updates** It was noted that this work was progressing and would be included in a future report. This work would link to the roll out of the electronic case card. **EASC 21/64 Ambulance Handover Delays** Members were aware that the CASC had written to Chief Executives and Chief Operating Officers (COOs) with a request for detailed handover improvement plans; the Minister had also written to Chairs in this regard. The CASC reported that responses had been received from each organisation and that these included many actions to be undertaken across the system. Members noted that the next step would be to for the CASC to discuss actions with the COOs including how the actions would align; the impact of the ongoing system reset and anticipated outcomes would be included. Some health boards had identified specific actions and those would be shared with Members as soon as possible. Members noted that any actions that had a significant impact would be shared as soon as practicable. The CASC summarised the actions and shared the concern that safe ambulance services would not be able to be provided due to the escalating handover delays. **EASC 21-26 Committee Effectiveness** Members were reminded that the Chair was keen to ensure that appropriate representation of the 'patient voice' was included in the work of the Joint Committee. It was noted that the new national arrangements for the patient's voice may help in this regard. An update would be provided as soon as possible. **EASC 20/74, 21/22 Serious Adverse Incidents (SAIs)** It was noted that it was difficult to realistically benchmark the different ambulance services across the UK due to differing reporting arrangements that exist. In order to ensure that an element of benchmarking was available, it was agreed that the Association of Ambulance Chief Executives Report 'Delayed Hospital Handovers: Impact Assessment of Patient Harm' (AACE, Nov 2021)' would be circulated. The Deputy CASC reported that some work has recently been undertaken by Welsh Government Officials who had asked the Delivery Unit (DU) to review 'Appendix B Reports'.	WAST CASC Chair Ctte Sec

	Members were aware that the nationally reported incident approach required incidents to be passed on from WAST to health boards for investigation where ambulance handover delays were deemed to be the underlying cause. Members noted that the report would be received and discussed by the Directors of Nursing (25 March 2022). Members noted that one recommendation within the draft report suggested that the EASC Team take a lead role in coordinating the work required within the system to improve processes and outcomes. Members noted that the EASC Team had not previously been involved in this work and it was felt this would be helpful to have additional input into this work. It was anticipated that the report would be shared with Members as soon as available and Members of the DU would be invited to attend the next meeting of the Joint Committee to present their findings. **EASC 19/76 Emergency Medical Retrieval and Transfer Service (EMRTS) Evaluation** It was noted that the EMRTS technical evaluation report had now been received and provided a positive review of the service to date. Members noted that the report would be received by the EMRTS Delivery Assurance Group at its next meeting and would then be shared with the Joint Committee. **EASC 19/75 Chair and CASC Meetings** Members noted that the Chair and CASC had presented slide packs at health board meetings developed to reflect the needs and challenges of the specific areas. The Chair explained that helpful discussions had been held and a generic feedback session report would be developed to share with Members. Members **RESOLVED** to: • **NOTE** the Action Log.	Ctte Sec Forward Look Forward Look Forward Look
EASC 22/18	**MATTERS ARISING** There were no matters arising.	Chair
EASC 22/19	**CHAIR'S REPORT** The Chair's report was received, Members noted that the Chair's objectives had been agreed and were included for information. Members **RESOLVED** to: • **NOTE** the Chair's report	Chair

Part 2. ITEMS FOR DISCUSSION AND APPROVAL		**ACTION**
EASC 22/20	**PERFORMANCE REPORT INCLUDING THE ANNUAL QUALITY INDICATORS (OCTOBER-DECEMBER 2021)** The Performance Report was received. Members were reminded that the report presented information in line with the most recent publication of Ambulance Quality Indicators. Members noted that the AQIs would be published monthly from April 2022 providing an opportunity to discuss more recent information. In presenting the report, Ross Whitehead highlighted: • the continued challenges around 999 call wait times • the growing gap between the number of calls answered and the number of incidents generated • slightly less incidents in January and February • mitigating action taken including investment in staff and technology • significant challenges in achieving red 65th percentile • growth in red demand – at 53% response and median 7mins and 30secs; joint work with Welsh Government and Digital Health and Care Wales looking at linked data sets related to patient outcomes and would report findings at a future meeting • amber responsiveness 95th percentile continued to grow with significant waits seen; Amber median 1hour 30mins (ongoing impact on patient journey) • More media stories and political interest being seen • in light of previous commitments to reduce ambulance handover delays, increases over recent months were noted, with the trend continuing into March (currently 700 hours per day) • with reducing staffing capacity, WAST forecasting the impact and the level of the Clinical Safety Plan to ensure response at red and amber 1. The Chair thanked Ross Whitehead on the sobering performance information and invited further discussions. Nick Wood, Deputy Director of NHS Wales noted the mitigating actions and responses in place to deal with the current pressures within the system. Attention was drawn to the Red performance target being missed over a number of months and the record levels of handover delays across NHS Wales. Members were asked whether they felt their actions and mitigations would be sufficient to respond in a timely way to the current situation and reduce harm to patients.	Action Log

	Members recognised that the mitigation identified was maintaining the current level of performance but to improve the performance was the joint responsibility of WAST and health boards in responding to population needs and to ensure patient safety. Members highlighted the significant risks within the system for patients and suggestions were made to include the units of hours produced to understand where resources could be deployed. Members noted that despite the mitigations the risks continued to be realised. The recent reset underway over the last two weeks was also discussed although only marginal differences had been experienced by the ambulance services. Nick Wood asked regarding the EASC perspective and the need for a joint response from WAST and health boards in relation to the safety of the service and meeting community expectations; the impact of the significant drift in lost hours, the deterioration in response rates, the increasing numbers of concerns and increasing numbers of serious adverse incidents. Members were asked if they were confident that their actions would mitigate against the identified risks and would lead to improvements in performance and reduce patient safety incidents. Members felt this was a fair challenge although there were expectations that the actions identified in the health board plans would lead to improvements in reducing lost hours and a consequence improvement in working towards meeting the performance targets. The CASC agreed that the Committee was not in a position to provide the level of assurance needed due to the position with handover delays. The Joint Committee had not been complacent, and Members were aware that the planning assumptions had assumed a maximum of 5,000 handover hours in one month. Once these levels had been overtaken a number of mitigating actions had been put in place which included the WAST Clinical Safety Plan. At 20,000 lost hours per month Members were aware that ambulances would not be sent for Amber 2 patients. Suggested solutions were proposed including to: • provide temporary additional front-line ambulance capacity into WAST to support the system over the coming months to mitigate the removal of the support from the military and until the required improvements are in place to handover delays and impacting across the system • continue to work with health boards to understand the variation across the system identified within the action plans submitted and to identify and share best practice	

	• ensure that the handover improvement plans deliver the required gains, to be monitored by the governance arrangements including the Commissioning Framework • constantly challenge the current culture where handover delays are tolerated. It was proposed that the following actions were put in place as the key elements of the system-wide handover improvement plan to address the patient safety concerns, particularly with the withdrawal of support from the military in April: • maximise temporary additional front-line ambulance capacity during the coming period including overtime and WAST to operate at a higher state of emergency alert to maximise front-line resource • use of the agreed whole system escalation process and the actions taken • re-focus on 'red release' to allow WAST to respond appropriately and promptly (had been slippage) • health board resources in place such as same day emergency care, urgent primary care centres, flow centres or communication hub etc and identify two or three deliverables as part of this Handover Improvement Plan. This would include managing or challenging slippage and monitoring the impact on the patient experience and recognised the need to move at pace. The key points of the discussion that followed included: • acceptance that patients were waiting too long for ambulance services • the inclusion of the availability of resources in the performance report to add to the understanding of ambulance performance and response • that only marginal improvements had been experienced by the ambulance service following the recent system reset • that system wide responses were required including the need to improve flow and discharge patients, to address staffing challenges in community and social services although this would not be addressed quickly • a 'cultural acceptance' had emerged in relation to current levels of handover delay which was unhelpful in relation to patient safety and harm • re-visiting discussions with WAST on a health board by health board basis, understanding the local issues and jointly agreeing actions and trajectories. • The importance of the consistency of the approach • Receiving information from the North West Ambulance Service in terms of their approach to handover delays and seeking different solutions	All

	• acknowledgement of the continued existence of COVID-19 and its impact within the system. Nick Wood asked why the action plans for handover delays had not been included on the agenda for the meeting as he considered this matter the most pressing for ambulance services; this coupled with the loss of the military support for the service would have a significant impact. Furthermore, he asked whether further actions would be undertaken as when he met with the Chief Operating Officers (COO) this necessarily was not their key issue to resolve. Nick Wood confirmed that he was very concerned regarding the actions and the timescales involved. The CASC confirmed that detailed operational matters were discussed at the EASC Management Group and would be escalated by exception to the EAS Joint Committee. The CASC confirmed that he attended the COO meeting to discuss handover delays and receive updates on the actions taken. The Chair thanked Members for the helpful discussion and emphasised the requirement for all Committee Members to respond urgently to the current position related to handover delays and to work with WAST to mitigate the impact of the loss of military resource at the end of March. The suggestions set out by the CASC were accepted and the Chair articulated the hope to see an improved position at the next meeting. Following discussion, Members **RESOLVED** to: • **NOTE** the content of the report and additional actions that would be taken to improve performance delivery to be included in the EASC Action Plan. • **AGREE** to include the units of hours produced to the next iteration of the Performance Report.	
EASC 22/21	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) UPDATE** The Welsh Ambulance Services NHS Trust update report was received. In presenting the report Jason Killens highlighted: • phased withdrawal of the military support of approximately 250 staff (reduction in capacity of approximately 15% of production) by 31 March 2022 • approximately 100 members of staff were currently in operational training and would become operational in quarter 1, the capacity of the Clinical Service Desk would be doubled early in quarter 1 and this would allow the volume of calls closed via the 'consult and close' process to lift from 10-12% to approximately 15%	

	• the additional offer to roll on some winter schemes including cohorting and third-party support should the required support and funding be available (non-core activities) • red performance remained below target although an improving picture since December. A deep dive has been undertaken into red performance which was currently being finalised and would be presented to the EASC Management Group • There were 503 long patient waits in January, this was a reduction compared to December, but rates were still very high with patients waiting excessively long times for services (some waiting more than 24 hours) • the daily average handover position for the 10 services in England was shared, with WAST performance the worst, particularly in terms of the comparative fleet size • electronic patient case card – this would be live in all health board areas by the end of March 2022, with many suggestions for improvements for phase 2 of the work • the detailed briefing issued last week regarding roster changes had been extremely helpful in addressing the significant local, regional and national political interest. It was important for all to portray the positive story, (70 FTE additional staff) information would be circulated more widely to illustrate local level impacts including that 34.5 additional emergency ambulances would be operational across Wales as a result of this work. This would impact in Quarter 3 2022-23 • high sickness levels and the work being undertaken to achieve the trajectory to return to pre-pandemic levels of 6.5%. It was acknowledged that current levels were far too high and that there would be a plan to reduce these in the next few months. Discussion followed regarding: • the arrangements and assessments being made to revisit the risk assessments in light of the reissued Infection Prevention and Control guidance which was active and ongoing • the impact of the strategic change agenda on the operational pressures, WAST would continue to work both individually and collectively with health boards where elements of this work required centralisation or regionalisation of services, this had been included in the IMTP • the roster review and the positive benefits from the work Members felt this was a good example of improving efficiency although this was sometimes perceived as a negative in some communities; WAST offered to share additional information if needed	EASC MG WAST

	• the need to apply best practice from other areas in the development of handover improvement plans and the need to ensure that the required accountability and escalation requirements were included within the Commissioning Framework's schedules. The CASC emphasised the current focus in terms of: • Being clear what could be delivered on a quarter by quarter basis • Encourage health boards to include gaps within plans to identify key requirements • Commissioning Framework to include detail in terms of what was required. The risks were clarified including the loss of the military personnel which would impact on about 15% of production and a further decay in performance. WAST would mitigate some of the issues but Members noted that quarter 1 was likely to be extremely difficult for the ambulance service and the consequential impact on patient experience. Members noted the additional service offer from WAST in its Transition Plan and the offer previously discussed. The Chair invited the CASC to outline other requirements for WAST which included: • reducing sickness and setting the required improvement trajectory • agreeing timescales for reducing post-production lost hours and managing the inefficiency in the system • ensuring all roster changes would be in place by end of November 2022 • reducing the variation within the service by adopting good operational practice on a day by day basis Members also noted that in relation to the handover improvement plans – the template circulated had included best practice and following on from the discussion it would be amended to include the work from the North West Ambulance Service. The Chair asked Members to actively support the roster review changes and recommended the use of the detailed briefing which had recently been shared. This was cited as an example of good practice which could be replicated for other areas of work. Members **RESOLVED** to: • **NOTE** the report.	WAST CASC

EASC 22/22	**WELSH AMBULANCE SERVICES NHS TRUST DRAFT INTEGRATED MEDIUM-TERM PLAN (WAST IMTP) UPDATE** The WAST IMTP report was received. In presenting the report, Rachel Marsh highlighted the executive summary and key elements of the Plan including progress made in terms of: • Progress to recruit the additional 127 full time equivalent (FTE) staff as agreed following the Emergency Medical Services Demand and Capacity Review • doubling the capacity of the Clinical Support Desk • introducing mental health practitioners to the organisation • completing the roll-out of NHS Wales 111 with the programme team • completing the transfers of Non-Emergency Patient Transport Services (NEPTS) from health boards. The plan also set out the organisation's desire to progress their ambition to 'invert the triangle' as presented and discussed at previous EASC meetings. The plan set out the strategy and a programme of work going forward. Members noted the offer from WAST for the provision of additional capacity to mitigate some of the immediate pressures on the system and releasing paramedics as part of their advanced paramedic practitioner training. For the NEPT Service the eligibility criteria and finding other ways of attending health care were considered important. Members noted that the plan did not include financial information at this point, as this was subject to ongoing discussions at WAST. A letter had been sent to Welsh Government and work was continuing in order to provide a balanced financial plan. Opportunities for joint working with academic institutions were noted and further discussions would be held outside of the meeting to consider opportunities across the system including joint appointments. The ongoing dialogue had continued between WAST and Health Education and Improvement Wales (HEIW) was noted along with WAST's ambitions to pursue University Trust status. The CASC highlighted the consistency between the WAST IMTP, the agreed Commissioning Intentions (CIs) and Welsh Government targets. The shortage of capital within the system was noted and, while WAST had a significant capital allocation, work would also be required to understand how capital could be a restricting factor in delivering some of the transformational initiatives.	

	The scale of WAST's change programme was also highlighted and the risks associated with this, in relation to the impact on the workforce and working with trade unions and staff side organisations. Members noted that in terms of NHS Wales 111, a pragmatic approach had been adopted and an assumption that there would be no overhead contribution out of the 111 allocation had been made. In terms of the financial allocation, this would need to be clarified although there was a need for EASC to approve its own IMTP and this would provide the commissioning allocation that would need to be consistent with the WAST IMTP. If this was not so, the Chair and the CASC would not be able to support the WAST IMTP prior to submission to the Welsh Government (as in previous years). Assurance was given that no approval would be taken outside of the delegated authority of the Committee or outside of the EASC IMTP. Members noted that WAST had not presumed additional funding but would be able to move forward on proposed schemes if supported by the commissioners. Members **RESOLVED** to: • **SUPPORT** the WAST IMTP, noting the risks and financial information to be worked through and mitigated, • The Chair and the CASC to subsequently endorse the final plan in line with the discussions at the meeting following WAST Board approval and prior to submission to the Welsh Government by the 31 March 2022.	
EASC 22/23	**EASC INTEGRATED MEDIUM TERM PLAN** The EASC IMTP was received. In presenting the report, Ross Whitehead highlighted that the EASC IMTP was consistent with principles presented at the Joint Committee meeting in January 2022 and had been presented at the recent EASC Management Group for endorsement. The plan focused on Commissioning Intentions (CIs) along with other priority areas for 2022-23 and the three-year planning cycle included the appetite for the commissioning of 111 Services and the development of a National Transfer and Discharge Service reflecting the regionalisation and reconfiguration of services.	

	The plan also articulated the need to respond to emerging system change and the role of EASC in working towards contributing to the delivery the 6 Goals for Urgent and Emergency Care. In particular the focus for EASC would be on Goal 4 but it was recognised that there could be a wider contribution to other goals. Members noted the intention to constantly refresh the Commissioning Framework to reflect these developments. The draft EASC financial plan was included, this was consistent with that presented at the November Joint Committee meeting and subsequently presented to Deputy and Directors of Finance. Regular meetings also were taking place between the EASC Team and WAST Directors. The CASC emphasised the consistency between EASC and WAST IMTPs and explained that the plan has been endorsed by EASC Management Group and shared with Welsh Government colleagues for comment. It was agreed that the joint commitment to optimise conveyance strategy, including joint trajectories and expectations was a key part and joint commitment of the IMTP and that this should be emphasised. The CASC reported that a financial allocation had initially been presented to Members in November, this had been shared with Deputy and Directors of Finance. Members noted that no assumption had been made regarding transformation within the financial schedules. For consistency, these schedules remained in the plan. No specific responses had been received in relation to the information presented. Conversations with peer groups, EAS Joint Committee and EASC Management Group Members indicated that they would support the submission of a bid to the Welsh Government for funding from the 6 Goals for Urgent and Emergency Care programme; this assumption was included in the plan which asked that funding be made available to EASC from the £25m previously announced. The proposed use of the funding would be to expand the clinical resource 'hear and treat' and ensure that clinical advice using the emergency communications nurse system (ECNS) to support a clinical safety valve within the system to avoid harm to patients. The aim of the proposal was to ensure sufficient clinicians in the ambulance control to provide a ring back service to advise patients within an hour when an ambulance response could not be sent. This would strengthen clinical governance and allow individuals callers to have a more timely and flexible response.	

	This could include upgrading or downgrading of calls and would assist clinicians to provide alternatives for patients and facilitate referrals to available services such as urgent primary care, same day emergency care services, assessment centres, communication hubs etc where available. Members noted that approximately 30% of patients taken to an emergency department by WAST were discharged with no follow up required. The CASC highlighted to Members the key inefficiencies in the system which included: • Handover delays - It was suggested that the required system improvements that would reduce ambulance handover delays sufficiently would not be in place for some time and that it would be sensible to retain front line ambulance resource for the start of the 2022-23 financial year to manage the clinical risk and patient safety concerns that exist, until wider system improvements could be made. • WAST financial plan included a £1.8m cost reduction plan to impact on front line costs which would reduce overtime and hold vacancies - it was suggested that this £1.8m be waived due to the current issues related to handover hours and the loss of the military personnel on a 'non-recurrent basis'. The proposal for the temporary resource recognised both the need for action across the system but also the length of time that it was anticipated that required improvements would take place. Members noted that a scrutiny panel for the WAST Transition Plan had been held with health board colleagues on 8 February 2022 and that one of the outcomes was an expectation to revisit the cost improvement programme (CIP) level and to ensure that this was consistent with that required of health boards. Members noted that there was a choice to be made in this regard. At a 1% CIP level it was clarified that this assumed the £1.8m CIP would not be delivered. The CASC suggested that if a 1% CIP for WAST be maintained this would support the issues identified within Q1 in terms of the increasing handover delays and also the loss of the military personnel. The CASC suggested that, on a non-recurrent basis to waive the £1.8m. If the improvements in handover delays did not materialise and if WAST did not meet their improved efficiencies, then a significant pressure would remain in the system. However, if improvements were made within the system and handover delays reduced then the ask for the funding would also be reduced. A mixture of improvement across the system would give a shared risk which would need to be further clarified.	

	Nick Wood asked the CASC to confirm the detail in the financial year 2022-23 which related to the assumptions of a non-recurrent bid to the Welsh Government 6 Goals for Urgent and Emergency Care funding (£25m). Stephen Harrhy confirmed that the assumption within the financial plan was a minimum of £750k but possibly would require some additionality in terms of coverage for the ECNS scheme. Nick Wood noted this and explained that this was under discussion by the Welsh Government Policy Lead officials who were considering the allocation. Stephen Harrhy explained that this had been the approach suggested by health boards to apply for specific urgent and emergency care funding from the £25m which was reflected in the plan. Nick Wood thanked Stephen Harrhy for the clarification. Members questioned the level of the CIP (1% would have been 2% if the £1.8m was included) and the CASC explained the WAST had also been asked not to make assumptions regarding their Transition Plan within the IMTP as this had not been widely supported at the scrutiny session. The option related to the WAST CIP which included the £1.8 million from front line staff remained contentious but the CASC suggested that the increasing concerns related to patient safety and the likelihood of harm within the current system this was an option to try and get to a balanced financial plan for WAST. Members confirmed that the financial envelope had been agreed by the Directors of Finance but questioned whether the CIP needed to be made from savings around front line staff, i.e. were there other options. Members explained that much higher levels of CIP had been agreed within health boards and felt that WAST should not be subject to different efficiency measures. Members were keen that the CIP was revisited to be in line with health boards across Wales. The CASC responded and suggested that if additional funding, albeit on a temporary basis, was not provided to WAST the performance would deteriorate further and this would increase risks in terms of patient safety and experience. Stephen Harrhy suggested that if handover delays were reduced to 15,000 hours by April (which seemed unlikely) there remained a need for temporary funding for WAST. Furthermore, the CASC explained that without the temporary funding information would need to be provided to explain exactly what services could be offered by WAST.	

	Members suggested that they required more financial detail to discuss within health boards which would need to be balanced against other priority areas. Members felt they would need more granularity in relation to the ambulance services to balance for the wider health of local populations in decisions made by health boards. Stephen Harrhy agreed to write to Members to explain clearly how the options and opportunities on a Health Board by Health Board basis. This information could be presented in different ways including having a 2% CIP and a non-recurrent allocation of £1.8m. The implications of all options would be clarified although the CASC felt it was essential that WAST have additional funding due to the level of inefficiency within the system at present. Members agreed to the need for additional non-recurrent funding to ensure additional front-line ambulance capacity however more detail would need to be provided, as requested. Members **RESOLVED** to: • **NOTE** the process of engagement undertaken in the development of the EASC Integrated Medium Term Plan • **APPROVE** the EASC Integrated Medium Term Plan (2022-25) for submission to Welsh Government • Receive information on a health board by health board basis in terms of the WAST CIP and additional temporary funding	CASC
EASC 22/24	**CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT** The CASC report was received. Stephen Harrhy presented the report and highlighted the following: • Non Emergency Patient Transport Services (NEPTS) Members noted that detailed work was now being undertaken on NEPTS and the impact of health boards reset and reconfiguration on different elements of NEPTS activity, for example reduced outpatient journeys and an increase in demand for transfers and discharge. A 'Focus on' session will be held at the next EASC meeting exploring this on a health board by health board basis. • EASC Action Plan It was reported that the Minister had requested that the EASC Action Plan be updated to incorporate the expected impact of the actions being taken across the system. The latest version had been appended to the CASC report, this would now be updated.	Forward Look

	• System Wide Escalation Members noted that a conversation had been held at the recent NHS Wales Leadership regarding the final version of the System Escalation Plan. Members noted that the final version would be endorsed at the next meeting of the Leadership Board and implemented in April 2022. Members **RESOLVED** to: • **NOTE** the report.	
EASC 22/25	**EMERGENCY MEDICAL SERVICES (EMS) COMMISSIONING FRAMEWORK** The EMS Commissioning Framework report was received. Ross Whitehead presented the report and noted previous discussions at EASC Management Group and the recent scrutiny panel on the WAST Transition Plan held with health board representatives. Members noted that it had become clear from these recent discussions that health boards expected clarity on the commissioning of core ambulance service provision, separately from the transformation elements. This approach would provide health boards with the required clarity on how framework resources were being utilised to deliver the priorities of the Committee and would allow the development of different and transformational service offers within each health board areas to address the needs of their populations. Rachel Marsh suggested that it would be helpful to have a conversation with the team at WAST to discuss this approach to the development of the Commissioning Framework to understand what this would mean from the provider perspective. The ability to separate core service provision from transformational programmes was raised and whether it would be possible. Ross Whitehead responded and explained that at the scrutiny panel meeting to discuss the WAST Transition Plan and at the last EASC meeting health boards had their own views and expectations around WAST developments relating to pre hospital urgent and emergency care and that having clear lines of sight within the Commissioning Framework would be helpful. Members were also reminded that the framework was a live document that would be refreshed every 6 months, responding to developments within the service.	

	The Chair added that the key principle here was that as things progress Members did not lose sight of the core services; further detailed conversation with the WAST Team on this matter would be helpful and was agreed. Following discussion Members **RESOLVED** to: • **APPROVE** the development of a framework that distinguishes between core service provision and transformational services • **APPROVE** the extension of the interim arrangements until the May Committee meeting.	
EASC 22/26	**FOCUS ON SESSION – HEALTHCARE INSPECTORATE WALES (HIW) - REVIEW OF PATIENT SAFETY, PRIVACY, DIGNITY AND EXPERIENCE WHILST WAITING IN AMBULANCES DURING DELAYED HANDOVER** The HIW review of Patient Safety, Privacy, Dignity and Experience whilst waiting in Ambulances during Delayed Handover was received. Ross Whitehead presented the session and Members noted that many elements of this 'Focus On' agenda item had already been discussed earlier in the meeting. Members noted that the HIW report focusing on ambulance handover delays had already been considered at many health board sub committees. Twenty recommendations had been made which required a system wide response and it was confirmed that the action plan had been accepted by HIW. The EASC Management Group (EASC MG) agreed to establish a task and finish group to deliver the recommendations. Draft terms of reference had been circulated to EASC MG members with dates of the first two meetings and a request for clinical and operational representatives from each health board. It was agreed that regular updates on this work would be provided at future meetings of the Committee and the EASC Team would work closely with HIW on this matter. The first meeting would take place in early April and had been planned for 6 months in the first instance. Members **RESOLVED** to: • **RECEIVE** the HIW Review and responses to the recommendations • **NOTE** the establishment of a task and finish group to focus on delivery of the recommendations via the EASC Management Group.	Forward Look

EASC 22/26	**FINANCE REPORT MONTH 11** The Month 11 Finance Report was received. Stuart Davies presented the report and highlighted no significant changes and forecast end of year position of a £383k underspend. No significant movements were anticipated. Members **RESOLVED** to: • **NOTE** the report.	
EASC 22/27	**EASC SUB GROUPS CONFIRMED MINUTES** The confirmed minutes from the following EASC sub-groups were received: • EASC Management Group – 21 Oct 2021 • NEPTS Delivery Assurance Group – 12 Oct 2021 • NEPTS Delivery Assurance Group – 30 Nov 2021 Members **RESOLVED** to: • **APPROVE** the confirmed minutes.	
EASC 22/28	**EASC GOVERNANCE** The report on EASC Governance was received. Gwenan Roberts, Committee Secretary presented the report and highlighted: • The EASC Risk Register including 2 new risks and the three red risks which were also being reported to the CTMUHB Audit and Risk Committee • Internal Audit report on EASC Governance. Members noted that the report provided reasonable assurance and the five recommendations have now been added to audit tracker. The two audit recommendations from a previous report had now been closed. • Standing Financial Instructions reflected those approved by WHSSC and were the first specific SFIs for EASC • The summary of the progress made to complete EASC Standing Orders, Members noted that actions would be completed by the July meeting of the Committee. • Scheme of Delegation and Schedule of Powers had been updated • The Annual Business Plan was received • Declarations of interest have all been received and would be reported in the Annual Governance Statement. Members **RESOLVED** to: • **APPROVE** the risk register • **APPROVE** the Model Standing Financial Instructions	

	• **APPROVE** the final information for the model Standing Orders namely the Delegation of Powers and Scheme of Delegation • **NOTE** and **APPROVE** the Draft Annual Business plan • **NOTE** the updates relating to red performance and the additional new risks • **NOTE** the progress with the actions to complete the EASC Standing Orders and the aim to complete all actions by the next meeting • **NOTE** the Internal Audit on EASC Governance and the plans to track the recommendations.	
EASC 22/29	**FORWARD LOOK** The Forward Look was received Members **RESOLVED** to: • **NOTE** the report.	
Part 3. OTHER MATTERS		**ACTION**
EASC 22/30	**ANY OTHER BUSINESS** The Chair closed the meeting by reminding Members of the urgency of the work to reduce handover delays which were a matter of real concern in relation to patient safety and the patient experience.	

DATE AND TIME OF NEXT MEETING		
EASC 22/31	The next scheduled meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 10 May 2022 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 10 MAY 2022 AT 13:30HOURS VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Glyn Jones	Interim Chief Executive, Aneurin Bevan ABUHB
Suzanne Rankin	Chief Executive, Cardiff and Vale CVUHB
Steve Moore	Chief Executive, Hywel Dda HDdUHB
Carol Shillabeer	Chief Executive, Powys PTHB
Sian Harrop-Griffiths	Director of Strategy, Swansea Bay SBUHB
Associate Members:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Steve Ham	Chief Executive, Velindre University NHS Trust
In Attendance:	
Jeremy Griffith	Director of Operations NHS Wales Health and Social Services Group Welsh Government
Claire Nelson	Assistant Director of Planning, Cwm Taf Morgannwg UHB
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Gwenan Roberts	Committee Secretary
Ricky Thomas	Head of Informatics, National Collaborative Commissioning Unit (NCCU)
Julian Baker	Director of National Collaborative Commissioning, NCCU
Matthew Edwards	Head of Commissioning & Performance, EASC Team, NCCU

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 22/52	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee and gave an overview of the arrangements for the meeting.	Chair

	The Chair welcomed Claire Nelson representing Cwm Taf Morgannwg UHB.	
EASC 22/53	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Mark Hackett, Paul Mears, Linda Prosser, Ross Whitehead and Stuart Davies.	Chair
EASC 22/54	**DECLARATIONS OF INTERESTS** There were none.	Chair
EASC 22/55	**MINUTES OF THE MEETING HELD ON 18 JANUARY 2022** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 15 March 2022 with the exception of the need to include Carol Shillabeer's apologies for the meeting. Members **RESOLVED** to: • **APPROVE** the minutes of the meeting held 15 March 2022 subject to the one amendment noted above.	Chair
EASC 22/56	**ACTION LOG** Members **RECEIVED** the action log and **NOTED**: **EASC 22/20 Performance Report** It was noted that work on patient outcomes data was ongoing with Digital Health and Care Wales and that a report would be presented to a future Committee meeting. **EASC 22/21 WAST Deep Dive into Red Performance** Jason Killens suggested that the detailed report focussing on red performance would be presented at an upcoming meeting of the EASC Management Group. **EASC 22/21 Requirements for WAST** In addition to the WAST Update provided against agenda item 2.3, it was noted that: • trajectories had been set to achieve pre-pandemic sickness rates, these were included in a detailed action plan that had been reported to WAST Executives and would be included in the next WAST update report • positive discussions had recently been held with Trades Union representatives and further updates would be provided as the work continued • work was continuing to reduce variation across the service	WAST WAST WAST WAST WAST

	• new rosters were on track for implementation in Quarter 3, and Members were aware of political and public interest in the work. **EASC 22/22 Handover Improvement Plans** Due to the variation in the status and development of plans, Members noted that not all health boards had found it helpful to use a template; however, there was a degree of consistency in terms of the actions being undertaken. The action regarding the use of a template was closed. **EASC 22/10 Key Reports and Updates** Further work would be required for WAST to report on episodes where ambulance resources had not been able to be deployed and patients had found their own way to hospital. This would remain on the action log. **EASC 21/65 Focus on session – Update on Demand and Capacity and modelling assumptions** The link to the Final Emergency Medical Services Demand and Capacity Report was shared during the meeting by Jason Killens. Action completed. **EASC 21-26 Committee Effectiveness – patient voice** Discussions ongoing with an update to be provided as soon as possible. Remain on Action Log. **EASC 20/74, 21/22 Serious Adverse Incidents (SAIs)** Members had already noted that it was difficult to realistically benchmark the different ambulance services across the UK due to differing reporting arrangements that exist. Members noted that the EASC Management Group had agreed to establish a Task and Finish Group to consider the NHS Wales Delivery Unit's Review of Appendix B Serious Adverse Incidents. It was agreed that this work would provide some indications of comparative performance as well as ensuring that appropriate processes were in place. Action to be removed from the Action Log. Members **RESOLVED** to: **NOTE** the Action Log.	WAST WAST Chair / Ctte Sec EASC Management Group
EASC 22/57	**MATTERS ARISING** There were no matters arising.	Chair
EASC 22/58	**CHAIR'S REPORT** The Chair's report was received, Members noted the recent meetings attended by the Chair and that the end of year assessment with the Minister would take place on 30 May 2022.	Chair

	Members also noted recent conversations with the All Wales Chairs' Group relating to the EASC agreed 'red lines' for ambulance handover delays (November 2021). Members were aware that the Chair's Summary was prepared as soon as possible following each Committee meeting and circulated to Members, along with the draft minutes. A further conversation had been held with the Chair of the All Wales Chairs' Group regarding this matter and it was agreed that the Chair's Summary would also be sent directly to the Chairs. Members **RESOLVED** to: • **NOTE** the Chair's report and the wider circulation to the Chairs.	
Part 2. ITEMS FOR DISCUSSION AND APPROVAL		**ACTION**
EASC 22/59	**AMBULANCE HANDOVER DELAYS** The report on Ambulance Handover Delays was received. Stephen Harrhy used presentation slides to inform discussion of the key areas. Members noted that the slides contained (currently) unverified data used as day-to-day management information, in addition to the verified data within the performance report. Members noted: • the current unsustainable levels of ambulance handover delay and the inability to deliver safe and effective ambulance responses • the need for handover improvement plans that concentrated on the pre-front door and front door • a summary of the position (January-April 2022) in terms of delivering safe and effective ambulance response including red 8-minute performance, Clinical Safety Plan (CSP) levels, numbers of 'no send', units of hours produced (UHP), lost hours and post-production hours lost (PPHL) • the work undertaken by the EASC team to produce a first draft 'patient conditions' analysis (including breathing problems, cardiac arrest, chest pain, falls, heart problems and stroke) • concerns regarding HM Coroner's Regulation 28 Report to Prevent Future Deaths • the NHS Wales Delivery Unit's Review of Appendix B serious adverse incidents that are passed to health boards by WAST for investigation • additional data to March 2022 for "hear and treat" services, sickness and post-production lost hours • actions already being undertaken, including: – Fortnightly tripartite meetings (HBs, WAST & CASC) – Evolving handover improvement plans	

	– NHS Leadership Board 'System Wide Review' – WAST Integrated Medium Term Plan (IMTP) commitments – All-Wales Escalation Framework – Welsh Government Integrated Quality Performance and Delivery (IQPD) meetings – Commissioning Framework. Carol Shillabeer updated Members in relation to the progress made at the NHS Wales Leadership Board in response to the sustained pressure across the health and social care system and increasing risk of harm to patients and staff. Members noted that the NHS Leadership Board had recognised the need for a different approach across the system involving defined deliverables, a key one being to increase the community care capacity across the system by an equivalent of 1,000 beds by October 2022. Members also noted: • The high level of patients within hospital system who are awaiting care support within the community • While the number of plans in the medium term and policy intent had been noted, the Leadership Board had expressed the urgent need for short term action • Positive discussions had taken place with local government colleagues in this regard to ensure the required whole system approach, at the same time ensuring the required political support and also the involvement and support of core enabling functions such as NHS Wales Shared Services Partnership Committee and Health Education Improvement Wales (HEIW). • A task team had been established to progress the approach and plan with the required momentum, ensuring appropriate governance and the necessary collaborative approach. • This work would not solve all of the issues across the system and that there was a need to look across the system and not just at community 'care capacity'. • The cautious approach to the focus on the defined number of beds and that work would continue with organisations across health and social care to deliver the maximum number possible. • The links to the Six Goals for Urgent and Emergency Care Programme, Regional Investment Funds via the Regional Partnership Boards (community care capacity) and the Strategic Programme for Primary Care (community infrastructure elements). Members commented that there was a significant energy in relation to this work currently but also a recognition that this work would not in itself solve all of the current issues.	

	Members noted that Hywel Dda UHB had commenced engagement with WAST staff in relation to direct paramedic referral into the Same Day Emergency Care (SDEC) service at Withybush hospital as an alternative to the Emergency Department and the positive response of staff to this development. Jeremy Griffith highlighted the significant risk implications that existed for patients in relation to ambulance handover delays and their continued pattern of deterioration. Members noted that the recalibrated Welsh Government Integrated Quality Planning and Delivery (IQPD) meetings would test the progress and impact made by organisations as part of the handover improvement plans. The key focus would be to assess the appropriate level of attention and urgency given to this issue to ensure the required wider system change. Members noted that the IQPD agenda would take a risk-based approach during the May round of meetings, while 3 health boards had shown signs of improvement some organisations were showing no improvement, and that this would require appropriate escalation going forward. Members also discussed: • the need to understand the increase in red call demand (approximately 70% in the last two years), although it was noted that there had been an agreed system change in the application of the triage tool which had led to a slight increase in red demand together with an underlying increase in terms of patient acuity. It was agreed that the analysis that had been undertaken would be shared with Members and considered in more detail at the EASC Management Group • the consistent use of statistical analysis in order to understand the impact of actions taken across the system in order to prioritise future actions • the requirement to better understand the demographic data and the need for improved data linkages – the introduction of the electronic patient clinical record and improved information relating to patient outcomes would help in this regard • the link to the Six Goals for Urgent and Emergency Care programme, particularly Goal 1 • adhering to the existing targets rather than agreeing further 'red lines' with a focus on service improvement and quality and enhanced patient experience • the ongoing unacceptable risk in the community as a result of the unprecedented levels of ambulance handover delays	WAST

	• the need to re-consider and agree a system-wide position for 'red-release requests' from the ambulance service with release refusal to be considered a 'never event' • collective discussions among HM Coroners regarding their concerns and Regulation 28 Prevent Future Deaths Report. In addition to the existing actions being taken, there was also a need to develop a 'Plan B' via the EASC Management Group in order to address the current position and patient safety risks across the system, this would be presented to the EASC Committee for approval. Members noted the ongoing work in relation to Handover Improvement Plans and the need to analyse the impact on the patient experience and the requirement that actions must lead to improved outcomes for patients. Members **RESOLVED** to: • **NOTE** the content of the report • **NOTE** the ongoing work in relation to handover improvement plans.	All CEO WAST / CASC EASC Management Group
EASC 22/60	**PERFORMANCE REPORT INCLUDING THE ANNUAL QUALITY INDICATORS (JANUARY-MARCH 2022)** The Performance Report was received. Members noted the information contained within the Ambulance Quality Indicators (January to March 2022), including the: • reduction in the volume of 999 calls relating to breathing difficulties • number of re-contacts into the system within the following 24 hours • impact of Community First Responders (CFR), particularly in rural areas and the ongoing discussions regarding the role of CFRs as part of the emergency ambulance services provision. In addition, Members noted a reduction in both conveyance volume and percentage within the Performance Report (Chart 7), though it was noted that the impact needed to be considered in light of the information provided which showed the reduction in attendance in response to escalation decisions relating to the impact of the Clinical Safety Plan. Members were reminded that optimising appropriate conveyance was a key aim of the Six Goals for Urgent and Emergency Care programme within Goal 4. Following discussion, Members **RESOLVED** to: • **NOTE** the content of the report and the published Ambulance Quality Indicators.	

EASC 22/61	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) UPDATE** The Welsh Ambulance Services NHS Trust update report was received. In presenting the report Jason Killens highlighted: • Key challenges in relation to handover delays and current positon in terms of red and amber performance • Table (paragraph 2.8) illustrating the number of patients waiting more than 12 hours in the community, noting over 800 patients in March 2022 with some patients not receiving a same day service. Members noted that these numbers would be higher in April • Items relating to Non-Emergency Patient Transport Services (NEPTS) would be discussed in the 'Focus On' session • Electronic Patient Clinical Record (ePCR) was live nationally, phase 2 would include connecting to the Welsh Clinical Portal and access to patient records for WAST clinicians in the community to support decision-making in terms of non-conveyance, see and treat and see, treat and refer in the community • The implementation of the Emergency Communication Nurse System (ECNS - software to support and enhance 999 clinical triage) for 'consult and close' on track for planned implementation • The offers made by WAST in relation to the Six Goals for Urgent and Emergency Care Programme, particularly for Goals 2, 3 and 4. Members noted that no specific resource had been made available to WAST to establish a dedicated team to progress the work in this area. Members were asked to confirm their health board leads for this work in order that the WAST team could make contact as a minimum to contribute to the work to deliver the Six Goals. The CASC noted that no resource allocation had been made for WAST from the £25m earmarked for urgent and emergency care and that WAST were bidding for resources following allocations made to health boards. Members noted that the CASC report included a bid for ECNS to ensure that urgent and emergency care services in Wales received an allocation from the Six Goals for Urgent and Emergency Care programme funding. Members **RESOLVED** to: **NOTE** the report.	
EASC 22/62	**CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT** The Chief Ambulance Services Commissioner's report was received. Stephen Harrhy presented the report and highlighted the following:	

	• The £1.8m temporary funding agreed at the last meeting was being utilised to continue services such as cohorting in order to support patients within the system • System-wide Escalation Framework agreed by the NHS Wales Leadership Board; the proposed next steps were noted • A proposal to create a new Commissioning Framework to be presented to the EASC Management Group for development and to be received at the next EAS Joint Committee meeting for approval • A bid for funding had been made to the Six Goals for Urgent and Emergency Care Programme relating to the Emergency Communication Nurse System (ECNS), this would ensure the ability to clinically assess, advise and re-direct patients within the system. Members noted this would provide a key element of patient safety during the current and ongoing pressures • NHS Wales Delivery Unit (DU) Review of Serious Adverse Incidents (SAI) in relation to Appendix B (transferred from WAST to health boards). Members noted that the DU had undertaken a review and that there appeared to be a mismatch between the incidents referred for further investigation in health boards and the subsequent assessment and reporting of those incidents formally to Welsh Government as SAIs. Members approved the recommendation of the EASC Management Group to establish a task and finish group that would review the Appendix B process and agree a way forward. Members **RESOLVED** to: **NOTE** the report.	CASC CASC DCASC
EASC 22/63	**CHAIR'S SUMMARY EASC MANAGEMENT GROUP – 21 APRIL 2022** The Chair reminded Members that the Committee currently received the minutes of EASCs sub-groups for approval once they had been confirmed at the subsequent sub-group meeting. Members noted that the time delay in receiving confirmed minutes could be as much as six months when a quarterly meeting had been cancelled. Therefore, it was proposed that a Chair's Summary is produced after each sub-group meeting to mirror the arrangements of the EAS Joint Committee. For illustrative purposes, the Chair's Summary for the EASC Management Group meeting held on 21 April 2022 was presented in order to ensure that Committee Members were fully updated on the discussions held and progress made at this recent meeting.	

	Members **RESOLVED** to: • **APPROVE** the preparation of a Chair's Summary following each sub-group meeting.	DCASC
EASC 22/64	**EASC COMMISSIONING UPDATE** Members noted that there were a number of operational and commissioning documents that had been prepared and updated for the EASC Committee. The EASC Commissioning Update had been prepared to provide Members with an overview of the progress being made against the key elements of the collaborative commissioning approach including: • Commissioning Frameworks • EASC Integrated Medium Term Plan (IMTP) • Commissioning Intentions • EASC Action Plan. Members noted that the EMS Commissioning Framework was currently being refined to reflect recent discussions at EASC Management Group and would be presented at the next meeting of the Committee. This included utilising data relating to the front door (this had already been shared with Chief Operating Officers and Directors of Planning) and the development of local commissioning plans. Members noted that further discussion would take place at the next meeting of the EASC Management Group. Presentation slides had been developed to share with Members in relation to plans for the work to develop the new Commissioning Framework. Julian Baker agreed to share the slides with Members and key contacts within health boards to include those leading on the work to implement the Six Goals for Urgent and Emergency Care. Members noted the aim of the work was to improve the patient experience in both emergency ambulance services and emergency departments; this would include linking the patient clinical outcome data utilising a statistical analysis approach. Members noted that the EASC Team would continue to progress the work and would engage further with the WAST team for presentation at the next EASC Management Group. It was noted that the EASC IMTP had been included for information and that a quarterly update with regard progress made against the IMTP would be provided going forward. Members **RESOLVED** to: • **NOTE** the collaborative commissioning approach • **NOTE** the aims of the approach	CASC CASC DCASC DCASC

	• **RECEIVE** the EASC IMTP, Commissioning Intentions Update (2021-22), the EASC Commissioning Intentions for 2022-23 and the EASC Action Plan • **NOTE** the proposal to develop the EASC Commissioning Update to provide Members with an overview of the progress being made against the key elements of the collaborative commissioning approach.	
EASC 22/65	**FOCUS ON SESSION: NON-EMERGENCY PATIENT TRANSPORT SERVICES (NEPTS)** The presentation on NEPTS was received. Members noted that Mark Harris (Assistant Director of Operations and lead for NEPTS) was unable to join the meeting and Rachel Marsh gave the presentation on the NEPTS service including the scope and scale of the service, managing demand and also the development of transfer and discharge services. Areas highlighted included: • The differences with the Emergency Medical Services (EMS) including higher daily patient volumes and differing mobility requirements • In addition to WAST, the different transport providers of NEPTS as part of the plurality model • It was a predominantly daytime weekday service with a small volume of activity at weekends • Patient journey types, mainly for outpatient or enhanced care appointments • The impact of the pandemic on core outpatient demand and also the effects of social distancing regulations (relaxed in recent weeks) – with additional resources provided in 2021-2022 in order to engage private sector capacity to meet service demand • The requirement to understand health board plans for reset and recovery • Performance metrics centred around timeliness; Members noted a need for improvement particularly in relation to oncology patient journeys arriving within 30 minutes of appointment time and lost hours on transfers and discharges in order to meet the target • Eligibility criteria and suggested that an indicative 30% of NEPTS transport provided to patients that were not eligible and WASTs intention to work with commissioners and health boards towards a position where non-eligible patients were steered towards alternative providers • NEPTS Demand and Capacity Review; identification of a range of efficiencies to be worked towards and the predicted impact on performance • The agreed commissioning intentions for NEPTS	

	• Map of key strategic changes being undertaken across health boards and the modelling undertaken in order to understand the impact on patient transport • Ambitions for the NEPTS service within the WAST IMTP. The Chair thanked Rachel Marsh for the very helpful presentation and a detailed discussion was held on a number of matters, which included: • the current weekday nature of the service, it was confirmed that there could be flexibility to provide patient transport for services being delivered at weekends subject to the required activity profiles, workforce discussions and changes to roster patterns • that patient demand was at approximately 90% of the pre-pandemic levels including the sharp increase experienced in March and that work would be undertaken to understand this in light of the reduction in outpatient activities and increase use of digital technology • in terms of eligibility criteria, the likely political and public interest in relation to any proposal for changes to patient transport provision and the need to collectively undertake a robust equality impact assessment to progress this work • the need to agree the scope of the work to deliver a National Transfer and Discharge Service and sign off the sequencing of the implementation at a future meeting • the need for WAST to provide assurance regarding the efficiencies and additional investment intended for renal and oncology services that were included in the original case for transforming NEPTS services • the need to consider the challenges and complexities regarding the cross-border activity and nature of Powys THB and the associated procurement routes • the fragmented NEPTS services that exist in England, with many small providers under differing contractual arrangements were noted in comparison. Members stated that the specific need for performance improvement for oncology patients and it was agreed that this would be provided to Members. Members **RESOLVED** to: • **NOTE** the key discussion points and agreed actions.	
EASC 22/66	**FINANCE REPORT MONTH 12** The Month 12 Finance Report was received. The Month 12 outturn showed an underspend of £347k. Members **RESOLVED** to: **NOTE** the report.	

EASC 22/67	**EASC SUB-GROUPS CONFIRMED MINUTES** The confirmed minutes from the following EASC sub-groups were received: • EASC Management Group – 24 February 2022 • NEPTS Delivery Assurance Group – 3 February 2022 • EMRTS Delivery Assurance Group – 28 September 2021. Members **RESOLVED** to: • **APPROVE** the confirmed minutes.	
EASC 22/68	**EASC GOVERNANCE** The report on EASC Governance was received. Gwenan Roberts, Committee Secretary presented the report and highlighted a number of items for approval, including: • The EASC Risk Register included 3 red risks relating to items already discussed at the meeting, these would continue to be reported to the CTMUHB Audit and Risk Committee • The EASC did not have a statutory duty to produce an Annual Governance Statement (AGS) but did so, as a matter of good governance, to provide assurance to the LHBs and, in particular, to CTMUHB, as its host organisation. The AGS would be forwarded to the CTMUHB Audit and Risk Committee and would inform the CTMUHB's Annual Governance Statement • The Annual Audit Enquiries Letter 2021-2022 • The draft EASC Annual Report that provided an overview of the business undertaken by the EASC as well as providing an opportunity to assess the effectiveness of the Committee in achieving its stated purpose. • Progress made against the EASC Audit Recommendations Tracker • Annual Reports for the EASC Sub-Groups Annual Reports for 2021-2022, including the EASC Management Group and Non-Emergency Patient Transport Services Delivery Assurance Group Annual Report. The Annual Report for the Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) Delivery Assurance Group would be considered at the next meeting in June 2022 for endorsement, prior to submission to EASC for approval in July 2022 • That plans were in place to deliver the requirements of the Standing Orders by July 22. Members **RESOLVED** to: • **APPROVE** the risk register and **NOTE** the updates relating to red performance • **APPROVE** the EASC Annual Governance Statement 2021-2022	

	• **APPROVE** the EASC Response to the Annual Audit Enquiries Letter 2021-2022. • **APPROVE** the EASC Annual Report 2021-2022 • **APPROVE** the EASC Audit Recommendations Tracker • **APPROVE** the EASC Sub-Groups Annual Reports 2021-2022 for EASC Management Group and the NEPTS DAG • **NOTE** the EMRTS DAG Annual Report for 2021-2022 will be presented at the next Committee meeting.	
EASC 22/69	**FORWARD LOOK AND ANNUAL BUSINESS PLAN** The Forward Look and Annual Business Plan was received. Members **RESOLVED** to: • **NOTE** the report.	
Part 3. OTHER MATTERS		**ACTION**
EASC 22/50	**ANY OTHER BUSINESS** The Chair closed the meeting by thanking Members for their contribution to the discussion particularly regarding ambulance handover delays and the key challenges for NEPTS.	

DATE AND TIME OF NEXT MEETING		
EASC 22/51	The next scheduled meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 12 July 2022 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 27th July 2022 Agenda Item: 4.7

Aneurin Bevan University Health Board

Committee and Advisory Group Update and Assurance Reports

Purpose of the Report

This report acts as a mechanism for Committees to provide assurance to the Board with regard to business undertaken in the last reporting period. It also allows the Committee to highlight any areas that require further consideration or approval by the Board.

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

The Board is asked to:	
Approve the Report.	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Board Secretary		
Report Author:	Bryony Codd, Head of Corporate Governance		
Report Received consideration and supported by:			
Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**As outlined.**
Date of the Report: 11th July 2022			
Supplementary Papers Attached: Committee Assurance Reports			

Background and Context

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

- Audit, Finance and Risk Committee
- Charitable Funds Committee
- Patient Safety, Quality and Outcomes Committee
- Mental Health Act Monitoring Committee
- People and Culture Committee
- Remuneration and Terms of Service Committee
- Partnerships, Population Health and Planning Committee
- Stakeholder Reference Group
- Healthcare Professionals Forum

Assurance Reporting

The following Committee assurance reports are included:

1. Patient Safety, Quality and Outcomes Committee – 7th June 2022
2. Audit, Risk and Assurance Committee – 13th June 2022
3. Mental Health Act Monitoring Committee – 13th June 2022
4. Finance and Performance Committee – 6th July 2022

5. Partnerships, Population Health and Planning Committee – 7th July 2022

External Committees and Group

Representatives from the Health Board also attend a number of Joint sub-Committees or partnerships of the Health Board, these are:

- Emergency Ambulance Services Committee
- Welsh Health Specialised Services Committee
- Shared Services Partnership Committee

In order to provide the Board with an update on the work of these Committees and Groups the following minutes, assurance reports and briefings are included:

- Shared Services Partnership Committee – 19th May 2022
- WHSSC/EASC – provided within Agenda item 4.7 – An Overview of Joint Committee Activity.

Assessment and Conclusion

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

Recommendation

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report. However, it is good governance practice to ensure that Committee business and minutes are reported to the Board. Therefore, each of the assurance reports might include key risks being highlighted by Committees.
Financial Assessment, including Value for Money.	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within committee's considerations.
Glossary of New Terms	None
Public Interest	This report is written for the public domain.

Name of Committee:	**Patient Quality, Safety and Outcomes Committee (PQSOC)**
Chair of Committee:	**Pippa Britton**
Reporting Period:	**7th June 2022**
Key Decisions and Matters Considered by the Committee:	

Audit Wales Review of ABUHB's Quality Governance Arrangements and Management Response

The Committee received the report and overview, and findings of the Quality Governance Arrangements review. Key findings showed that the Health Board had clear, articulated corporate arrangements for quality governance and key areas of quality and safety; however, further improvement was required at Divisional and Directorate level.

The Committee was assured that all recommendations had been agreed with the Health Board, appropriate actions outlined, alongside agreed completion dates and Executive ownership.

Committee members discussed whether or not there was sufficient ability to support quality governance and how this linked to Health Board job planning. Members were assured that each Division had appointed leads in for quality and safety, and that a review of resources would be undertaken by Clinical Executives and divisional leads to assess any perceived infrastructure gaps.

Committee members were assured that the recommendations outlined in the report would be monitored through the Audit, Risk and Assurance Committee tracker and through PQSOC. A report highlighting progress against recommendations would come back to the Committee at the October 2022 meeting, with verbal updates at the next Committee meeting in August 2022.

The Committee was assured that learning from the review and findings would be shared with all Divisions encouraging organisational learning and promoting best practice.

The Committee received the report for assurance and noted the findings.

Theatres Safety Programme Update

The Committee received the presentation and update on the Theatres safety Programme, relating to concerns raised regarding an increase in 'never events' in surgical and theatres directorates.

The Health Boards plans on work being undertaken in theatres and scheduled care, relating to theatre safety, were discussed. Several initiatives had been implemented, including a Theatre Safety Group, and a Theatre Safety & Compliance programme, containing 23 workstreams, overseen by programme leads. The workstreams provided assurance through the Health Board by identifying areas of elevated risk and areas that needed enhanced or ongoing support.

The Committee noted that the Health Board was an outlier in terms of 'Never Events' in the surgical and theatre directorates in 2018/2019, which triggered the workstreams being undertaken. Aside from the recent spike, it was discussed that there was no data to show that the Health Board was an outlier at present.

For each 'never event' there were robust processes in place, with open and transparent communication between staff and patients; although it was discussed that further work was underway to improve communication across the Health Board.

Committee members discussed support for patients and staff relating to 'Never Events'. Members were informed that each individual case was assessed and if further psychological support was considered appropriate, a referral would be made for the patient concerned. A formal review process for staff was in place and signposting to well-being services formed an aspect of the template. Patients and families are assigned a key link contact for support and 'lay' summaries and glossaries are produced alongside reports to encourage transparency and enhance understanding.

Covid-19 Concerns and Claims: The National Framework & Investigative Process
The Committee received the presentation of the Health Boards expectations around the National Covid-19 investigative framework.

Members were informed that there was a Welsh Government requirement for all incidents of nosocomial (hospital acquired infections) Covid-19 to be investigated. Funding had been received across Health Boards in Wales to support a Covid-19 investigation team, with a two-year timeframe. Current investigations would include patients only, with separate investigations to take place for staff members who had acquired nosocomial Covid-19.

The Committee was informed that that recruitment was commencing for the multidisciplinary team required to support robust investigations within the two-year required timeframe. The relevant number of clinical investigators had been recruited and there was a requirement for investigations to commence prior to all recruitment posts being filled, due to time restraints.

The Committee requested regular updates on the investigation process and that progress be monitored through the Committee. Members were informed that a report would be presented in January 2023, with regular updates to the Committee to be included as part of the standing item, Patient Quality, Safety and Outcomes Report.

The Committee received the presentation, noting the requirements and timeframes.

Learning from Death Report
The Committee noted the report and discussed the learning and improvements being implemented in the Health Board.

The Committee was informed that the Health Board's multidisciplinary Mortality Screening Panels meet to assess all referrals from the Medical Examiner (ME). Medical Directors from across Wales had also met to discuss the ME service. Great value can be taken from identifying themes/clusters.

Members discussed the theme relating to patients with Learning Disabilities cared for in acute hospital settings. The Committee was assured that recognised themes were being investigated and noted that work was underway to improve patient experience and care with all patients, particularly patients with Learning Disabilities (LD). A future update on the review of patient care for individuals with a Learning Disability would come back to the Committee for further discussion.

HIW Unannounced Visit to the Grange University Hospital (November 2021)
The Committee received the update report for assurance alongside an overview of the Health Inspectorate Wales (HIW) unannounced visit findings.

Members were informed that HIW had also identified 71 recommendations, of which there were 112 actions. At the time of the meeting there were 15 actions outstanding, all of which

would be completed by October 2022. A further update on progress and compliance against actions would come back to the October Committee meeting.

Members discussed the additional waiting space for the emergency Department at GUH, as outlined in the report, and noted the ongoing concerns from clinical teams around the use of the space given current staff deficits. This would be discussed further at a Board development session.

Members were informed that system pressures and recruitment issues continued to influence staff morale; however, progress had been made around nursing recruitment. In addition to this, a recent staff survey had been completed, the results of which would be shared with the People and Culture Committee.

Members welcomed an update on the final response to HIW at the next Committee meeting.

The Independent Review of Maternity Services at SATH (The Ockenden Review)
The Committee received an overview of the *Independent Review of Maternity Services at SATH* (The Ockenden Review) and the Health Boards planned response.

Members noted the All-Wales WG requirement for the health Board to undertake a self-assessment of maternity services, to include relevant elements from the Ockenden Report, the earlier review of maternity services conducted by HIW, and in addition, compliance with recommendations and actions from the Cwm Taf Morgannwg maternity review. The Health Board's self-assessment and WG response would come back to the Committee.

Patient Quality and Safety Outcomes Report
The Committee received an overview of the report, noting that reporting continues to adopt a proportionate approach due to Health Board challenges, focusing on high-risk matters. The update focused on three of the four risk areas with a red rag rating; Urgent Care, Stroke Services and Cancer Performance. The fourth area of concern was Never Events, which had been discussed earlier on the agenda.

Members were informed of an addition to the risk list of 'inter-site hospital transfers', falling under the 'safe care' category and currently rated as amber.

Members were informed that cancer performance had continued to decline, with challenges to manage backlog compounded by increasing referrals. Cancer harm reviews have commenced to consider the impact of breaches in patients' care.

Members were informed that relating to Infection Prevention and Control (IPAC) there had been a reduction in the number of patients diagnosed with Covid. There had been an improvement in the rate of CDif, noting the occurrence remained above target, mirrored across Wales. Infection control teams were undertaking reviews to further understand this position.

Members noted that the report included options to implement a Child and Adolescent Mental health crisis Hub. A full report of this will come to the Committee.

Members were informed that a draft report had been received via Welsh Risk Pool, following their review of the Venous Thromboembolism. The Health Board was undertaking a review of the current position and an action plan and an update would be submitted to Welsh Risk Pool by July 2022. Further update would come back to Committee.

Members were informed that the Urgent and Emergency Care system remained under sustained pressure. Urgent Care performance has been flagged as a national issue. WG had published the requirements for '6 Goals for Urgent and Emergency Care' and an extraordinary meeting of Board members and Executives had been scheduled to discuss this and the Health Board response in June 2022.

Members were informed that the Stroke pathway required further strengthening and focus. The Stroke Directorate had invited the 'Getting It Right First Time' external review team in to complete an analysis of the situation. The Health Board was awaiting a formal report containing recommendations and the full report and management response would come back to the Partnerships, Population Health, and Planning Committee for discussion.

Members were assured that, progress had been made on protecting the Hyper Acute Stroke Unit (HASU) for stroke patients.

Members were informed that the Health Board was working towards improving the '62 days from referral to treatment' cancer pathway target. Some of the influencing factors were discussed, including staffing issues and a significant increase in referrals. A future update on current risk relating to Cancer Services to come back to the Committee.

The Committee received the report and noted the risks and actions being taken to mitigate the position.

Operation Jasmine and the Coroner's Inquests - further reflection and learning
The Committee received an overview of the Health Board's approach to continued organisational learning in respect of Operation Jasmine.

Members were informed the Health Board had produced an improvement plan, beginning work on the nine recommended actions for improvement, previously approved by the Board in April 2022. A further update on the progress of the improvement plan to be presented to the Committee in February 2022.

Patient Safety, Quality and Outcomes Committee Risk Report
The Committee was advised that the report included risks that had recently been reported to the Board as part of the Corporate Risk Register.

Members were assured that the risk report and corporate risk register would continue to inform the Committee workplan and priorities going forward.

Committee Priorities 2022/23

Members received the presentation outlining the Committee priorities for the next year. Members were content that the item would be rescheduled for the next Committee meeting.

Highlight Assurance Reports:

a. **Maternity & Neonatal Services Assurance Group**
   Report received for information.
b. **Welsh Helath Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chair's Report**
   Report received for information.

An overview of 'Enhanced Care': linking provision, cost, and outcome
The report was received by the Committee.

Internal Audit Report: Facilities (Care After Death) Report- Reasonable Assurance
The report was received by the Committee.

Matters Requiring Board Level Consideration or Approval:

An oversight of wider maternity services, to include the future of Midwife led Units, to be discussed at Board level.

Key Risks and Issues/Matters of Concern:

None highlighted.

Planned Committee business for the Next Reporting Period:

- Committee Priorities 2022/23
- Detailed report on risk relating to Cancer Services
- Audit Wales Review of ABUHB's Quality Governance Arrangements and Management Response-verbal update on progress against each recommendation
- Health & Safety Annual Report
- Assurance Report: Health and Care standard 2.1, Managing Risk and Promoting Health and Safety
- National review of Venous Thromboembolisms (VTE) Draft Report

Date of Next Meeting: Tuesday 16th August 2022

Name of Committee:	**Mental Health Act Monitoring Committee**
Chair of Committee:	**Pippa Britton**
Reporting Period:	**13th June 2022**

Key Decisions and Matters Considered by the Committee:

Mental Health Act Update- The Committee received a report on the use of the Mental Health Act for Quarter 4 2021/22. The Committee was advised that comparative data from pre-COVID and during COVID indicated a 4% rise in the use of the Mental Health Act. No data trends had been established at present and this would continue to be monitored. It was reported that the introduction of the Psychological Wellbeing Practitioner role in Primary Care has significant decreased pressure of other primary care and mental health services. Committee members expressed concern over the potential long-term funding for the Psychological Wellbeing Practitioner role. Support from the Board around securing funding and prioritising the initiative was welcomed. The Committee requested an update on the

Psychological Wellbeing Practitioner role on the use of the Mental Health Act at the next meeting. It was reported that there had been a 26% increase in front door presentations from children and young people in mental health services. Committee members supported the approach of early intervention to support children and their families.

Power of Discharge Committee- The Committee received the update. Committee members supported the additional recruitment and training of 10 Hospital Managers (volunteers), noting the work undertaken by the Health Board towards completing the backlog of managers hearings.

Update on Pilot Projects with Potential Impact on the MHA- The Committee received the update. The Committee was assured that all pilots would be evaluated through the Health Board's IMTP, with regular updates to the Committee through the MHA Compliance Report.

The Committee was informed of a national 'Single Point of Contact' for mental health services and the Health Board's plans to have a Gwent Single Point of Contact, accessible through the 111 service. Committee members requested further discussion at a Board development session in respect of the evaluation of the 111 service and how the new Gwent Single Point of Contact service would fit in, with a focus on effective communication to members of the public. In addition, Committee members requested further information on the directory that the 111 operators would be accessing to provide information on mental health services for the population.

Section 117- Update and progress on the Monmouthshire County Council Pilot- The Committee received an update on the initial plans for the Monmouthshire County Council Pilot. Due to the ongoing impact of the pandemic and the non-recurring funding, the Committee supported the decision to end the Monmouthshire County Council Pilot action. The Committee requested that future updates on Section 117 and its connections to the MHA be brought to future meetings.

Matters Requiring Board Level Consideration or Approval:

The Chair and Committee members requested further discussion at a Board development session evaluating the 111 service and how the new Gwent Single Point of Contact service would fit in, with a focus on communication to members of the public.

Key Risks and Issues/Matters of Concern:

There were no issues or matters of concern.

Planned Committee Business for the Next Reporting Period:

- Mental Health Act Update.
- Power of Discharge Sub-Committee Update.

Date of Next Meeting: Tuesday 6th September 2022 at 10:00am via Microsoft Teams

Name of Committee:	**Audit Committee**
Chair of Committee:	**Shelley Bosson**
Reporting Period:	**13 June 2022**
Key Decisions and Matters Considered by the Committee:	

Counter Fraud Functional Standard Return Declaration 2021/2022
The Committee received the Counter Fraud Functional Standard Return Declaration 2021/2022 and noted that all requirements had received a green rating.

In response to members comments regarding whether more investment in resources would result in a higher return on fraud recovery and additional opportunities to be more proactive in prevention and deterrent work for the Health Board, the Interim Director of Finance agreed to compare the current Counter Fraud resource with those of other Health Boards. In addition, a briefing on benefits realisation would be presented at a future meeting.

Internal Audit Reviews from the 2021/22 Internal Audit Plan
The Committee accepted the reasonable assurance rating for the six (6) audits listed below and took note of the recommendations and corresponding action plans:

a) Flow Centre
b) Corporate Governance
c) Operational Plan for Resumption of Services
d) Financial Sustainability
e) Medicines Management (Including Controlled Drugs)
f) NIS Directive

The Medical Equipment and Devices Review had been reported to the Committee as 'Not Rated'; however, the Committee and the Lead Executive agreed this review remained at 'Limited' assurance until a full audit could be completed. The Committee agreed to maintain an oversight of progress in this area via delivery of actions within the audit recommendations tracker. Internal Audit also confirmed that a full audit would be scheduled at a point in the near future.

The Committee noted that the Waste Management Review had not been finalised ready for reporting to the Committee; this would be available at the next meeting.
The Audit Reviews presented from the 2021/22 Internal Audit Plan were RECIEIVED by the Committee.

Final Head of Internal Audit Opinion 2021/22
The Committee was pleased to note that for 2021/22, the Board could take reasonable assurance that arrangements to secure governance, risk management, and internal control within the areas under review were appropriately designed and effectively implemented.

The Committee noted that the final iteration had one (1) substantive change, which was a change in assurance rating for the NIS Directive Review (which was finalised with a reasonable assurance rating).

Final Audit of Accounts 2021/22 (ISA260)
The Committee was pleased to note from the report of Audit Wales that the Auditor General for Wales intended to issue an unqualified audit opinion on the Health Board's annual accounts 2021/22, except for the regularity opinion which the Auditor General intended to qualify. The latter, because the financial statements included a provision (and corresponding expenditure) of £756,155, relating to the Health Board's estimated liability arising from a Ministerial Direction in 2019. The Direction instructed payments to be made to clinical staff, if claimed, to restore the value of their pension benefits packages. The Committee recognised this issue is relevant to all Health Bodies in Wales and not just Aneurin Bevan University Health Board.

The report also confirmed that there was one misstatement identified in the financial statements which remained uncorrected, relating to full revaluation of NHS land and buildings. Audit Wales advised the Committee that this had been discussed with management, but in line with Welsh Government guidance it would remain uncorrected. The Committee was satisfied with management's response on this matter. Other issues reported by Audit Wales from the audit of the annual accounts 2021/22 were noted by the Committee.

It was noted, Audit Wales and management had agreed to schedule a de-brief following the closure of the annual accounts to inform learning and improvement for future years. The Committee welcomed the opportunity for reflection and continuous improvement.

Final Draft Annual Report 2021/22 (Part 1 & 2)
The Committee APPROVED the Performance and Accountability Report.

Review of the Draft Financial Statements 2021/22 (Part 3)
The Committee APPROVED the Final Financial Statements 2021/22.

Final Letter of Representation for 2021/22
The Committee NOTED the final letter of Representation for 2021/22.

Recommendation to the Board in respect of the Annual Report and Accounts 2021/22
The Committee agreed the following recommendations to the Board:

- To RECEIVE the Audit of Accounts Report (2021/22) of External Audit (Audit Wales)
- To APPROVE the Annual Report and Accounts 2021/22, which includes:
  1. The Performance Report; -
  2. The Annual Accountability Report; and
  3. The Financial Statements
- To APPROVE the Letter of Representation; and
- To AUTHORISE the Chair, Chief Executive Officer and Director of Finance, Procurement and VBH, to sign these documents where required.

Matters Requiring Board Level Consideration or Approval:
• There were no matters requiring consideration or approval.
Key Risks and Issues/Matters of Concern:
• There were no issues or matters of concern.
Planned Committee Business for the Next Reporting Period:
Date of Next Meeting: Tuesday 2nd August at 09:30am via Microsoft Teams

Name of Committee:	**Finance & Performance Committee**
Chair of Committee:	**Richard Clark**
Reporting Period:	**7th July 2022**
Key Decisions and Matters Considered by the Committee:	

Finance & Performance Committee's Terms of Reference (ToR) and Operating Arrangements, as approved by Board
The Committee received its ToR and operating arrangements for 2022/23, following Board Approval in March 2022. Members requested that future ToRs include a reference to the Committee's role in monitoring outcomes linked to risk.

Committee's Priorities for 2022/23
The Committee received a high-level overview of the Committee priorities for 2022/23. The outlined priorities would inform the Committee workplan, as presented to the Board in May 2022. In addition to the presentation, members would receive a more detailed forward workplan, following Board approval in July 2022.

Members requested assurance about how Commissioned Services would be monitored through the Committee. Members were informed that a report on Commissioned Services, through a *Long-Term Agreement* lens, would be presented at the next meeting. Members were assured that a review of how the Health Board oversees Commissioned Services would be undertaken by the Executive Team, and would be fed back to the appropriate Committee.

Committee Strategic Risk Report
The Committee received and noted the report for assurance and compliance. The report provided assurance that the Committee's forward work plan was determined by the organisation's financial risk.

Members were informed that divisions had received targeted support and intervention to review current risks and to encourage tailored business meetings around emerging risk themes.

Members were informed that an review of risks aligned with the Committee's focus would take place, including broader performance risks related to Capital, Digital and overall performance.

Financial Performance Report at Month 2, 2022/23, including detailed savings analysis
The Committee received the report outlining the Health Board's financial performance, for the month of May 2022 (month 2) and the year-to-date performance position for 2022/23. The report summarised the Health Boards performance against financial targets and statutory financial duties and forecast position.

Members noted the significant level of risk in the financial position and forecast.

Members were informed that operating costs were in excess of planned costs. Members were assured that the Health Board had established an internal financial management approach for delivering the Integrated Medium-Term Plan (IMTP) with potential cost reductions, and teams were in the early stages of developing proposals. Any identified savings would be reported to WG at the end of Quarter 1.

Members were informed that a report would be presented to the Board in July 2022, with recommendations based upon anticipated COVID funding, allowing delegation to budget holders.

ABUHB's Sustainability Approach for 2022/23
The Committee received the report, which detailed the Health Boards proposed approach to achieving financial balance as part of the IMTP.

Members were informed that the 2022/23 IMTP identified a £26m requirement for savings and a £19m cost would require mitigation and management.

Members noted the Health Boards approach to improving service, workforce and financial sustainability by focusing on 4 key elements, workforce re-engagement, transformation, improved efficiency and cost reduction.

Members discussed the Prioritisation Framework, as outlined in the report. Members were informed that a draft framework would be presented to Board when finalised.

Members were informed that an internal financial recovery 'turnaround' status had been agreed by the Executive team to improve short term delivery and acceleration of savings. Proposals would be shared with the Board for consideration.

Members discussed possible long-term savings in Health Board maintained buildings. Members were assured that the Estates Efficiencies Framework and Agile Working Policy would highlight any potential savings.

ABUHB's efficiency Review and 'compendium' Presentation

The Committee received the report providing an 'Efficiency review' which used benchmarking data and other sources of information to provide an assessment of efficiencies and opportunities for improvement, measured against peer groups. The analysis had also been aligned with the key Planning Priorities as outlined in the 2022/2023 IMTP.

Members were informed of the Health Boards potential for efficiency. Coupled with a demonstration of the Health Boards 'Compendium', which highlighted the level of support and resources for divisions, finance teams would provide support and guidance to divisional teams, noting the requirement for divisional leads to utilise the 'Compendium' metrics to improve services.

Members were informed of plans for the Health Boards Corporate Risk teams to collaborate with the Finance teams to link the 'Compendium' with risks, as outlined on the Corporate Risk Register.

2021/22 Recovery Funding Utilisation Report

The Committee received the report which provided an overview of the utilisation of Covid Recovery funding received in financial year 2021-22.

Members were informed that the Welsh Government had awarded the Health Board a total of £26.9 million in non-recurrent recovery funding. The Committee noted the positive impact of COVID-19 funding on patient care in 2021/22.

Value based healthcare Achievement Annual Report 21/22 & Efficiency Opportunities 22/23

The Committee received the summary of the annual report, which demonstrated the collaborative work between the Value-Based healthcare teams (VBHT) and operational teams to deliver Value-Based healthcare across a range of priority programmes. Following the meeting, the full annual report would be posted on the Health Board website.

Members discussed opportunities for releasing greater efficiencies during 2022-23.

Variable Pay savings Plan (Agency Reduction)
The Committee received the report, noting the actions and next steps towards achieving the agency reduction action plan and progress to date.

Members were assured that progress against the 'variable pay reduction plan' would be monitored and reported to the Health Boards Strategic Nursing Workforce Group. In addition, a working group, with representatives from Finance, Divisions, Workforce & OD and nursing leadership would also be established to monitor and track progress against the plan.

Performance Management Dashboard
The Committee received a summary of the Health Boards Sitrep and Performance reporting for each level and frequency, alongside the timetable of performance reporting.

A Performance Report would be presented to the Committee each Quarter.

Members received a live demonstration of the Health Boards new automated version of the Performance Management Dashboard. A link to the dashboard and an offer of further tuition would be provided to members outside of the meeting.

Members requested that future updates include a summary report linked to the Health Boards performance against the IMTP aims and objectives. Members were informed that the committee forward workplan, which was linked to risk management principles, would allow for more focused and relevant discussions on key areas of focus for the Health Board. Members were assured that relevant headline summary reports would be presented at future committee meetings, with the Performance Dashboard serving as a tool for drilling down and focusing on pertinent issues.

Members were informed that the Outcomes Report and the Performance Dashboard would be presented to the Board in July 2022.

Matters Requiring Board Level Consideration or Approval:

No matters required additional Board level consideration.

Key Risks and Issues/Matters of Concern:

None noted.

Planned Committee business for the Next Reporting Period:
To be confirmed, pending Committee forward workplan approval at July Board.

Date of Next Meeting: Wednesday 5th October 2022

Name of Committee:	**Partnerships, Population Health, and Planning Committee**
Chair of Committee:	**Ann Lloyd**
Reporting Period:	**7th July 2022**

Key Decisions and Matters Considered by the Committee:

Committee Strategic Risk Report
The Committee received and noted the report for assurance and compliance.

Members were informed that divisions had received targeted support and intervention to review current risks and encourage tailored business meetings around emerging risk themes.

Members requested risk to be considered around the strategy for delivery of care, resources including finance and workforce for sustainability and interdependencies with partners. Members were informed that an overview of risks aligned with the Committee's focus would

take place, alongside discussion by the Executive Team. An update on points raised would be shared with members.

The Committee adopted the Strategic Risk Report, with the caveat that risk may increase.

To Receive an Update in respect of Creating a Marmot Region via the Public Services Board

The Committee received the report, noting the contents. The report provided an update on the Health Boards progress with the Gwent Marmot Region programme and a response to follow up actions recorded at the previous meeting of the Committee.

Members discussed the report that was presented to the PSB in June 2022. Members were informed that all recommendations outlined in the report had been agreed by the PSB during the meeting.

Members discussed the follow up action of the alignment of the Marmot Programme with the Gwent Well-being Plan 2023-27 and noted further discussions would take place with members of the PSB in the following weeks.

Members were informed of the establishment of the Gwent Marmot Region Leadership Programme Group, a subgroup of the PSB.

To Receive an Update on the Development and Delivery of a Strategy for Mental Health Services in Gwent

Members were presented with the update of the Health Boards progress and future for the Mental Health Strategy within Gwent.

Members noted that the implantation of the Mental Health Transformation Programme was one of the key priorities for the IMPT for 2022/23.

Members were informed that a Mental Health Transformation Board was in place to oversee delivery of the strategy for Mental Health, chaired by the Interim Executive Director of Primary Care and Mental Health.

Members were informed that the Health Board's Mental Health and Disability Division plan to implement change through a 'whole pathway approach'. Members were informed of the focus to support the population by supporting good mental wellbeing, encompassing partnership working alongside statutory agencies and third sector partners.

Members were presented with early data from the third 'All Wales' Wellbeing survey. Members to receive the report on the findings of the survey, due to be published early July 2022.

Members discussed the achievements and the vision for the provision of care, noting the constraints across Wales due to insufficient capital. It was noted that the CEO's across Wales were in the process of looking at the alternative provision of capital.

Members were informed of current issues with Health Board estates, particularly in Mental Health divisions. A re-focus of the Estate's Strategy and a formal strategy for MHLD estates, including a timeline of action to come back to the Committee.

It was agreed that the Chair and the Interim Executive Director of Primary Care and Mental Health would discuss Prison Mental Health Services outside of the meeting.

To Receive an Update on the Key Clinical Futures Models of Care
The Committee received an overview of the Health Board's priority Clinical Futures service models and links to the revised Clinical Futures Programme Priorities and noted the contents of the report.

Members received an update on areas of remaining concern that are forming a core part of the Clinical Futures Programme in 2022/23.

Members noted that a full service-readiness assessments had taken place in March 2020 on 23 service areas, in line with the planned changes to hospital structures due to the opening of GUH. The report proposed that a review of the Clinical Futures models be undertaken. It was estimated that this would take place in Quarter 3 of 2022.

Members were informed that demand capacity and workforce continued to be a challenge across the eLGH and GUH sites. Further work was required around the utilisation of workforce and improvement of pathways.

Members requested regular updates to the Committee.

To Receive an Update on the Development and Delivery of a Strategy for Agile Working in ABUHB
The Committee received and noted the update in relation to the Agile Working Strategy across the Health Board. The report outlined progress against key objectives, next steps and identified risks associated with the delivery of the strategic programme.

Members were informed that performance against Agile Working and associated risks are reported to the Health Bords Agile delivery Group.

Members were informed of plans for the Health Board to re-establish the Accommodation Group, linking the Agile Working agenda with best practice and changes in the Health Board footprint.

Matters Requiring Board Level Consideration or Approval:

The Chair requested that the following be reported;

- ***To Receive an Update on the Key Clinical Futures Models of Care***- The action in relation to the virtual review of the Clinical Futures models, estimated to take place in Quarter 3 of 2022.
- ***To Receive an Update on the Development and Delivery of a Strategy for Mental Health Services in Gwent-*** A brief overview of the Mental Health Strategy and its progress.

Key Risks and Issues/Matters of Concern:

None

Planned Committee business for the Next Reporting Period:
To be confirmed.

Date of Next Meeting: Tuesday 8th November 2022

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	19 May 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Recruitment Update

Gareth Hardacre, Director of People & OD gave an update on the progress being made on the Recruitment Modernisation Action Plan following the deep dive on this topic in the March Committee.

All organisations are now live on the latest version (3) of NHS Jobs. Progress has been made in letting the IT contract for the Pre-Employment Checks, but this has been slightly delayed as clarification is needed by the Home Office surrounding the cyber security requirements in the product specification. However, the deadline of September 2022, where either face-to-face checks are re-introduced or the IT solution is in place, should still be met.

The Action Plan for revising specific recruitment processes is due to go to Workforce Directors on May 20th and includes the proposal to establish a senior Programme Board to oversee delivery of the Plan. Performance against Recruitment Key Performance Indicators is improving, despite there being no drop in the level of activity across NHS Wales.

It has been agreed that a deep dive on Recruitment will be undertaken with the BCUHB Executive Board and the offer was made to do something similar with other NHS Wales organisations.

The Committee **NOTED** the update.

Medical Examiner Service

Andrew Evans, Director of Primary Care Services and Ruth Alcolado, Medical Director jointly presented to the Committee on progress with the development of the Medical Examiner Service. The service is currently examining around 1000 deaths a month, with a target of 2500 by the time the service is launched on a statutory footing, which is now likely to be April 2023 at the earliest. To date, the

service has been able to identify potential learning for Health Boards and Trusts in approximately 25% of cases reviewed, and it is considered that 10% of cases would benefit from a Stage 2 Mortality Review – these figures are consistent with what is being reported in England. There are however differences in the way that the service is operated in the two countries, and the nature of the set-up in Wales allows greater identification of local, regional, and national issues.

One of the key benefits of the service thus far is to give each family the opportunity to speak with a Medical Examiner Officer. This has been very well received and in many cases the families have expressed their gratitude for the care received by their family member from Health Boards and Trusts at the end of their life.

To further successfully develop the service Health Boards and Trusts need to ensure timely notification of death, availability of clinical notes, and access to the relevant doctor to discuss the cause of death. The commitment from the service to Health Boards includes that all deaths will be scrutinised by the autumn of this year; that there is effective communication on themes and trends; and that there should be effective monitoring of performance.

In summary it was noted that the service is already making a positive contribution to patient safety, and that consultation is underway and/or planned with clinical colleagues to address any issues and to maximise the benefits.

The Committee **NOTED** the presentation.

Chair's Report

The Chair updated the Committee on the activities that she had been involved with since the March meeting. These have included:

- Meeting with the Minister as part of the all-Wales Chairs' Group. It was helpful that the Minister had recently visited IP5 and consequently gained a good understanding of what NWSSP does and had been left with a positive impression of the organisation;
- Attending her first NWSSP Audit Committee which again had been very positive;
- Continuing to meet with senior NWSSP management, and in particular recently from Specialist Estates and the Temporary Medicines Unit, to gain a better understanding of what they do;
- Attending the DHCW Board Development session in April where NWSSP received positive feedback;
- Chairing the Welsh Risk Pool Committee; and
- Arranging to attend the Velindre Trust Board at the end of June as part of their Board Development session.

Looking further forward the Chair is keen to hold a development session with the Committee, ideally in person for a half-day in the autumn and including other members of the NWSSP Senior Leadership Group. This could include a stock-take

session on what works well and what doesn't work so well for the Committee; allow the Committee to better understand what NWSSP does, ensuring that it is aligned to NHS Wales's organisation priorities and also those of the Welsh Government; looking to the future in terms of which services it should provide; and assessing the current structure of the Committee and whether it needs wider (e.g. clinical) representation. A plan for how the session might work will be brought back to the July Committee.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Senior NWSSP management participated in the meeting with Welsh Government in early May to review the IMTP. The meeting was very positive, and the IMTP has been well-received with the Outcome Letter expected in June;
- Work has been undertaken with colleagues from Welsh Government and Public Health Wales regarding the future plans for the recently vacated Lighthouse Laboratory at the IP5 facility. Within IP5, the Surgical Materials Testing Laboratory have had a new laboratory completed which will enable them to perform additional tests and to develop new testing regimes for medical devices, which they were unable to do at the existing Bridgend site;
- Progress continues to be made in terms of the overarching Transforming Access to Medicine Outline Business Case, with a number of workshops held to consider site selection. There is on-going discussion with workforce colleagues and Chief Pharmacists regarding the Organisational Change Programme; and
- The recent cyber security assessment, conducted as part of the NHS Wales Cyber Resilience Unit's work to implement the Network Information Security (NIS) Regulation in all health organisations in Wales, demonstrated that generally NWSSP is well protected from cyber-attacks. A formal project has been launched to address the key areas for improvement identified in the report's recommendations. One of the key tasks in the initial phase, a desktop exercise based around a cyber incident, was carried out at the May Informal Senior Leadership Group.

Items Requiring SSPC Approval/Endorsement

Decarbonisation Action Plan

Chris Lewis, Environmental Management Advisor presented the Plan which had been formally submitted to Welsh Government on 31st March. The Committee had previously had the opportunity to review the plan in detail at its November 2021 meeting. Clarity was provided in terms of explaining that this was the inward-facing NWSSP plan and that NWSSP were substantially involved in the production of the national plan which embraces the role that NWSSP plays in supporting NHS Wales organisations to achieve their own decarbonisation targets. Key actions in the internal facing plan include reducing the impact of our buildings, fleet, and

new laundry service, as well as working with staff to help raise the profile of decarbonisation across the organisation.

The Committee **ENDORSED** the Action Plan.

Laundry Detergent Contract

Anthony Hayward, Assistant Director of Laundry Services, attended the Committee to present a paper for endorsement and approval by the Committee. Following the transfer of laundry services to NWSSP from April 2021, there is now the opportunity to tender for laundry detergent on an all-Wales basis. This should provide opportunities for economies of scale compared to the current fragmented arrangements. However, the Laundry Service are also keen to include the provision of dosing pumps and a management information system into the contract which is anticipated to total £2m over a five-year period.

The Committee **ENDORSED** the paper.

Draft Annual Governance Statement 2021/22

The Committee reviewed the draft Annual Governance Statement which will be taken to the NWSSP Audit Committee in July for formal approval. The statement is substantially complete, but the formal Head of Internal Audit Opinion is still to be received and the final energy consumption figures for the year are still being calculated. The Statement is a positive reflection on the past year and there are no significant matters of control weaknesses that need to be included. The final version of the Statement will be brought back to the July Partnership Committee for information.

The Committee **ENDORSED** the Statement **IN PRINCIPLE** recognising that it was still draft, and that formal approval would be sought at the Audit Committee.

Service Level Agreements 2022/23

The Committee received the Service Level Agreements for the core service provided by NWSSP to NHS Wales for formal annual approval. The papers included the overarching Service Level Agreement and a cover paper detailing any amendments to the supporting schedules, none of which were significant. (The schedules were provided separately to Committee members for information). It was however noted that the Procurement SLA element would need to be brought back to the July Committee as it is to be further amended to reflect changes resulting from the implementation of the new Operating Model.

The Committee **APPROVED** the SLAs for 2022/23 noting that the Procurement SLA is due to be further amended and resubmitted for approval.

Salary Sacrifice – Staff Benefits

The Committee was presented with a paper setting out the arrangements for the Home Electronics and Cycle to Work Staff Benefit Schemes. There are currently different arrangements in place across NHS Wales, with some schemes being operated by NWSSP on behalf of NHS Wales organisations and other schemes

being operated and managed within health organisations. As well as potentially not providing optimal value-for-money, there is a risk that staff could fall below minimum wage rates due to being members of schemes administered by different organisations. The paper asked the Committee to approve a tender for a scheme to be administered by NWSSP that would cover home electronics and cycle to work schemes.

The Committee **ENDORSED** the approach being taken by NWSSP in awarding a contract(s) for Home Electronics and Cycle to Work with an aim of having an All-Wales arrangement in place, centrally administered by NWSSP, which will be made available to all Health Board, Trusts and Special Health Authorities.

Finance, Performance, People, Programme and Governance Updates

Finance – The Director of Finance & Corporate Services reported the outturn position, which is currently subject to external audit, and highlighted that a small surplus of £11k had been generated against total income of £870m. The DEL expenditure for the Welsh Risk Pool was £129.615m and the risk share agreement was invoked at the IMTP value of £16.495m. Additional Welsh Government risk pool funding of £4.861m was agreed above the core allocation and risk share funding to account for the additional cases settled in 2021/22. £17.018m capital funding was received in 2021/22 and fully utilised. £12.348m was spent in March 2022, including the purchase of Matrix House which completed on 30th March. The Committee were complimentary of the new style finance report.

Performance – Most KPIs are on track except for those relating to Recruitment Services, where the situation is improving due to the implementation of the Modernisation Plan, which was covered earlier on the agenda, but where there is still further progress to be made.

Project Management Office Update – Of the 24 schemes being managed by the PMO, there is only one that is currently rated as red. This is the project for the replacement of the Student Awards System which is approaching end-of-life and with no option to extend the support contract arrangements beyond March 2023. The deadline to issue a tender for the procurement of a replacement system is 31st May, but currently there is no guarantee of funding for this from Welsh Government.

People & OD Update – Sickness absence rates remain at very low levels with an absence rate of 2.61% for March. Performance and Development Reviews and Statutory and Mandatory training results continue to improve although there is still room for further improvement. Part of the issue is in areas such as the Medical Examiner Service where staff may be on multiple contracts, but a solution is being sought for this. Headcount is increasing due mainly to the additional staff recruited as part of the Single Lead Employer Scheme.

Corporate Risk Register – there remain two red risks relating to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services, and the energy price increase. A new risk has been added relating to the Student Awards system, which was

highlighted earlier in the Project Management Office Progress Report.
Papers for Information
The following items were provided for information only: • Transforming Access to Medicine Progress Report • Information Governance Annual Report 2021/22 • Audit Committee Highlight Report • Quality and Safety Assurance Report • Complaints Annual Report 2021/22 • Finance Monitoring Returns (Months 12 and 1)
AOB
N/a
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.
Matters referred to other Committees
N/A

Date of next meeting	21 July 2022